STAR+PLUS Medicare-Medicaid Plan Provider Manual

superior healthplan™

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SuperiorHealthPlan.com

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Quick Reference Guide

Superior has staff to assist you with your day-to-day operations, questions and/or concerns. Every provider will have a designated Provider Account Manager that can coordinate an in-service/training for facility staff, provide face-to-face support in the facility and assist with answering questions about Superior's policies and procedures. You can also contact Superior's Provider Services department at 1-877-391-5921 for information or questions on benefits, claims, authorizations and billing inquiries, 8:00 a.m. to 5:00 p.m., Monday-Friday. During after hours, state-approved holidays and weekends the Provider Service line is answered by Superior's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services.

For help finding your assigned Account Manager's office contact information, go to https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html. Click on the state map of Texas where each county is linked to the office contact.

The following table includes several important telephone and fax numbers available to providers and their office staff.

HEALTH PLAN INFORMATION		
Website	www.SuperiorHealthPlan.com	
Address	5900 E. Ben White Blvd. Austin, Texas 78741	
Phone Numbers	**Phone**	**TTY/TDD**
Superior HealthPlan	1-877-391-5921	1-800-735-2989
Department	**Phone**	**Fax/E-mail**
Provider Services	1-877-391-5921	
Member Services	1-866-896-1844	
Medical Management Inpatient and Outpatient Prior Authorization	1-800-218-7508	
Behavioral Health Concurrent Review/Clinical Information	1-844-842-2537	1-866-900-6918
Concurrent Review/Clinical Information	1-800-218-7508	1-877-259-6960
Admission/Census Reports/Facesheets	1-800-218-7508	1-877-259-6960
Part C and D Appeals	1-877-398-9461	1-866-918-2266
Service Coordination	1-855-772-7075	1-866-895-7856
Behavioral Health Prior Authorization	1-844-744-5315	1-855-772-7079
24-Hour Nurse Advice Line	1-866-896-1844	
TurningPoint Healthcare Solutions	1-855-336-4391	
Evolent (high tech imaging and Interventional Pain Management)	1-800-642-7554	
Routine Vision Services	1-888-756-8768	
Medical Eye Care Services	1-877-391-5921	
American Specialty Health (acupuncture benefits)	1-800-678-9133	
Interpreter Services	1-866-896-1844	
To report suspected fraud, waste and abuse	1-866-685-8664	
EDI Claims Assistance		EDIBA@centene.com

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SECTION 1
INTRODUCTION

Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual-eligible Medicare beneficiaries.

Superior STAR+PLUS MMP is contracted with both Texas Health and Human Services (HHS) and the Centers of Medicare and Medicaid Services (CMS), to provide Medicare and Texas Medicaid benefits into one plan. In addition to the provider manual, Superior provides additional reference materials and policy updates on its website at www.SuperiorHealthPlan.com.

Superior Policies and Objectives

Superior conducts its business affairs in accordance with the standards and rules of ethical business conduct, and abides by all applicable federal and state laws. Changes to procedures and the most updated information will be posted on the Superior website. Superior's policies are designed to assist HHS and CMS in achieving the following four main objectives:

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

Superior has processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations. The services provided by providers in Superior's network are critical to meeting the objectives above. Our goal is to reinforce the relationship between our members and their Primary Care Provider (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care by utilizing contracted hospitals and specialists. The PCP is responsible for coordinating our members' health services, maintaining a complete medical record for each member under their care and ensuring continuity of care. The PCP advises the member about their health status and medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

Member Rights and Responsibilities

Member Rights

Providers must comply with the rights of members as set forth below.

1. Members have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that their medical records and discussions with their providers will be kept private and confidential.
2. Members have the right to a reasonable opportunity to choose a health-care plan and PCP. This is the doctor or health-care provider they will see most of the time and who will coordinate their care. Members have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change their health plan and their PCP.
    b. Choose any health plan they want that is available in their area and choose their PCP from that plan.
    c. Change their PCP.
    d. Change their health plan without penalty.
    e. Be told how to change their health plan or their PCP.
3. Members have the right to ask questions and get answers about anything they do not understand. That includes the right to:
    a. Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
    b. Be told why care or services were denied and not given.
4. Members have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with their provider in deciding what health care is best for them.
    b. Say yes or no to the care recommended by their provider.
5. Members have the right to use each available complaint and appeal process through the MCO and through Medicaid, and get a timely response to complaints, appeals and State Fair Hearings. That includes the right to:
    a. Make a complaint to their health plan or to the state Medicaid program about their health care, their provider or their health plan.
    b. Get a timely answer to their complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for a State Fair Hearing from the state Medicaid program and get information about how that process works.
6. Members have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care they need.
    b. Get medical care in a timely manner.

c. Be able to get in and out of a health-care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

d. Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, help someone with a disability or help them understand the information.

e. Be given information they can understand about their health plan rules, including the health-care services they can get and how to get them.

7. Members have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force them to do something they do not want to do or to punish them.
8. Members have the right to know that doctors, hospitals and others who care for them can advise them about their health status, medical care and treatment. Their health plan cannot prevent them from giving members this information, even if the care or treatment is not a covered service.
9. Members have the right to know that they are not responsible for paying for covered services. Doctors, hospitals and others cannot require members to pay copayments or any other amounts for covered services.
10. Members have the right to make recommendations about Superior's Member Rights and Responsibilities Policies.

Member Responsibilities

1. Members must learn and understand each right they have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand their rights under the Medicaid program.
   b. Ask questions if they do not understand their rights.
   c. Learn what choices of health plans are available in their area.
2. Members must abide by the health plans and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow their health plan's rules and Medicaid rules.
   b. Choose their health plan and a PCP quickly.
   c. Make any changes in their health plan and PCP in the ways established by Medicaid and by the health plan.
   d. Keep their scheduled appointments.
   e. Cancel appointments in advance when they cannot keep them.
   f. Always contact their PCP first for their non-emergency medical needs.
   g. Be sure they have approval from their PCP before going to a specialist.
   h. Understand when they should and should not go to the emergency room.
3. Members must share information about their health with their PCP and learn about service and treatment options. That includes the responsibility to:
   a. Tell their PCP about their health.
   b. Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
   c. Help their providers get their medical records.

4. Members must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain their health. That includes the responsibility to:
    a. Work as a team with their provider in deciding what health care is best for them.
    b. Understand how the things they do can affect their health.
    c. Do the best they can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to their provider about all of their medications.
5. Members of Superior HealthPlan can ask for and get the following information each year:
    a. Information about Superior and our network providers – at a minimum primary care doctors, specialists and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of providers that are not accepting new patients and qualifications for each network provider such as:
        - Professional qualifications
        - Specialty
        - Medical school attended
        - Residency completion
        - Board certification status
        - Provider demographics
    b. Any limits on the member's freedom of choice among network providers.
    c. Member rights and responsibilities.
    d. Information on complaint, appeal and State Fair Hearing procedures.
    e. Information about Superior's Quality Improvement Program. To request a hard copy, call Member Services at 1-877-277-9772 or visit our website at www.SuperiorHealthPlan.com.
    f. Information about benefits available under the Medicaid program including the amount, duration and scope of benefits. This is designed to make sure members understand the benefits to which they are entitled.
    g. How members can get benefits, including authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
    h. How members get after hours and emergency coverage and/or limits to those kinds of benefits, including:
        - What makes up emergency medical conditions, emergency services and post-stabilization services.
        - The fact that members do not need prior authorization from their PCP for emergency care services.
        - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
        - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
        - A statement saying the member has the right to use any hospital or other settings for emergency care.
        - Post-stabilization rules.
    i. Policy on referrals for specialty care and for other benefits a member cannot get through their PCP.
    j. Superior's practice guidelines.

Additional Member Responsibilities While Using Superior's Medical Ride Program (NEMT Services):

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT Services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT Services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact SafeRide, the NEMT Service Provider, who helped you arrange your transportation as soon as possible.

STAR+PLUS MMP Program Objectives

Superior STAR+PLUS MMP provides coverage to eligible members under the Texas Dual Demonstration project. The Texas Dual Demonstration project, which became effective March 1, 2015, is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid. Services include all Medicare benefits, including parts A, B and D and Medicaid benefits, including wrap-around services and Long-Term Services and Support (LTSS).

Superior STAR+PLUS MMP is designed to achieve the following main objectives:

- Ensure the member’s Medicare and Medicaid services are provided.
- Utilize Care Management teams for targeted member outreach and care coordination.
- Improve quality and individual experience in accessing care by:
  - Improving the coordination of care.
  - Ensuring access to care in underserved areas.
  - Increasing primary care visits.
  - Reducing unnecessary Emergency Room visits.
  - Reducing the need for in-patient hospital care and institutional care.
- Promote independence in the community.
- Eliminate cost shifting between Medicare and Medicaid.
- Achieve cost savings for the State and Federal Government through improvement in care coordination.

All Superior programs, policies and procedures are designed with these objectives in mind. These objectives mirror and support the objective of the Centers for Medicare and Medicaid Services (CMS) and Texas state guidelines to provide covered health-care services to low-income, elderly and physically disabled members.

Contacting Superior

Provider Services

Superior has customer service staff to assist you telephonically with your day-to-day operations, questions and/or concerns. You can contact Superior's Provider Services department Monday through Friday, 8 a.m. to 5 p.m., (CST) toll-free for inquiries such as, but not limited to: member eligibility, covered services for each applicable STAR+PLUS MMP member, benefits, authorization requirements, how to access our Secure Provider Portal, and general program questions. After hours, state-approved holidays and weekends, the hotlines are answered by Superior's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services, and instructions on how to verify enrollment for a member with an urgent condition or an emergency medical condition. Superior's Provider Services department can be reached at 1-877-391-5921.

Account Management

Your office is assigned an Account Manager to help you with contracting questions and inquiries, as well as any training needs related to our programs. Additionally, personalized support is provided by field support staff.

To find your local Account Manager's contact information, call Provider Services or visit SuperiorHealthPlan.com/FindMyAM.

SECTION 2
PROVIDER ROLES, RESPONSIBILITIES AND REQUIREMENTS

The Role of a Primary Care Provider

The Primary Care Provider (PCP) is the cornerstone of Superior. The PCP serves as the "medical home" for the patient. The "medical home" concept should assist in establishing a member and provider relationship and, ultimately, better health outcomes. The PCP is responsible for the provision of all primary care services for Superior members. In addition, the PCP is responsible for referring and obtaining referral authorization for members needing specialty services to Superior network providers. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the member's medical condition, but no later than five Days. Visit www.SuperiorHealthPlan.com for a list of services and procedures requiring prior authorization.

The PCP is responsible for providing all primary care services for Superior members including but not limited to:

- Supervision, coordination and provision of care to each assigned member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiating a behavioral health referral.

Superior's Care Managers will partner with the PCP not only to ensure the member receives any necessary care, but also to assist the PCP in providing a "medical home" for the patient. All PCPs may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member's choice, Superior does not guarantee a PCP will receive a set number of patients. A PCP must contact their Account Manager if they choose to change their panel size or close their panel and only accept established patients. Panel changes may also be made through the Secure Provider Portal, Provider.SuperiorHealthPlan.com. If Superior determines that a PCP fails to maintain quality, accessible care, Superior reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Who Can Serve as a Primary Care Provider (PCP)

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

- Advanced Family Practice Nurse
- Family Practitioner
- General Practitioner
- Internal Medicine Practitioner
- OB/GYN
- Geriatrician
- Certified Nurse Midwife
- Pediatrician
- Physician Assistant
- Specialist (when appropriate, as described on page 7)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

A Specialist as a Primary Care Provider

Members with disabilities, special health-care needs and chronic or complex conditions have the right to designate a specialist as their PCP. A specialist may serve as a PCP only under certain circumstances, and with approval of Superior's Chief Medical Officer. To be eligible to serve as a PCP, the specialist must:

- Meet Superior's requirements for PCP participation, including credentialing.
- Contract with Superior as a PCP.

All requests for a specialist to serve as a PCP must be submitted to Superior on the Specialist as PCP Request Form located on Superior's website.

The request should contain the following information:

- Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
- A statement signed by the specialist that they are willing to accept responsibility for the coordination of all of the member's health-care needs.
- Signature of the member on the completed Specialist as PCP Request Form.

Superior will approve or deny the request for a specialist to serve as a PCP and provide notification of the decision to the member no later than 30 Days after receiving the request. The effective date of the designation of a specialist as a member's PCP may not be applied retroactively.

If the request is denied, Superior will provide a written notification to the member, which will include the reasons for the denial. The member may file an appeal as a result of the decision to deny the request for specialist as a PCP. See Section 10 for an explanation of the member appeal process.

Roles of Specialty Care Providers (Specialist)

The specialist partners with the PCP to deliver specialty care to members. A key component of the specialist's responsibility is to maintain ongoing communication with the member's PCP. Superior prefers that specialists are board-certified in their area of expertise, but it is not required.

Specialty care practitioners and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services.

Specialty Care Physicians

The specialty care physician or specialist agrees to partner with the member's PCP and Care Manager to deliver care. A key component of the specialist's responsibility is to maintain ongoing communication with the member's PCP. Most visits to specialists do not require a prior authorization. Most specialists will require a written referral from the member's PCP; however, the referral is not required for the claim to be reimbursed by Superior. Specialists can elect to limit their practice to established patients only upon request to their Account Manager.

Specialty care physicians include, but are not limited to:

- Cardiology
- Gynecology and Women's Services.
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics

- Podiatry
- Pulmonology
- Rheumatology
- Urology

Role of an OB/GYN

Superior allows female members to select an obstetrician/gynecologist (OB/GYN) without a referral from their PCP. An OB/GYN can provide a member:

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

Female members may:

- Go to any Superior contracted OB/GYN for all women's care services. Neither a referral nor prior authorization is required.
- Receive family planning services from an in or out-of-network provider without a referral or prior authorization.

As noted above, an OB/GYN may also serve as a PCP. Superior allows members to pick any OB/GYN, whether that doctor is in the same network as the member's PCP or not.

Role of a Pharmacy

Members have the right to obtain covered medications from any Superior network pharmacy. These pharmacies are indicated on Superior's website. Providers and members can also call Superior's Member Services department to locate a network pharmacy. Network pharmacies are required to perform prospective and retrospective drug utilization reviews, coordinate with the prescribing physician, ensure members receive all medications for which they are eligible, and ensure adherence to the appropriate formulary. The network pharmacy is responsible for coordination of benefits between Medicare Part D services or other insurance benefits.

A link to the formulary is available on our website in addition to the listing found at https://mmp.superiorhealthplan.com/prescription-drug-part-d/formulary.html. Additional pharmacy information is located on Superior's website at https://www.SuperiorHealthPlan.com/providers/resources/pharmacy.html.

Role of a Dental Provider

Dental plan members may choose their main dental homes. Dental plans will assign each member to a main dental home if they do not choose one in a timely manner. Whether chosen or assigned, each member who is six months or older must have a designated main dental home.

Role of a Main Dental Home

A main dental home serves as the member's main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that member to provide comprehensive, continually accessible, coordinated and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers (FQHC) and individuals who are general dentists and pediatric dentists can serve as main dental homes.

Helping Members Find Dental Care

The dental plan member ID card lists the name and phone number of a member's main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five Business Days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Enrollment Broker's toll free telephone number at 1-800-964-2777 (Medicaid members).

Role of Health Home

The role of the Health Home is to provide members, with multiple chronic physical and emotional conditions, with a team-based approach to care while covering a holistic array of services and supports extending beyond what can be provided by the member's PCP. Health Homes operate in conjunction with two other entities; a primary care practice and/or a specialty care practice. Health Homes are designed to provide easy access to care between providers while ensuring quality of care.

Health Homes provide for the following services:

1. Patient self-management education
2. Provider education
3. Patient-centered and family-centered care
4. Evidence-based models and minimum standards of care
5. Patient and family support (including authorized representatives)

Role of a Long-Term Services and Supports Provider

The Long-Term Services and Supports (LTSS) provider serves certain members participating in the STAR+PLUS MMP program. An LTSS provider assists a patient by providing a variety of non-medical services, such as adult day care, adult foster care, home delivered meals, personal attendant services, home modifications, respite services, etc. LTSS services require a prior authorization.

Long-Term Services and Supports Provider Responsibilities

LTSS providers deliver a continuum of care and assistance such as in home and community-based services for elderly people, providing assistance to individuals with disabilities to allow them to maintain their independence, persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals while providing the support required. LTSS providers have certain responsibilities for the STAR+PLUS MMP program and the members they serve. This includes, but is not limited to:

- Contacting Superior to verify member eligibility and/or authorizations for service.
- Providing continuity of care.
- Coordinating with Medicare and Medicaid.
- Notifying Superior of any change in member's physical condition or eligibility.

LTSS providers are required to provide covered health services to members within the scope of their Superior agreement and specialty license. Superior offers LTSS providers access to necessary supports and resources, access to emergency services for their safety and protection and a means to communicate grievances.

Superior must require that LTSS providers submit periodic cost reports and supplemental reports to HHS in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS provider fails to comply with these requirements, HHS will notify Superior to hold payments to the LTSS provider until HHS instructs Superior to release the payments. HHS will forward notices directly to LTSS providers about such costs reports and information that is required to be submitted. LTSS services must be previously authorized and all requests should be faxed to the STAR+PLUS Service Coordination department at 1-866-895-7856.

STAR+PLUS MMP Attendant Care Rate Enhancement LTSS providers contracted with Superior may participate in the STAR+PLUS MMP Attendant Care Enhanced Payment Program if they currently participate in the Attendant Compensation Rate Enhancement program with HHS*. The following LTSS services are eligible for enhanced payments:

- Personal Assistant Services (PAS) both waiver and non-waiver
- Day Activity and Health Services (DAHS) both waiver and non-waiver
- Assisted Living and Residential Care Services (ALRC)
- Habilitation (under CFC)

Enrollment in Superior's Rate Enhancement program must be done annually. Non-participating providers are not eligible to participate.

There are two distinct processes that encompass Superior's Rate Enhancement program for participating providers. These processes are Annual Enrollment and Rate Level Changes.

In the event LTSS providers require assistance in the delivery of service they may:

1. Contact Provider Services, available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, except for state-approved holidays.
2. Contact the 24-hour Nurse Advice Line at 1-866-896-1844, available 24 hours a day, seven days a week to obtain medical guidance and support from a nurse.

Annual Enrollment

Providers who wish to join, or continue to participate in Superior's Rate Enhancement program, must submit an affidavit annually attesting to their participation in the Rate Enhancement program for STAR+PLUS MMP and the pass-through of enhanced payments to their direct care staff. Each affidavit is effective for a specific calendar year. However, any affidavit received on or after September 1 will be processed for both the current and upcoming calendar year. The affidavit can be found on the Superior website at https://www.superiorhealthplan.com/providers/resources.html. Providers should not wait until HHS releases the new participation levels to submit the affidavit. Please note, the affidavit does not contain your rate information (see rate level changes). The affidavit must be completed and the HHS contract number must be provided along with your TIN, NPI/API. The HHS contract number is different from an HHS license number. The HHS contract number is used to verify the level assigned by HHS. If you no longer participate, or have never participated with HHS, you must indicate so on the affidavit.

*Note: Superior providers who have never contracted with HHS for Rate Enhancement can formally apply to participate in Superior's Rate Enhancement program. They will need to provide a formal attestation to their Account Manager. Participation is not guaranteed and is subject to approval.

Providers who contract with Superior during the plan year and wish to participate in rate enhancement, need to submit an affidavit that would be valid for the existing state fiscal year.

Rate Level Changes

Providers may communicate changes to their rate enhancement level at any time during the year. For providers that are assigned a new participation level by HHS for PAS or DAHS services, these providers must submit the updated level in writing to Superior requesting a change in participation level.

Superior will verify the new participation level using the list as published on the HHS website under the Attendant Compensation Rate Enhancement webpage. All rate enhancement level changes are effective the month following the month the notice was provided to Superior. Rate enhancement level changes are made prospectively, and will not be made retrospectively.

Please note: Without an affidavit on file, Superior cannot process a rate change. Providers will need to submit an affidavit with their level change for the remaining plan year, if there is none on file.

Role of First-Tier and Downstream Providers

Through written agreement, Superior may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management and provider training. Superior oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. Superior will ensure written agreements which specify these responsibilities by Superior and the delegated entity are clear and concise. Agreements will be kept on file by Superior for reference.

Role of a Nursing Facility

Nursing Facilities are residential facilities that provide care for people whose medical condition regularly requires the skills of licensed nurses. Nursing Facilities provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies and equipment and personal needs items.

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

- Inviting the MCO SC to provide input for the development of the NF plan of care, subject to the member's right to refuse, by notifying the MCO SC when the interdisciplinary team is scheduled to meet. NF plan of care meetings should not be contingent on MCO SC participation.
- Notifying the MCO SC within one Business Day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home.
- Notifying the MCO SC if a member moves into hospice care.
- Notifying the MCO SC within one Business Day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization.
- Coordinating with the MCO SC to plan discharge and transition from a NF.

- Notifying the MCO SC within one Business Day of an emergency room visit.
- Notifying the MCO SC within 72 hours of a member's death.
- Notifying the MCO SC of any other important circumstances such as the relocation of members due to a natural disaster; and providing the MCO SC access to the facility, NF staff, and members' medical information and records.
- Responsibilities as outlined in Superior's Nursing Facilities Provider Manual, under Provider Responsibilities.

Role of Hospitals

Superior has contracted with several hospitals in the counties we serve, however any facility can be used in the event of an emergency. We also contract with other facilities such as rehabilitation facilities and ambulatory surgery centers to assist our members. It is important that our contracted providers have privileges at a contracted facility or have an agreement with a hospital list group to care for their member when hospitalized. Please visit https://www.SuperiorHealthPlan.com/members/medicaid/find-a-provider.html for a list of contracted hospitals in each county.

Role of Ancillary Providers

Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Home Health
- Hospice Care
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (physical, occupational, speech)

Medicare Regulatory Requirements

As a Medicare contracted provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others are described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare members in any way based on the health status of the member.
- Providers must ensure that members have adequate access to covered health services.
- Providers may not impose cost sharing on members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow members to directly access screening mammography and influenza vaccinations.
- Providers must provide female members with direct access to women's health specialists for routine and preventive health care.
- Providers must comply with Plan processes to identify, access and establish treatment for complex and serious medical conditions.
- Superior will inform providers with at least 60 Days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 Days. Providers agree to notify

Superior according to the terms outlined in the Participation Agreement.

- Providers will ensure that their hours of operations are convenient to the member and do not discriminate against the member for any reason. Providers will ensure necessary services are available to members 24 hours a day, seven days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Superior members without CMS approval of the materials and forms.
- Providers must cooperate with Superior in notifying members of provider contract terminations.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- Providers will work with Superior procedures to inform our members of health-care needs that require follow-up and provide necessary training in selfcare.
- Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Superior to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Superior medical policies, QI programs and medical management procedures.
- Providers will cooperate with Superior in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Superior procedures for handling complaints, appeals and expedited appeals.
- Providers must fully disclose to all members before providing a service, if the service may not be covered by Superior. The member must sign an agreement of this understanding. If the member does not, the claim may be denied and the provider will be liable for the cost of the service.

Network Limitations

Superior members must seek services from a Superior contracted provider. Exceptions include when a provider is not accessible within the network, or to ensure continuity of care for a newly enrolled Superior member as described below. All out-of-network services require an authorization.

A referral is needed to access most specialists. A specialist may not refer to another specialist.

Continuity of Care

There are situations that arise when Superior may need to approve services that are out-of-network. Superior may need to provide authorization for continuity in the care of a member whose health condition has been treated by a specialty care provider or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. In these cases, Superior may provide authorization to a non-contracted provider to provide the medically necessary services until the transition to a network provider may be completed. The following are circumstances in which continuity of care apply. Pre-existing conditions not imposed.

Newly Enrolled Members

Prior authorizations may be requested for up to a 90-Day initial continuity of care period to allow time for the transition to a Superior participating provider.

- Continuity of care will no longer apply after the initial 90-Day period or until Superior has evaluated and assessed the member and issued or denied a new authorization.
- If covered services are not available within Superior's network, Superior may authorize or continue authorizing services to a non participating provider for as long as those services are necessary and not available in the network.

Members Diagnosed with a Terminal Illness

Continuity of care also applies to prior authorization requests for members diagnosed with a terminal illness. A member can continue receiving care from their current provider for a period of nine months from the date the member became eligible with Superior.

Pregnant Members

Superior will provide out-of-network authorization to a pregnant member who is in their second or third trimester of pregnancy to remain under the care of her current OB/GYN through her immediate postpartum care, and the follow-up checkup within the first six weeks for delivery.

- In cases where the member wishes to change her OB/GYN to one who is in-network, the member will be allowed to do so as long as the provider agrees to accept her in the second trimester of pregnancy.

Community-Based Long-Term Care Services

At the time of new program implementation, Superior will provide continued authorization for services prior authorized for a period not to exceed six months or until a new assessment is completed and a new authorization is issued, whichever comes first.

Members Who Move Out of the Service Area

Superior will continue to provide and coordinate services for members who move out of the service area until the member is disenrolled from Superior.

Direct Access to Care

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

- Obstetric or gynecologic services for female members (as described above).
- Routine vision services, to include eye exams and eyewear (according to benefit limitations).
- Behavioral health services.
- Network ophthalmologists or therapeutic optometrists to provide eye health-care services other than surgery.

Telemedicine and Telehealth Services

As a second option to face-to-face visits, any provider in the Superior network can offer telehealth services to Superior members (except for STAR+PLUS dual members) for certain healthcare needs. "Telehealth services" are virtual health-care visits with a provider through a mobile app, online video or other electronic method. These may include, but are not be limited to telemedicine, telemonitoring and telehealth services.

Superior treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers.

- A telehealth visit with an in-network Superior provider does not require prior authorization.

Providers should follow CMS billing and coverage guidelines for Medicaid telemedicine and telehealth services.

Primary Care Providers Patient Panels

All providers have the right to regulate the number of members they are willing to accept into their practice. Since assignment is based on the member's choice, Superior does not guarantee that any provider will receive a set number of members.

If a provider declares a specific capacity for their Superior patient panel size and wants to make a change to that capacity, the provider must:

- Contact Superior's Account Management department.
- Provide notification of the change on or before the 15th of the month for the change to become effective on the first of the following month. If the change is requested after the 15th of the month, the change will become effective the first day of the second month following the request.

When an existing provider, with an assigned panel, terminates from a group, the group may request in writing to have the patient panel transferred to a participating provider within the group. This request should be sent to Account Management. Call Provider Services for your Account Manager's contact information or visit https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html.

PCPs are able to access their Panel Reports on Superior's Secure Provider Portal. Please see Section 16 – Secure Provider Portal. A member may choose to select another provider to act as the member's PCP.

Under no circumstance can a provider take retaliatory action against a member due to disenrollment from the provider's panel.

Provider Rights

1. To be treated by their patients, who are Superior members, and other health-care workers with dignity and respect.
2. To receive accurate and complete information and medical histories for members' care.
3. To have their patients, who are Superior members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital or other offices running smoothly.
4. To expect other network providers to act as partners in members' treatment plans.
5. To expect members to follow their health-care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Superior and/or a member.
7. To file a grievance on behalf of a member, with the member's consent.

8. To have access to information about Superior quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Provider Services with any questions, comments or problems.
10. To collaborate with other health-care professionals who are involved in the care of members.
11. To not be excluded, penalized or terminated from participating with Superior for having developed or accumulated a substantial number of patients in Superior with high cost medical conditions.

Provider Responsibilities

Providers must comply with each of the items listed below:

- Provide Superior's members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Superior's clinical and non-clinical guidelines and within the practice of your professional license.
- Abide by the terms of your Superior Provider Participation Agreement.
- Comply with all of Superior's policies, procedures, rules and regulations, including those found in the Provider Manual.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within Superior's network.
- Verify member eligibility for authorizations or services.
- Ensure member understands right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Superior's medical records guidelines and as applicable to HIPAA regulations. *Please note: Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.*
- Maintain a facility that promotes patient safety.
- Participate in Superior's Quality Improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify Superior if you are undergoing an investigation, or agree to written orders by the state licensing agency.
- Notify Superior if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in the amounts that meet Superior's credentialing requirements and/or state-mandated requirements.
- Notify Superior if there is a change in your office address, tax ID number or any other demographic changes.
- Maintain enrollment status with Texas Medicaid. *Please note: Superior HealthPlan will deny claims for prescriptions, items and services ordered, referred or prescribed for any Superior Medicaid or CHIP member when the provider who ordered, referred or prescribed the items or services is not enrolled in Texas Medicaid. This applies to both in-state and out-of-state providers.*
- Comply with the requirements of Texas Government Code §531.024161 regarding the submission of claims involving supervised providers.

- Maintain the Participating Provider Conflict of Interest and Health Care Entity Financial Interest Policy and Disclosure statements to reflect current status.
- Further details about the designees and types of requests can be found within network provider contracts.
- Provide at no cost to HHS or its delegates any requested records in accordance with the timelines, definitions, formats and instructions specified by HHS.

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Superior to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing department. Upon receipt of this information, the practitioner will have 30 Days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee.

The Credentialing Committee will then include this information as part of the credentialing or re-credentialing process.

Provider Enrollment and Contracting

Providers who wish to contract with Superior must be actively enrolled as a Texas Medicaid and/or CHIP provider by the Texas HHSC. All providers delivering Medicaid and CHIP services must complete HHSC Program enrollment, to include acute care practitioners, facilities, and ancillary providers, as well as all LTSS providers, including long term care facilities. Superior is prohibited from reimbursing providers who are not actively enrolled in Texas Medicaid or CHIP at the time services are rendered to Superior eligible members.

The HHSC provider enrollment process must be initiated via the TMHP website. Providers must complete a periodic re-enrollment process on the TMHP site; the re-enrollment date is determined by TMHP. The website link to enroll and re-enroll is: https://www.tmhp.com/topics/provider-enrollment/how-apply-enrollment. Questions about Texas Medicaid and CHIP enrollment, including requests for application status, must be directed to the TMHP Contact Center: 1-800-925-9126. Superior is not able to provide status of Texas Medicaid enrollment applications and Superior cannot accept the enrollment verifications submitted to the provider by TMHP as proof of the provider's active program enrollment. Superior is obligated to utilize the Medicaid provider enrollment files provided by HHSC as the verification of a provider's active HHSC program enrollment.

Superior's provider enrollment and Medicaid and CHIP program enrollment processes through TMHP can be initiated concurrently. Superior will provide a contract that includes a provider's network effective date, reimbursement terms and Superior and provider responsibilities. Credentialing must be completed before a provider's contract with Superior is finalized for participation in Superior' network.

Superior will supply each provider with information required to facilitate Superior's credentialing of the provider. Superior will also notify a provider upon completion of credentialing. In addition, Superior must be notified of any new practitioner that joins an existing contracted provider group, and that practitioner must be credentialed prior to delivering services to Superior's members. Some practitioners may be eligible for expedited credentialing; refer

to Section 13, Expedited Credentialing, in this manual for more information.

For all covered Medicaid and CHIP services, providers must be actively enrolled through HHSC prior to rendering services to Superior members. Providers must also participate in Superior's provider network to render services to Superior enrolled members, with the exception of emergency services. Claims submitted by Superior contracted providers for service dates in which Superior is unable to confirm active HHSC Program enrollment according to the HHSC Medicaid/CHIP provider enrollment files supplied by HHSC will be denied upon receipt, and subject to the claim reconsideration and appeal processes outlined under Section 9, Claims and Encounters Administration, of this Manual.

Non-contracted facilities and practitioners who wish to contract with Superior may initiate the process by submitting a contract request form on Superior's website at: SuperiorHealthPlan.com/JoinOurNetwork. To ensure prompt and efficient contracting and credentialing processes, providers must submit all applicable credentialing documentation upon request and in a timely manner.

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join the Superior network have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Services department at 1-877-391-5921.

Practitioner Right to Appeal Adverse Initial and Re-credentialing Determinations

Applicants who are existing providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 14 Days of the date of the notice.

New applicants who are declined participation may request reconsideration within 30 Days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant’s appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 Days from the receipt of the additional documentation.

Updates to Contact Information

Superior-contracted providers must inform Superior of any changes to the provider’s address, telephone number, group affiliation, etc. Updates to provider practice or demographic information can be made through the Secure Provider Portal, Provider.SuperiorHealthPlan.com. Medicaid enrolled providers providing Medicaid only covered services and Long Term Services and Supports must also notify the Texas Medicaid and Health Partnership (TMHP) of any changes in organizational structure or demographic information.

Advance Directives

Providers must inform Superior members, 18 years of age and older, of their rights to be involved in decisions regarding their medical care. This includes documentation of advance directives, their right to refuse withhold or withdraw medical and mental treatment and the rights of the member or member’s representative to facilitate medical care or make treatment decisions when the member is unable to do so as stipulated in the Advance

Directives Act, Chapter 166, Texas Health and Safety Code:
http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.166.htm.

Providers must document such information in the member's permanent medical record. Primary Care Providers are responsible for informing their patients about completing an advance directive. The forms can be found on our website at www.SuperiorHealthPlan.com.

If you would like a printed copy, or need assistance regarding advance directives, contact Provider Services.

Appointment Availability

Consistent with the HHS Uniform Managed Care Contracts for STAR+PLUS, the appointment availability standards are required as noted in the table below. Superior has added examples of presenting symptoms to clarify the type of care that may be required.

Superior requires the hours of operation that providers offer to STAR+PLUS MMP members be no less than those offered to commercial patients. Superior's PCPs and specialty care providers must have adequate office hours to accommodate appointments for members using the following appointment access guide. Members must have access to covered services within the timelines specified by HHS and Texas Department of Insurance (TDI). "Day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

Superior's Quality Improvement (QI) department performs accessibility and availability studies on Superior's network to ensure access and quality of care for all Superior members. If Superior determines that a provider fails to comply with access standards, corrective action will be required of that provider to maintain their contract with Superior.

The following standards are established regarding appointment availability:

- A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- Emergency services must be provided upon the member's presentation at the service delivery site, including at non-network and out-of-area facilities.
- Urgent care, including urgent specialty care, must be provided within 24 hours.
- Routine primary care must be provided within 14 Days.
- Initial outpatient behavioral health visits must be provided within 14 Days.
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the member's medical condition, but no later than 30 Days.
- Prenatal care must be provided within 14 Days, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within five Days, or immediately, if an emergency exists.
- Preventive health services for adults must be offered within 90 Days of the request. Community-Based LTSS Enrollees must be initiated within seven Days from the start date on the Individual Service Plan (ISP) or the eligibility effective date for non-waiver LTSS unless the referring provider, enrollee or STAR+PLUS handbook states otherwise.

Note: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare Members.

Appointment Access Guide

Type of Care	Example	Appointment Availability	Primary Provider Type
"Emergency Care" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: • Death, placing the member's health in serious jeopardy, permanent impairment of bodily functions, serious dysfunction of any bodily organ or part. • With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.	Radiating chest pain, severe shortness of breath.	Services must be provided upon member presentation at the service delivery site.	PCP, Specialist, Hospital.
"Urgent Care" is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health. "Urgent Behavioral Health Situation" is defined as a behavioral health condition that requires attention and assessment within 24 hours but which does not place the member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.	Fever, persistent vomiting, wants to hurt or has thoughts about hurting themselves or others.	Appointment must be offered within 24 hours of the request, including urgent specialty care.	PCP, Specialist.
"Routine Primary Care" is defined as health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.	Services designed to prevent disease, to detect disease and treat early, or to manage the course of disease effectively.	Within 14 Days of request.	PCP.
Routine Specialty Care.	Referral for non-urgent condition.	Within 21 Days of request.	Specialist.
Preventive Health Services for Adults.	Annual physical, well woman examination.	Within 90 Days of request.	PCP, Gynecologist.
Prenatal Care.	Routine prenatal care visits.	Within 14 Days of request.	Obstetrical services providers.
High risk pregnancy or new member in the third trimester.	Bleeding, no previous prenatal care.	Within 5 Days of request or immediately if an emergency exists.	Obstetrical services providers.
Routine Initial Visits and Follow-Up Behavioral Health Care.	Acute/chronic psychiatric and substance use disorders.	Within 14 Days of request	Behavioral Health Care Provider, Psychiatrist, Psychologist.

Accessibility 24/7

PCPs must be accessible to Superior members 24 hours per day, seven days per week. The provider must comply with the following after-hours telephone availability standards:

- Office phone is answered during normal business hours.

- After business hours, provider must have the following arrangements:
  - The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups (English and Spanish) and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
  - The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served (English and Spanish), directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
  - The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Examples of unacceptable after-hours coverage include:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells patients to leave a message.
- The answering machine is not bilingual (English and Spanish).
- The office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning after-hours calls outside of 30 minutes.

Note: If after-hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Superior will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement department.

Covering Providers

PCPs must arrange for coverage with another Superior-contracted provider during scheduled or unscheduled time off. In the event of a PCP having unscheduled time off, notify the Account Management department of the coverage arrangements that have been made in the PCP's absence. Covering providers must have an active National Provider Identifier (NPI) number in order to receive payment. For provision of services to Medicaid members, providers must also be actively enrolled in Texas Medicaid.

Member Education

Superior abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services for our members. Materials are also made available in large print, braille and on CD when requested. A variety of sources are used to inform Superior members, in a culturally sensitive manner, about the health plan and the services available to them. This includes, but is not limited to:

- Superior member handbooks
- Superior's member quarterly newsletter
- Targeted disease management brochures
- Superior provider directory
- Superior web site, www.SuperiorHealthPlan.com
- Special mailings

To obtain a sample of any of the materials listed above, contact Provider Services.

All educational materials are available in written text in both English and Spanish, and in other languages, if needed. These materials are also modified to a 6th grade reading level or below, as measured by the appropriate score on the Flesch-Kincaid Readability Scale.

You can refer your patients to our member advocate staff for personalized member education. Contact Provider Services for a referral form.

Superior encourages providers to assist in member education regarding healthy lifestyles. Preventive health guidelines, which include health education and counseling topics are included in Section 11 – Quality Improvement - Practice Guidelines.

Referrals

Superior providers are required to refer members for specialty services within the Superior network. Referral to out-of-network providers will be made when medically necessary to do so. All out-of-network services require an authorization.

Key highlights:

- A PCP is required to refer a member to a specialist when medically necessary care is needed beyond the scope of the PCP.
- A member should be referred to a specialist by their PCP.
- A specialist cannot refer to another specialist. All member care should be coordinated through the PCP.
- Some services require prior authorization. Visit https://www.SuperiorHealthPlan.com/providers/preauth-check.html to view Superior's Prior Authorization List.
- PCPs are required to request authorization for services requiring authorization.
- PCPs must document the coordination of referrals and services provided between the PCP and specialist.

All providers are required to follow the processes outlined in Section 7 - Medical Management.

Reporting Abuse, Neglect or Exploitation (ANE)

Superior and providers must report any allegation or suspicion of ANE that occurs within the delivery of Long-Term Services and Supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to Texas Human Health and Human Services (HHS)

Report to HHS if the victim is an adult who resides in or receives services from:

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

To report, contact HHS at 1-800-458-9858.

Report to the Department of Family and Protective Services

Report to the Department of Family and Protective Services (DFPS) within one Business Day if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - HCSSAs – also required to report any HCSSA allegation to HHS.
  - Unlicensed adult foster care provider with three or fewer beds.
- An adult with a disability or child residing in, or receiving services from, one of the following providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHAs), community center or mental health facility operated by the Department of State Health Services;
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - A managed care organization;
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option.

Providers must also provide Superior with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt, of the findings from DFPS. Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org.

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Report to Superior HealthPlan

- In addition to reporting to HHS and DFPS, a care provider must report the findings within one Business Day to Superior HealthPlan.
- Providers should submit a copy of the ANE findings within one Business Day of receipt of the findings from DFPS and the individual remediation, on confirmed allegations, to Superior's secure fax line at 1-833-856-6863.

Failure to Report or False Reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHS or a law enforcement agency (see: Texas Human Resources Code, Section 48.052; Texas Health and Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS or a law enforcement agency regarding ANE (see: Texas Human Resources Code, Sec. 48.052; Texas Health and Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation or at a childcare center.

Fraud, Waste and Abuse Prevention

The Medicaid programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of Superior's contracted providers in prevention and reporting of potential fraud,

waste or abuse. Superior has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501- 353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. It is your responsibility as a participating provider to report any member or provider suspected of potential fraud, waste or abuse. All reports will remain confidential.

Reporting Fraud, Waste or Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that were not provided or necessary.
- Upcoding for services provided to receive higher reimbursement.
- Unbundling when billing for services provided.
- Using someone else's Medicaid ID.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

To report fraud, waste or abuse, you may file a report directly to the Texas Office of Inspector General (HHS OIG), or you may report an issue to Superior. To report fraud, waste or abuse:

- Call the OIG Hotline at 1-800-436-6184.
- Visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and select "Report Fraud" to report fraud, waste and abuse to complete the online form.
- Contact Superior's Corporate Special Investigative Unit directly at 1-866-685-8664 or:
  Centene Corporation
  Superior HealthPlan Fraud and Abuse Unit
  1390 Timberlake Manor Pkwy
  STE 450
  Chesterfield, MO 63017

Information Needed to Report Fraud, Waste or Abuse

When reporting a provider (doctor, dentist, therapist, pharmacist, etc.) include as much information as possible, such as:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- NPI of the provider.
- Dates of events.
- Type of provider (physician, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can aid in the investigation.
- Summary of what happened.

When reporting a member (a person who receives benefits), include:

- The person's name.
- The program in which the member is/was enrolled (STAR+PLUS MMP).

- The city where the person resides.
- The person's date of birth, social security number or case number if available.
- Specific details about the fraud, waste or abuse.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. Knowingly presenting, or causing to be presented a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying Government property from an unauthorized officer of the Government; and
7. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims Act, please visit www.cms.hhs.gov.

Coordination of Care

Superior and providers partner to identify and manage services for all members, including persons with disabilities, chronic or complex conditions and members and Children with Special Health Care Needs (MSHCN/ CSHCN). This includes the development of a plan of care to meet the needs of the member, which is updated at least annually. The plan of care is based on health needs, PCP and specialist(s) recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs. For members needing a referral to Care Management, please see Section 7 - Medical Management.

As a provider managing a member with special health-care needs, Superior looks to its providers serving that member to:

- Be part of a multidisciplinary team responsible for the delivery of care, when determined to be medically necessary for effective treatment, to avoid separate and fragmented evaluations and service plans.
- Provide an adequate plan of care for the member so the needs of care can be reasonably met.
- Develop specialty care and support service recommendations to be incorporated into the plan of care.
- Include the patient's behavioral health provider, if applicable in the multidisciplinary team serving the member's physical and behavioral health needs, to include an exchange of medical records for the patient as needed.
- Provide information to the member and the member's family concerning the specialty care recommendations.
- Provide necessary medical tests or procedures to monitor disabilities within the provider's office (if available), or at a Superior-contracted provider's office/facility, which is located at or near the provider's office.
- Participate in preadmission hospital planning for non-emergency hospitalizations.
- Participate in hospital discharge planning.

Community First Choice Provider Responsibilities

Community First Choice (CFC) provider responsibilities are as follows:

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must maintain current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable).
- The Home and Community-Based Services (HCS) or Texas Home Living (TxHmL) program provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member that are required to ensure the member's health, safety and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified, that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/Legally Authorized Representative (LAR) with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline. (1-800-647-7418).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member) or other person who files a complaint, presents a complaint or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check and OIG checks).
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC Personal Assistance Services (PAS) or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to Superior's financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the

program provider, staff member or service provider could financially benefit.

- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Provider Responsibilities for Employment Assistance (EA) and Supported Employment (SE)

Employment Assistance (EA) is provided as an HCBS STAR+PLUS Waiver service to a member to help the member locate competitive employment or self-employment. EA services include, but are not limited to, the following:

- Identifying a member's employment preferences, job skills and requirements for a work setting and work conditions;
- Locating prospective employers offering employment compatible with an member's identified preferences, skills and requirements; and
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

SE services provide assistance as HCBS Waiver service to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. SE provides the supports necessary in order to sustain paid employment. SE services include, but are not limited to, the following:

- Employment adaptations, supervision and training related to a member's diagnosis;
- If the member is 21 years of age, ensure provision of SE, as needed, if the services are not available through the local school district; and
- If the member is 21 years of age, SE may be provided through the STAR+PLUS Waiver (SPW) if documentation is maintained in the member's record, that the service is not available to the member, under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq).

The provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:

- Name of the member;
- Member's employment goal;
- Strategies for achieving the member's employment goal, including those addressing the member's anticipated employment support needs;
- Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing;
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns;
- Progress toward the member's employment goal; and
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the member's employment search.

Medical Record Keeping

Superior's Requirements

Superior requires all providers (physician, hospital and ancillary) to maintain sound medical record keeping practices that are consistent with Superior's medical records guidelines. Superior requires that records be maintained in compliance with all HIPAA regulations and other federal and state laws. Records must be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Whether using paper or electronic record keeping systems, medical records need to be identifiable by the patient name and be accessible. All medical records must be kept for at least seven years from the anniversary date of last treatment. Records of patients younger than 18 shall be retained until the patient reaches age 21 or for seven years from the last treatment date, whichever is longer. Medical records must be accessible at the site of the member's PCP or other provider.

Compliance Audits for Medical Record Documentation

Superior may audit record-keeping practices and individual member medical records in conjunction with ongoing Quality Assessment and Performance Improvement (QAPI) program activities. Superior's Medical Records Guidelines will be utilized during medical record documentation reviews by Superior. Providers scoring less than 80% on medical record audits may be placed under a corrective action plan, subject to additional medical record reviews or referred to Superior's Quality Improvement Committee (QIC) for recommendations.

Superior encourages providers to request medical records that document care previously provided to members that are new to their panel. This will assist in assuring the member receives continuous care, as well as helping determine the most appropriate course of treatment for the patient.

Pre-Payment Audits

To maintain program integrity and payment accuracy Superior will conduct regular reviews of provider claims data through implementation of claims edits. Superior's claims payment system is designed to audit claims concurrently, to detect and prevent paying claims that are inappropriate. Superior's pre-payment claims auditing process identifies frequent coding billing errors ensuring that claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD) and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Superior may, at the request of a state program or at its own discretion, subject a provider to prepayment reviews whereupon the provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the provider can provide sufficient accurate support. This process aims to gain a comprehensive understanding of the billing activity and ensure that the services align with relevant medical necessity, policy, and coding requirements.

If a provider is placed on prepayment review a notice will be sent to the provider. The notice will state the provider

is being placed on Pre-Pay because their claims, or a portion thereof, have been selected for pre-payment review by the SIU. This means that, for at least some period going forward, some or a portion of the submitted claims will be denied pending submission of records to validate services as billed. If the provider has any question regarding the prepayment review notice they can contact Prepay at SIUPrePayInbox@Centene.com.

To facilitate the prompt review and processing of the claims, the provider is requested to review the Explanation of Payment (EOP) correspondence, which may identify claims or services as denied with explanation code ye- "DENY SIU PREPAY: MED RECS/DOCUMENTATION REQ'D TO SUPPORT SVC(S) BILLED".

Once these claims or services have been identified on the EOP, we request all records documenting the service that was rendered, including any documentation relevant to reviewing whether the service met applicable medical necessity, policy, and coding requirements.

Superior offers two convenient ways to submit requested records:

- Provider Portal: Documents may be submitted through our Secure Provider Portal (5MB Limit) under the "Reconsider Claim" section. Select "Audit-Medical Records Requested" from the drop-down to ensure the records are routed accordingly for review. For more information regarding the Secure Provider Portal and to get enrolled, please visit: SuperiorHealthPlan.com/ProviderPortal
- Mail: Alternatively, hard copy documents may be submitted by mail. To assist us in processing the records received, a submission by mail should include a copy of the Explanation of Payment (EOP). Please mail the documentation to:

  Superior Claims Department
  PO Box 3003
  Farmington, MO 63640-3803

Superior will review each record individually and either reprocess the claim or deny the claim. Superior does outline the specific reasons the review resulted in a denial. If Superior does not receive the requested documentation timely, this may result in the claim being denied for failure to submit records and/or documentation. If the claim is denied, the provider will have the right to request reconsideration of the decision.

The provider has 120 days from the date on the denial letter to file for an appeal for claims denied in the Pre-Pay Audit review because of the review of the requested documentation. Any such appeal should be submitted in writing within the timeframe specified and mailed to:

Superior HealthPlan Appeals
P.O. Box 6300
Farmington, MO 63640

If the appeal is upheld, a reviewer not involved with the original denial will make that determination of your request. If the services have been rendered, this is not eligible for an expedited appeal. When the appeal process has been exhausted, you have a right to arbitration. Remember that you cannot bill the patient/member for Medicaid services, even if the claim is denied. At the conclusion of the Pre-Pay Audit, Superior's Account Management Department will offer to schedule an Exit Conference with the Provider.

Exit Conference Process

Superior's Account Management Department will conduct an exit conference with the provider designee including an overview of the State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, CMS, Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the NPFS, the MUE table, NCCI files, LCD/NCD, and State-specific policy manuals and guidelines as specified by a defined set of indicators in the MPFSDB.

Required Use of Forms

Superior does not require specific forms for medical record documentation. Various professional organizations have created flow sheets or templates that can improve documentation processes. Superior encourages the use of flow sheets and standardized forms for documentation as a method to improve continuity and coordination of care for members.

Confidentiality of Medical Records

All providers rendering services to Superior members are required to maintain medical records that conform to the requirements of the HIPAA and other federal and state laws. Practitioners should maintain confidentiality of medical records and treatment information in accordance with state and federal laws. To ensure the member's privacy, medical records should be kept in a secure location and accessible only by authorized personnel. Practitioners must periodically train their staff about member information confidentiality.

Network Termination

A provider may terminate from the Superior network in accordance with the provider's Participation Agreement. Refer to your Superior contract for written notification time frames and/or contact the Provider Services department.

All termination requests must be received in writing. Please include the TIN, NPI, termination date and the reason for the termination. Your Account Manager can help you facilitate a termination.

Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Superior must disclose to CMS any Physician Incentive programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive program;
- Type of incentive arrangement;
- Amount and type of stop-loss protection;
- Patient panel size;
- Description of the pooling method, if applicable;
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services;
- The calculation of Substantial Financial Risk (SFR);
- Whether Superior does or does not have a Physician Incentive program; and
- The name, address and other contact information of the person at Superior who may be contacted with questions regarding Physician Incentive programs.

Physician Incentive programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive programs that place providers/provider groups at SFR may not operate unless there is adequate stop loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive program regulations.

Substantial Financial Risk (SFR) occurs when the incentive arrangement places the provider/provider group at risk

beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/ provider group's referral levels. Bonuses, capitation and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive program regulations, please contact your Account Manager.

Provider Training

Superior providers are required to receive training annually which includes Annual Fraud, Waste and Abuse Training, Compliance Training and Model of Care Training. Superior provides training on a wide variety of topics ranging from billing to cultural competency and literacy, all of which are accessible online at www.SuperiorHealthPlan.com/ProviderTrainings. Superior training includes training modules centered on Nursing Facilities, STAR+PLUS MMP, LTSS providers and services, in addition to acute care. Training is offered both locally and via webinar. The provider training calendar, accessible at SuperiorHealthPlan.com/ProviderCalendar, details the type of training, location and RSVP information for each event. Providers can also contact their local Account Manager to obtain personalized training on any of the training modules we offer or to help with questions.

SECTION 3
ELIGIBILITY AND DISENROLLMENT

HHS and Centers for Medicare and Medicaid Services (CMS) are responsible for determining STAR+PLUS MMP eligibility. The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the STAR+PLUS MMP program. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at 1-800-964-2777.

When a member gains eligibility, the state's Enrollment Broker sends the member an enrollment packet, informing the member of the health plan choices in their area. The packet will also inform the member to select a health plan and a PCP within 15 Days.

Verifying Member Eligibility

Each member approved for STAR+PLUS MMP benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the member has current coverage. It is imperative that providers verify the member's eligibility for the date of service prior to services being rendered. There are two ways to do this:

HHS Resources

Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.

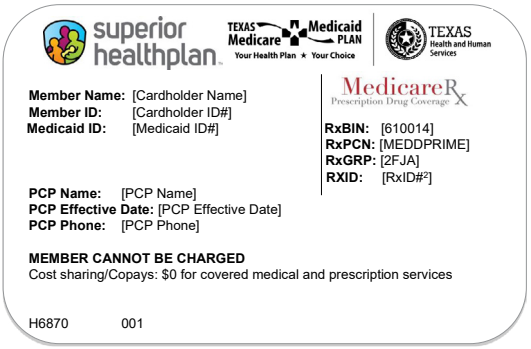
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling 1-800-252-8263. members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view Texas Health Steps Alerts, and more. Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by members. A copy is required during the appeal process if the member's eligibility becomes an issue.

Member Identification Card

All members will receive a Superior member identification card. Below is a sample member identification card.

Note: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.


superior healthplan
TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice
TEXAS Health and Human Services

Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]
Medicaid ID: [Medicaid ID#]

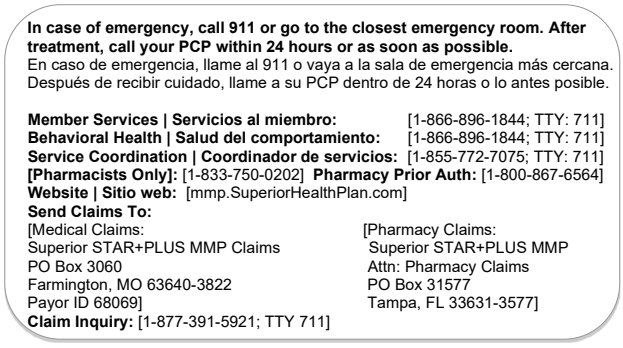
MedicareRx Prescription Drug Coverage

RxBIN: [610014]
RxPCN: [MEDDPRIME]
RxGRP: [2FJA]
RXID: [RxID#²]

PCP Name: [PCP Name]
PCP Effective Date: [PCP Effective Date]
PCP Phone: [PCP Phone]

MEMBER CANNOT BE CHARGED
Cost sharing/Copays: $0 for covered medical and prescription services

H6870 001


In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.

Member Services | Servicios al miembro: [1-866-896-1844; TTY: 711]
Behavioral Health | Salud del comportamiento: [1-866-896-1844; TTY: 711]
Service Coordination | Coordinador de servicios: [1-855-772-7075; TTY: 711]
[Pharmacists Only]: [1-833-750-0202] **Pharmacy Prior Auth:** [1-800-867-6564]
Website | Sitio web: [mmp.SuperiorHealthPlan.com]
Send Claims To:
[Medical Claims:
Superior STAR+PLUS MMP Claims
PO Box 3060
Farmington, MO 63640-3822
Payor ID 68069]

[Pharmacy Claims:
Superior STAR+PLUS MMP
Attn: Pharmacy Claims
PO Box 31577
Tampa, FL 33631-3577]

Claim Inquiry: [1-877-391-5921; TTY 711]

Superior Resources

Access Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com. This website is updated upon receipt of information from the state and eligibility may change (i.e. be retroactive or terminate). As a result, eligibility verification from the website does not guarantee payment. Using the portal, any registered provider can quickly check member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

- The member's plan-issued Superior ID card. Possession of a member ID card is not a guarantee of current enrollment or guarantee of payment.
- Calling Superior's member hotline at 1-866-898-1844 will provide an interactive IVR or you can also contact a live agent.

Note: If the member gets Medicare, Medicare is responsible for most primary, acute and behavioral health services. The member (STAR+PLUS dual-eligible) receives long-term services and supports through Superior.

Pharmacies

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

Important: Do not send patients who forgot or lost their cards to an HHS benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

Additional Forms that Can be Used to Verify Eligibility

Form 1027-A: Temporary Medicaid Eligibility Verification form can be used as evidence of Medicaid eligibility. This form is issued as temporary proof of Medicaid eligibility while the member is waiting for their Your Texas Benefits Medicaid Card.

Enrollment

Individuals who meet all of the following criteria will be eligible for STAR+PLUS MMP:

- Age 21 or older at 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.

Certain Superior STAR+PLUS populations excluded from participation in the STAR+PLUS MMP demonstration include those who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions and individuals with developmental disabilities who get services through one of these waivers:

- Community Living Assistance and Support Services (CLASS)
- Home and Community-based Services (HSC)
- Deaf Blind with Multiple Disabilities program (DBMD)
- Texas Home Living program (TxHmL)

Plan Enrollment

Enrollment for eligible individuals into STAR+PLUS MMP may be conducted (when no active choice has otherwise been made) using a seamless, passive enrollment process that provides the opportunity for individuals to make

a voluntary choice to enroll or disenroll from STAR+PLUS MMP at any time. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no less than 60 Days prior to the effective date of enrollment, and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment. Disenrollment from STAR+PLUS MMP MCOs and enrollment from one STAR+PLUS MMP MCO to a different STAR+PLUS MMP MCO will be allowed on a month-to-month basis any time during the year. However, coverage for these individuals will continue through the end of the month. As mutually agreed upon, CMS and the State will utilize an Enrollment Broker, independent of the STAR+PLUS MMP MCO, to facilitate all enrollment into the STAR+PLUS MMP program. STAR+PLUS MMP enrollments, including enrollment from one STAR+PLUS MMP MCO to a different STAR+PLUS MMP MCO, and opt-outs, shall become effective on the same day for both Medicare and Medicaid. For those who lose Medicaid eligibility during the month, coverage and Federal Financial Participation (FFP) will continue through the end of that month.

Members who do not participate in STAR+PLUS MMP will remain enrolled in Superior STAR+PLUS and will continue to receive their Long-Term Service and Supports (LTSS) through Superior.

Accountable Care Organizations (ACOs)

Members enrolled in a Medicare Accountable Care Organization (ACO) are considered to be fee-for-service (FFS) Medicare and may also be eligible for enrollment in STAR+PLUS MMP. To preserve the infrastructure of existing ACOs in the counties in which the demonstration will operate, HHS will reduce the number of members who will be passively enrolled from an ACO. Further, HHS has required participating STAR+PLUS MMPs to contract with ACOs to develop shared savings and/or quality incentives. However, these arrangements will not count as enrollment in a Medicare ACO for purposes of shared savings with Medicare. This will be an ongoing process that only applies to ACOs that were in operation prior to the Dual Demonstration implementation on March 1, 2015.

HHS will work with the STAR+PLUS MMPs in an attempt to limit passive enrollment for members in an ACO with the following attributes:

- Operating in a demonstration county (Bexar, Dallas or Hidalgo).
- Fewer than 9,000 members.
- Established by March 1, 2015.

However, members can elect to participate. Members in an ACO that are excluded from passive enrollment will receive notification about the option to enroll in STAR+PLUS MMP. If a member of an ACO elects to participate in the demonstration, they can continue to receive services from their primary care provider (PCP) aligned with the ACO once enrolled if the PCP is a Superior STAR+PLUS MMP network provider.

Please note: The Enrollment Broker will not facilitate PCP assignment. Members enrolled in Superior will be assigned through the plan's PCP auto-assignment process and not through the state Enrollment Broker. Members are encouraged to select their own PCP, and are able to call Member Services and change their PCP assignment at any time. PCP assignments are effective the first of the month after they are received.

As with all dual-eligible demonstrations, members will be able to opt-out of the program and will be enrolled back into STAR+PLUS.

Members who opt into STAR+PLUS MMP will be enrolled based on when their request is provided to the Enrollment Broker. For enrollment requests received through the 12th of the month, the effective date of coverage will be the first Day of the next month. Enrollment requests received after the 12th of the month, will be effective the first Day of the second month following initial receipt of the request.

Disenrollment

Required Involuntary Disenrollment

Texas and CMS will terminate a member's enrollment in the STAR+PLUS MMP upon the occurrence of any of the conditions listed below:

- Change in residence makes the individual ineligible to remain enrolled in the MMP.
- The member loses entitlement to either Medicare Part A or Part B.
- The member dies.
- The member loses Medicaid eligibility or additional State-specific eligibility requirements.
- The MMP's contract with CMS is terminated, or the MMP reduces its service area to exclude the member.
- The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage.
- When Superior verifies the member as having third-party coverage with Superior or with another carrier.
- Upon incarceration in a county jail, Texas Department of Corrections facility or Federal penal institution.
- Upon the occurrence of any of the conditions described in this section.

Except for the Contract Management Team (CMT)'s role in reviewing documentation related to a member's residence outside the service area or alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering disenrollment transactions described elsewhere in this contract.

Superior will be responsible for ceasing the provision of covered services to a member upon the effective date of disenrollment. Superior must first provide documentation, satisfactory to the CMT, that the member meets one of the disenrollment criteria. Termination of the coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the CMT determines that the member is no longer eligible.

Involuntary Disenrollment Due to Member Non-Compliance

There may be instances when a PCP feels that a member should be removed from their panel. Superior requires notification of such requests so educational outreach can be arranged with the member. All notifications to remove a patient from a panel must:

- Be made in writing.
- Contain detailed documentation.
- Be directed to Superior's Compliance department.

Upon receipt of a request, Superior may:

- Interview the provider or their staff requesting the disenrollment, as well as any additional providers who are relevant to the request.
- Interview the member.
- Review any relevant medical records.

Examples of reasons a PCP may request to remove a member from their panel could include, but are not limited to:

- If a member is disruptive, unruly, threatening or uncooperative to the extent that the member seriously

impairs the provider's ability to provide services to the member, or to other patients, and the member's behavior is not caused by a physical or behavioral condition.

- If a member refuses to comply with managed care guidelines, such as repeated emergency room use, combined with refusal to allow the provider to treat the underlying medical condition.

A PCP cannot request a member be disenrolled for any of the following reasons:

- Adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition.
- On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion.

A member will receive an Advance Notice and Notice of Intent as described in the 2013 Medicare –Medicaid Plan Enrollment and Disenrollment Guidance. Termination of a member's enrollment shall take effect at 11:59 p.m. on the last day of the month following the month the disenrollment is processed.

Under no circumstances can a provider take retaliatory action against a member due to disenrollment from either the provider or a plan. HHS will make the final decision for member disenrollment.

Renewal

Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to recertify with HHS each year. To maintain SSI benefits, the SSA may require information from the person related to their SSI benefits. The person or their representative payee may call the SSA. HHS does not play a role in determining SSI eligibility. Providers are encouraged to remind members to keep their information current with SSA.

If a Superior member becomes temporarily ineligible (for six months or less) for Medicaid, but regains Medicaid eligibility within the six month timeframe and resides in the same service area, the member will be automatically re-enrolled by HHS in Superior. Superior and the state's Enrollment Broker will make every effort to re-enroll the member with the previous PCP. The member will also have the option to switch plans.

SECTION 4
COVERED BENEFITS AND FLEXIBLE BENEFITS

Program Benefits for STAR+PLUS MMP

Superior is required to provide specific, medically necessary services to its STAR+PLUS MMP members. Please refer to the current Texas Medicaid Provider Procedures Manual and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions.

Superior will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in the STAR+PLUS MMP program.

The table below displays a list of covered services and the monthly premium, deductible and limits on how much members pay. This list does not include all benefits available to members and should be used for quick reference only. Please visit our Secure Provider Portal at Provider.SuperiorHealthPlan.com or contact Provider Services at 1-877-391-5921 with any questions you may have regarding benefits.

Monthly Premium, Deductible and Limits on How Much Members Pay	
Covered services	Member pays nothing.
How much is the members deductible?	Member pays nothing.
Is there any limit on how much member will pay for covered services?	No. This plan doesn't have any limits since the member has no deductible. Please note that member will still need to pay their cost sharing for Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in network benefits. See below for additional details.
Benefit Coverage	
Outpatient Care Services	
Additional Services: • Tobacco Cessation Counseling for Pregnant Women • Freestanding Birth Center Services • Family Planning Services • Nursing Home Services • Home and Community Based Services • Self-Directed Personal Assistance Services • Institution for Mental Disease Services for Individuals 65 and older • Personal Assistance Services (30 visits per year, requires prior authorization)	Member pays nothing.
Acupuncture Services administered by American Specialty Health (Medicare-covered services limited to the treatment of chronic low back pain with no identifiable systemic cause, and is not associated with surgery or pregnancy), up to 20 visits per year.	Member pays nothing.
Ambulance	Member pays nothing.
Cardiac and Pulmonary Rehabilitation Services	Member pays nothing.

Chiropractic Care (Manipulation of the spine to correct a subluxation when I or more bones of your spine move out of position) up to 12 visits a year	Member pays nothing.
Dental Services (Limited Dental Services: This doesn't include services in connection with care, treatment, filling, removal, or replacement of teeth)	Member pays nothing.
Diabetic Supplies and Services (includes diabetes monitoring supplies, diabetes self-management training, therapeutic shoes or inserts)	Member pays nothing.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Includes Diagnostic Radiology Services (Such as MRI's, CT scans), Diagnostic Test and Procedures, Lab Services, Outpatient X-Rays, Therapeutic Radiology Services (Such as Radiation treatment for cancer)	Member pays nothing.
Doctor's Office Visits (includes primary care physician visit and specialist visit)	Member pays nothing.
Durable Medical Equipment (Medicare Part B - includes wheelchairs, oxygen, etc. and durable medical equipment for use outside the home)	Member pays nothing.
Emergency Care	Member pays nothing.
End-Stage Renal Disease	Member pays nothing.
Enhanced Benefits (Flexible Benefits) – See Member Handbook or SuperiorHealthPlan.com	Member pays nothing.
Foot Care Includes Podiatry Services (foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions, routine foot care)	Member pays nothing.
Hearing Services (includes exam to diagnose and treat hearing and balance issues, routine hearing exam, hearing aid fitting/evaluations [for up to one] and hearing aid)	Member pays nothing.
Home Health Care (includes additional hours of care)	Member pays nothing.
Inpatient Visit (benefits and limits as described in the Texas Medicaid Provider and Procedures Manual)	Member pays nothing.
Long-Term Services and Supports (LTSS) – Waiver program, requires prior authorizations • Nursing Services • Minor Home Modifications* • Emergency Response Services • Assisted Living • Adult Foster Care • Transitional Assistance Services^^ • Respite Care** • Employment Assistance • Supported Employment • Cognitive Rehabilitations Therapy • Adaptive Aids and Medical Supplies^^^ • Home Delivered Meals • Speech, Physical, Occupational Therapy • Dental Services^ • Support Consultations *$7,500 maximum benefit lifetime limit, $300 per year for repairs. **Up to 30 visits per year. ^$,5000 maximum benefit per year. ^^$2,500 maximum benefit lifetime limit. ^^^$10,000 maximum benefit per year.	Member pays nothing.
Mental Health (outpatient group therapy visit, outpatient individual therapy visit) (authorizations must be obtained from Superior)	Member pays nothing.

Non-Emergency Medical Transportation (Superior's Medical Ride Program Provided by SafeRide)	Member pays nothing.
Outpatient Rehabilitation (respiratory care services, occupational therapy visits, occupational therapy, physical therapy and speech and language therapy visit, physical therapy, additional speech, hearing and language therapy) (must receive a prior authorization and submit to Medical Director/Utilization Management review)	Member pays nothing.
Outpatient Substance Use Disorder Treatment (includes group therapy visits and individual therapy visits) (authorizations must be obtained from Superior)	Member pays nothing.
Outpatient Surgery (includes ambulatory surgical center, outpatient hospital, free-standing birth center services)	Member pays nothing.
Physician Specialist Services	Member pays nothing.
Podiatry Services (routine foot care)	Member pays nothing.
Prosthetic Devices (includes braces, artificial limbs, etc., prosthetic devices, related medical supplies, additional medical supplies)	Member pays nothing.
Psychiatric Services	See "Mental Health Care Inpatient Visit" Section.
Renal Dialysis	Member pays nothing.
Urgent Care	Member pays nothing.
Vision Services (includes exam to diagnose and treat diseases and conditions of the eye [including yearly glaucoma screening], routine eye exam, every calendar year, contact lenses and eyeglasses (lenses and frames every year (maximum allowance of $200) and eyeglasses or contact lenses after cataract surgery)	Member pays nothing.
Preventive Care	
Preventive Care (covers many preventive services, including: abdominal aortic aneurysm screening, alcohol misuse counseling, bone mass measurement, breast cancer screening [Mammogram], cardiovascular disease [behavioral therapy], cardiovascular screenings, cervical and vaginal cancer screening, colonoscopy, colorectal cancer screenings, depression screening, diabetes screening, fecal occult blood test, flexible sigmoidoscopy, HIV screening, medical nutrition therapy services, obesity screening and counseling, prostate cancer screenings, sexually transmitted infections screening and counseling, tobacco use cessation counseling [counseling for people with no sign of tobacco-related disease], vaccines, including flu, hepatitis b, pneumococcal, "welcome to medicare" preventive visit [one time], yearly "wellness" visit, family planning services, tobacco cessation counseling for pregnant women)	Member pays nothing (additional Preventive Services approved by Medicare during the contract year will be covered).
Hospice	
Hospice Care from Medicare-Certified Hospice	Member pays nothing (Member has to pay part of the cost for drugs and respite care).
Inpatient Care	
Inpatient Hospital Care (Our plan covers all medically necessary Days for an inpatient hospital stay)	Member pays nothing.
Inpatient Mental Health Care	See the "Mental Health Care" Section.
Institutional Care (Institution for mental disease services for individuals 65 or older)	Member pays nothing.
Institutional Care (Institution for mental disease services for individuals 65 or older) Non-skilled Nursing Facility	Member has to pay part of the cost as determined by the State.
Nursing Home Services	Member pays nothing
Skilled Nursing Facility (SNF) (Medicare Part A – can be submitted without having required three Day hospital stay. Secure prior authorization)	Member pays nothing
Prescription Drug Benefits	
Part B Drugs (chemotherapy drugs)	Member pays nothing.
Other Part B Drugs	Member pays nothing.
Pre-Catastrophic Coverage	

Member may get drugs at Network Retail Pharmacies and Mail Order Pharmacies	Member pays the following:
Standard Retail Cost Sharing	Tier 1 (Generic Drugs): $0 Tier 2 (Brand Drugs): $0 Tier 3 (Non-Medicare Rx/OTC Drugs): $0
Standard Mail Order Cost-Sharing	Tier 1 (Generic Drugs): $0 Tier 2 (Brand Drugs): $0 Tier 3 (Non-Medicare Rx/OTC Drugs): $0
If member resides in a long-term care facility, you pay the same as at a retail pharmacy. Member may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.	
Catastrophic Coverage	
Member may pay the following:	Tier 1 (Generic Drugs): $0 Tier 2 (Brand Drugs): $0 Tier 3 (Non-Medicare Rx/OTC Drugs): $0

Member Handbook

Every Superior STAR+PLUS MMP member receives a member handbook when enrolled in Superior. Each handbook includes information about Superior that the member needs to know, including benefits. A copy of each Superior member handbook can be accessed through:

- The Superior STAR+PLUS MMP website at MMP.SuperiorHealthPlan.com.
- Superior's Member Services department by calling 1-866-896-1844.

Spell of Illness and Annual Maximum Limitation

In the traditional Medicaid program, the spell of illness limitation is defined as 30 Days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 Days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for 60 consecutive days. This limitation applies to Superior STAR+PLUS MMP members; however does not apply to STAR+PLUS members who are admitted to an inpatient facility with a diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder, schizoaffective disorder, or schizophrenia as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). These diagnoses will remove the SOI limitation for the entire inpatient hospital stay. Also, the $200,000 annual limit on inpatient services does not apply.

Superior HealthPlan Medical Ride Program (Non-Emergency Medical Transportation Services)

What is Superior's Medical Ride Program?

Superior's Medical Ride Program provides NEMT to non-emergency health-care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. Ambulance transportation is not covered under this program Transportation services are available to MMP members.

Eligibility is based on product and program requirements. Superior is required to facilitate the most cost-effective mode of curb-to-curb transportation that meets a member's individual need. Superior can authorize an attendant to accompany the member if an additional level of service is required.

What Services Are Offered by Superior's Medical Ride Program?

There are many types of transportation services included in Superior's Medical Ride Program. They include:

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, if necessary. These are types of rides where the member is picked up and dropped off at the entrance/exit of their home or clinic.
- Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle for a covered verified completed trip to a health-care service. The ITP can be the member, the member's family member, friend, or neighbor.

If you have a member needing assistance while traveling to and from their appointment with you, Superior's Medical Ride Program will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health-care services are being provided, but may remain in the waiting room during the member's appointment.

If you have a member you think would benefit from receiving Superior's Medical Ride Program services, please refer them to Superior's Medical Ride Program provided by SafeRide at 1-855-932-2318 for more information.

How to Schedule a Ride

To request NEMT Services or for more information about services offered by Superior's Medical Ride Program, members, advocates and providers can call Superior's Medical Ride Program provided by SafeRide.

Superior members should request rides as early as possible, and at least two Business Days before they need the ride. In certain circumstances, they may request a ride with less than two Business Days' notice. These circumstances include:

- Being picked up after being discharged from a hospital;
- Trips to the pharmacy to pick up a medication or approved medical supplies;
- Trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

SafeRide

Dedicated Provider ONLY Line:	1-855-932-2322; TTY: 7-1-1
Hours:	8:00 a.m.- 6:00 p.m Monday-Friday
Appointments/Call Center:	1-855-932-2318; TTY: 7-1-1
Hours:	8:00 a.m.-6:00 p.m Monday-Friday
Where's My Ride:	1-855-932-2319; TTY: 7-1-1
Hours:	4:00 a.m. - 8:00 p.m. Monday-Saturday

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. The member should be advised to follow up with SafeRide to check on their status prior to the request date.

In situations where transportation is not part of a member's covered benefit, additional transportation assistance may be available to qualifying Superior members. Please refer members to the Value-added Services section of

their member handbook for specific information on transportation-related benefits. Providers can also direct members to contact Member Services to see if additional benefits are available to them.

How to Change or Cancel a Ride

Members must notify SafeRide prior to the approved and scheduled trip if their medical appointment is cancelled. To change or cancel a ride, the member should log into the SafeRide member portal or call SafeRide at 1-855-932-2318 at least 24 hours in advance.

Coordination with Other State Program Services

Coordination with Public Health

Superior is required, through its contractual relationship with HHS, to coordinate with public health entities regarding the provision of services for essential public health services. Providers must assist Superior in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving members.
- Reporting to the local public health entity for Tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons whom the member has come into contact within one Business Day of identification:
  - Ensuring all members who have TB or are at-risk are screened for TB.
  - Accessing procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/forms.
  - Contacting Superior's Member Services department.
- Reporting all confirmed cases of STD/HIV to the local public health entity for STD/HIV contact investigation, and evaluation and preventive treatment of persons whom the member has come into contact:
  - Accessing required forms for reporting from: http://www.dshs.texas.gov/hivstd/reporting/ or by calling Superior's Member Services department.
  - Keeping information confidential about members who have received STD/HIV services.
- Referring for Women, Infant and Children (WIC) services and information sharing for the purposes of eligibility determination.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Referring lead screening tests to the HHS laboratory.
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment.
- Identifying members who are less than three years of age and suspected of having a developmental delay or disability, and referring to Early Childhood Education (ECI) providers for screening and assessment within two Business Days from the Day the member is identified.

- Using materials from HHS available on https://hhs.texas.gov/services/disability or by contacting 1-877-787-8999.
- Complying with the release of records within 45 Days so that screening may be completed.

Coordination for Services Not Directly Provided Through Superior

There are several services that are available to Superior STAR+PLUS MMP members based on their eligibility and are accessed outside of Superior's provider network. In addition, the services are not a part of the managed care program. These services are found in the Texas Medicaid Provider Procedures Manual (TMPPM) and include the following:

- Court-ordered commitments to inpatient mental health facilities as a condition of probation.
- PASRR screenings, evaluations and specialized services for STAR+PLUS members.
- HHS-contracted providers of Long-Term Services and Supports (LTSS), Case Management or service coordination for individuals who have intellectual or developmental disabilities.
- Mental health rehabilitation services.
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- HHS hospice care.
- HHS or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, TxHmL and YES.

All network providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Superior's Member Services department.

Benefits Overview

Members participating in the STAR+PLUS MMP program receive the benefits, as listed in this section.

Superior will provide functionally necessary community LTSS services to all STAR+PLUS members beginning on the member's date of enrollment regardless of pre-existing condition, prior diagnosis and/or receipt of any prior health-care services. Superior will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in the STAR+PLUS program.

All adult members in STAR+PLUS who are not covered by Medicare, or are dual eligible and receiving STAR+PLUS Waiver (SPW) services receive unlimited medically necessary prescription drugs. Dual eligible STAR+PLUS members will continue to receive pharmacy benefits from their Medicare Part D pharmacy plan.

Long-Term Services and Supports (LTSS)

Below is a listing of the community-based LTSS included under the STAR+PLUS Medicaid managed care program. Additional information on LTSS may be found online at https://hhs.texas.gov/

The HHS Uniform Managed Care Contract Terms and Conditions is the final authority on STAR+PLUS.

Key Information for Long-Term Services and Supports Providers

As a reminder, the following are tips to providing LTSS services:

- Verify member eligibility with Superior before performing services.
- Ensure necessary referral/authorizations have been obtained from Superior prior to provision of services.
- Use the HHS provider ID given to you by Superior or your NPI and taxonomy code when filing claims for LTSS services.

- Bill and report LTSS services in compliance with the LTSS HCPCS codes and STAR+PLUS Modifiers Matrix.
- Notify the member's service coordinator whenever there is a change in the member's physical or mental condition, upon knowledge of an inpatient or nursing facility admission, all member complaints or grievances, or if you identify a member needs services outside the Superior contracted scope of services with the provider.
- Ensure for members who are eligible for both Medicare and Medicaid that covered Medicare services are billed to Medicare as primary prior to accessing services under Medicaid or HCBS STAR+PLUS waiver (SPW) services.
- Refer to the LTSS bulletin(s) posted on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com for additional information.

Traditional Benefits

Medicaid facility and community-based LTSS benefits available include:

Personal Assistant Services (PAS)

Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and delegated nursing tasks that have been delegated by a registered nurse (RN). PAS are subject to Electronic Visit Verification (EVV). See Section 19 for more details on EVV. There are three options available to STAR+PLUS members desiring the delivery of PAS:

1. **Consumer-Directed Services** - In the consumer-directed model, the member or the member's legally authorized representative is the employer of record and retains control over the hiring, management and termination of an individual providing PAS. The member is responsible for assuring that the employee meets the requirements for PAS, including the criminal history check. The member uses a Financial Management Services Agency (FMSA) to handle the employer related administrative functions such as payroll, substitute (back-up) attendant in place and filing tax-related reports of PAS.
2. **Service Responsibility Option** - In the service responsibility option, the member or the member's legally authorized representative chooses an agency in the Superior provider network who is the employer of record. In this model, the member selects the personal attendant from the agency's personal attendant employees. The schedule is set up based on the member's input, and the member manages the PAS. The member retains the right to supervise and train the personal attendant. The member may request a different personal attendant and the agency would be expected to honor the request. The agency establishes the payment rate, benefits and provides all administrative functions such as payroll, substitute (back-up) and filing tax related reports of PAS.
3. **Agency Model** - In the agency model, the member chooses an agency to hire, manage and terminate the individual providing PAS. The agency is selected by the member from a list of agencies within Superior's provider network. The Service Coordinator and member develop the schedule and send it to the agency. The member retains the right to supervise and train the personal attendant. The member may request a different personal attendant and the agency is expected to honor the request. The agency establishes the payment rate, benefits and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports of PAS. To participate as a Superior FMSA providing services under the consumer-directed model, a FMSA must be specifically identified to provide consumer direct services by HHS.

To participate as a PAS network provider with Superior, the provider must have an executed agreement with Superior, be licensed by HHS for the delivery of PAS services and must comply with the Texas Administrative Code (TAC) in Title 40, Part 1, Chapter 41, Sections 41.101, 41.103, and 41.105 and Chapter 43.

Day Activity and Health Services (DAHS)

LTSS offered to individuals residing in the community, Monday-Friday, except holidays, for a minimum of 10 hours/Day. Services include nursing and personal care services, nutrition services, transportation services, social and recreational activities and other supportive services. These services are provided at adult day care facilities licensed by the Department of State Health Services (DSHS) and certified by HHS.

Providers submitting requests for initial authorization of DAHS services should submit the relevant HHS-approved forms, or provide the following clinical elements:

1. A list of all active diagnoses related to the member's need for DAHS.
2. A description of any functional disability related to the member's medical diagnoses.
3. A current medication list, including any PRN medications.
4. A record of the member's vital signs as obtained at the time of the assessment, to include blood pressure, pulse, respiration, height, weight and blood sugar, if applicable.
5. An indication of the member's dietary needs, specifying whether the member has no special dietary requirements, or needs (for example, a bland diet, diabetic diet, low sodium diet, etc.).
6. A description of the member's personal care requirements, to include an indication of the degree of assistance required (no setup or physical assistance, one-person physical assistance or two-person physical assistance), in the following areas:
    a. Transfer
    b. Ambulation
    c. Eating
    d. Toileting
7. A description of the member's potential to stabilize, maintain or improve functioning from attending DAHS.
8. A list of the interventions to be performed by the nurse at the DAHS facility, to include the nature of the intervention as well as the frequency. For example, this may include:
    a. Occupational therapy, physical therapy or speech therapy
    b. Respiratory therapy
    c. Medication administration
    d. Wound care
    e. Meal setup
    f. Health teaching/training
    g. Other
9. Physician's orders indicating the need for LVN or RN care/supervision, along with the above elements.

Minimum Wage Requirements for STAR+PLUS Attendants

Persons providing attendant services must be paid at the prevailing minimum wage rate as set by HHS. Superior must ensure that facilities and agencies that provide attendant services in community settings pay attendants at or above the minimum rates described below. This requirement applies to the following types of services, whether or not the member chooses to self-direct these services:

- Day Activity Health Care Services (DAHS)
- Personal Assistance Services (PAS)
- Habilitation (under CFC)

This requirement does not apply to attendant services provided by non-institutional facilities, such as assisted living, adult foster care, residential care and nursing facilities.

Title 40 Texas Administrative Code §§49.312 requires that persons working as personal attendants in the services/

programs listed above, whether as employees or contractors of a provider or as employees or contractors of subcontractors, be paid at or above a specified hourly base wage.

In addition, providers are required to notify persons hired as personal attendants of the required base wage.

Newly employed or contracting attendants hired on or after September 1, 2013, must be notified of the required base wages within three Days of being hired.

Superior may require providers to submit annual attestations and sample notices to employees/contracted employees, ensuring that the minimum wage requirements were paid at or above the required hourly base wages as specified above.

HCBS STAR+PLUS Waiver (SPW) Services

Superior will provide an array of services under the HCBS STAR+PLUS Waiver (SPW). This includes the following benefits:

- **Adaptive aids and medical supplies**: Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.
- **Adult Foster Care (AFC)**: Provides a 24-hour living arrangement in an HHS-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, nursing tasks, supervision, companion services, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one Day.
- **Assisted Living (AL) Services**: Provides 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own home. Services are provided in personal care facilities licensed by HHS. Participants are responsible for their room and board costs and, if applicable, copayments for assisted living services.
- **Dental Services**: Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries. Services are capped at $5,000 per waiver plan year, but may be extended an additional $5,000 when oral surgeon services are required.
- **Emergency Response Services (ERS)**: Provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven days a week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from the individual.
- **Employment Assistance**: Provides identification of member's preferences, skills and work setting/condition needs, locating available jobs that match the member's criteria/needs and negotiating the member's potential employment with the employer. Please note, Employment Assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
- **Financial Management Services**: Services provided by Certified Financial Management Services Agencies (FMSA) to support members who hire their own service providers under the Consumer Directed Services (CDS) option.
- **Home Delivered Meals**: Meal services provide hot, nutritious meals delivered to an individual’s home. The benefit limitation is one meal per Day, and the need for a home delivered meal must be part of the individual service plan. Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered

meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food.

- **In-Home Skilled Nursing Care**: Direct delivery of skilled tasks/procedures by a registered or practical nurse based on an assessment of the member's health-care needs, guidance by professional practice standards and physician order if required. The Texas Board of Nurse Examiners allows delegation of nursing tasks to unlicensed persons following the development of a care plan and education on proper health maintenance.
- **Mental Health Rehabilitative Services**: Services are defined as age-appropriate services determined by HHS and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional behavioral or mental disorders, and to restore the member to their best possible functioning level in the community.
- **Mental Health Targeted Case Management**: Assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.
  - SPMI is defined as a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental disorders, 5th Edition (DSM-5) accompanied by:
    - Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
    - Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.
  - SED is defined as psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.
- **Minor Home Modifications**: Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home.
- **Personal Assistant Services (PAS)**: Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse (RN). PAS is subject to Electronic Visit Verification (EVV). See Section 19 for more details.
- **Respite Care Services**: Available on an emergency or short-term basis to relieve those persons normally providing unpaid care for a SPW member unable to care for themselves. In-home respite care services are subject to EVV. See Section 19 for details on EVV.
- **Supported Employment**: Service available to members who earn at least minimum wage, which provides employment adaptations, supervision and additional training to sustain employment.
- **Therapy (Occupational, Physical and Speech)**: Includes the evaluation, examination and treatment of physical, functional, speech and hearing disorders and/or limitations. A full range of services are provided in the member's home or a rehabilitative center by a licensed therapist or an assistant under the direction of a licensed therapist.

- **Transitional Assistance Services (TAS)**: Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings and set-up fees for utilities.

Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) services are provided to help Medicaid eligible children and pregnant women to gain access to necessary medical, social, educational, and other services related to a member's condition, health risk, or high-risk condition. Superior assesses a person's need for these services and then develops a service plan to address those needs. Superior is responsible for managing the delivery of CPW services for the STAR+PLUS programs. CPW services for STAR+PLUS members are limited to members who are not in Department of Family and Protective Services (DFPS) conservatorship.

Prior authorization Superior will not require prior authorization for CPW services. Services must be provided within 14 days of referral.

Program/ Population	SUPERIOR HEALTHPLAN Care Management Team (Case Managers, Service Coordinators, Service Managers)	CPW Network Provider
STAR+PLUS MMP	• Performs comprehensive screening / assessment to evaluate care needs – Identify the Member's physical, behavioral, functional, and psychosocial needs. • Engage / coordinate with the Member / Member's Legally Authorized Representative (LAR) and appropriate providers in the development, review / updates of the goals and interventions on Member's Individual Service Plan (ISP) or Plan of Care. • Assist the member / LAR in obtaining access to services including making referrals to specialty providers and scheduling appointments; with follow up to ensure needed services are provided. • Conduct post-hospitalization discharge calls to address any potential unmet needs, perform reassessments, and encourage importance of compliance with follow-up appointments and connects families to value added services. • Assist / link members with appropriate resources to address Social Determinants of Health issues such as transportation, housing, or food. • Provide health education related to the Member's health condition, health risk, or high-risk condition. • Connect the Member to Covered and non-covered services necessary to meet the Member's identified needs. • Follow up outreach and monitor to ensure needs identified in member's service plan is being met.	**CPW CAN PROVIDE:** • Conduct in-person visits for family needs assessment / evaluation of member's unmet needs, identify family challenges and strengths. • Development of service plans to meet or address the member's unmet needs. • Assist with care coordination to appropriate community resources or service providers to meet member's needs. • Follow up to ensure needs identified in the service plan are being met. **CPW CANNOT PROVIDE:** • Direct health care or health education. • Direct clinical, medical or therapy services. • Diagnosing a client, or determining a need for a specialist.

Coding & Claims submission

- CPW services are Medicaid physical health benefits, and should be billed to the appropriate physical health Superior Payer. Refer to Section 9, Claims and Encounters Administration for billing information for paper claims. Electronic claims should be submitted to Payer ID 68069.
- Procedure code G9012 is to be used for all CPW services.
- Modifiers are used to identify which service component is provided.
- CPW services are limited to one visit per day, per member.
- Additional visits on the same day from any provider will be denied as part of another service rendered on the same day.
- In addition, CPW services are not billable when a person is an inpatient at a hospital or other treatment facility.

Reminder: Billable services are defined in program rule 25 TAC §27.11.

Additional Benefits

Adult Well Check

This annual adult physical exam is an additional benefit for STAR+PLUS MMP members 21 years and older. The annual adult well exam may be received in addition to the member's annual OB/GYN visit for females. Members can self-refer to an OB/GYN provider without a referral from their PCP. All newly enrolled members should obtain a well checkup within 90 Days of enrollment.

Community First Choice (CFC)

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. The services available under CFC are:

- Personal Assistance Services (PAS): Help with daily living activities and health-related tasks.
- Habilitation: Services to help members learn new skills and care for themselves.
- Emergency Response Services (ERS): Help members who live alone or are alone for most of the day.
- Support Management: Training to help members learn how to select, manage and dismiss attendants.

Who Can Receive CFC Services?

To be eligible for Community First Choice services through Superior HealthPlan, an individual must:

- Be eligible for Medicaid and enrolled in STAR+PLUS MMP.
- Need an institutional level of care such as a hospital, an Intermediate Care Facility (ICF) for Individuals with an Intellectual Disability (IID), Nursing Facility or Institution for Mental Disease (IMD).
- Need services provided in the CFC program.

Assessments

- For STAR+PLUS MMP members with physical disabilities, Superior will complete the Medical Necessity Level of Care assessment (MN/LOC) and CFC Assessment. MN/LOC assessments will be transmitted to TMHP who makes the determinations on the NF LOC.

- For STAR+PLUS MMP members with IDD, the Local Intellectual and Developmental Disability Authority (LIDDA) will complete the Intellectual Disability/Related Condition (ID/RC) assessment and the CFC assessment for members 21 and over. Superior will complete the CFC Assessments for all members under 21. The LIDDA will transmit the ID/RC to HHS who makes the determinations on the ICF LOC.
- All CFC assessments will be person-centered and will result in a plan of care reflecting the needs and goals of the member.
- Assessments will be conducted initially and at least annually.

Authorizations

- Upon completed and approved assessments, a plan of care will be created and presented to the member.
- Member and/or their LAR and/or medical consenter will accept the plan of care and select their providers/ provider agencies for their approved CFC services.
- Superior will create and issue authorizations that will be valid for a one-year time period from the date of the initial/annual assessment.
- If a member already receiving PAS becomes eligible for habilitation services, the member may desire to switch to a habilitation-contracted provider if necessary, or decline habilitation services.
- PAS Only:
  - Members with no identified habilitation service need will select a Superior-contracted PAS provider.
  - Authorization will utilize the CFC PAS-only codes/modifiers and rate.
- PAS with HAB:
  - Members with any identified habilitation service need will select a Superior-contracted HAB/PAS provider.
  - Must use a single provider for HAB and PAS services.
  - Single authorization will utilize the habilitation codes/modifiers and rate.
- HAB Only:
  - Members with a habilitation service need, but no PAS need, will select a Superior-contracted HAB provider.
  - Authorization will utilized the habilitation codes/modifiers and rate.
- Non-CFC PAS and ERS:
  - Continue to use existing LTSS codes/modifiers and rates.

CFC Standards

- CFC services must be provided in accordance with HHS rule 1 TAC, Part 15, Chapter 354, Subchapter A, Division 27 and includes the following:
  - CFC PAS/HAB assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing and acquisition, maintenance and enhancement of skills necessary for the member to accomplish ADLs, IADLs and health-related tasks;
  - CFC ERS: Electronic devices to ensure continuity of services and supports; and
  - Support Management: Voluntary training on how to select, manage and dismiss attendants.
- The CFC services must be delivered in accordance with the member's service plan.
- Provider must have current documentation, which includes the member's service plan, ID/RC when applicable, staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable).
- Provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).

- Provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member which are required to ensure the member's health, safety and welfare. The provider must maintain documentation of this training in the member's record.
- Provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified that a DFPS investigation has begun, through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline (1-800-252-5400).
- Provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- Provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member) or other person who files a complaint, presents a complaint, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- Provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- Per the CFR §441.565 for CFC, the provider must ensure that any additional training requested by the member/LAR of CFC PAS/HAB service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The provider must adhere to Superior's billing guidelines as outlined in Section 9 of this manual. In addition, proper procedure codes and CFC modifiers must be used when billing. Furthermore, all attendant services and habilitation providers/provider agencies must use an HHS-approved Electronic Visit Verification (EVV) vendor to submit their timesheets. Additional details about EVV can be found in Section 19 of this manual.
- The provider must prevent conflicts of interest between themselves, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The provider must prevent financial impropriety toward a member including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Cognitive Rehabilitation Therapy (CRT)

CRT is a service that assists an individual in learning or re-learning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT has been proven to help individuals with an acquired brain injury (ABI) recover or compensate for cognitive skills that have been lost or altered as a result of damage to brain cells or brain chemistry.

To qualify for CRT, the services must be deemed medically necessary, the member must be enrolled in the SPW and have:

- Medicaid eligibility.
- A need for at least one HCBS service.
- An approved medical necessity/level of care MN/ LOC.

Establishing Medical Necessity for CRT

One of the two following assessment tests must be performed on a qualifying member, and indicate the need for CRT. These tests are a covered benefit.

- Neurobehavioral Assessment - performed by a physician, nurse practitioner or physician assistant.
- Neuropsychological Assessment - performed by a psychiatrist, psychologist, neuro-psychologist or licensed psychological associate.

For dual eligible members receiving acute care through Medicare, Superior will still help establish medical necessity and coordinate the assessment test with the member's Medicare provider.

Providers of CRT

Treatment is provided in an outpatient setting or in the member's home and is overseen by a physician or neuro-psychologist and requires judgment, knowledge and skills of a speech and language pathologist or occupational therapist.

Dental Services

Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries are a benefit available to SPW members. Services are capped at $5,000 per waiver plan year, but may be extended an additional $5,000 when oral surgeon services are required.

Financial Management Services

Financial Management Services (FMS) are a benefit available to SPW members. Certified Financial Management Services Agencies (FMSA) provide assistance to members to manage funds associated with services elected for self-direction and is provided by a Consumer-Directed Service option. Examples of FMS include, but are not limited to:

- Providing required initial orientation, ongoing training, assistance and support for employer-related responsibilities.
- Verifying qualifications of applicants before services are delivered and monitoring continued eligibility of service providers.
- Approving and monitoring budgets for services delivered through the CDS option.
- Managing payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies (FMSAs are not allowed to use a payroll agent).
- Complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings and benefits.
- Preparing and filing required tax forms and reports.
- Paying allowable expenses incurred by the employer.
- Providing status reports concerning the individual's budget, expenditures and compliance with CDS option requirements.
- Responding to the employer or designated representative as soon as possible, but at least within two Business Days after receipt of information requiring a response from the CDS Agency.

Intellectual Disabilities (IDD)

Members with Intellectual and Developmental Disabilities (IDD) or Related Conditions (RC) who do not qualify for Medicare, and receive services through the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) program or an IDD waiver can receive Acute Care Services through Superior STAR+PLUS MMP. Authorization will be required for applicable medically necessary acute care services as well as any behavioral health services managed by Superior.

Note: These individuals will not be eligible for SPW services while enrolled in the ICF-IID program or an IDD waiver.

Prescriptions

All prescriptions for STAR+PLUS MMP members are adjudicated according to the tier structure in the table at the end of Section 4 of this manual. Benefits may change on January 1 of each year. Limitations and restrictions may apply.

Service Coordination

The Superior Service Coordinator provides a specialized level of care coordination that includes but is not limited to:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an integrated plan of care in coordination with the Primary Care Provider (PCP) and other managing providers, that considers the member's and caregiver's goals, preference and desired level of involvement in the plan of care.
- Identification of barriers to meeting goals or complying with the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Active coordination of care linking enrollees to providers, medical services, residential, social and other support services where needed.
- Continuity and coordination of care.
- Development of a schedule for follow-up and communication, ongoing monitoring, and documentation of all service coordination activities.
- A process to assess member's progress against the plan of care and revision of the plan of care as required by changes in the member's condition.
- Development and communication of member self-management plans.
- Addressing the member's right to decline participation in the service coordination program or disenrollment at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all service coordination procedures in compliance with HIPAA and state law.
- Completing mandatory telephonic or face-to-face contacts with members.

Service coordination services provided to members are:

- Reviewing of assessments and developing a plan of care utilizing input from member, family and providers.
- Coordinating with the member’s PCP, specialist and LTSS providers to ensure the member’s health and safety needs are met in the least restrictive setting.
- Referring members to support services such as disease management and community resources.
- Authorizing LTSS services.

Service coordination utilizes a multidisciplinary approach in meeting the member's needs, including behavioral health.

Levels of Service Coordination

Superior has a defined set of service coordination population criteria for stratification purposes within our lines of business. This creates efficiencies within the service coordination program and provides a consistent measurement process of service coordination program effectiveness. There are two levels of service coordination. Level 1 is reserved for the medically complex members who are supported by home and community based waiver services and or have complex medical needs. Level 2 service coordination is comprised of members who did not meet parameters for Level 1. Each member is assigned a Service Coordinator upon enrollment. Any member or provider may speak to the member's Service Coordinator by calling 1-855-772-7075, Monday through Friday 8:00 a.m. to 5:00 p.m.

Level 1

- Members receiving Home and Community-Based Services, STAR+PLUS Waiver (SPW) services and/or with complex medical needs.
- Members who reside in or move from nursing facility/institution to community.
- Members with SPMI.

Level 2

- Members who do not meet Level 1 criteria.
- Non-waiver members receiving Personal Assistance Services (PAS) or Day Activity and Health Services (DAHS).
- Members not receiving LTSS with a history of BH and/or substance use issues during the previous year.

Companion Cases

- Both members will be assigned the same Service Coordinator at the highest level of complexity.

Discharge Planning

The Service Coordinator collaborates in concurrent review with Superior's clinicians who follow members while they are in a hospital setting in order to schedule needed assessments and work with the member, family, attending physician, discharge planner, PCP and other relevant providers to coordinate services and equipment required at discharge. If a member was receiving any LTSS prior to admission to a hospital, once a member is discharged, service coordination staff notifies LTSS providers to resume services. If an LTSS provider becomes aware of a member that is admitted to a hospital, the provider should alert the Service Coordinator when services cease after the admission and resume once the member returns home from the hospital.

Transition Plan

Superior's Continuity of Care Transition Plan ensures consistent, unduplicated care without disruption for all new members receiving care at the time of enrollment from in-network and out-of-network providers including, but not limited to: PCPs, specialists, behavioral health (BH), LTSS and home health providers. We identify new members receiving care from out-of-network providers in multiple ways such as: current service files and information from the transferring MCO or HHS, provider authorization requests, completed Health Risk Assessment (HRA), outreach to LTSS providers, PCPs, BH and/or other specialty providers not reflected on transfer files, and other member or provider contact or referrals.

For services ordered prior to the member's enrollment, (e.g., medical equipment or supplies or home modifications approved but not completed prior to enrollment), Superior staff contact the provider to ensure the member continues to receive these services. The Service Coordinator will contact the member to ensure there are no gaps in services. LTSS

providers should contact service coordination for current service authorizations at the time of enrollment with Superior.

Effective March 1, 2015, Superior began managing members residing in nursing facilities.

Members entering into a nursing facility will receive an assessment within 30 Days of admission by their Service Coordinator. The Service Coordinator works with the member, family and providers to develop/implement a transition plan that includes necessary community LTSS and transition services. Members interested in transitioning out of the nursing facility will receive an assessment and education regarding the transition process from the Service Coordinator.

Level 1 and 2 members are assigned a Service Coordinator upon enrollment. Any member or provider may speak to the member's assigned Service Coordinator by calling 1-855-772-7075.

Members will be provided with the assigned Service Coordinator's contact information within 5 Business Days. Superior will post Service Coordinator assignments to the Secure Provider Portal as well as notify the member of any changes. Superior must notify members within 5 Business Days of the name and phone number of their new Service Coordinator, if their Service Coordinator changes.

Start Smart for Your Baby® Program

Start Smart for Your Baby® (Start Smart) is an award-winning program available to women who are pregnant or just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum and newborn periods. The program includes mailed educational materials for newly identified pregnant members and for new mothers after delivery.

Start Smart members are also encouraged to participate in educational seminars. Seminar topics include information related to plan benefits, pregnancy, breast feeding, postpartum and newborn health topics. These events are conducted with the assistance of community resource specialists. Home based visits are also available to members, as needed.

Puff Free Pregnancy® Program

Puff Free Pregnancy® is a program aimed at eliminating tobacco use during pregnancy. The program provides telephonic outreach, education and support services to reduce the health risks associated with smoking during pregnancy, such as low birth weight and perinatal mortality, by reducing the use of tobacco products. Internal clinical guidelines for the program are developed from nationally recognized evidenced based guidelines published by the American College of Obstetricians and Gynecologists and the U.S. Public Health Services. Members are identified for the program by a provider, Service Coordinator or through self-referral. A lifestyle coach works with the member to develop an individualized quit plan. Program length is from the date of enrollment until delivery with post-delivery abstinence status documented by telephone.

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother’s Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant’s Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR Health	STAR Health	STAR Health	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHS mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

Please note: Breast pumps are only a benefit after delivery.

Support Consultation Services (SCS)

Support consultation is an optional service offered to SPW members who receive services through the Consumer Directed Service (CDS) option. Support consultation, delivered by an HHS-certified support advisor, provides coaching and training for employer-related issues such as interviewing, hiring or managing of providers. Financial management services (FMS) are provided by financial management service agencies (FMSAs). A FMSA must have a sufficient number of certified support advisors available as an independent employee hired by the individual using the CDS option or through a contract to provide services when requested by an employer.

A certified support advisor may provide services as an independent employee or through an entity (not providing other program or Care Management services to the individual receiving services) or through employment or contract with a FMSA. Support consultation may be provided over the phone or in person. An applicant must be able and willing to fulfill the requirements of Texas Administrative Code, Title 40, Part 1, Chapter 41, Consumer Directed Services (CDS).

Support consultation is not a separate billable service to Superior. If SCS is needed for members who choose the CDS option, it can be built into the member's budget. Providers should refer to the HHS rate analysis for LTSS to determine rates that are allowed to be used for determining the member's budget.

Flexible Benefits

Superior STAR+PLUS MMP members have access to additional services, beyond covered services, depending on their health needs. Collectively, this additional coverage is referred to as Flexible Benefits. Flexible Benefits may vary based on whether or not a member has HCBS SPW coverage. Restrictions and limitations may apply. For an up-to-date list of these benefits, go to MMP.SuperiorHealthPlan.com.

For a list of Flexible Benefits, more information or other extra services, please call 1-877-391-5921.

STAR+PLUS MMP Covered Services (Wrap Services)

STAR+PLUS MMP members are eligible for covered wrap services, which include:

- Acute Covered Services (Medicare) - Medicare Part A covers hospital services, meals, general nursing and drugs as part of inpatient treatment, and other hospital services and supplies. This includes the care in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study and mental health care.
- Additional Days beyond Medicare-covered for Skilled Nursing Facility
- Additional Days for Inpatient Hospital Acute
- Additional Days for Inpatient Hospital Psychiatric
- Additional Physical Therapy and Speech Therapy Services
- Durable Medical Equipment for use outside the home
- Family Planning Services
- Flexible Benefits – STAR+PLUS MMP members also have access to extra services in addition to their regular benefits. These are referred to as flexible benefits. Prior authorization is required before use. Superior offers:
  - Access to unlimited routine Podiatry services in addition to what is currently available under

the Medicare program.
  - Emergency Response Services (ERS) available to non-waiver STAR+PLUS MMP members age 21 and older who do not reside in a nursing facility or ICF-IDD residential home.
  - Extra Dental Services available to non-waiver STAR+PLUS MMP members age 21 and older including preventive and comprehensive, up to a maximum allowance of $750.
  - Extra Vision services including one routine eye exam every calendar year. One pair of contact lenses and eyeglasses (lenses and frames) every calendar year with a maximum allowance of $200.
  - Home delivered meals available to non-waiver STAR+PLUS MMP members age 21 and older following discharge from a hospital or Nursing Facility.
  - Over-the counter (OTC) benefit offering up to $35 per month for certain commonly used OTC items.
  - Respite care available to non-waiver STAR+PLUS MMP members age 21 and older with certain complex and chronic conditions.
- Freestanding Birth Center Services
- Home and Community Based Services
- Home Health Services - Additional Hours of Care
- Institution for Mental Disease Services for Individuals 65 or Older
- Non-Emergency Medical Transportation (Superior's Medical Ride Program)
- Nursing Home Services
- Occupational Therapy Services - Non-Medicare benefit
- Personal Emergency Response System
- Prosthetics/Medical Supplies - Non-Medicare benefit
- Rewards and Incentives offered by Superior:
  - A $20 gift card for annual diabetes screening - HbA1c test.
  - A $20 gift card for annual diabetes screening - kidney screening.
  - A $20 gift card for annual diabetes screening - retinopathy screening (dilated eye exam).
  - A $20 gift card for members completing annual Breast Cancer Screening.
  - A $20 gift card for annual colorectal screening.
  - A $20 gift card for members completing an annual wellness visit, one per year.
  - A $20 gift card for members obtaining a flu vaccine, one per year.
- Self-Directed Personal Assistance Services
- Services for HCBS SPW members: Nursing Services
  - Adaptive Aids and Medical Supplies
  - Adult Foster Care
  - Assisted Living Services
  - Behavioral Health Care Services
  - Cognitive Rehabilitation Therapy
  - Counseling Services
  - Dental Services
  - Emergency Response Services
  - Employment Assistance
  - Enhanced Disease Management
  - Habilitation Services
  - Home Delivered Meals

  - Minor Home Modifications
  - Occupational Therapy.
  - Personal Assistance Services
  - Remote Access Technologies
  - Respite Care
  - Speech, Hearing and Language Therapy
  - Support Consultation
  - Supported Employment
  - Telemonitoring Services
  - Transitional Assistance Services
- Tobacco Cessation Counseling for Pregnant Women

Nominal Gifts

The Medicare/Medicaid anti-kickback statute prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value to induce referrals for items or services payable by a federal health-care program.

The beneficiary inducement statute prohibits a provider from giving anything of value to a Medicare beneficiary to influence the beneficiary including purchasing an item from the provider. There is a nominal value exception to the inducement statute, which provides that a provider can give a gift to a beneficiary so long as the gift has a retail value of $10 or less and so long as the collective retail value of gifts given to any one beneficiary does not exceed $50 over 12 months.

Providers should never give a gift in exchange for a referral.

For Medicare and Medicaid patients: Each item may not have a retail value in excess of $10; the retail value of all items given in any one-year period to any one patient must not exceed $50.

Gifts with a retail value greater than $10 may be donated to charities, including patient advocacy groups, to benefit families and individuals in need, provided that the gifts do not specify which group—such as ABC patients—or which individual is to receive the gift.

- Providers are encouraged to refer to the Medicare Marketing Guidelines available at www.cms.gov for additional information.

SECTION 5
ROUTINE, URGENT AND EMERGENCY SERVICES

Routine, Urgent and Emergency Services Defined

Medically necessary health services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided. Medically necessary health services must also be provided at the most appropriate level or supply of service which can safely be provided and could not be omitted without adversely affecting the member's physical health or the quality of life.

Except for emergency care in a true emergency, members are encouraged to contact the PCP prior to seeking care. In the case of a true emergency, members are encouraged to visit their nearest emergency department.

The following are definitions for routine, urgent and emergency care:

- Routine care is health care for covered preventive and medically necessary health-care services that are non-emergent or non-urgent, designed to prevent disease altogether, to detect and treat it early or to manage its course most effectively. Examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.
- An urgent condition is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical treatment evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.
- An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:
  - Placing the member's health in serious jeopardy.
  - Serious impairment of bodily functions.
  - Serious dysfunction of any bodily organ or part.
  - Serious disfigurement.
  - With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Access to Routine, Urgent and Emergent Care

Members must have access to covered services within the timelines specified by HHS and Texas Department of Insurance (TDI). "Day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first. In coordination with the definitions above, this includes the following:

- Routine primary care must be provided within 14 Days (unless requested earlier by DFPS).

- Routine specialty care referrals must be made on a timely basis, based on the urgency of the member's medical condition, but no later than five Days.
- Initial outpatient behavioral health visits must be provided within 14 Days.
- Urgent care, including urgent specialty care, must be provided within 24 hours.
- Emergency services must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities.

Non-Emergency Services

Non-emergency primary care services are not covered benefits for members of Medicaid managed care health plans when those services are delivered in the hospital-based emergency department (ED). A PCP and/or specialist physician in a physician office and/or clinic setting primarily provides these services. When a member seeks services that are not considered a covered benefit in the hospital-based ED, the provider of those services can bill a member if the member has been properly informed in advance of their potential financial liability. The determination of an emergency condition is based on the prudent layperson definition as described above under emergency medical condition.

Below are examples of non-emergency situations:

- Routine follow up care
- Removal of sutures
- Well child checkups/adult checkups
- Immunizations, including tuberculosis
- Other non-emergency primary care services

Hospital Emergency Department Claims

Hospital ED claims are coordinated in accordance to the rate schedule included in the Medicare contract agreement between Superior and the hospital. For out-of-network providers, hospital emergency department claims are coordinated in accordance with CMS and state guidelines.

Emergency Service Claims Appeals

Providers may appeal determinations made during this emergency department claims adjudication process. Emergency department denials are based on a prudent lay person's determination, and are therefore not Adverse Benefit Determinations. Emergency department claims denied as not meeting the prudent layperson definition of emergency care are considered non-covered benefits, and the member can be held financially responsible for the denied services, if the appropriate financial responsibility documents have been signed by the member. Superior recognizes that it is not in the member's best interest to receive routine (non-emergency) episodic care in the emergency department and members are best served by receiving care from their PCP. Superior has an education process for its members and providers through several modes of communication. The goal is to form a clear understanding of what constitutes covered emergency benefits, what access standards are contractually required for all PCPs and how improved access to appropriate levels of care will result in improved health outcomes.

Urgent/Emergent Hospital-to-Hospital Transportation

Superior is required to cover emergency ambulance transportation services. Urgent/emergency hospital-to-hospital transportation does not require prior authorization. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition is not available at the first facility and Superior has not

included payment for such transports in the hospital reimbursement. Emergency air transportation providers should notify Superior within one Business Day of providing emergency air transportation, when applicable.

Non-Emergent Ambulance Transportation

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

All ambulance transports which do not meet the definition of an emergency medical condition as per 1 TAC §353.2 require prior authorization, including:

- All facility-to-facility transports
- All out of state transports
- All air, ground and water transports

Prior authorization may be obtained by:

- Calling the Medical Management department at 1-800-218-7508.
- Faxing a request for prior authorization.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through our Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Authorization Tips

Authorizations are only accepted from a Medicaid-enrolled physician, Nursing Facility, health-care provider or other responsible party in accordance with Human Resources Code (HRC) §32.024 (t). Other responsible parties include staff working with a health-care service provider submitting prior authorizations on behalf of the provider or facility.

If the request is submitted by administrative staff, the request will still be required to include the physician's or physician extender's orders with the prior authorization unless the physician or physician extender sign the prior authorization form.

An ambulance provider may not request a prior authorization for non-emergent ambulance transports. Ambulance providers may assist in providing necessary information such as NPI number, fax and business address to the requesting physician but the prior-authorization request must be signed and submitted by the Medicaid-enrolled physician, health-care provider or other responsible party.

Approvals/Denials

Superior utilizes approved utilization management criteria to review requests for medical necessity. Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider. The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied. Appeals for denials of medical necessity follow the standard provider appeal process, refer to the Appeals section (Section 10: Adverse Benefit Determinations, Actions and Appeals) of this manual.

SECTION 6
BEHAVIORAL HEALTH SERVICES

Superior manages behavioral health services (mental health and substance use disorder) for Superior members. Superior is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance use disorder providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals and Local Mental Health Authority (LMHA) facilities.

The availability of specific behavioral health services is determined by the scope of Medicaid benefits offered through HHS programs. Please refer to Section 4 - Covered Benefits and Flexible Benefits.

Please note inpatient hospital services require notification through Superior. This includes services provided in freestanding psychiatric facilities. Notification requirements are outlined in Section 8 - Prior Authorization, Notification and Referrals.

Some members are eligible for Flexible Benefits. Flexible Benefits are behavioral health services, benefits or positive incentives that HHS determines will promote healthy lifestyles and improve health outcomes among members. For a complete listing of Superior's current flexible benefits, refer to the Superior member handbook.

To access behavioral health benefits, please contact Provider Services or visit the Superior website at SuperiorHealthPlan.com.

Behavioral Health Services Explained

Behavioral health services are covered services for the treatment of mental or emotional disorders and for the treatment of substance use disorders. Superior has defined "behavioral health" as encompassing both acute and chronic psychiatric and substance use disorders as referenced in the most recent ICD-10-CM/PCS. Superior reviews, authorizes and pays medically necessary claims for behavioral health providers when the primary diagnosis is for behavioral health services.

Superior will authorize, review and pay claims for medically necessary treatment, including inpatient hospital services. Superior's clinical program focuses on individualized treatment strategies that promote resiliency and recovery using evidence-based practices. The goal of this program is to support the provision and maintenance of a quality-oriented patient care environment, and to provide easy access to quality mental health and substance use disorder, treatment services. Providers may reach out to Superior for available trainings on these programs, including Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), Trauma Informed Care (TIC), Parent-Child Interaction Therapy (PCIT), Trust Based Relational Intervention (TBRI) and Child Parent Psychotherapy (CPP).

Primary Care Provider's Role in Behavioral Health

Primary Care Providers (PCPs) are responsible for coordinating the member's physical and behavioral health care, including making referrals to behavioral health practitioners when necessary. However, the member does not need a referral to access mental health or substance use disorder treatment with a participating Superior provider. The PCP serves as the "medical home" for the patient.

In addition, PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. PCPs can also reference Superior's behavioral health assessment tool online at SuperiorHealthPlan.com to assist in making appropriate referrals.

PCPs may provide behavioral health-related services within the scope of their practice.

Reimbursement

Claims billed by a physical health provider will be considered for reimbursement by Superior when billed with an ADHD diagnosis code. Reimbursement will be based on the prevailing Texas Medicaid fee schedule and the contracted reimbursement agreement with Superior.

Intensive and/or Complex Care Management

Superior operates a behavioral health Intensive Care Management (ICM) program staffed with licensed behavioral professionals and led by the Superior medical director. PCPs can refer members into this program by contacting Superior's Provider Services department at 1-877-391-5921, Monday through Friday 8:00 a.m. to 5:00 p.m. Members demonstrating a high level of risk or high needs, or that have unmet psychosocial needs, may be included in this program. The program components include:

- A screening assessment tool.
- A comprehensive assessment once admitted to the program.
- The development of a care plan in conjunction with the member, the member's family, social support system and the managing practitioner.
- A referral to the appropriate providers, as necessary.
- Regular monitoring of the member's progress in the care plan.
- Focus studies and utilization management reporting requirements (specified by individual mental health service type).

Superior's Intensive Care Management staff collaborate on members with both medical and behavioral health diagnoses. With permission from the member, efforts are made to collaborate and share information with both medical and behavioral health providers treating the member. Coordination with other agencies and service providers that enhance the ability of members to receive appropriate and necessary services, such as transportation or community service organizations, are also considered an integral part of the program.

Emergency Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. In an emergency, without immediate intervention and/or medical attention, the member would present an immediate danger to himself/herself or others, or would be rendered incapable of controlling, knowing or understanding the consequences of their actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service.

An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:

- Suicidal.
- Homicidal.
- Violent towards others.
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living.
- Alcohol or drug dependent with signs of severe withdrawal.

There is no required pre-certification or notification of emergency services, including emergency room and ambulance services.

Mental Health Targeted Case Management

STAR+PLUS MMP members may qualify for Targeted Case Management. Targeted Case Management is designed to assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these based on a standardized assessment (the Child and Adolescent Needs and Strengths [CANS] or Adult Needs and Strengths Assessment [ANSA]) and other diagnostic criteria used to establish medical necessity. Targeted Case Management does not require prior authorization through Superior for participating providers.

Mental Health Rehabilitative Services

STAR+PLUS MMP members may qualify to receive Mental Health Rehabilitative Services. Mental Health Rehabilitation Services are defined as age-appropriate services determined by HHS and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders, and to restore the member to their best possible functioning level in the community.

Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan. Mental Health Rehabilitation Services do not require prior authorization through Superior for participating providers.

Member Access to Behavioral Health Services

Superior members may access behavioral health services via the following:

- A referral from their PCP (however, a referral from the PCP is not required to access behavioral health services).
- Member self-referral to any Superior network behavioral health provider. Contact Superior directly at 1-866-896-1844 .

Coordination Between Behavioral Health and Physical Health Services

Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success. To advance this objective, providers are required to obtain a consent for disclosure of information from the member, permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.

If the member refuses to release the information, they should indicate their refusal on the release form. In addition, the provider will document the reasons for declination in the medical record. Superior monitors compliance of the behavioral health providers to ensure a consent and an authorization to disclose information form has been signed by the member. Superior also ensures that regular reports are sent to the PCP, for members agreeing to the disclosure.

Superior promotes the development of Integrated Primary Care (IPC) at the member's Medical Home (Primary care) and involves the integration of behavioral health services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same provider ideally, or by the behavioral health provider seeing the member in tandem with the PCP. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes behavioral health care that occurs either before or after the primary care and at the same or a different location. Information on IPC, integrated physical and behavioral health care, and other useful resources and tools can be found online at http://www.integratedprimarycare.com.

Primary Care Provider Requirements

Primary Care Providers are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must include, at a minimum:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider that referred the member.

- Make referrals to behavioral health providers when assessment and/or screening tools reveal the need for:
  - A mental health referral, including identification of Severe Emotional Disturbance [SED]
  - Substance use disorder
  - Developmental disability assessment

Behavioral Health Provider Requirements

Behavioral health providers agree to:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment, with the member's or the member's legal guardian's consent.
- Only provide physical health services if such services are within the scope of the network practitioner's clinical licensure.
- Send initial and quarterly (or more frequently if clinically indicated or court-ordered) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent.
- Contact members who have missed appointments within 24 hours to reschedule appointments.
- Ensure Network Facilities and Community Mental Health Centers discharging members from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven Days from the date of discharge.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities.
- Provide an attestation to the MCO that the organization has the ability to provide, either directly or through sub-contract, the members with the full array of MHR and TCM services as outlined in the Recovery Utilization Management Guidelines (RRUMG), and the Uniform Managed Care Manual, Chapter 15 as part of Credentialing process.
- Complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools if providing Mental Health Rehabilitative Services (MHR) and Targeted Case Management (TCM).
- Use Department of State Health Services Resiliency and RRUMG as the medical necessity criteria for MHR and TCM services.
- Qualified Mental Health Professionals for Community Services (QMHP-CS) requirement minimums are as follows:
  - Demonstrated competency in the work to be performed.
  - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education or early childhood intervention; or be a Registered Nurse (RN).
  - An LPHA is automatically certified as a QMHP-CS. A Community Services Specialist (CSSP), a Peer Provider and a Family Partner can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. A Peer Provider must be a certified peer specialist, and a Family Partner must be a certified Family Partner.
  - The name of a performing provider is not required on claims submitted to Superior, if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs and Targeted Case Managers).

- A qualified provider of Mental Health Rehabilitative and Targeted Case Management services must:
  - Demonstrate competency in the work performed.
  - Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education or early childhood intervention.
  - Be a Registered Nurse (RN).
  - Follow HHS established qualification and supervisory protocols.
- Superior is prohibited from establishing additional supervisory protocols with respect to the providers of TCM or MHR.

ICD-10 Diagnostic Codes for Behavioral Health Claims

Medical record documentation and referral information must be documented using the ICD-10 classifications, as well as the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Laboratory Services

Behavioral health providers should facilitate the provision of in-office laboratory services for behavioral health patients whenever possible or at a location that is within close proximity to the behavioral health provider's office. Providers may refer Superior members to any in-network independent laboratory as needed for laboratory services.

Department of Family and Protective Services

Behavioral health providers and/or physical health providers who are treating a behavioral health condition are responsible for appropriate referrals to the Department of Family and Protective Services (DFPS) for suspected or confirmed cases of abuse.

To report concerns of abuse, neglect or exploitation of children, the elderly or people with disabilities, contact the Texas Abuse/Neglect Hotline at 1-800-252-5400 or www.txabusehotline.org.

Behavioral health providers and/or physical health providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from, or has been placed in, conservatorship of DFPS and must respond to request from DFPS by providing medical records.

Court-Ordered Commitments and Claims

A member, birth through 20 years of age and 65 years of age and older, who has been ordered to receive inpatient psychiatric services by a court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Superior cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for members, birth through 20 years of age and 65 years of age and older. Superior will not deny, reduce or controvert the court orders for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute

care hospital. Superior may not limit substance use disorder treatment or outpatient mental health services for members of any age provided pursuant to a court order or a condition of probation. The member can only appeal the commitment through the court system. These requirements are not applicable when the member is considered incarcerated, as defined by Uniform Managed Care Manual (UMCM) Chapter 16.

To ensure services are not inadvertently denied, providers must contact Superior at the numbers listed in this section and provide telephonic or written clinical information as well as a copy of the court order.

Any professional services provided that are part of a court order must be billed with an H9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court-Ordered Services that require authorization or notification per Superior's prior authorization list must also have an authorization.

Facilities providing Court-Ordered Services should bill using the appropriate code (8 or 08 per the Texas Medicaid Provider Procedures Manual) in the Source of Admission field of the UB-04 claim form.

Superior will make best efforts to authorize services from the court order once provided. To ensure accurate claims payment, the provider should call 1-877-391-5921.

SECTION 7
MEDICAL MANAGEMENT

Superior's Medical Management department works with its network providers to facilitate quality care through its refined Medical Management program. This program includes utilization management and disease management, as well as other features such as 24-hour nurse triage, referrals, second opinions, prior authorization/pre-certification, concurrent review, retrospective review and discharge planning. This section focuses on utilization management and disease management. See Section 8 for information on prior authorization, notifications and referrals.

A special certification for Utilization Review Agents (URA) is issued through the Texas Department of Insurance (TDI), and required to conduct utilization review in Texas. Superior contracts with several Texas licensed URAs to perform utilization review. A list of the name and license number for each contracted URA is listed below.

- Centene Management Company, LLC - URA #5396
- Centene Pharmacy Services, Inc. - URA #1774935
- Magellan Healthcare, Inc. - URA #5197
- Evolent (Formerly National Imaging Associates Inc.)- URA #5258
- TurningPoint Healthcare Solutions, LLC - URA #2395464

Utilization Management Criteria

Utilization management decisions are made in accordance with currently accepted medical or health-care practices, taking into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. Criteria are used for the review of medical necessity, as well as provider peer-to-peer review. The medical director reviews all potential Adverse Benefit Determinations for medical necessity. At least annually, the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria. Providers can contact Provider Services at 1-877-391-5921 to request a copy of the criteria used to make a specific decision. Utilization review decision making is based on appropriateness of care and service and the existence of decision. Superior does not reward providers or other individuals for issuing medically necessary denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

InterQual criteria are used to determine medical necessity. InterQual was developed by generalist and specialist physicians representing a national panel from academic as well as community-based practices, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. Superior also utilizes 28 T.A.C. §3.8001 et seq. for substance use disorders.

Disease Management

Disease management is defined as a system of coordinated health-care interventions and communications for populations with conditions in which patient self-care efforts are significant. Superior provides disease management for chronic medical and behavioral health conditions to help individuals improve their health and well-being. Superior health coaches coordinate with both the member and their providers to focus on disease-

specific conditions as listed below. To refer a member for disease management services, contact Superior HealthPlan at 1-800-218-7453. To learn more about Superior's Disease Management Programs, please see the Disease Management Program Guides located at https://www.SuperiorHealthPlan.com/providers/resources/quality-improvement.html under Quality Resources.

Types of Disease Management

Available disease management programs vary by product in which the member is enrolled. Superior's available disease management programs available include:

- Asthma
- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Depression

Disease Management Process

Superior uses medical and pharmacy claims, utilization and health screening data and referrals to identify potentially eligible members with qualifying conditions for disease management. Once identified, members are sent an introductory mailing. Outreach calls to the member are made by a health coach to introduce the disease management program, assess their willingness to participate, enroll them in the program and complete an initial assessment. Members are assigned a health coach with expertise in the member's primary condition. The health coach will coordinate with providers, members of the service coordination or Care Management teams (if applicable), and assist with special needs such as nutrition, exercise and social services. Coaching includes a series of pre-scheduled outbound phone sessions.

SECTION 8
PRIOR AUTHORIZATION, NOTIFICATION AND REFERRALS

A prior authorization is a formal medical necessity determination request submitted to Superior by a provider prior to a service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior Authorization Requirements

Superior has adopted a prior authorization process for specific procedures and/or services. These procedures and/or services are listed on Superior's prior authorization list. The prior authorization list can be found by visiting Superior's website at www.SuperiorHealthPlan.com. To look up by code, refer to the prior authorization look up tool found on SuperiorHealthPlan.com/MMPPriorAuth.

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

Authorization Process

When calling in to request an authorization or to notify of a patient admission, please have available the Tax Identification Number (TIN) and National Provider Identifier (NPI) or LTSS ID Number (Atypical ID) that you will use to bill your claim. The representative handling your call will be requesting the numbers from you. If you do not have your identifiers available, your request will not be processed and you will be asked to call back with the necessary information. It will be very important that the numbers you use to request your authorization match the numbers you will use to bill your claim or your claim will deny.

If you have any questions about this requirement, you can call the Provider Services hotline, Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, 1-877-391-5921. During after-hours, state-approved holidays, and weekends the Provider Service line is answered by Superior's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services.

Timelines for Initiating a Prior Authorization

Requesting providers must initiate a prior authorization of non-emergency services (e.g., elective inpatient admissions, elective/outpatient services) prior to providing the requested service. It is recommended that requests be submitted five Business Days prior to the desired start date in order to allow time for processing. Submit requests by contacting Superior's Prior Authorization department at:

Phone: 1-800-218-7508 (For discharge planning, contact 1-844-495-2361. For behavioral health, contact 1-844-744-5315.)
Fax: 1-800-690-7030 (for behavioral health, fax 1-855-772-7079)
Website: www.SuperiorHealthPlan.com

Please note, if any prior authorization form is returned with the language "PA Not Required" the requesting provider should verify if the service is a covered benefit and requires authorization. To see if a service requires prior authorization, providers should use the prior authorization tool located on the Superior website https://www.SuperiorHealthPlan.com/providers/preauth-check.html. If you have an urgent request that requires immediate attention after normal business hours, or on the weekend, please contact Superior's 24/7 Nurse Advice Line at 1-866-896-1844.

Prior Authorization Notification Process for Incomplete Information or Insufficient Documentation (IPAR)

For any incomplete or insufficient documentation prior authorization request for STAR+PLUS MMP members for Medicaid only covered services, Superior will return the request to the provider by faxing a letter detailing the information necessary to complete the prior authorization request. Superior will notify the member of the request for additional/complete information that was sent to the provider.

If the documentation/information is not provided within three Business Days from Superior's provider notification of insufficient or incomplete documentation, the request may result in an adverse benefit determination. The provider may resubmit with a new request once they have the necessary documentation that would render the request complete.

Prior Authorization Turn Around Times (TAT)

Superior will respond to prior authorization requests within three Business Days, after receipt of the complete request for authorization of services. This excludes LTSS authorizations.

Urgent requests for services to be rendered within 24 hours may be submitted with a signed acknowledgement of the requesting physician. These requests will be completed by the close of the next Business Day after receipt.

Superior's prior authorization form and Inpatient Notification form include requirements for a physician's signature. In order to eliminate any delays, all clinical information required must be submitted along with the authorization request signed by the requesting physician.

Authorization TAT Requirements

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

Description	Turnaround Time
Initial Concurrent	As soon as medically indicated up to 3 Calendar Days.
Ongoing Concurrent	As soon as medically indicated; usually within one Business Day of request
Standard Authorization	Three Business Days after receipt of the request.
Urgent Expedited Prior Authorization	One Business Day after receipt of the request

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any member of the member's health-care team, including the member, parent and/or guardian or a social worker exercising a custodial responsibility.

Authorization for a second opinion will be granted to a network provider or an out-of-network provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the member.

If the provider who will see the member for a second opinion is not in-network, an authorization is required. An authorization can be obtained by:

- Calling the Prior Authorization department at 1-800-218-7508.
- Faxing the request to 1-800-690-7030.
- Requesting online at www.SuperiorHealthPlan.com.

Retrospective Authorizations

Retrospective requests are requests for authorization of services or supplies that have already been provided to a member. This includes acute hospital stays when initial notification is received after the member has been discharged.

Providers must submit a claim for payment. If the claim is denied, the provider and/or member will also have the ability to file an appeal. Superior will complete a medical necessity review for reason of lack of medical necessity, or when authorization or timely notification to Superior was not obtained due to extenuating circumstances:

- Unable to know situations - member was unconscious at presentation.
- Services authorized by another payer who subsequently determined member was not eligible at the time of service.
- Member did not have their Superior ID card or otherwise indicated other coverage.
- Not enough time situations - the member requires immediate medical services and prior authorization cannot be completed prior to service delivery.

Participating and non-participating providers have 95 Days from the first date of service to submit a claim. If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 Days following receipt of all necessary information.

Expedited Authorizations

Superior follows the Centers for Medicare & Medicaid Services (CMS) guidelines for PA requests. Decisions are made as the member's health condition requires, but no later than three 3 Business Days after receipt of standard requests and no later than one Business Day after receipt of expedited requests. An expedited PA request should be made if you believe the member's life, health, or ability to regain maximum function could be seriously harmed by waiting the standard three Days for a decision.

Superior requires all expedited PA requests to be submitted by phone. To make an expedited PA request, please call the Prior Authorization Unit at 1-800-218-7508, and ensure you have the clinical information needed to support your request.

Discharge Planning

As part of our ongoing mission to ensure better health outcomes for our members, Superior provides timely and appropriate discharge planning services for a seamless transition from a hospital, emergency room or observation stay to the member's home setting. Discharge planning services includes:

- Home Health Services:
  - Skilled Nurse Visits
  - Private Duty Nursing
  - Home Health Aides
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Outpatient Services:
  - Physical Therapy, Occupational Therapy, Speech Therapy, Wound Care
- Durable Medical Equipment including supplies
- Any other urgent discharge needs for member's transitioning in the home setting

Requests for prior authorization for discharge planning services for all products; except STAR+PLUS dual and STAR+PLUS dual waiver, can be made by phone, fax or web contacting Superior at:

- Phone: 1-800-218-7453, ext. 22271 (Medicaid), and ext. 22295 (Medicare)
- Fax: 1-844-495-2361
- Website: www.SuperiorHealthPlan.com

Please ensure that prior authorization requests for discharge planning are submitted within 48 hours of discharge from a hospital, emergency room or observation stay. If a member is discharged during non-business hours and/or the weekend, providers should submit discharge planning requests the following Business Day.

Completing a Prior Authorization Form for Discharge Planning

Fill out a Superior HealthPlan prior authorization form. Visit www.SuperiorHealthPlan.com to download the form.

- Attach a discharge order from the hospital (signed order, discharge paperwork and electronic or verbal order). Provide ICD-10, CPT codes and HCPC codes with frequency, duration and amount of units or visits being requested.
- Fax request (form and discharge order) to 1-844-495-2361.
  - Please note: On the fax cover sheet and the prior authorization form, be sure to write URGENT DISCHARGE PLANNING. This will expedite the processing of the request and authorization will be received within 24 business hours of submission.

Outpatient Authorization Information

Tips for Outpatient Prior Authorization Requests

To request prior authorization, use Superior's Prior Authorization Request Form located at www.SuperiorHealthPlan.com. In order to ensure the request can be processed promptly, include member information, provider information (NPI, tax ID, fax number, contact number), requested service, date of service (DOS) and objective clinical information to support medical necessity.

Occupational Therapy (OT), Physical Therapy (PT) and/or Speech Therapy (ST)

Prior authorization is needed for treatment requests.

Initial Treatment requests should include:

1. Date of evaluation.
2. Member's age and birth date.
3. A brief statement of the member's medical history, including onset date of the illness, injury or exacerbation that requires the therapy services and any prior therapy treatment.
4. Relevant review of systems.
5. Pertinent physical assessment including a description of the member's current functional deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, and percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
6. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
7. A description of the member's functional impairment with a comparison of prior level of function to current level of function.
8. A statement of the prescribed treatment modalities and their recommended frequency/duration.
9. Proposed patient and/or caregiver education.
10. Functional treatment goals which are specific to the member's diagnosed condition or impairment. Functional treatment goals must be specific, measurable, attainable and time-based.
11. Treatment plan may not be more than 60 Days old.
12. If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

Note: Initial prior authorization for Therapy requests must be received no later than three Business Days from the start of care date.

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

1. Number of therapy visits authorized and number of therapy visits attended.
2. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
3. A description of the member's current functional deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, and percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
4. Objective demonstration of the member's progress towards each prior treatment goal. Treatment goals are developed by the treating therapist to be met within the timeframe specified on the treatment plan. If any goals are unmet, it is the treating therapist's responsibility to objectively describe specific barriers to progress that were encountered and make appropriate modifications to the treatment plan in order to meet the member's needs. For all unmet treatment goals, report the status of the goal at the beginning of the previous treatment period, and the current status at the time of reporting as they compare to the target. If the treatment plan was written with maintenance goals, a status statement would be expected for each maintenance goal directed at a skilled service.

5. If the member has not met the expected level of progress, the request must be reviewed by the medical director to determine if there is medical necessity to continue treatment.
6. An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
7. A brief prognosis with clearly established discharge criteria.
8. Updated treatment goals which are specific to the member's diagnosed condition or impairment. Treatment goals must be functional, measurable, attainable and time-based.
9. Updated treatment plan/progress summary may be no older than 90 Days old.
10. Treatment plan must be signed and dated by the treating therapist.

Therapy order must be signed and dated by the member's PCP (MD, DO, PA, CNS or NP) or appropriate specialist. Therapy orders signed by doctors of philosophy are not accepted.

All services that are rendered by a therapy assistant must be billed utilizing a UB modifier.

Place of service decisions should be based on the member's medical condition, therapy goals, appropriateness of equipment, environment and service, rather than convenience of the member or provider.

Guidelines for OT, PT and/or ST treatment service can be found online at www.SuperiorHealthPlan.com.

Requests for Durable Medical Equipment

To verify if the requested Durable Medical Equipment requires prior authorization, please utilize the Pre-Auth Needed Tool online at SuperiorHealthPlan.com/MMPPriorAuth. Documentation requirements include:

- An MD order on a prescription or request form (signature must be current, on or before the start date, and no older than 90 Days before the actual date of service) and must contain all of the following elements:
  - Member's name
  - Description of the item or items, quantity, price
  - Appropriate HCPC codes
  - Pertinent diagnosis/conditions that relate to the need for the item
  - Objective supporting clinical documentation
  - Length of need
  - The treating physician's name and signature
  - The date the treating physician signed the order

DME orders signed by doctors of philosophy are not accepted.

No prior authorization is required for incontinence supplies up to the allowable amount when using a preferred DME supplier. For the list of preferred DME suppliers, go to www.SuperiorHealthPlan.com.

Specialized Services Team

Specialized Services require prior authorization, these services include, but are not limited to: Inpatient electives, Chiropractic, Dental Therapy Under General Anesthesia, Podiatry, Bariatric Surgery, Allergen Immunotherapy Services, Genetic Testing, Quantitative Urine Drug Testing, Non-Emergent Ambulance Transport, Ophthalmology Services, Excision of Lesions, Facility Based Sleep Studies and Multiple Sleep Latency Testing.

- Member's name
- Pertinent diagnosis/conditions that relate to the need for the service
- Appropriate CPT codes
- Objective supporting clinical documentation
- Frequency and duration
- Date of service (start and end date)

Non-Emergent Transports

11. For non-emergent ambulance transport services not covered by Medicare, prior authorization is required for Medicaid covered enrollees. To verify if the service requires prior authorization, please utilize the Pre-Auth Needed Tool online at www.SuperiorHealthPlan.com/providers/preauth-check.html.
    a. A Medicaid-enrolled physician, Nursing Facility, health-care provider or other responsible party is required to obtain authorization before an ambulance is used to transport a member in circumstances not involving an emergency.
    b. Other responsible party is defined as staff working with a health-care service provider submitting prior authorizations on behalf of the provider or facility.
12. When a prior authorization is requested, one of the below documents, with a physician or physician-extender signature, is required and must be submitted with the request.
    a. Prior authorization form.
    b. Physician or physician-extender order for non-emergent ambulance transport.
13. Ambulance providers may not request a prior authorization for non-emergent ambulance transports. However, they may coordinate the prior authorization request between the Medicaid-enrolled physician, health-care provider and other responsible party.
    a. Ambulance provider may assist in providing necessary information such as NPI number, fax and business address.
    b. Ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport.
    c. Non-payment may result for services provided without a prior authorization or when the authorization request is denied by CCTX.

Quantitative Testing for Drugs of Abuse and Genetic Diagnostic Testing

Superior is committed to delivering cost effective, quality care to its members. This effort includes prior authorization protocols that include medical necessity review to ensure that certain diagnostic lab tests are medically necessary. Requests for prior authorization will be accepted up to 10 Business Days after specimen collection and reviewed for medical necessity.

Quantitative Testing for Drugs of Abuse

Superior requires prior authorization for Quantitative Testing for Drugs of Abuse. Laboratory providers must ensure that any Genetic/Molecular diagnostic testing is prior authorized to facilitate payment. Superior requires laboratory providers to contact ordering providers to verify that a prior authorization number has been obtained for these services. It is the ordering provider's responsibility to request prior authorization for these tests. Laboratory providers may request a prior authorization for Quantitative Testing if the ordering physician fails to request for these services.

Genetic/Molecular Diagnostic Testing

Superior currently requires prior authorization as a condition of payment for Genetic/Molecular diagnostic testing. Laboratory providers must ensure that any Genetic/Molecular diagnostic testing is prior authorized to facilitate payment. Superior requires laboratory providers to contact ordering providers to verify that a prior authorization number has been obtained for these services. It is the ordering provider's responsibility to request prior authorization for Genetic/Molecular diagnostic testing services. Laboratory providers can request prior authorization for Genetic/Molecular testing if the ordering physician fails to do so.

Immunotherapy Services

Non-allergists, such as PCPs, may apply for credentialing to perform allergy skin testing and to prescribe immunotherapy. PCPs continue to be permitted to administer allergy shots in their offices and clinics. Allergy shots may be given to Superior members who are under the care of an allergist or other credentialed allergy service provider. However, the allergist or other allergy service provider should maintain the responsibility for prescribing and determining the composition and dosing of the allergen serum.

Superior does not require a prior authorization for non-allergists who wish to only administer allergy shots prescribed by a credentialed allergy services provider as long as the non-allergist has submitted a one-time attestation which states that they have been informed of the recommendations for the appropriate equipment and personnel to provide allergy immunotherapy safely.

These include:

- Allergen and venom extract storage (4°C refrigerator with alarm).
- 1 ml (for AIT) and 3 ml (for VIT) disposable (safety) syringes with 27-gauge 5/8 inch needles.
- Epi-pen auto injectors – 0.3 mg for adults and 0.15 mg for children.
- Crash cart, BLS+ level.
- Glucagon.
- Vital signs monitor.
- Oxygen administration equipment.
- Personnel with BLS+ training.
- Personnel trained to give shots and to recognize and treat anaphylaxis.

Attestation forms can be found at www.SuperiorHealthPlan.com.

Once completed, all attestation requests should be emailed to Credentialing@SuperiorHealthPlan.com. Providers will receive notice of verification, or of denial or requests for additional information within 30 Days of submission. Providers must receive verification before administering allergy shots.

Codes 95115 or 95117 should be used when administering these services.

Prior authorization is required for Immunotherapy Services that are above the Medicaid allowable.

Physician Verbal Orders

Verbal physician orders may only be given to people authorized to receive them under state and federal law. It must be documented as a verbal order from a physician. They must be written, signed and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service.

Verbal orders will be considered for the full duration of the request. The provider is responsible for obtaining the physical physician signature within two weeks. The provider must keep this documentation in the member's file. Superior will do a random, monthly audit for compliance. If it is found that a provider is not in compliance, Superior will no longer accept verbal orders for their requested services.

Out-of-Network Authorization Requests

Superior recognizes that there may be instances when an out-of-network referral is justified. The Prior Authorization department will work with Superior's medical director and the referring physician to determine the medical necessity of the out-of-network request, and to reach a decision that is in the best interest of the member. All out-of-network services require an authorization.

Specialty Referrals

A PCP is required to refer a member to a specialist when medically necessary care is needed, beyond the scope of care provided by the PCP. All health-care services should be coordinated through the PCP for referrals to an in-network provider, when available. Some services, such as family planning and ECI, are an exception and only require self-referral. An authorization number is provided when a request meets criteria after review. An authorization is not a guarantee of payment and is subject to eligibility criteria.

Specialist Referrals to Another Specialist

Superior does not allow specialty providers to refer directly to another specialist. This request must be coordinated through and submitted by the PCP. The specialist may order diagnostic tests without PCP involvement. For members with disabilities, special health-care needs, or chronic and complex conditions, there may be instances where a specialist may choose to act as the PCP for a member and assume all of the responsibilities of a PCP. In these situations, members are allowed direct access to the specialist PCP. If the specialist accepts PCP assignment for this member, the specialist may refer the member to other specialists or admit the member to the hospital.

Inpatient Notification Requirements

Hospitals must notify Superior of all emergent admissions no later than the close of the next Business Day. Prior authorization is not required for emergency services, urgent care services, and if applicable, post-stabilization services. All non-emergency, elective inpatient admissions require a prior authorization and notification of admission. Emergent inpatient admissions to an acute level of care or behavioral health facility require notification. Sub-acute care, skilled nursing admissions and rehabilitation admissions require prior authorization. Phone notifications may be completed by contacting 1-855-594-6103. Expedited requests can be made by calling 1-800-218-7508, ext. 6031951 and Standard (Elective Admission)/Concurrent request fax notifications can be sent to 1-877-259-6960. For behavioral health admissions, phone notifications may be completed by contacting 1-844-842-2537 or faxing 1-866-900-6918.

Failure to notify Superior of inpatient admission by the next Business Day will result in a late notification denial, unless otherwise stated within a contract with Superior. Once the timely request for authorization is received, the request is screened for eligibility and benefit coverage and an authorization number is provided to the hospital by Superior. Clinical will be obtained through a request to the hospital Care Management or Utilization Review department.

Superior must make a determination by the close of the next Business Day following the date of request for authorization. In order to meet the state requirements, Superior requires receipt of the clinical on the Day following the request for authorization unless otherwise stated within a contract with Superior. The Superior utilization management clinician will review the clinical to determine medical necessity and appropriateness of services, including setting of care, are met according to InterQual criteria, clinical policy or 28 T.A.C. §3.8001 et seq. for substance use disorders. If medical necessity is not met through InterQual clinical policy or 28 T.A.C. §3.8001 et seq. criteria, a secondary review is completed by a physician (medical director) to make a final determination.

If approved, a letter will be faxed to the hospital, with approved days and the date of the next review. If denied, a letter is sent to the provider with instructions regarding the appeal process.

Long-Term Services and Supports

Long-Term Services and Supports (LTSS) services must obtain prior authorizations. All requests should be faxed to the STAR+PLUS MMP Service Coordination department at 1-855-277-5700.

Radiology

For imaging services, Superior uses Evolent (Formerly National Imaging Associates Inc.) to provide prior authorization of services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. It is the responsibility of the ordering physician to obtain authorization. Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA
- MRI/MRA
- PET Scan
- Cardiac imaging modalities: CCTA Stress Echo, Echocardiography (only for STAR+PLUS) and Nuclear Cardiology

Other imaging policies and procedures:

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

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

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR+PLUS MMP. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below.

- Spinal Epidural Injections
- Spinal Cord Stimulators
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered.

Prior authorization is not required through Evolent for services performed in the emergency department or on an inpatient basis. Prior authorization and/or notification of admission is still required through Superior. To obtain authorization through Evolent, visit RadMD.com or call 1-800-642-7554.

Physical Medicine

Evolent provides utilization management for outpatient rehabilitative and habilitative physical (PT), occupational (OT), and speech (ST) therapy services for Superior Medicaid (STAR, STAR+PLUS*) and CHIP members. ** This program is consistent with industry-wide efforts to manage the increasing utilization of these services and to ensure quality of care. The provider specialties included in this program are in network PT, OT, and ST providers only.

* Please note: For Medicaid STAR+PLUS members, this expansion is only applicable to non-STAR+PLUS HCBS Waiver members. ** Prior authorization is not required for Early Childhood Intervention services.

Evolent manages the prior authorization process for outpatient therapy services for in network PT, OT, and ST

providers only. Claims continue to be processed by Superior.

Services requiring authorization:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Places of service included in the program:

- Outpatient facilities
- Skilled nursing facilities
- Home health settings

Places of service excluded from the program:

- Hospital emergency departments
- Inpatient hospital or observation status settings
- Acute rehab hospitals

Initial PT, OT, and ST evaluation CPT codes do not require authorization. All other billed codes, even if performed on the same date as the initial evaluation, will require authorization prior to billing. After the initial visit, providers will have up to three business days to request approval for the first visit. If requests are received within this timeframe, Evolent can backdate the authorization to include other services rendered on the same day as the evaluation.

Providers are encouraged to utilize www.RadMD.com to request prior authorization for therapy services. If providers are unable to use the website, they may call 1-800-424-4916.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to Superior HealthPlan members, Superior HealthPlan has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Superior HealthPlan members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery - Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery - Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery - Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion -Single & Multiple Levels
- Cervical Posterior Decompression with Fusion -Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement - Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression - Single & Multiple Levels
- Lumbar Artificial Disc - Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page (https://www.RadMD.com) for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

For questions, please contact Evolent at 1-800-642-7554.

Cardiac Surgeries

Superior uses TurningPoint Healthcare Solutions for prior authorizations requests related to Cardiac Surgeries. The program is designed to work collaboratively with physicians to promote member safety through the practice of high quality and cost-effective care for MMP members undergoing cardiac surgeries.

Prior authorization will be required for the following cardiac surgeries 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

Emergency-related services do not require authorization. It is the responsibility of the ordering physician to obtain

authorization; however, the rendering provider should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.

For questions regarding prior authorization requirements, or impacted CPT codes, please contact TurningPoint by email at providersupport@turningpoint-healthcare.com or by calling TurningPoint Provider Support at 1-855-336-4391.

Ear, Nose and Throat Surgery

Superior uses TurningPoint Healthcare Solutions for prior authorizations requests related to Ear, Nose, and Throat (ENT) Surgery. This program applies to all MMP members undergoing ENT surgeries.

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

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

For questions regarding prior authorization requirements, or impacted CPT codes, please contact TurningPoint by email at providersupport@turningpoint-healthcare.com or by calling TurningPoint Provider Support at 1-855-336-4391.

Member Self-Referrals

There are some services to which a member has access without a referral from the PCP. Superior's STAR+PLUS MMP members do not need a referral from the PCP for the following services:

- Family planning
- Care Management for pregnant women
- Vision
- True emergency services
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope)
- Well woman annual examinations
- OB care

Transition Policy

Under certain circumstances for Medicare Part D drugs, Superior can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

- The drug the member has been taking is no longer on the Superior formulary or the drug is now restricted in some way.
- The member must be in one of the situations described below:
- For those members who were enrolled with Superior last year and are not in a long-term care facility: We will cover a temporary supply of the drug one time only during the first 90 Days enrolled in Superior of the

calendar year. This temporary supply will be for a maximum of a 30-Day supply, or less if the prescription is written for fewer Days. The prescription must be filled at a network pharmacy.

- For those members who are new to Superior and are not in a long-term care facility: Superior will cover a temporary supply of the drug one time only during the first 90 Days of the membership in Superior. This temporary supply will be for a maximum of a 30-Day supply, or less if the prescription is written for fewer Days. The prescription must be filled at a network pharmacy.
- For those who are new Superior members, and are residents in a long-term care facility: Superior will cover a temporary supply of the drug during the first 90 Days of membership in Superior. The first supply will be for a maximum of a 31-Day supply, or less if the prescription is written for fewer days. If needed, we will cover additional refills during the first 90 Days in Superior up to a maximum of 91 – 98 Day supply.
- For those who have been a member of Superior for more than 90 Days, are a resident of a long-term care facility and need a supply right away; Superior will cover one 31-Day supply or less if the prescription is written for fewer Days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.

Women's Health Care

Female members may see a network provider, who is contracted with Superior to provide women's health-care services directly, without prior authorization for:

- Medically necessary maternity care.
- Covered reproductive health services.
- Preventive care (well care) and general examinations particular to women.
- Gynecological care.
- Follow-up visits for the above services.

If the member's women's health-care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Superior's prior authorization requirements.

Medically Necessary

Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These services include:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the health-care provider or hospital.

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 Days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Superior clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by

applying clinical judgment and experience. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website. In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the “Complaint Process” section of the contract.

Emergency Medical Condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe Transfer to another hospital before delivery, or (2) that Transfer may pose a threat to the health or safety of the woman or the unborn child.

SECTION 9
CLAIMS AND ENCOUNTERS ADMINISTRATION

Depending on a provider's contractual arrangement with Superior, providers are required to submit a claim or encounter for each service rendered to a Superior member, to the applicable address and/or submission methods referenced in this section. Superior will not accept claims submitted to addresses and/or by submission methods not specified in this section.

Network providers are encouraged to participate in Superior's electronic claims/encounter filing program through Centene Corporation, Superior's parent organization. Centene has the capability to receive an ANSI X12N 837 professional, institutional and encounter transactions. In addition, Centene has the capability to generate an ANSI X12N 835 electronic Explanation of Payment (EOP). Superior also has the capability to receive an ANSI X12N 276 health claims status inquiry, and to generate an ANSI X12N 277 health claims status response transaction through Centene. For more information on electronic claim filing and transactions, contact the Centene EDI department at 1-800-225-2573 ext. 6075525 or at EDIBA@centene.com.

Providers may elect to submit electronic professional or institutional claims through Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com. Providers may also use a clearinghouse for electronic claim submissions.

Providers may submit claims on paper, utilizing the standardized CMS-1500 and/or UB-04/CMS-1450 claim forms.

For assistance with accessing the Provider Portal, contact the web applications support desk 1-866-895-8443 or at TX.WebApplications@SuperiorHealthPlan.com.

To file a claim or encounter for behavioral health, routine vision, dental or pharmacy services, see specific filing information under Submitting Paper Claims and/or Electronic Filing within this section.

Claims Information

A claim is a request for reimbursement, either electronically or by paper, for any health-care service provided. A claim must be filed on the approved claim form such as CMS 1500 or UB-04/CMS 1450. Any UB-04/CMS 1450 and CMS 1500 paper claim forms received that do not meet the CMS printing requirements will be rejected back to the provider upon receipt.

A clean claim is a claim submitted on an approved standardized claim format (CMS 1500 or UB-04/CMS 1450) that contains all data fields required by Superior, as specified in this section for adjudication of the claim as a clean claim. The required data fields must be complete and accurate. A clean claim must include all published clean claim requirements including Tax Identification Number (TIN) number, National Provider Identifier (NPI) and taxonomy.

Processing and Payment Requirements

Superior must administer an effective, accurate and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the contract, including Chapter 2 of the HHS Uniform Managed Care Manual. In addition, STAR+PLUS MMP claim requirements are exempt from the Texas Insurance and Administrative Code claims Prompt Pay requirements.

Superior and its subcontractors cannot directly or indirectly charge or hold a member or provider responsible for claims adjudication or transaction fees.

Superior may deny a claim submitted by a provider for failure to file in a timely manner, as provided for in the HHS Uniform Managed Care Manual Chapter 2.

Superior will not pay any claim submitted by a provider:

- Excluded or suspended from the Medicare or Medicaid programs for fraud, abuse or waste.
- On payment hold under the authority of HHS or its authorized agent(s).
- For neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHS.*
- For maternal services provided 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 the 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.

Superior validates the following when adjudicating a claim:

- Institutional claims must contain Present on Admission (POA) indicators.
  - Superior utilizes 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.

Upon receipt of a clean claim, Superior will adjudicate the claim for payment or denial within the 30-Day claim processing timeframe. If denied in whole or in part, Superior will notify the provider of why the claim will not be paid.

Superior must receive a provider's appeal of a claim within 120 Days from the date of disposition (date of the EOP). Superior will process the claim appeal within 30 Days from the date of receipt of the claim appeal.

The date of a claim payment is the date of issue of a check for payment, or the date of Electronic Funds Transmission (EFT) if payment is made electronically.

The Patient Protection and Affordable Care Act (PPACA) as amended by Section 1202 of the Health Care and Education Reconciliation Act. HHS will make supplemental payments to Superior for these rate increases, and Superior will pass through the full amount of the supplemental payments to qualified providers no later than 30 Days after receipt of HHS' supplemental payment report, contingent upon receipt of the allocation.

Providers must bill compounded drugs using the drug code and metric decimal quantity for each National Drug Code in the compound. Providers may bill for up to 10 ingredients through the on-line system. Payment requests for ingredients exceeding 10 must be submitted to the Pharmacy Relations and Provider help desk.

Questions about Claims

For all questions related to claim filing, claim status and claim appeals, call the Provider Services department at 1-877-391-5921.

Capitated Provider Claims

Some providers may receive a monthly capitation for services. These services may vary per each individual provider, and if applicable, will be listed in the provider's contract with Superior. Providers that receive monthly capitation for services must file a proxy claim on a CMS 1500 for each service provided. This is referred to as an "encounter."

Capitated services are adjudicated to reflect zero dollar payment amounts. It is mandatory that a capitated provider submit encounter claims to Superior, in order for Superior to utilize the encounter data to evaluate all aspects of quality and utilization management.

Coinsurance Claims

The payment of the Medicare Part A coinsurance and deductibles for Medicaid members who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

For more information and details on coinsurance reimbursement contact Superior at 1-877-391-5921.

Claims and Appeal Submission Timeframes

All claims and encounters must be received by Superior within 95 Days for EDI submission. Superior accepts electronic claims 24/7, all 365 Days of the year. All claim appeal requests must be received within 120 Days from the date of the EOP or denial letter. For clean claim submissions, denial letters would not be valid proof of timely filing as this is an unclean claim.

For retrospective medical necessity claim appeals, please refer to Section 10, regarding Adverse Benefit Determinations and Appeals.

Claims Payment Timeliness

Clean claims will be processed within 30 Days of receipt.

Each adjudicated claim will be reflected on an EOP, which includes details of the denied or paid claim.

Note: For STAR+PLUS MMP Skilled Nursing Facility reimbursement, providers do not submit daily rates for Skilled Nursing Facility services on the Medicare side. Providers should bill Medicare Skilled Nursing Facility services to Superior and Superior will process the claims in 30 Days. Providers must then submit a claim for the Medicaid daily rates, which are processed in 10 Days under Medicaid.

Claims Submission Information

All Superior STAR+PLUS MMP claims should be submitted to:

Superior HealthPlan STAR+PLUS MMP
PO BOX 3060
Farmington, MO 63640-3822

Claims for behavioral health services are submitted to Superior:

Superior HealthPlan
P.O. Box 6300
Farmington, MO 63640-3806

Claims for eye care services (routine eye exams, eyewear) are submitted to Envolve Vision Services:

Envolve Vision Services - Claims
PO Box 7548
Rocky Mount, North Carolina 27804
1-866-897-4785

Please note: Effective January 1, 2020, medical eye care services will be submitted to Superior.

Dental claims for STAR+PLUS MMP (flexible benefits and waiver services) are submitted to DentaQuest:

DentaQuest TX HHS Dental Program - Claims
PO Box 2906
Milwaukee, WI 53201-2906
1-888-308-4766

Claims for non-emergency medical transportation (NEMT) services should be submitted through the vendor's electronic adjudication system. Questions surrounding NEMT claims should be directed to:

SafeRide Health
106 Jefferson St.
Suite 300
San Antonio, TX 78205 .....
1-855-932-2320

Claims for pharmacy benefits should be submitted electronically through the vendor PBM's adjudication system. Questions surrounding pharmacy claims should be directed to:

Pharmacy Services
PO Box 989000 West
Sacramento, CA 95795
1-800-460-8988

Claims Status

Claim status can be obtained through Superior's Secure Provider Portal. Providers can also call Provider Services at 1-877-391-5921 and use the IVR claims self-service menu 24 hours a day, 7 days a week. Our phone staff has access only to the same general status information as the portal and automated system.

Reporting Overpayments to Superior HealthPlan

A provider may identify an overpayment as result of multiple reasons, but may include:

- Erroneous billing by a provider using incorrect NPI or taxonomy, or incorrect member identification number.
- Payment to the provider by a primary insurance Payer, previously unknown or unreported to Superior.
- Duplicative billing by a provider for services previously billed or paid.
- Erroneous billing by a provider for services not rendered.

A provider has an obligation to notify Superior in writing immediately upon identification of an overpayment, but no more than 30 Days from the date of discovery. Providers must submit the notification of overpayment in writing to Superior. The overpayment can be remediated through refund to Superior, or a provider may request Superior recoup the payment issued in error.

The written notification of overpayment can be submitted to Superior electronically (email/Superior website) or in written form through USPS.

- "Contact Us" Form on the Superior website
- Email: Provider_Operations@centene.com
- Mail to:

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

The notification should include details of whether the provider plans to submit a refund as a result of the overpayment, or is requesting Superior recoup the overpayment. The notice of overpayment must include the following details:

- Claim number
- Date of Payment/Explanation of Payment (EOP)
- Provider NPI
- Member identification number
- Date of Service

Recoupment

If a provider requests Superior recoup the overpayment, the prior erroneous payment(s) will be reversed by Superior within 30-60 Days of receipt of the request. When the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

Refund

If a provider wishes to refund the overpayment by issuing a check to Superior, the refund check must be submitted to Superior within 30 Days of notification of the overpayment, or 60 Days from the date of the discovery of the overpayment, whichever is less. If a refund check is not received within that timeframe, Superior will proceed with recoupment of the overpayment(s).

Each claim overpayment should be accompanied with a copy of the EOP indicating the overpaid claim or claims for which the refund is being submitted, and a brief description of the reason for the overpayment.

Alternatively, a provider may submit the following information with the refund check, if a copy of the EOP is not available:

- Provider Name, Tax ID and NPI; and
- Member Name, date of birth, and Member Medicaid or CHIP identification number; and
- Claim date(s) of service; and
- Brief description/reason for the overpayment.

To submit a refund check, a provider should mail the check and supporting documents to:

Superior HealthPlan
P.O. Box 664007
Dallas, TX 75266-4007

Overpayments Identified by Superior HealthPlan

Superior HealthPlan may also identify overpayments made to a provider, that may occur as result of HHS' retroactive disenrollment of a member who was eligible with Superior at the time of service/submission and payment of the claim, claims processing errors, retroactive Medicaid or CHIP program or benefit changes, or identification of a primary insurance Payer responsible for payment of a portion or full payment of the claim.

In these circumstances, Superior will typically reverse the prior payment of the claim and recoup the monies paid in error, unless the provider contract requires, or the provider has previously requested that Superior allow the provider the opportunity to refund the overpayment prior to recoupment.

If a provider receives notification of overpayment, and request for refund, the provider should include a copy of the notification of overpayment letter with the refund check, and mail to:

Superior HealthPlan
P.O. Box 664007
Dallas, TX 75266-4007

If the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

If a provider has requested, or the provider's contract requires prior notification and opportunity to submit a refund as result of an overpayment identified by Superior, the provider will receive a letter explaining the reason for the overpayment, and requesting a refund be submitted within the appropriate timeframe as documented in the overpayment notice to the provider. If the refund is not received within that timeframe, Superior will proceed with reversal of the erroneous payment, recouping the payment prior issued.

Third Party Liability

Third party liability is defined as the legal responsibility of another individual or entity to pay for all or part of the services provided to members. Federal and state law require Medicaid be the payer of last resort. STAR+PLUS MMP providers must comply with the provisions of 1 TAC §354, relating to third party recovery in the Medicaid program.

Coordination of Benefits

Any other insurance, including Medicare, is always primary to Medicaid coverage. If a STAR+PLUS MMP member has other insurance, providers must submit claims to the primary insurance for consideration. For Superior payment consideration, file the claim with a copy of the EOB, EOP or rejection letter from the other insurance. If this information is not sent with an initial claim filed for a member with other insurance, the claim will pend and/or deny until this information is received. If a member has more than one primary insurance (Medicaid would be the third payer), the claim can be submitted through EDI, the Secure Provider Portal or on paper.

Information Sources for Third Party Recovery

Third Party Recovery (TPR) means the recovery of payments on behalf of a member by Superior from an individual or entity with the legal responsibility to pay for the covered service. Superior providers are requested to provide Superior with any TPR information that they obtain from the member. TPR information should be reported to Superior's Provider Services department at 1-877-391-5921.

The Your Texas Benefits Medicaid card (formerly Medicaid Form 3087) also contains a TPR column. The TPR column will indicate if other insurance has been reported by including an "M" (Medicare) and/or a "P" (Other Insurance).

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in denial/rejection of the claim and a consequent delay in payment. Claims should be billed using the following coding:

- Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes.
- Submit institutional claims with valid revenue codes and CPT-4 or HCPCS (when applicable), ICD- 10 codes and DRG codes (when applicable).

Claims must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 11-148), regarding mandatory state use of national correct coding initiatives, including all applicable rules, regulations and methodologies implemented as a result of this initiative.

Superior requires the use of valid ICD-10 diagnosis codes to the ultimate specificity, for all claims. See the ICD-10 coding manual for details.

The highest degree of detail can be determined by using the tabular list (volume one) of the ICD-10 coding manual in addition to the alphabetic list (volume two), when locating and designating diagnosis codes. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

The tabular list gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to ultimate specificity if appropriate.

Ancillary providers (e.g., labs, radiologists, etc.) and those physicians interpreting diagnostic testing may use appropriate and most current V codes for laboratory exam, radiological exam, NEC and other specified exam as the principal diagnosis on the claim. Please consult your ICD-10 Manual for further instruction.

Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

Medicare Part B Services and Supplies Billing

When billing for Medicare Part B services and supplies, Superior reimburses the provider the lesser of:

- The Medicare Part B coinsurance and deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed.

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Superior does not make a payment for coinsurance.

Private Duty Nursing Billing

Home Health agencies must bill Private Duty Nursing (PDN) services to clients, from birth through age 20, who have either had a tracheostomy or are ventilator-dependent. Superior requires providers to bill procedure code C-T1000 with modifiers TD UA (services performed by a RN) or TE UA (services performed by a LVN) or procedure codes C-T1002 and C-T1003 with the modifier UA in addition to one of the diagnosis codes in the grid below for these services for children.

Superior requires providers to bill the modifier or modifier combinations noted above AND the most appropriate higher-tier diagnosis codes from the list below in the first DX position on the claim form.

Diagnosis Codes						
J9500	J9501	J9502	J9503	J9504	J9509	Z930
Z990	Z9911	Z9912	J95850	Z9989	Z430	

National Drug Code

The National Drug Code (NDC) is an 11-digit number on the package or container from which the medication is administered. All providers must submit an NDC for professional or outpatient claims submitted with provider-administered prescription drug procedure. Codes in the “A” code series do not require an NDC. N4 must be entered before the NDC on claims. Units of measurement are required for each NDC code submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN – Unit

Unit quantities are also required for each NDC code submitted.

Superior will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare and Medicaid Services (CMS) Drug Rebate program and that show as active on the CMS list for the date of service the drug is administered. CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code of the administered drug as indicated on the drug packaging. Superior will deny claims for drug procedure codes under the following circumstances:

The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.

The NDC submitted with the drug procedure code has been terminated.

The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs

Code Auditing

Superior uses code auditing software to assist in improving accuracy and efficiency in claims processing, payment, reporting and to meet HIPAA compliance. The code auditing software will detect, correct and document coding errors on provider claims prior to payment. Superior's software will analyze CPT-4 codes, HCPCS Level II codes, industry standard modifiers and location to compare against rules that have been established by the American Medical Association (AMA) and CMS.

In order to maintain its high standard of clinical accuracy, credibility and physician acceptance, our code auditing software is updated regularly to keep current with medical practices, coding practices, annual changes to the CPT Manual and other industry standards. Superior conducts regular reviews to focus on the annual changes to the CPT Manual and the specialty sections of the CPT Manual.

When a change is made on a provider's submitted code(s), we will provide a general explanation of the reason for the change on the provider's EOP (or remittance advice). The following list gives examples of conditions where code-auditing software will make a change on submitted codes:

- Unbundling - Submitting a comprehensive procedure code along with multiple incidental procedure codes that are an inherent part of performing the procedure.
- Fragmentation - Billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.
- Age/Gender – Submitting codes inappropriate for the member's age or gender because of the nature of the procedure.

Superior may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted or review of the procedure billed.

Electronic Filing

Superior encourages all providers to file claims and/or encounters electronically.

Electronic claims have the same filing deadlines as paper claims (please see Claims Information in this section). Electronic claims submissions are required within 95 Days of the date of service for participating and non-participating providers.

Options for electronic filing:

1. Electronic claims/encounter program through the EDI department:
   Network providers are encouraged to participate in Superior's electronic claims/encounter filing program through Centene Corporation. Centene has the capability to receive an ANSI X12N 837 professional, institutional and encounter transaction. In addition, Centene has the capability to generate an ANSI X12N 835 electronic EOP. For more information on electronic claim filing, contact the EDI department at 1-800-225-2573 ext. 6075525 or at EDIBA@centene.com.

Submission of a claim to the clearing house does not guarantee that the claim was transmitted or received by Superior. Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports.

2. Website filing through Superior's Secure Provider Portal:
   Providers may also elect to submit claims both CMS-1500 and UB-04/CMS 1450 through Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

   This option does not require use of a clearing house. Claims are submitted directly to Superior for consideration of payment. There is no cost for this service. Providers can also use this website to review status of claim submissions. For more information on the Provider Portal and other website features, refer to Section 16 – Secure Provider Portal.

To process a provider claim or encounter, please remember the following:

- All documentation must be legible.
- Superior utilizes the EDI version 5010 guidelines as mandated by HIPAA rules.
- PCPs and all participating providers must submit claims or encounter data for every patient visit, even though they may receive a monthly capitation payment.
- All claims and encounter data must be submitted on either a CMS 1500 or UB-04/CMS 1450 form, or on electronic media in an approved, HIPAA-compliant format.
- Superior members should not be billed by any provider for covered services. Please refer to your provider contract with Superior.
- Superior STAR+PLUS MMP members do not have copayments or out-of-pocket expenses for covered benefits.
- Emergency services claims should follow standard billing procedures outlined herein and as noted in terms of individual contracts.

Behavioral health providers who wish to file claims electronically should contact Provider Services at 1-877-391-5921.

Vision providers should contact the Envolve Vision Services department at 1-888-756-8768 for information regarding electronic billing.

Dental providers should contact DentaQuest regarding dental claims at 1-888-308-9345.

Pharmacy claims questions should be directed to Pharmacy Services at 1-888-865-6567 or eftsupport@envolvehealth.com.

Billing the Member

Providers may not bill members directly for STAR+PLUS MMP covered services. Superior reimburses only those services that are medically necessary and a covered benefit in the STAR+PLUS MMP program. This information can be found in your provider contract with Superior.

Superior STAR+PLUS MMP members do not have copayments.

Balance Billing

Providers should never balance bill dual-eligible members of Superior HealthPlan. Dual-eligible beneficiaries receive coverage from both Medicare and Medicaid plans and should not be charged for Medicare or Medicaid-covered services, including copayments, co-insurance or deductibles.

Dual–eligible STAR+PLUS MMP enrollees receive benefits and services from both Medicare and Medicaid:

- Medicare provides primary coverage for health-care services and prescription drugs.
- Medicaid covers additional benefits, such as long-term services and supports.
- Medicaid also provides help to pay Medicare premiums and cost sharing.

Balance billing is illegal under both state and federal law*. If a provider has balance billed a member, the provider must take action to correct the situation. Providers are required to stop the bill collection process and work with credit reporting agencies to amend any resulting issues for the member. If an organizational determination has happened and a prior written agreement has been signed by the provider and the member for non-covered services, an exception may be made.

For more information about balance billing and dual-eligible beneficiaries, visit the CMS website or contact your Account Manager.

* For federal and state laws regarding balance billing, refer to Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.

Member Acknowledgement Statement

The only occasion when a provider may bill a member is when the member has completed a member acknowledgement statement.

A provider may bill a member for a claim denied as not being medically necessary or not a part of a covered service if both of the following conditions are met:

- A specific service or item is provided at the request of the patient.
- The provider has obtained and kept a written member acknowledgement statement signed by the client. The member acknowledgment statement must read as follows: “I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Assistance program or the Children’s Health Insurance program as being reasonable and medically necessary for my care. I understand that Superior, through its contract with HHS, determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

Use of Assistant Surgeons

An assistant surgeon is defined as a physician who utilizes professional skills to assist the primary surgeon on a specific procedure. An assistant surgeon’s presence at the surgeries listed on the Medicare-approved assistant surgeon list are presumed to be medically necessary. All assistant surgeon’s procedures, including those on the assistant surgeon’s list, are subject to retrospective review for medical necessity by Superior’s Medical Management department. All assistant surgeon’s procedures are subject to Superior policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an assistant surgeon be present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon’s service is based on the medical necessity of the procedure itself and the assistant surgeon’s presence at the procedure.

Claims Tied To Multiple Authorizations

Superior frequently issues authorizations that extend to multiple dates of service. To avoid claim denials, the dates of service billed on a claim must be covered under a single authorization. If the dates of service billed are covered by multiple authorizations, the claim may be split and billed one of the following ways for each authorization:

- On separate lines within a single claim; or
- On separate claim forms as multiple claims.

Ensure that each claim dates of services match the authorization dates of service.

Common Billing Errors

Table 11-1 lists common billing errors. Accessing the information in this table may help you to avoid rejected claims or encounters.

Table 11-1 Common Billing Errors

Type	Information
Modifier	The order that modifiers are listed on a claim are critical. Modifier TH should always be billed in the first position. Also, pricing modifiers such as, NU, RR, 81, AS, etc. or provider type designation modifiers such as, AM, AJ, SA, TD, TE or U7 must be noted in the first position of the claim unless the TH modifier is required. To prevent duplicate or global denials for multiple emergency room visits on the same date of service, by the same facility, hospitals must billl modifier 27 on the Revenue 450 service on the second claim. Modifier 25 should not be used for multiple ER visits.
CPT/HCPCS	Use specific CPT or HCPCS codes. Avoid the use of non-specific or “catch-all” codes (i.e. 99070) unless required by HHS. Use the most current CPT or HCPCS codes according to Texas Medicaid guidelines.
Diagnosis Codes	Use current diagnosis codes and code to the highest level of specificity available.
Accident Claims	Attach liability carrier disposition or accident details/supporting documentation if no liability carrier is involved.
Paper Ambulance	Paper ambulance claims require "to" and "from" destination (full address) on box 32.
NPI number CMS 1500	Field 17a: Qualifier ZZ plus taxonomy of referring. Field 17b: NPI of referring providers (If unable to attain please populate with servicing provider’s NPI. This field will not be used for claims processing but is required to be filled) Field 24jb: NPI of servicing providers. Enter the billing NPI if services are not provided by an individual (e.g., DME, independent lab, home health, RHC/FQHC general medical exam, etc.). Field 24i : Qualifier = ZZ. Field 24ja: Servicing provider primary taxonomy code. Field 25 : Tax identification number. Field 33: ZIP+4 of the billing provider’s service location. Field 33a: NPI of billing provider. Field 33b: Qualifier = ZZ plus taxonomy code of the billing provider.
NPI number UB-04/ CMS 1450	Form Locator Field 1: Billing provider service location name, address and ZIP+4. Form Locator Field 5: Tax identification number of billing provider. Form Locator Field 56: NPI number of billing provider. Form Locator Field 81: B3 qualifier. Form Locator Field 76: NPI of attending physician. Form Locator Field 76 Qual: B3 plus taxonomy of attending physicians. Form Locator Field 77: NPI of operating physician. Form Locator Field 77 Qual: B3 plus taxonomy of operating physician.

Note: Table continued on next page

Type	Information
Member Information	Ensure that member's name, date of birth and ID number coincides with Superior ID card, DFPS Medicaid 2085 or HHS "Your Texas Benefits" Medicaid card (formerly Medicaid form 3087).
Other Insurance	Verify other insurance information and attach primary insurance EOP with the paper claim or include primary insurance EOP electronically using EDI or Superior's Secure Provider Portal.
Therapy Services	Attach MD evaluation order for processing.

Claims Reconsiderations

When a provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim may be submitted. A red and white claim form is required. Refer to Common Billing Errors section and Table 11-1 for examples. The following includes definitions of when a claim may be reconsidered:

- Adjustment – An adjustment to a previously finalized clean claim in which no additional information from the provider is required to perform the adjustment. An adjustment could be prompted by the provider or by the plan.
- Claim Appeal - An appeal is a claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification to Superior and in accordance with the appeal process as defined in this Provider Manual. An appeal must include supporting documentation. Examples of supporting documentation may include, but are not limited to:
  - A letter from the provider stating why they feel the claim payment is incorrect (required).
  - A copy of the original claim.
  - A copy of the Superior EOP (required).
  - An EOP from another insurance company.
  - Overnight or certified mail receipt as proof of filing date.
  - Documentation of eligibility verification such as copy of ID card, "Your Texas Benefits" Medicaid card (formerly Medicaid form 3087), TMHP documentation or call log, etc.
  - EDI acceptance reports showing the claim was accepted by Superior.
  - Prior authorization number and/or form or fax.

To submit paper reconsiderations, mail to the following address:

Superior HealthPlan STAR+PLUS MMP
Attn: Claims - Reconsiderations
PO BOX 4000
Farmington, MO 63640-4000

Retrospective Medical Necessity Claims Appeal

A medical necessity appeal is a written request from a member or provider who is appealing on the member's behalf to reconsider a medical necessity denial. This can apply to a denial for a service that was requested but has not yet been performed, or a retrospective review of a service that has already been performed but is partially or wholly denied. Please refer to Section 10 - Adverse Benefit Determinations and Appeals, for instruction on how to submit medical necessity appeals.

Rejected Claim

Rejected claims are returned with messages that explain what is wrong, so the claim can be corrected and resubmitted. Rejected claims are considered unclean claim submissions. Providers must ensure they submit claims within 95 Days from DOS in order to avoid claim rejection. Reject letters are not a valid proof of timely filing. If a claim is outside the applicable timely filing limits, a reject letter or report will not allow a timely override since they are considered unclean claims.

Claims that are rejected must be corrected and resubmitted for payment consideration. If a claim is within the applicable timely filing limits, it may be submitted as a first time claim. If a claim is outside the applicable timely filing limits, then the claim must be submitted as an adjustment along with a copy of the rejection report or may be submitted electronically with the claim number assigned on the rejection report.

Corrected Claim

A corrected claim is a correction or change of information to a previously finalized clean claim in which additional information from the provider is required to perform the adjustment. A corrected claim can be the result of:

- An original claim that was either denied or rejected as being deficient, as it did not contain all required elements to appropriately process the claim.
- An original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission were erroneous.

Providers may correct, but are not limited to, the following:

- Patient control number (PCN)
- Date of birth
- Date on onset
- X-ray date
- Place of service (POS)
- Present on Admission (POA)
- Quantity billed
- Prior authorization number (PAN)
- Beginning date of service (DOS)
- Ending date of service or discharge date

Corrected Claims Process

Corrected claims may be submitted via EDI, the Superior Provider Portal or by mail. All corrected claims submitted by mail on paper should be free of handwritten or stamped verbiage and must be submitted on a standard red and white UB-04 or HCFA 1500 claim form. Corrected claims submitted by mail must include the Corrected Claim Form available on our website at www.SuperiorHealthPlan.com. Any UB-04 or HCFA 1500 form received that is submitted on black and white paper will be rejected back to the provider upon receipt.

Additionally, the original (corrected) claim number must be inserted in field 64 of the UB-04 or field 22 of the HCFA 1500. The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 and 22 of the HCFA 1500. The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for HCFA 1500 claim forms or the UB Editor (Uniform Billing Editor) for UB-04 claim forms. Omission of these data elements may result in denials.

Providers may contact their local Account Manager with any questions or by calling Provider Services at 1-877-391-5921.

Corrected claims must be sent within 120 Days of the initial claim disposition. Corrected claims can be submitted via EDI, the Provider Portal or on paper. To submit paper corrected claims, mail to the following address:

Superior HealthPlan STAR+PLUS MMP
Attn: Claims - Correction
PO BOX 4000
Farmington, MO 63640-4000

Submitting a Claim Appeal

A claim 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. All claim appeals regarding the amount reimbursed or regarding a denial for a particular service must be submitted in writing and include all necessary documentation. Any adjustments as the result of a claim appeal will be provided by check with an EOP, reflecting the adjustment of the claim. A Claim Appeal form must be sent in with a claim appeal.

When submitting claims, please follow these guidelines:

- Claims must be received by Superior within 95 Days from each date of service on the claim. Final inpatient hospital claims must be received by Superior within 95 Days from the date of discharge.
- All claim appeals must be finalized within 24 months from the date of service.
- All appeals of claims and requests for adjustments must be received by Superior within 120 Days from the date of the last denial of and/or adjustment to the original claim.

To submit an appeal on paper, mail the appeal to the following address:

Superior HealthPlan STAR+PLUS MMP
Attn: Claims Appeals
PO BOX 4000
Farmington, MO 63640-4000

Superior will process the appeal and make a determination within 30 Days from the date of receipt of the appeal. Superior's contract with each provider allows for the resolution of disputes through binding arbitration.

Completing a CMS 1500 Form

Only CMS 1500 claim forms printed in Flint OCR Red, J6983 ink (or exact match) are acceptable. Although the CMS- 1500 form can be downloaded and printed, copies of the form cannot be used for submission of claims, since the copy may not accurately replicate the scale or OCR color of the form.

Paper claims submitted outside of this format will be rejected. Providers are highly encouraged to submit forms electronically via Superior's Secure Provider Portal.

CMS 1500 Claim Form Instructions

The following table outlines each field within a CMS 1500 form. Please note:

- Required fields (indicated as "R") must be completed on all claims. Claims with missing or invalid required field information will be rejected or denied.

- Conditional fields (indicated as “C”) must be completed if the information applies to the situation or the service provided.
- Not Required field (indicated as “Not Required”) will not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select “D”, other.	Not Required
1a	Insured ID Number	The 10 digit Medicaid ID number on the member’s Superior ID card.	R
2	Patient’s Name (Last Name, First Name, Middle Initial)	Enter the patient’s name as it appears on the member’s Superior ID card. Do not use nicknames.	R
3	Patient’s Birth Date / Sex	Enter the patient’s eight digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient’s sex/gender. M = male F = female	R
4	Insured’s Name	Enter the patient’s name as it appears on the member’s Superior ID card.	R
5	Patient’s Address (Number, Street, City, State, Zip code), Telephone (include area code)	Enter the patient’s complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient’s telephone does not exist in the electronic 837 Professional 4010A1.	R
6	Patient’s Relation to Insured	Always mark to indicate self.	C
7	Insured’s Address (Number, Street, City, State, Zip code), Telephone (include area code)	Enter the patient’s complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient’s telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	Reserved for NUCC use		Not Required
9	Other Insured’s Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. Required if patient is covered by another insurance plan. Enter the complete name of the insured. NOTE: COB claims that require attached EOBs must be submitted on paper.	C
9a	Other Insured’s Policy or Group Number	Required if # 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	Reserved for NUCC use	This field was previously used to report “Other Insured’s Date of Birth, Sex” but it does not exist in 5010A1. The NUCC will provide instructions for any use of this field.	Not Required
9c	Reserved for NUCC use	This field was previously used to report “Employers Name or School Name” but it does not exits in 5010A1. The NUCC will provide instructions for any use of this field.	Not Required
9d	Insurance Plan Name or Program Name	Required if # 9 is completed. Enter the other insured’s (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	Is Patient’s Condition Related To:	Enter a yes or no for each category/line (a, b and c). Do not enter a yes and no in the same category/line.	R
10d	Reserved for Local Use		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
11	Insured's policy group or FECA number	Required when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	Insured's Date of Birth / Sex	Same as field 3.	C
11b	Other Claim ID (Designated by NUCC)	The "Other Claim ID" is another identifier applicable to the claim.	
11c	Insurance Plan Name or Program Name	Enter name of the insurance health plan or program.	C
11d	Is There Another Health Benefit Plan	Mark yes or no. If yes, complete # 9a-d and #11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	Patient's or Authorized Person's Signature		Not Required
14	Date of Current Illness), or Injury (), or Pregnancy (LMP)	Enter the six digit (MM/DD/YY) or eight digit (MM/DD/YYYY) date reflecting the first date of onset for the Present Illness, Injury or LMP (last menstrual period) if pregnant. Enter the applicable qualifier to identify which date is being reported: • 431 Onset of Current Symptoms or Illness • 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.	C
15	Other Date	Enter another date related to the patient's condition or treatment. Enter the date in the six digit (MM|DD|YY) or eight digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported: • 454 Initial Treatment • 304 Latest visit or Consultation • 453 Acute manifestation of a Chronic Condition • 439 Accident • 455 Last X-ray • 471 Prescription • 090 Report Start (Assumed Care Date) • 091 Report End (Relinquished Care Date) • 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the patient's condition or treatment.	C
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, a six digit (MM/DD/YY) or eight digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.	C
17	Name of Referring Physician or Other Source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring provider 2. Ordering provider 3. Supervising provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported: • DN Referring provider • DK Ordering provider • DQ Supervising provider Enter the qualifier to the left of the vertical, dotted line.	C
17a	ID Number of Referring Physician	Required if 17 is completed. Use ZZ qualifier for taxonomy code. Must bill taxonomy provider is attested to.	C

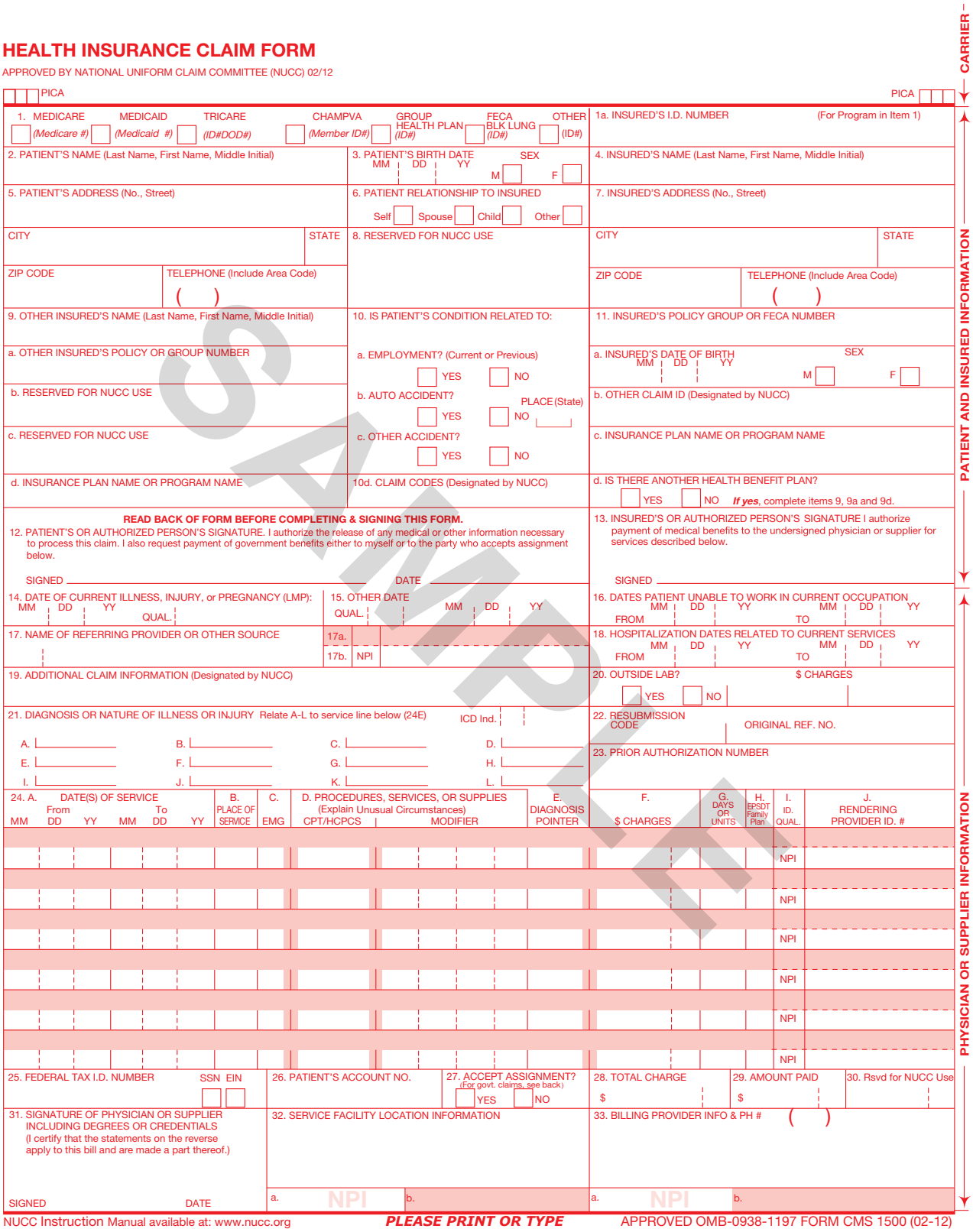
Field #	Field Description	Instruction or Comments	Required or Conditional
17b	NPI Number of Referring Physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		Not Required
19	Supervising Physician for Referring Physician	If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.	Not Required
20	Outside Lab/Charges	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32	Not Required
21	Diagnosis or Nature of Illness or Injury. (Relate Items A-L to service line below (24E)	The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. Enter the applicable ICD indicator to identify which version of ICD codes is being reported: • 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	Resubmission Code / Original Reference Number	For resubmissions or adjustments, enter the 12 character document control number (DCN) of the original claim.. Note: For resubmissions submitted via EDI, the CLM05-3 must be "7" and in the web loop a RED "F8" must be sent with the original claim number.	R
23	Prior Authorization Number	Superior does not require the Prior Authorization Number on the Claims form; it is stored with the case internally, so must still be requested as needed. Providers are encouraged to enter their Clinical Laboratory Improvement Amendments (CLIA) Number as assigned. Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. Do not enter hyphens or spaces within the number. CMS 1500 Claim Form Instructions Box 23 can also be for ambulance zip code.	C
24A -J	General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-G, 24H, 24J and 24Jb. Fields 24A-G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information. Shaded boxes A-G is for line item supplemental information and is a continuous line that accepts up to 61 characters. The un-shaded area of a claim line is for the entry of claim line item detail.	See Below
24A-G Shaded	Supplemental Information	The shaded top portion of each service claim line is used to report supplemental information for: Qualifier along with NDC, units and base measurement code are required where applicable Compound drug elements Anesthesia start/stop time and duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions HIBCC or GTIN number/code	C

<table>
<tr><th>Field #</th><th>Field Description</th><th>Instruction or Comments</th><th>Required or Conditional</th></tr>
<tr><td>24A
Unshaded</td><td>Date(s) of Service</td><td>Enter the date the service listed in 24D was performed (MM/DD/YY). If there is only one date, enter that date in the From field. The To field may be left blank or populated with the From date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.</td><td>R</td></tr>
<tr><td>24B
Unshaded</td><td>Place of Service</td><td>Enter the appropriate two digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html</td><td>R</td></tr>
<tr><td>24C
Unshaded</td><td>EMG</td><td>Enter Y (yes) or N (no) to indicate if the service was an emergency.</td><td>R</td></tr>
<tr><td>24D
Unshaded</td><td>Procedures, Services or Supplies CPT/HCPCS Modifier</td><td>Enter the five digit CPT or HCPC code and two character modifier if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.
Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national modifiers are recognized as modifiers that will impact the pricing of your claim.
<table>
<tr><td>26</td><td>50</td><td>54</td><td>55</td><td>62</td></tr>
<tr><td>66</td><td>76</td><td>80</td><td>81</td><td>82</td></tr>
<tr><td>AA</td><td>AD</td><td>AS</td><td>ET</td><td>FP</td></tr>
<tr><td>GN</td><td>GO</td><td>GP</td><td>NU</td><td>QK</td></tr>
<tr><td>QX</td><td>QY</td><td>QZ</td><td>RR</td><td>SA</td></tr>
<tr><td>TC</td><td>TD</td><td>TE</td><td>TF</td><td>TG</td></tr>
<tr><td>TH</td><td>U1</td><td>U5</td><td>U6</td><td>U7</td></tr>
</table></td><td>R</td></tr>
<tr><td>24E
Unshaded</td><td>Diagnosis Pointer</td><td>In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.</td><td>R</td></tr>
<tr><td>24F
Unshaded</td><td>Charges</td><td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td><td>R</td></tr>
<tr><td>24G
Unshaded</td><td>Days or Units</td><td>Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.
Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.
Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as “daily management”).</td><td>R</td></tr>
<tr><td>24H</td><td>Shaded EPSDT (Chcup) Family Planning</td><td>Leave blank.</td><td>Not Required</td></tr>
</table>

Field #	Field Description	Instruction or Comments	Required or Conditional
24H Unshaded	EPSDT (Chcup) Family Planning	For Early & Periodic Screening, Diagnosis and Treatment related services, enter the response in the shaded portion of the field as follows: • If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. • If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: • AV Available – Not Used (Patient refused referral.) • S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) • ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) • NU Not Used (Used when no EPSDT patient referral was given.) • If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.	C
24I Shaded	ID Qualifier	Use ZZ qualifier for attested taxonomy. Must bill taxonomy provider is attested to. Use 1D qualifier for Medicaid ID, if an atypical provider.	R
24J Shaded	Non-NPI Provider ID	Enter taxonomy code the provider is attested to. Typical providers: • Enter the provider taxonomy code that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code.	R
24J Unshaded	NPI Provider Id	Enter the 10 character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10 character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, independent lab, home health, RHC/FQHC general medical exam, etc.)	R
25	Federal Tax ID Number Ssn/ Ein	Enter the provider or supplier nine digit federal Tax ID number and mark the box labeled EIN.	R
26	Patient's Account Number	Enter the provider's billing account number.	Not Required
27	Accept Assignment	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid payments.	R
28	Total Charges	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Superior. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	Reserved for NUCC Use	This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
31	Signature of Physician or Supplier Including Degrees or Credentials	Acceptable Signature Requirements for Submission include: • Typed signature in box 31 • Name of group in box 33 is listed in box 31 • Handwritten signature in box 31 • Stamped signatrue in box 31 • Signature on file • This feature does not exist in the electronic 837P.	Required
32	Service Facility Location Information	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. CMS 1500 Claim Form Instructions Box 32 is required for ambulance paper claims with complete "to" and "from" destinations.	C
32a	NPI Where Services Rendered	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10 character NPI ID of the facility where services were rendered.	R, if Field #32 is populated
32b	Other Provider ID	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the two character qualifier ZZ followed by the taxonomy code (no spaces).	R, if Field #32 is populated
33	Billing Provider Info and Phone Number	Enter the billing provider's complete name, address (include the zip + 4 code) and phone number. First line – Enter the business/facility/practice name. Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R
33a	Group Billing Npi	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10 character NPI ID.	R
33b	Group Billing Other Id	Enter as designated below the Billing Group Medicaid ID number or taxonomy code the provider is attested to. Enter the provider taxonomy code. Use ZZ qualifier.	R

CMS 1500 Claim Form (Sample Only)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)

Completing a UB-04/CMS 1450 Claim Form

A UB-04/CMS 1450 is the only acceptable claim form for submitting inpatient or outpatient hospital claims (including hospital-based ASCs and technical services) charges for reimbursement by Superior, per Section 10 - Claims Information. In addition, a UB-04/CMS 1450 is required for comprehensive outpatient rehabilitation facilities (CORF), Federally Qualified Health Centers, Rural Health Centers, home health agencies, nursing home admissions, inpatient hospice services and dialysis services.

Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections.

UB-04/CMS 1450 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.

Exceptions

Please refer to your provider contract with Superior or to National Standard Billing requirements for revenue codes that do not require a CPT 4 code.

UB-04/CMS 1450 Outpatient and Ambulatory Surgery Claim Documentation

Additional specific information may be required in order to finalize a claim and should be submitted to Superior upon request.

UB-04/CMS 1450 Claim Instructions

The following table outlines each field within a UB-04/CMS 1450 claim form. Please note that:

- Required fields (indicated as “R”) must be completed on the claim form.
- Conditional fields (indicated as “C”) must be completed if the information applies to the situation or the service provided.
- Not Required fields (indicated as “Not Required”) do not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	(Unlabeled Field)	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state and zip+4 code (include hyphen). Line 4: Enter the area code and phone number.	R
2	(Unlabeled Field)	Enter the pay-to name and address.	Not Required
3a	Patient Control Number	Enter the facility patient account/control number	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type of Bill	Enter the appropriate three digit type of bill (TOB) code as specified by theNUBC UB-04/CMS 1450 Uniform Billing Manual minus the leading zero ("0"). A leading "0" is not needed. Digits should be reflected as follows: 1st digit - Indicating the type of facility. 2nd digit - Indicating the type of care. 3rd digit - Indicating the billing sequence.	R
5	Federal Tax ID Number	Enter the nine digit number assigned by the federal government for tax reporting purposes.	R
6	Statement Covers Period From/Through	Enter begining and ending or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MM/DD/YY).	R
7	(Unlabeled Field)	Not used.	Not Required
8 a-b	Patient Name	8a – Enter the patient's 10 digit Medicaid ID number on the member's Superior ID card. 8b – Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name e.g. McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
9 a-e	Patient Address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (not required)	R
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY)	R(except line 9e)
11	Sex	Enter the patient's sex. Only M or F is accepted.	R
12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
13	Admission Hour	Enter the time using two digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
14	Admission Type	Required for inpatient admissions TOB 11X, 118X, 21X, 41X. Enter the one digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	C
15	Admission Source	Enter the one digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5: 1 Physician referral 2 Clinic referral 3 Health maintenance referral (HMO) 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available	C
16	Discharge Hour	Enter the time using two digit military time (00-23) for the time of inpatient or outpatient discharge. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
17	Patient Status	Required for inpatient claims. Enter the two digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine discharge 02 Discharged to another short-term general hospital for inpatient care 03 Discharged to SNF 04 Discharged to ICF 05 Discharged/transferred to a designated cancer center or children's hospital 06 Discharged to care of home health service organization 07 Left against medical advice 08 Reserved for national assignment 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (to be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/transferred to a federal hospital (such as a veteran's administration [VA] hospital or VA skilled nursing facility) 50 Hospice—home 51 Hospice—medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care) 61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH) 71 Discharged to another institution of outpatient services 72 Discharged to another institution	C
18-28	Condition Codes	Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual.	
29	Accident State	Optional: Accident state	
30	(Unlabeled Field)	Not used.	

Field #	Field Description	Instruction or Comments	Required or Conditional
31-34 a-b	Occurrence Code And Occurence Date	Occurrence Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format. Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61,62, and 80 must also be completed as required. Refer to Subsection 6.6.5, Occurrence Codes, in this section. Use one of the following codes if applicable: 01 Auto accident/auto liability insurance involved 02 Auto or other accident/no fault involved 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim 10 Last menstrual period 11 Onset of symptoms 16 Date of last therapy 17 Date outpatient OT plan established or last reviewed 24 Date other insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan of treatment was established 29 Date outpatient PT plan established or last reviewed 30 Date outpatient speech pathology plan established or last reviewed 35 Date treatment started for PT 44 Date treatment started for OT 45 Date treatment started for speech language pathology (SLP) 50 Date other insurance paid 51 Date claim filed with other insurance 52 Date renal dialysis initiated	C
35-36 a-b	Occurrence Span Code And Occurrence Date	Occurrence Span Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span Code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/YYYY format. For inpatient claims, enter code 71 if this hospital admission is a readmission within seven Days of a previous stay. Enter the dates of the previous stay.	C
37	(Unlabeled Field)	Required for resubmissions or adjustments. Enter the 12 character document control number (DCN) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “resubmission” to avoid denials for duplicate submission. Note: For resubmissions submitted via EDI, the CLM05-3 must be “7” and in the 2300 loop a REF “F8” must be sent with the original claim number.	R
38	Responsible Party Name and Address		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
39-41 a-d	Value Codes Codes and Amounts	Code: Required when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Amount: Required when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. Accident hour: For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.	C
General	Revenue Codes and Description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. NDC: Enter N4 and the 11 digit NDC number (number on packaged or container from which the medication was administered). Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to three digits) can also be submitted but they are not required. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025 Refer to: Subsection 6.3.4, National Drug Code (NDC), in this section.	C
42 Line 1-22	Rev CD	Enter the appropriate four digit revenue codes itemizing accommodations, services and items furnished to the patient. Refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42. Qualifier along with NDC, units and base measurement code are required where applicable, compound drug elements.	R

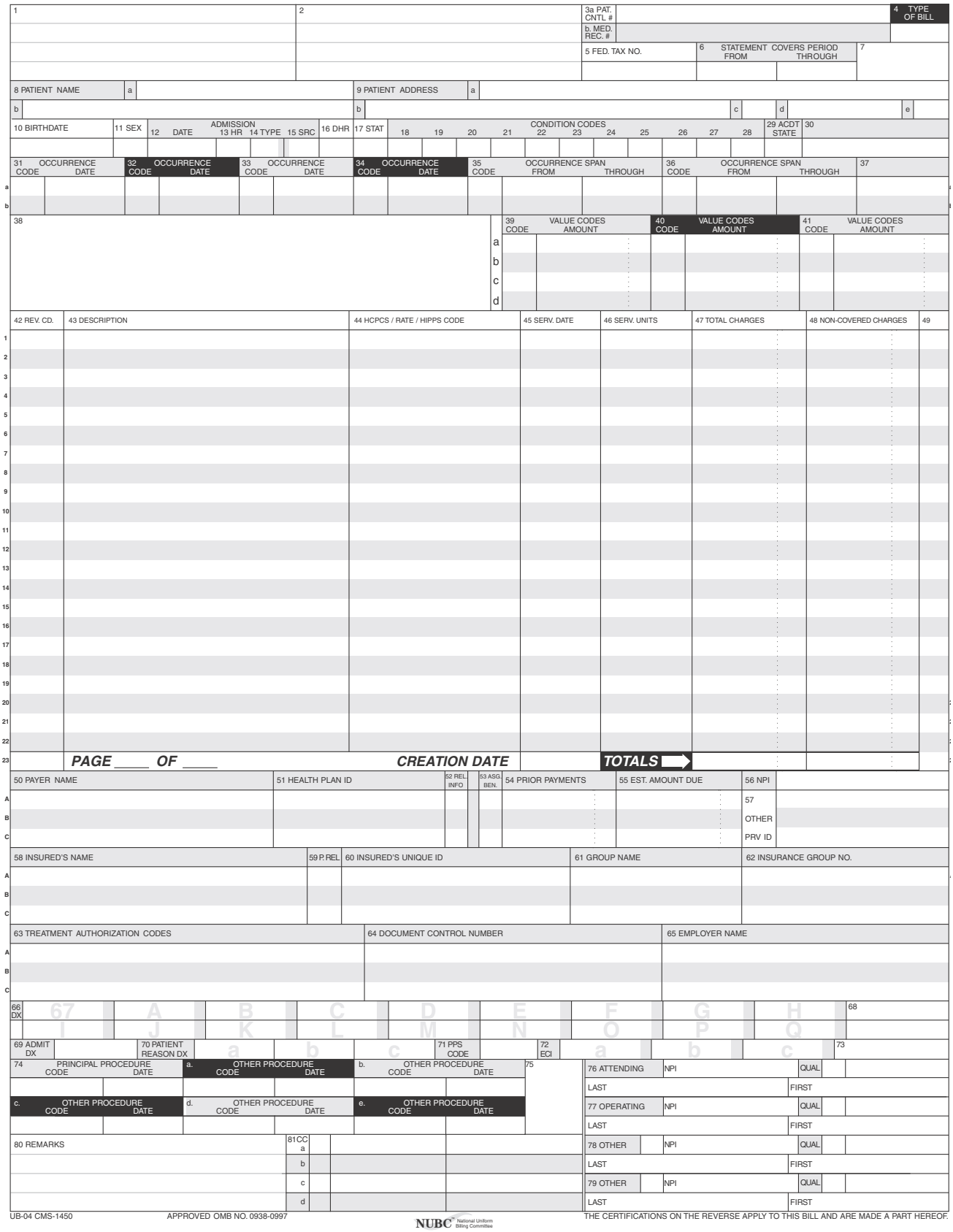
Field #	Field Description	Instruction or Comments	Required or Conditional
43 Line 23	Page ___ of ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1").	R
44	HCPCS/Rates	Required for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions. Inpatient: Enter the accommodation rate per Day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Home Health Services Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. Outpatient: Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. Note: The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.	C
45 Line 1-22	Service Date	Required on all outpatient claims. Enter the date of service for each service line billed (MM/DD/YY). Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted (MM/DD/YY).	R
46	Service Units	Provide units of service, if applicable. For inpatient room charges, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.	R
47 Line 1-22	Total Charges	Enter the total charge for each service line. Note: For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.	R
47 Line 23	Totals	Enter the total charges for all service lines.	R
48 Line 1-22	Non-Covered Charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	Totals	Enter the total non-covered charges for all service lines.	C
49	(Unlabeled Field)	Not used.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
50 a-c	Payer	Enter the name for each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer, B - secondary and C - tertiary.	R
51 a-c	Health Plan Identification Number		Not Required
52 a-c	Related Information	Required for each line (A, B, C) completed in field 50, Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	R
53	Asg. Ben.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	Prior Payments	Enter the amount received from the primary payer on the appropriate line when Medicaid/Superior is listed as secondary or tertiary.	C
55	Estimated Amount Due		Not Required
56	National Provider Identifier or Provider ID	Enter the provider's 10 character NPI ID.	R
57	Taxonomy Code	Enter the provider billing taxonomy code the provider is attested to.	R
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	Required: Enter the patient's insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the insurance /Medicaid ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group Number		Not Required
63	Treatment Authorization Codes		Not Required
64	Document Control Number	Enter the 12 character document control number (DCN), which is the original (corrected) claim number, of the paid health claim when submitting a replacement or void on the corresponding A, B, C line reflecting Superior from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to appeals/corrected claims section.	C
65	Employer Name		Not Required
66	Dx		Not Required
67	Principal Diagnosis Code and Present On Admission (POA) Indicator	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-10-CM code(s) for the date of service. Diagnosis code submitted must be a valid ICD-10-CM (once mandated) code for the date of service and carried out to its highest level of specificity – four or five digit. "E" and most "V" codes are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied Enter the applicable POA indicator in the shaded area for inpatient claims. Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
67 a-q	Other Diagnosis Code and POA Indicator	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM code(s) for the date of service. Diagnosis codes submitted must be valid ICD-10-CM code(s) for the date of service and carried out to its highest level of specificity – four or five. "E" and most "V" codes are not acceptable as a primary diagnosis. Claims with incomplete or invalid diagnosis codes will be denied. Enter the applicable POA indicator in the shaded area for inpatient claims. Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied.	C
68	(Unlabeled)	Not used.	Not Required
69	Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-10-CM code(s) for the date of service. Diagnosis codes submitted must be valid ICD-10-CM code(s) for the date of service and carried out to its highest level of specificity – four or five digit. "E" codes and most "V" are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied.	R
70 a,b,c	Patient Reason Code	Enter the ICD-10-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-10-CM for the date of service and carried out to its highest digit – four or five. "E" codes and most "V" are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS / DRG Code		Not Required
72 a,b,c	External Cause Code	If ECI diagnosis are billed, they must follow the POA exempt guidelines.	Conditional
73	(Unlabeled)		Not Required
74	Principal Procedure Code / Date	Required on inpatient claims when a procedure is performed during the date span of the bill. Code: Enter the ICD-10-CM code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. Date: Enter the date the principal procedure was performed (MM/DD/YY). Required for EDI submissions.	C
74 a-e	Other Procedure Code / Date	Required on inpatient claims when a procedure is performed during the date span of the bill. Code: Enter the ICD-10-CM code(s) that identify a significant procedure(s) performed other than the principal/primary procedure. Up to fiveICD-10-CM codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. Date: Enter the date the principal procedure was performed (MM/DD/YY).	C
75	(Unlabeled)		Not Required

Table 11-3 UB-04/CMS 1450 Data Elements

6.6.3 UB-04 CMS-1450 Blank Paper Claim Form



Clean Claim

A clean claim is a claim submitted using a national standard electronic or paper claim format (CMS or UB) that contains all data fields required by Superior for adjudication of the claim. The "Required (R)" data fields, as indicated in this Manual Section must be complete and accurate.

Electronic Funds Transfers and Electronic Remittance Advices

Superior provides electronic funds transfer (EFT) and electronic remittance advice (ERA) to participating providers to help reduce costs, improve speed for secondary billings and improve cash flow by enabling online access of remittance information and straight forward reconciliation payments. Providers can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses - ERAs can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improve cash flow - Electronic payments mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts - Keep total control over the destination of claim payment funds, plus multiple practices and accounts are supported.
- Match payments to advices quickly - Associate electronic payments with ERAs quickly and easily.

For more information on EFT and ERA services, please contact PaySpan®, Superior's electronic billing partner, at 1-877- 331-7154 or at providersupport@payspanhealth.com.

Payment/Accrual of Interest by Superior

Payment and accrual of interest is reviewed and determined on a case by case basis. If deemed to be eligible for interest, the interest payment will be calculated daily for the full period in which the clean claim remains un-adjudicated beyond the 30-Day claims processing timeframe for a clean claim.

How to Find a List of Prior Authorization (PA) Required Services and Codes

Providers can reference the Superior website for PA requirements. The prescreen tool can be found at https://www.SuperiorHealthPlan.com/providers/preauth-check.html.

Providers will need to pick a health plan, answer the questions by selecting the radio buttons and enter procedure code for authorization requirement. Authorization does not guarantee payment.

Additional Information for Claims and Encounters Administration

Claims Filing

Long-Term Services and Supports

All providers rendering LTSS services, with the exception of atypical providers, must use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing claims. Atypical providers are LTSS providers that render non-health or non-medical services to STAR+PLUS members. Examples include pest control services and building and supply services. Atypical providers will submit appropriate documentation to Superior to accurately populate an 837 Professional Encounter.

Providers will bill and report LTSS in compliance with the STAR+PLUS LTSS Health Care Common Procedure Codes (HCPC) and STAR+PLUS Modifiers Matrix (Matrix). The uniform billing requirements and billing Matrix can be found in the STAR+PLUS Handbook Appendices at https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-appendices.

LTSS providers must use the designated position of the modifiers as indicated on the matrix when filing claims.

Nursing Facility

For complete nursing facility claims filing guidelines for Superior STAR+PLUS members, see the Superior Nursing Facility Provider Manual posted at www.SuperiorHealthPlan.com.

Providers Using Paper CMS 1500

Providers billing on paper will provide complete information about the service event and will use the HHS state assigned provider identification (provider ID) or NPI and taxonomy to represent the provider(s) involved in the service event. The provider ID or NPI (billing and/or rendering) will be located in block 33 on the paper form.

For providers billing NPI, taxonomy code should be located in block 24J.

If the billing provider and the rendering provider are the same, then the provider ID or NPI will be populated in block 33 and 24 ZZ qualifier, 24 (Ja) (ZZ) taxonomy (Jb) NPI.

If the rendering provider is different than the billing provider, then the billing provider ID or NPI will be populated in block 33, and the rendering provider ID or NPI will be populated in block 24 (Ja) (ZZ) taxonomy (Jb) NPI.

Under specific scenarios, the additional usage of block 17, name, 17a (ZZ) taxonomy, 17b NPI a (referring provider), and block 24 J can be used to report additional information on providers that are involved in the service event.

Providers Using the Electronic HIPAA 837

Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the provider(s) involved in the service event.

Attendant Care Enhanced Payment Methodology

LTSS providers contracted with Superior may participate in the STAR+PLUS attendant care enhanced payment program if they currently participate in the attendant compensation rate enhancement program with HHS. The following LTSS services are eligible for enhanced payments:

- Personal Assistant Services (PAS) both waiver and non-waiver
- Day Activity and Health Services (DAHS)
- Assisted Living (AL)
- Habilitation (under CFC)

Superior will reimburse providers at the same participation level as they are assigned by HHS. Superior will increase the fee schedules for the codes included in the enhancement program for Superior contracted providers who are contracted to participate in Superior's Attendant Care Enhanced Payment program. For providers who are enrolled and subsequently do not continue participation in HHS, the level will remain the same throughout the duration of their participation in the program.

For assisted living facilities that do not hold an HHS contract, Superior will establish an additional amount to be added on to the unit rates by type of service. If based upon Superior's review of quality measures and determines a change to the provider's level, Superior will supply appropriate advance notice to such providers.

There are two distinct processes that encompass Superior's Rate Enhancement program which is in place for participating providers. These processes are Annual Attestation and Rate Level Changes. Non-participating providers cannot participate in rate enhancement through Superior.

Annual Attestation Process

Annually, Superior conducts outreach to providers in its Rate Enhancement program to obtain an affidavit attesting to their participation in the Rate Enhancement program for STAR+PLUS and the pass through of enhanced payments to their direct care staff. Towards the end of each year, these providers will be asked to submit a new attestation for the following calendar year.

Each affidavit is effective for a specific calendar year. However, any affidavit received on or after September 1 will be processed for both the current and upcoming calendar year.

Providers who contract during the plan year, and are participating in rate enhancement, should submit an affidavit that would be good for the existing plan year.

Rate Level Changes

Providers may communicate changes to their rate enhancement level at any time during the year. For providers that are assigned a new participation level by HHS for PAS or DAHS services, these providers must submit the updated level in writing to Superior requesting a change in participation level.

Superior will verify new participation levels using the list as published on the HHS website under the Attendant Compensation Rate Enhancement webpage. All rate enhancement level changes are effective the month following the month the notice was provided to Superior. Rate enhancement level changes are made prospectively, and will not be made retrospectively.

Please note: Without an affidavit on file, Superior cannot process a rate change. Providers will need to submit an affidavit with their level change for the remaining plan year, if there is none on file.

SECTION 10
ADVERSE BENEFIT DETERMINATIONS AND APPEALS

Superior's Utilization Management program outlines the process the member, a member's authorized representative or a provider must follow when a covered service is denied.

Adverse Benefit Determinations

Adverse Benefit Determination is the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, or payment or a service; the failure to provide services in a timely manner; the failure of the STAR+PLUS MMP to act within the required timeframes for the standard resolution of Grievances and Appeals; the denial of a member's request to obtain out of network services, or the denial of a member's request to dispute a financial liability.

For the processing of requests for initial and continuing authorizations of services, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

A medical director will review all potential medical necessity adverse determinations and render a final decision. Authorizations for medications may be reviewed by a pharmacist. The review may include a discussion with the ordering physician in order to obtain any information that may not have been submitted with the request. If the final decision is to deny the service request, then an adverse determination is rendered. The member and requesting provider are notified in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The member is notified of all applicable STAR+PLUS MMP, Medicare, and Medicaid Appeal rights through a single Notice. The Notice explains: the adverse benefit determination made or intended to make; the reasons for the adverse benefit determination; the right of the member to request and receive, fee of charge, access to and copies of all documents, records and other information relevant to the adverse benefit determination; the member's right to request an appeal, including information on exhausting the internal appeal, and the right to request a State Fair Hearing; the procedures for exercising appeal rights; the circumstances under which an appeal can be expedited; and the member's right to have benefits continue pending resolution of the appeal, how to request continuation of benefits, and under what circumstance.

Peer-To-Peer Discussion and Opportunity to Discuss

A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination for a Medicaid covered service, and an opportunity to discuss is available to the member's requesting or servicing provider after the adverse determination has been rendered. To schedule a pre or post denial discussion with the Medical Director who has reviewed the case or made the denial determination, the provider may contact Medical Management at 1-877-398-9461, option 3.

Provider Contractual Denials

Contractual (administrative) denials are not determined based on medical necessity. Upon notice of a contractual denial to a provider for failure to comply with the Plan's authorization requirements, the opportunity to submit documentation as evidence for reconsideration of the contractual denial is offered.

Providers have 30 Days from the date of the contractual denial to submit written documentation of the provider's compliance with authorization requirements. The required documentation for reconsideration of the contractual denial must be specific to address and remediate the reason for the contractual denial, and may include evidence of the provider's timely request for prior authorization or notification of inpatient admission, as well as documents reflecting retroactive member enrollment that did not afford the provider information that authorization through Superior's Medical Management was required. If the dispute of the contractual denial and associated documentation and evidence to support reconsideration is not received within 30 Days, the provider may forfeit the right for reconsideration of the denial.

Written request and documentation to reconsider a contractual denial must be submitted in writing by mail or FAX:

FOR MEDICAID COVERED SERVICES TO:

Superior HealthPlan
ATTN: Medical Management Appeals
5900 E. Ben White Blvd.
Austin, Texas 78741
FAX: 866-918-2266

FOR MEDICARE COVERED SERVICES TO:

Centene Corporation
Attn: Grievances & Appeals Medicare Operations
7700 Forsyth Blvd
Saint Louis, MO 63105
Fax: 1-844-273-2671

Non-Covered Benefit Denials

Request for authorization of a service that is not a covered Medicaid state plan service will be denied as not a covered Medicaid benefit. Medicaid non-covered benefit denials that are not based on medical necessity review are eligible for State Fair Hearing appeals and member complaint rights, but are not eligible for internal medical necessity appeals or External Medical Review rights.

Grievance rights are available for denial of authorization for a service that is neither a Medicare nor Medicaid state plan covered service. See Section 14 of this Manual, Member Complaint Rights for more information.

Standard Medical Appeals

STAR+PLUS MMP members have the right to appeal any Adverse Benefit Determination. The initial appeal is filed to Superior's STAR+PLUS MMP.

Member Advocate

Superior has designated member advocates who can assist a member or their representative through the denial

and appeals process, the adherence to timelines and their rights as an appellant. To speak with a member advocate call the Member Services department at 1-866-896-1844.

Member Appeals

Members, a member's authorized representative, their physician or other health-care provider may request an appeal of an Adverse Benefit Determination. All STAR+PLUS MMP standard appeal requests (including verbal requests) must be signed by the member or the member's authorized representative, unless an expedited appeal is requested. Appeals can be submitted orally or in writing.

MMP Medicaid appeal requests must be received within 65 days from the date of notification of the Adverse Benefit Determination. Superior will acknowledge a standard appeal request within five Business Days of receipt at the plan. The standard appeal process must be completed within 30 Days. For Medicare Part B standard appeals, the process must be completed in seven Days. Any additional information that may be used in consideration of the appeal must be submitted to Superior, within the requested timeframe.

Members, or their authorized representative, may request an extension of the appeal time frame, for an additional 14 Days, if they feel an extension would be in their best interest. If Superior does not agree with the extension, a letter will be sent to the member. Superior can also request an extension by contacting the appellant, informing them of the reason for the request for an extension and indicating why the extension would be in the best interest of the member. Superior's request for an extension will be confirmed in writing to the member or member's authorized representative.

A physician, who was not involved in any previous level of review or decision making and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the appeal. An appeal resolution letter will be mailed to the member or member's authorized representative with the appeal decision. If the final decision is adverse to the member, the member may be required to pay the cost of services furnished while the appeal was pending.

Superior STAR+PLUS MMP has a diverse committee in place for reviewing Member Appeals. The STAR+PLUS MMP Medical Director has a significant role in monitoring, investigating and hearing Appeals.

Members, or a person acting on their behalf with their written consent, who disagree with the appeal decision, have External Appeal Rights through the CMS Independent Review Entity (IRE), or the HHS State Fair Hearing office. See information in this Section on External Appeals for STAR+PLUS MMP members.

Post-service claim appeals for reconsideration of a medical necessity denial on behalf of a member should not be sent to the claims appeal address.

Medical necessity appeals must be mailed or faxed as indicated below and include the reason for appeal and the additional clinical information for appeal review:

Centene Management Company
ATTN: Medical Management Appeals
5900 E. Ben White Blvd
Austin, Texas 78741
Fax number: 1-866-918-2266

Continuing Services During The Appeal Process

To continue services while the appeal is being processed, the appeal must involve the termination, suspension or reduction of a previously authorized course of treatment and have been ordered by an authorized provider. If the decision is upheld and services are continued, the member may be financially responsible for the charges.

- A request for an appeal must be submitted by the member (or authorized representative acting on the member's behalf) on or before the later of 10 Days from the date of the original denial letter, or the Day the service will be reduced or end.
- The time period covered by the original authorization must not have ended.
- The member or their representative requests an extension of these benefits.

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

- The appeal is cancelled
- The appeal or State Fair Hearing is denied; or
- The time period covered by the original authorization has ended.

Expedited Appeals

A STAR+PLUS MMP member, authorized representative or the member's provider can request an expedited appeal if the timeframe to complete a standard appeal may jeopardize life, health, or ability to attain, maintain, or regain maximum function. Expedited appeal requests may be submitted verbally or in writing. Superior's member advocate can also help a member file an expedited appeal. STAR+PLUS MMP members must request an expedited appeal within 60 Days from the date of the adverse determination letter. Superior must review and provide response to an expedited appeal within 72 hours of receipt of the request. If a member's request for an Expedited Appeal is denied, the Appeal is transferred to the timeframe for standard resolution of Appeals, and reasonable efforts are made to give the member prompt oral notice of the denial and a written notice is sent to the Member within two Calendar Days of the expedited appeal denial, and the member is given his/her right to file a Grievance disputing the denial, if desired.

The appellant or member's authorized representative may request an extension of the expedited appeal timeframe, for an additional 14 Days, if they feel an extension would be in the best interest of the member. If Superior does not agree with the extension, a letter will be sent to the member. Superior can also request an extension by contacting the appellant, informing them of the reason for the request for an extension and indicating why the extension would be in the best interest of the member. Superior's request for an extension will be confirmed in writing to the member or member's authorized representative.

A physician who was not involved in any previous level of review or decision making, and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the expedited appeal.

An appeal resolution letter will be mailed to the member or member's authorized representative with the expedited appeal decision. An expedited appeal for emergency care, or continued hospitalization, will be resolved and notification sent of the resolution within one Business Day, but no later than 72 hours of the request. Expedited appeals that are not for emergency care or continued hospitalization will be resolved within 72 hours of the request. If Superior's decision is to uphold the adverse determination, the member or authorized representative can request an expedited State Fair Hearing. See information in this section State Fair Hearings.

External Appeals

STAR+PLUS MMP members have external appeal rights to both CMS and HHS, depending on the type of service being appealed; whether a traditional Medicare service, a Medicaid only service, or services that overlap both Medicare and Medicaid services.

Appeal of Superior's adverse decision on appeal for traditional Medicare A and B services not fully in favor of the

Member are automatically forwarded to the Medicare Independent Review Entity (IRE) by Superior. Appeals for services covered by Medicaid only, including, but not limited to, LTSS, Texas Medicaid-covered drugs excluded from Medicare Part D, and some Behavioral Health Care Services, may also be appealed to the HHSC Appeals Division for a State Fair Hearing. For services for which Medicare and Medical overlap, including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, adverse benefit determinations made by Superior's STAR+PLUS MMP that are not fully in favor of the Member are automatically sent to the IRE by Superior. A member may also file a request for a State Fair Hearing for these services. If an Appeal is both sent to the IRE and requested to the State Fair Hearing office by the member, any determination in favor of the member binds Superior to that decision, and results in an overturn of Superior's denial, in whole or in part.

CMS Independent Review Entity (IRE)

If, on internal Appeal, Superior STAR+PLUS MMP does not decide fully in the Member's favor within the relevant time frame, Superior automatically forwards the case file regarding Medicare services to the CMS Independent Review Entity (IRE) for a new and impartial review.

For standard External Appeals, the CMS IRE will send the Member and Superior a letter with its decision within 30 Calendar Days after it receives the case, or at the end of up to a 14 Calendar Day extension, and a payment decision within 60 Calendar Days. If the CMS IRE decides in the Enrollee's favor and reverses Superior's adverse decision, Superior will authorize the service under dispute as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Superior receives the notice reversing the decision.

For expedited External Appeals, the CMS IRE will send the Member and Superior a letter with its decision within 72 hours after it receives the case from Superior, or at the end of up to a 14 calendar Day extension. If Superior or the member disagrees with the CMS IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. Superior must comply with any requests for information or participation from such further Appeal entities.

State Fair Hearings

Appeals for services covered by Medicaid only, including, but not limited to, LTSS, Texas Medicaid-covered drugs excluded from Medicare Part D, and some Behavioral Health Care Services, may also be appealed to the HHS Appeals Division for a State Fair Hearing. A provider may be the member's representative. The member or the member's representative must ask for the State Fair Hearing within 120 Days of Superior's decision to deny the member's appeal. If the member does not ask for the State Fair Hearing within 120 Days, the member may lose their right to a State Fair Hearing. If Superior continues or reinstates benefits and the request for continued services is not approved by the State Fair Hearing officer, Superior will not pursue recovery of payment for those services without written permission from HHS.

To ask for a State Fair Hearing, the member or the member's representative should contact the health plan at:

Superior HealthPlan
ATTN: State Fair Hearings Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
Phone: 1-877-398-9461
Fax: 1-866-918-2266

If the member asks for a State Fair Hearing by the later of 10 Days from the date the appeal was denied, or the Day the health plan's letter says the service will be reduced or end, the member has the right to keep getting any

service the health plan denied, at least until the final hearing decision is made. If the member does not request a State Fair Hearing by this date, the service the health plan denied will be stopped.

If the member asks for a State Fair Hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied. HHS will give the member a final decision within 90 Days from the date the member asked for the hearing.

Expedited External Reviews

Expedited internal appeals that are adverse determinations made by Superior STAR+PLUS MMP will be forwarded to the CMS Independent Review Entity (IRE) to be processed by the IRE as expedited. The CMS IRE will send the member and Superior a letter with its decision within 72 hours after it receives the case from Superior, or at the end of up to a fourteen 14 Calendar Day extension. STAR+PLUS MMP members, or their authorized representatives, may also request an expedited State Fair Hearing if they believe that waiting for a standard State Fair Hearing could seriously jeopardize the member's life or health. In order to qualify for an expedited State Fair Hearing the member must first complete Superior's expedited appeal process.

An expedited State Fair Hearing may be requested verbally by calling Superior or by completing the State Fair Hearing Form, and attaching the adverse determination letter or the appeal resolution letter, and sending to Superior. Expedited Medicaid State Fair Hearings will be resolved within 72 hours, or as expeditiously as the member's condition requires, and may also be extended up to an additional 14 Calendar Days if the member requests the extension, or if Superior requests the extension in the best interest of the member.

Contact Information

To request an internal appeal or appeal, State Fair Hearing, the member, member's authorized representative or provider may call, fax or write Superior at:

Superior HealthPlan
Attn: Appeals/Denials Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
Phone: 1-877-398-9461
Fax: 1-866-918-2266

Please note, Superior maintains all documentation (fax, electronic and telephonic) related to the receipt and response of appeals.

SECTION 11
QUALITY IMPROVEMENT

Quality Assessment and Performance Improvement Program

Superior is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement (QAPI) program. Superior's culture, systems and processes are structured around its mission to improve the quality of services delivered to our providers and to our members. The purpose of the QAPI program is to plan, implement and monitor ongoing efforts that demonstrate improvements in member safety, overall health and care experience.

Superior is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to improving health-care quality. The NCQA seal is a widely recognized symbol of quality. NCQA health plan accreditation surveys include rigorous, on-site and off-site evaluations standards and selected HEDIS measures. A national oversight committee of physicians analyzes the survey findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's standards. This recognition is the result of Superior's long-standing dedication to provide quality health-care service and programs to our members. Superior requires all practitioners and providers to cooperate with all QAPI activities, as well as allow the plan to use practitioner and/or provider performance data to ensure success of the QAPI Program.

Goals and Objectives

The following are Superior's goals and objectives for its QAPI program:

- Safety - Care doesn't harm members.
- Member Experience - Members feel valued.
- Efficiency - Resources are used to maximize quality and minimize waste.
- Eliminating Disparities - Quality care is reliably received regardless of geography, income, language or diagnosis.

In support of the QAPI program, the QI department monitors the quality of health-care services provided to Superior members, addressing two basic areas:

- Quality of service.
- Quality of care.

To monitor the quality of services provided to Superior's members, the QI department reviews the availability of appointments for emergencies, urgent care and preventive care. Superior also monitors availability for after-hours calls from members, as well as how satisfied members are with services provided by you and your office staff.

To monitor quality of service, Superior's QI department may assess:

- Satisfaction levels from Superior providers and members utilizing both satisfaction surveys and complaints.
- Turn-around time in responding to provider issues.
- Appropriate claims payment and adjustment timeframes.
- Customer service performance with incoming provider calls.

To monitor quality of care, Superior's review processes may include:

- Review and distribution of practice guidelines for diseases and conditions most likely to impact Superior's members, as well as pediatric and adult preventive health-care guidelines, including compliance with practice guidelines.
- Targeted audits of primary care practices to promote the confidentiality of medical information and compliance with standards for appropriate medical record documentation, when necessary.
- Monitoring and support of communication systems that promote continuity and coordination of care.
- Investigation of potential quality of care complaints, including the tracking and trending of complaints.

The QI department also monitors reports of Abuse, Neglect and Exploitation (ANE). Such reports are submitted to applicable agencies in accordance with state rules and regulations. Quarterly, Superior will submit the number of critical incidents and abuse report for members receiving LTSS. Annually, Superior will submit the number of service coordinators receiving CDS training. Below are the types of ANE that Superior will report:

- Physical Abuse: any knowing, reckless, or intentional act or failure to act, including unreasonable confinement, corporal punishment, inappropriate or excessive force, or intimidation, which caused physical injury, death, or emotional harm by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Sexual Abuse: nonconsensual sexual activity, which may include, but is not limited to, any activity that would be a sexually-oriented offense per Texas Penal Code, Chapters 21, 22, or 43 by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Emotional/Verbal Abuse: any act or use of verbal or other communication to threaten violence that makes a reasonable person fearful of imminent physical injury; communication that is used to curse, vilify, humiliate, degrade, or threaten and that results in emotional harm; or of such a serious nature that a reasonable person would consider it emotionally harmful by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Neglect: failure to provide the protection, food, shelter or care necessary to avoid emotional harm or physical injury; or a negligent act or omission that caused or may have caused emotional harm, physical injury, or death by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Exploitation: the illegal or improper act or process of using, or attempting to use, the resources of the alleged victim, including the alleged victim's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the alleged victim by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Emergency: any abuse, neglect, or financial exploitation, which, without immediate intervention, would result in the victim being in a state of, or at risk of, immediate and serious physical harm.

Other Program Activities

QI initiatives (clinical and non-clinical Performance Improvement Projects [PIPs], focus studies, medical record audits, etc.) are selected:

- Based on having the greatest potential for improving health outcomes or the quality of service delivered to Superior's members and network providers;
- To test an innovative strategy; and
- To reflect distinctive regional emphasis on populations and cultures.

Superior's PIPs, focused studies and other QI initiatives are selected, designed and implemented in accordance with principles of sound research design and appropriate statistical analysis.

Superior's QAPI program description is posted on the secure portion of the Provider Portal at Provider.SuperiorHealthPlan.com.

Participation in the Quality Assessment and Performance Improvement Program

There are several ways that providers can participate in Superior's QAPI program. Providers can participate by:

- Volunteering for committee service. Superior has an active Quality Improvement Committee (QIC) structure that is comprised of physician peers. The QIC and its subcommittees provide the voice of the provider in determining the current community standard of care and in providing direction to the plan on clinical and non-clinical issues that are most relevant to Superior's members. Stipends are usually provided for attendees.
- Being vocal. We are here to help providers. If there is a problem we do not know about, Superior wants to hear why you are not happy with the plan, as well as your suggestions for how to fix the problem. Superior would also like to hear about things we do well, to model other processes after our successes.
- Responding to surveys and requests for information. If we do not hear your opinion, it cannot be a factor in our decision making.

For reporting of quality issues, or if you have questions related to Superior's QAPI program, you can contact Superior's QI department at:

Superior HealthPlan
ATTN: Senior Vice President, Population Health & Clinical Operations
5900 E. Ben White Blvd.
Austin, Texas 78741
1-800-218-7453

The Quality Improvement Committee (QIC)

This committee is an important link between Superior and its network providers. The QIC is comprised of contracted providers representing most geographic areas and a variety of specialties. Superior's Chief Medical Director appoints providers to the committee. Once appointed, members are asked to serve a minimum of one year.

This committee advises the plan regarding proposed quality improvement activities and projects, evaluates the design as well as the results of clinical studies, reviews and approves clinical practice and preventive health-care guidelines and oversees the activities of the Utilization Management Committee (UMC). The QIC also serves as the Peer Review Committee (PRC) when reviewing significant quality of care issues involving network providers.

The Utilization Management Committee

The UMC is a subcommittee of the QIC. This committee focuses on evaluation and monitoring of the Utilization Management Program and reporting requirements, which includes review of criteria used for decision making as well as oversight of the denial and appeal processes. This committee reviews specific issues related to over-and under-utilization and assists in the development of interventions or processes to improve the appropriateness of services available to and received by Superior's members.

Committee Meeting Schedules

The QIC and UMC meet every other month, on alternating months. Meetings are scheduled at a time agreed upon by the committee members and generally last one hour. Meetings are held at the Austin Superior office. Those members unable to easily travel to the Austin location may participate by telephone.

If you have an interest in taking an active role on the QIC or UMC, please contact Provider Services.

Provider Profiling

In accordance with our HHS contract, Superior adopted a formal profiling process as a tool to partner with PCPs, high-volume specialists and hospitals to improve care and services provided to Superior members. The profiling process is intended to increase provider awareness of their performance, identify areas for process improvement and expand opportunities for Superior to work closely with providers in development, implementation and ongoing monitoring of site-based practice performance improvement initiatives. The Chief Medical Director has final authority and responsibility for the provider profiling program.

Program Goals

The following are Superior's goals for the provider profiling program:

- Increase provider awareness of performance in areas identified as key indicators.
- Motivate providers to establish measurable performance improvement processes in their practice sites relevant to Superior's member populations.
- Identify the best practices of high-performing providers by comparing findings to the state average, other providers of the same type and (when possible) other comparable data.
- Increase opportunities for Superior to partner with providers to achieve measurable improvement in health outcomes.

Program Objectives

The following are Superior's objectives for the provider profiling program:

- Produce and distribute provider-specific reports containing meaningful, reliable and valid data for evaluation by the plan monthly for PCPs, and annually for acute care hospitals and high-volume OB/GYNs and specialists.
- Establish and maintain an open dialogue related to performance improvement initiatives with identified providers.

Program Scope

Superior's provider profiling program includes monthly review of high-volume PCPs and annual reviews of high-volume OB/GYNs, specialists and acute care hospitals.

On average, high-volume providers deliver services to 70 percent of Superior's membership. High-volume providers who participate in the STAR+PLUS MMP program are included in the profiling activities.

PCP Provider Profiling Process

Superior provides PCP's quarterly profile reports which provides insight into actual patterns of care of their patients. Superior utilizes reports available through Impact Intelligence. Impact Intelligence uses Superior claims data, risk adjusted, to provide providers with details on, as available, patterns of care, gaps in care on quality measures, cost and utilization summary measures, cost index summary by service category (i.e., emergency department and hospital information) and PCP visits episode detail and analysis.

High-Volume OB/GYN, High-Volume Specialists and Acute Care Hospital Provider Profiling Process

High-volume OB/GYNs, specialists, including behavioral health specialist providers, and hospitals are identified annually by Superior. Specific inclusion criteria are outlined in Table 14-1.

Table 14-1 Provider Profiling Applicability

Provider Type	Criteria	Data Source
High-Volume OB/GYNs	OB/GYN groups who served 50 or more members during the reporting year.	Claims data.
High-Volume Specialists	Specialists who served 50 or more members during the reporting year.	Claims data.
Acute Care Hospitals	Hospitals with 100 or more admissions during the reporting year.	Claims data.

When evaluating inclusion criteria or claims, the provider's total experience in all program types is used. Providers may be included in the profiles individually or as part of a group or system. Determination of providers included in the provider profiling process is the joint responsibility of select staff from the Quality Improvement, Medical Management and Account Management departments.

All indicators are reviewed and approved by the QIC annually. Additionally, Superior disseminates all approved inclusion criteria, indicators and performance benchmarks to providers through the Provider Portal before each measurement cycle. All indicators selected for inclusion in the process must have the following characteristics:

- Indicator data must be reliable and valid.
- Reliable comparative data must be available.
- Indicator topics must be meaningful to the provider, the plan and the membership.
- The provider must have the capability to effect improvement in performance.

Once identified, Superior will continue reporting indicators over multiple cycles to identify measurable performance improvement at both the system and provider levels.

Quality Indicator Data Source

The analytical software that is used by Superior applies the concept of a peer definition to make comparisons. All peer definitions start with a specialty designation and include all providers of the same specialty for purposes of comparison. Thus, for the set of episodes or population a provider is attributed to, their performance is compared to all participating same specialty providers in Superior's provider database.

Superior uses evidence-based medicine rules that can be measured in claims. These apply at the member level. Performance is determined by comparing the compliance rate for the quality rules attributed to a provider to the compliance rate of the other providers in the peer definition for that exact same mix of attributed rules. A quality index is calculated by dividing a provider's compliance rate for the attributed rules by the compliance rate for the exact same mix of rules by their peers. Thus, an index greater than one would indicate that a compliance rate is greater than peers for the exact mix of attributed rules.

Provider Profile Analysis

Aggregate data on provider profiles is analyzed by the Superior's QIC. Select staff from the Quality Improvement, Medical Management and Account Management departments analyzes individual data. Analysis includes identification of outliers, generally defined as those providers in the top and bottom five percent of the aggregate scoring for their peer group.

Provider Practice Profiles in Recredentialing

A copy of each provider profile may be utilized as the quality report in the provider recredentialing process and may be filed with select credentialing files.

Provider Profile Distribution

The PCP profile is available quarterly through the provider portal. The High-Volume OB/GYN, Specialist and Acute Care Hospital profile is mailed to select providers. Staff from the Clinical Engagement Team (CET) are available to assist with review of performance detailed in the provider profile. The service area Medical Director, Quality Practice Advisor and Chief Medical Director may accompany CET staff in visiting those providers identified as outliers. Standards used to measure the provider are available to the provider.

Practice Guidelines

Superior's Practice and Preventive Health Guidelines are based on the health needs of its membership. Selected guidelines are evidence-based, adopted from recognized sources, and promoted to providers in an effort

to ensure healthcare quality and uniformity of care provision to Superior's enrolled members. Superior's QI department reviews all guidelines annually for updating and/or when new scientific evidence or national standards are published. All guidelines are approved by Superior's Quality Improvement Committee (QIC) annually and disseminated to providers via the provider e-newsletter, targeted mailings and other media sources. The most up-to-date list of approved guidelines are available on Superior's Provider Portal: Provider.SuperiorHealthPlan.com.

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

- Adopted guidelines are approved by Superior's QIC annually.
- Adopted guidelines are evidence-based and include preventive health services.
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than annually.
- Guidelines are disseminated to providers in a timely manner via the following appropriate communication settings:
  - Provider orientations and other group sessions
  - Provider e-newsletters
  - Online via https://www.superiorhealthplan.com/providers/resources/quality-improvement/practice-guidelines.html
  - Targeted mailings
  - Guidelines are posted on Superior's website or paper copies are available upon request by contacting

Superior's Quality Improvement department at:

Superior HealthPlan
ATTN: Senior Vice President, Population Health & Clinical Operations
5900 E. Ben White Blvd.
Austin, Texas 78741
1-800-218-7453

Office Site Survey

Superior's Quality Improvement Committee (QIC) has adopted guidelines for office sites. Superior may conduct a site visit to the office of any physician or provider at any time for cause. Superior will conduct the site visit to evaluate any complaints or other precipitating events, which may include an evaluation of any facilities or services related to the complaint and an evaluation of any/all of the following:

- Physical accessibility (provider offices are required to be accessible to members with disabilities);
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Appointment availability; and
- Equipment.

The survey will be conducted by Superior's Account Management staff or designee or through a contracted vendor.

Once the survey is completed, it is scored. If the score is less than 80%, or if any elements in the "access for the disabled" section of the form are not met, the provider office is required to submit a corrective action plan to Superior within 30 Days. Following submission of the corrective action plan, a second survey is scheduled within six

months to evaluate compliance with office site guidelines.

If Superior receives another complaint about the same aspect of the performance for the office site within six months after completing the site visit, Superior will determine whether the practitioner's previous office site visit met the plan's standards and thresholds. If that is the case, Superior will follow up on the complaint and a subsequent visit is not required.

Survey Results

At the conclusion of an office site survey, the results will be reviewed with you or a designated member of your staff. You may make a copy of your survey for your records. If there are deficiencies, you may be asked to submit a corrective action plan.

Medicare Star Ratings

The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Star Ratings system in order to provide information to consumers about Medicare Plans and to reward top-performing health plans. CMS developed a set of Quality Performance Ratings for Health Plans that includes specific clinical, member perceptions and operational measures. The Star Ratings are drawn from various data sources including but not limited to: Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS®); Healthcare Outcomes Survey (HOS).

How Can Providers Help to Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Continue to talk to your patients and document interventions regarding topics such as: fall prevention; bladder control; and the importance of physical activity.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members.
- Review the gap in care files listing members with open gaps.
- Identify opportunities for you or your office to have an impact.

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources by monitoring health plan performance and rewarding top-performing health plans and helping Medicare beneficiaries make informed health-care choices. Superior must participate in the Medicare Health Outcomes Survey.

SECTION 12
CULTURAL COMPETENCY

Cultural Sensitivity

Superior places great emphasis on the wellness of its members. A large part of quality health-care delivery is treating the whole patient and not just the medical condition. Superior encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Superior maintains policies which emphasize the importance of culturally and linguistically competent care to Superior's membership of all cultures, races, languages, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees while protecting and preserving the dignity of each member. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and, in the long run, the health and wellness of the patients themselves. Providers may request Superior's Cultural Competency Plan by contacting their Account Manager.

The following is a list of principles for health-care providers to include knowledge, skills and attitudes related to cultural competency in the delivery of health-care services to Superior members.

Knowledge

- Provider's self-understanding of health disparities, as related to race, ethnicity or influence and the critical link between quality health care and the clinical encounter.
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns and the importance of building physician, patient-centered relationships.
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress and socioeconomic status.
- Understanding of the cultural differences within minority groups and how cultural dynamics influence cross-cultural behaviors.
- Understanding of the health service resources for minority patients.
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network.
- Understanding of the differences between culturally acceptable behaviors of psycho-pathological characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
- Understanding of cultural factors that can affect decision-making based on cultural beliefs, lack of trust or other behavior patterns within minority groups.
- Understanding of the public health policies and its impact on minority patients and communities.

Skills

- Ability to facilitate and assess minority patients based on a psychological, social, biological, cultural, political or spiritual model.
- Ability to enhance patient communication effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority patients with an understanding of cultural differences in pathology.
- Ability to avoid under diagnosis or over diagnosis.
- Ability to apply treatment methods that enhance clinical assessment processes and adherence.
- Ability to utilize community resources including church, Community-Based Organizations (CBOs), self-help groups.
- Ability to provide therapeutic and pharmacological interventions with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Ability to ask for consultation.

Attitudes

- Respect the "survival merits" of immigrants and refugees.
- Respect the importance of cultural forces.
- Respect the holistic view of health and illness.
- Respect the importance of spiritual beliefs.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Be aware of transference and counter transference issues.

Resources for Cultural Competency

Superior provides CLAS-related educational opportunities for providers per its Secure Provider Portal. Providers are able to participate in Superior's Cultural Competency Health Literacy Training, as well as participate in training opportunities administered by the State or nationally recognized organizations, found at www.SuperiorHealthPlan.com. Providers are also encouraged to participate in training provided by other organizations. For additional information regarding resources and trainings, visit:

- Texas Health and Human Services Culturally Effective Health Care online course https://www.txhealthsteps.com/courses
- "A Physician's Practical Guide to Culturally Competent Care," developed by the U.S. Department of Health and Human Services, Office of Minority Health - https://cccm.thinkculturalhealth.hhs.gov.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) site, https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy. Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Superior also provides ongoing provider training, which includes topics of health equity, including cultural competence, bias, diversity and inclusion, and is conducted through webinars, quarterly and refresher trainings

on an as-needed-basis, during routine on-site visits and upon request. In addition, your local, state and national provider organizations are likely to have information resources available as well. Providers may request information and resources by contacting their Account Manager.

Interpreter/Translation Services

Superior is committed to ensuring that staff and subcontractors are educated about, remain aware of and are sensitive to the linguistic needs and cultural differences of our membership. Information about cultural and linguistic competency and interpreter and translation services are included in a variety of communications media via Superior's Provider Manual, Provider Newsflash (e-newsletter), the Primary Care Update (in certain editions), training tools, etc., all of which are accessible on Superior's website. Providers are also informed of their ability to request assistance with professional interpreter and translation services with the utilization of Superior's interpreter and translation partners, 24-Hour Nurse Advice Line, Relay Texas and Telephone Interpreter Services Vendors to assist with Superior's membership when language or hearing impairment is a barrier to communication.

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

- A Member Services and Member Connections department that is staffed with bilingual personnel (Spanish and English).
- Trained professional language interpreters, including American Sign Language, are available for face-to-face communication at your office, if necessary, or via telephone to assist providers with discussing technical, medical or treatment information with members.
- A link to language interpreter services is available 24 hours a day, seven days a week to assist providers and members in communicating with each other when there are no other translators available for the language.
- TTY (text telephone for the hearing impaired) access for members who are hearing impaired (Relay Texas, 1-800-735-2989).
- Superior's Nurse Advice Line, which provides a 24-hours-a-day, seven-days-a-week bilingual (Spanish and English) line for medical assistance with access to the "language services associates" line for other languages.
- Superior member and health education materials are available in English and Spanish.

To access interpreter services for your patients, contact Superior's Member Services department at 1-866-896-1844.

SECTION 13
CREDENTIALING PROGRAM

Superior has established rigorous standards for conducting the functions of provider selection and retention. To participate in the Superior network, all licensed individual practitioners and organizational providers must meet the qualifications specific to Superior along with government regulations and standards of approved accrediting bodies.

The provider application process focuses on the review and verification of each provider's license, accreditation, and attributes, according to the guidelines of the National Committee for Quality Assurance (NCQA), the regulations of applicable governing bodies for Texas Department of Insurance (TDI) and the Office of Inspector General (OIG).

Superior's Credentials Committee, which is a subcommittee of Superior's Quality Improvement Committee (QIC), has final authority for review and appropriate approval of licensed physicians, other licensed healthcare professionals and certain facilities that have an independent relationship with the plan.

All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686 or Credentialing@SuperiorHealthPlan.com.

Credentialing Process

Applicants or affiliates applying for network status are required to undergo an in-depth evaluation and a primary source verification of their credentials to include but not limited to:

- Work history.
- Educational background.
- Training.
- Competency.

All participating providers within Superior's credentialing scope must be re-credentialed every 36 months to remain a participating provider within Superior's network.

Facilities interested in participating with Superior are required to undergo a state site survey or be accredited by an appropriate accrediting body. If the facility is not accredited, or does not have a current state site survey, it must meet the standards developed by Superior, by successfully passing a Superior site survey.

Superior requires the utilization of the statewide Texas Credentialing Alliance and the contracted Credentialing Verification Organization (CVO) as part of the credentialing and re-credentialing process.

Providers are required to complete the Texas Standard Credentialing Application (TSCA) for practitioners or the Superior Facility Credentialing application for facilities. VeriSys (CVO services provider) will assist with your credentialing process for Superior HealthPlan, and credentialing documents are submitted to VeriSys through CAQH or Availity.

- To submit a practitioner application to CAQH, go to https://proview.caqh.org. A practitioner will need to register as a first time user to get started.
- To submit a practitioner or facility application to Availity, at http://www.availity.com. Availity is the only forum to submit a facility credentialing application. Availity has a standard Facility credentialing application that is accepted by Superior. A new provider will need to register as a first time user to get started.
  - Once the completed application is completed through Availity or CAQH, VeriSys automatically retrieves the submitted information and performs the primary source verifications of submitted credentials.
  - VeriSys verifies the credentialing application and returns results to Superior for a Credentialing decision.

Initial Credentialing Process

All practitioner applicants are required to complete a TDI credentialing application form for participation. Facility and ancillary providers must fill out Superior's facility application for participation within Superior's network. The TDI and facility application form must be completed, signed and dated by the applicant.

Superior verifies the information provided on the application through external primary sources. During this process, the applicant is promptly notified of any problems related to the collection and/or verification of these documents. It is the sole responsibility of the applicant to produce all necessary information and documentation required to conduct a thorough examination of a provider's credentials. Failure to provide the necessary information within 60 Days from the initial application received date will result in termination/ discontinuation of credentialing. If the provider ever seeks to join Superior in the future, the provider must begin the process from inception.

Electronic Applications

Superior accepts electronic applications on the appropriate TDI credentialing application or Superior facility credentialing form. You can access an electronic format of the TDI practitioner application at http://www.tdi.texas.gov/forms/form9credential.html.

Superior also accepts Practitioners' Council for Affordable Quality Healthcare (CAQH) identification numbers. The CAQH is a catalyst for industry collaboration on initiatives that simplify health-care administration. For more information on CAQH, visit their website at http://www.caqh.org/. With the implementation of the CVO, facility applicants will be afforded a similar application resource, through Availity, which is a vendor similar to CAQH.

Credentialing Criteria

Each candidate must complete an application for participation that includes the following minimum requirements:

- A valid National Product Identifier (NPI) number.
- Completed, signed and dated application for participation.
- Attestation of history of loss of license and/or clinical privileges, disciplinary actions and/or felony convictions.
- Attestation of lack of current substance and/or alcohol abuse.
- Attestation to mental and physical competence to perform the essential duties of the profession.
- Attestation to the correctness/completeness of the application.
- Signed and dated Release of Information form.
- Current unrestricted license in the state where the practice is located. Exception applies for some Long-Term Services and Support (LTSS) provider types.
- Current valid federal Drug Enforcement Administration (DEA) certificate (as applicable).
- Current liability insurance in compliance with minimum limits set by Superior's provider agreement (exception applies for some LTSS provider types).
- Proof of highest level of education and, in the case of physicians, proof of graduation from an accredited medical school or school of osteopathy, proof of completion of an accredited residency program, or proof of board certification (verification of completion of a fellowship does not meet this requirement).
- Current admitting privileges in good standing at an in-network inpatient facility or written documentation from a physician or group of physicians, who participate with Superior, stating that they will assume the inpatient care of all of the practitioner's plan members who require admission, and that they will do so at a participating facility.
- Education Certificate Foreign Medical Graduate (ECFMG) certification or equivalent, if practitioner is a foreign medical graduate.

- History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner for the past five years or any cases that are pending professional liability actions (when reviewing this history, the credentials committee will consider the frequency of case(s) as well as the outcome of the case[s]).
- Written explanation if practitioner has been sanctioned in a Medicare/Medicaid program.
- Disclosure of ownership or financial interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, home health or other business dealing with the provision of ancillary health services, equipment or supplies.
- Work history for the previous five years. Any gap greater than six months must be explained by the practitioner.

Superior's credentialing staff will review each application for completeness and correctness. Applicants who meet the participation criteria and are determined to have a clean file may be approved for participation following review by the Superior medical director or chair of the Credentials Committee. Superior's credentialing policy defines a "clean file" as one with none of the following adverse activity present:

- No past or present suspensions or limitations of state licensure.
- No past or present suspensions or limitations of DEA licensure.
- Malpractice coverage in the amount required by plan.
- No past or present OIG sanction activity.
- No inclusion on CMS Preclusion List.
- No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file).
- No gaps in work history of six months or longer for a minimum of five years. If the practitioner has practiced fewer than five years from the date of credentialing, the work history starts at the time of initial licensure.
- No outstanding negative balance for a period of greater than 180 Days.

Recredentialing Process

Superior formally recredentials practitioners every 36 months. The recredentialing cycle begins with the date of the initial credentialing decision.

In order to be compliant with recredentialing expectations, a request for information is sent to the provider no later than 180 Days before the provider is due to be recredentialed. Superior verifies the information provided by the applicant in support of their application for continued participation within Superior's network through external primary sources.

During the recredentialing process, the applicant is notified promptly of any discrepancies related to the collection and/or verification of these documents. It is the sole responsibility of the applicant to produce all necessary information and documentation required to conduct a thorough examination. Failure to provide the necessary information within 60 Days from the date the application for recredentialing was received will result in termination/discontinuation of recredentialing. If the provider ever seeks to join Superior in the future, the provider must begin the process from inception.

Expedited Credentialing

To qualify for expedited credentialing the provider must: (1) be a member of an established health care provider group that has a current contract in place with Superior HealthPlan, (2) agree to comply with the terms of the contract between Superior and the health care provider group, and (3) timely submit all documentation and information required by Superior as necessary for the MCO to begin the credentialing process.

The following practitioner types may utilize the expedited credentialing pathway: Physicians (MD or DO), Podiatrist (DPM), and Therapeutic Optometrist (OD), Dentists (DDS/DMD), Dental specialists (including dentists and physicians providing dental specialty care; DDS/DMD), Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), and Psychologists (PhD/PsyD) and listed Significant Traditional Provider (STP), as provided by Health and Human Services Commission (HHSC), in markets where it is applicable to ensure a contract is offered in accordance with regulatory guidelines. Applicants, who qualify for the expedited credentialing process, as defined below, are identified as an "Expedited File." Expedited files, may be presented to the Credentials Committee or to the designated Medical Director for approval. Superior Credentialing defines an "expedited file" as one that meets the following criterion:

- Be licensed in this state by, and in good standing with, the appropriate Texas State Licensure Board;
- Submit all documentation and other information required by Superior as necessary to enable Superior to start the credentialing process; to include a signed participating provider attestation form and agree to comply with the terms of the current Superior's participating provider contract currently group contract to which they are joining.
- Verification of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) query.
- Verification that the practitioner is not excluded from participation in federal health-care programs.

While being credentialed, Superior will treat the applicant as if they were a participating provider, providing services to the managed care plan's enrollees, including:

1. Authorizing the applicant physician to collect copayments from the enrollees.
2. Making payments to the applicant physician.

Pending the approval of an expedited applicant, Superior will exclude the applicant from Superior's directory of participating physicians, website listing of participating physicians, or any other listing of participating physicians.

If, on completion of the credentialing process, Superior determines that the applicant does not meet the credentialing requirements:

1. Superior may recover from the applicant physician, podiatrist or therapeutic optometrist or the medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits.
2. The applicant physician, podiatrist or therapeutic optometrists or the medical group may retain any copayments collected, or in the process of being collected, as of the date of the credentialing determination.

Right to Review and Correct Information

During the credentialing and re-credentialing process, Superior will obtain information from various sources to evaluate applications. Providers/practitioners have the right to review any primary source information that Superior collects during this process such as the National Practitioner Data Bank (NPDB), licensing boards and board certification. However, this does not include the release of references, recommendations or other information that is peer-review protected.

Once a credentialing application is submitted, Superior's Credentialing Department may contact the provider/practitioner (or designated contact who completed the application) by phone, email and/or by mail to inform them of any information obtained from an outside primary source that varies from the information provided by the practitioner. A response from the practitioner will be requested at this time. The provider/practitioner has the right to correct any erroneous information submitted by another party if the information is:

- Used in the credentialing/recredentialing process incorrectly.
- Gathered as part of the primary source verification process and differs from what they submitted on an application.

To release this information, a written request must be submitted to Superior's Credentialing Department at:

Address:

Superior HealthPlan
Attn: Credentialing Department
5900 E. Ben White Blvd.
Austin, TX 78741

Email: Credentialing@SuperiorHealthPlan.com

Upon receipt of this information, the provider/practitioner will have 14 calendar days to provide a written explanation to Superior detailing the error or the difference in information. Written explanations may be submitted using the address or email address listed above.

Superior's Medical Director or Credentialing Committee will then include this information as part of the credentialing/recredentialing process.

Providers/practitioners have the right to be informed of the status of their credentialing/ recredentialing application upon written or verbal request to Superior's Credentialing Department.

- Written requests may be submitted at the address or email address listed in this notice.
  - Please include **practitioner or provider's name, NPI, and Tax ID**.
- Verbal requests may be submitted by phone at: 1-800-820-5686.
  - Phone inquiries will receive a response via email or phone within 14 days of receipt.

Requesting Reconsideration

If you are not satisfied with the Credentials Committee credentialing status determination, you may request reconsideration for new practitioners, or an appeal for established practitioners, of the decision in writing. Please send your written request to:

Superior HealthPlan
Attn: Credentialing Department
5900 E. Ben White Blvd.
Austin, Texas 78741

Credentialing@SuperiorHealthPlan.com

Reconsideration requests for new practitioners must be received by Superior within 30 Days of the formal notice of denial. The appointed committee members will review the information and notification of the decision will be provided.

Appeals for established practitioners must be received by Superior within 30 Days of the formal notice of denial. Superior will appoint an Appeals Committee. The Appeals Committee hears appeals of decisions from the Credentials Committee or plan to deny, suspend or restrict participation or to terminate the participation status of a practitioner or facility. The appeal hearing will be scheduled no later than 60 Days from the provider’s request.

The Appeals Committee may uphold, reject or modify the initial Credentials Committee recommendation. The Appeals Committee recommendation will be based upon the evidence admitted at the hearing and will be by the affirmative vote of the majority of the members of the Appeals Committee. The action of the Appeals Committee regarding any restriction, suspension or termination matter is a recommendation to Superior, with the plan retaining the final decision authority. The appeal decision will be communicated to the provider in writing.

SECTION 14
COMPLAINT PROCEDURES

Superior recognizes that there are times when providers may not be satisfied with a matter handled by Superior. Providers have the right to file a complaint related to that matter in accordance with regulations afforded by the Texas Department of Insurance and Texas Administrative Code. This section describes in detail the process to filing a complaint, the response timeframes and the complainant's rights during the process.

The complaint process does not include appeals for determinations/actions based on Medical Necessity Appeals for determinations/actions based on Medical Necessity are outlined in Section 10 - Adverse Benefit Determinations/ Actions and Appeals of this manual.

The complaint process does not include appeals for determinations/actions based on medical necessity.

Definition

A complaint is an expression of dissatisfaction communicated by a complainant, orally or in writing, about any matter related to Superior, other than an action/Adverse Benefit Determinations. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to:

1. The quality of care of services provided.
2. Aspects of interpersonal relationships such as rudeness of a provider or employee.
3. The failure to respect the Medicaid member's rights.

Provider Complaints

Filing a Provider Complaint

Superior offers a number of ways to file a complaint:

- Online through Superior's website at https://www.SuperiorHealthPlan.com/providers/resources/complaint-procedures.html.
- Faxing or mailing a complaint form to Superior. The link to the printable complaint form is https://www.SuperiorHealthPlan.com/providers/resources/complaint-procedures.html.

  Superior HealthPlan
  ATTN: Complaint Department
  5900 E. Ben White Blvd.
  Austin, Texas 78741
  FAX: 1-866-683-5369
- Calling the provider hotline at 1-877-391-5921.

What to Expect When You File a Complaint

When a complaint is received, a written acknowledgement letter is sent to the provider within five Business Days of receipt of the complaint. Superior then has 30 Days to resolve the complaint. The response to the complaint will be provided in writing in the form of a resolution letter. If the response is not satisfactory, a complaint appeal may be filed. Please note, Superior maintains all documentation (fax, electronic and telephonic) related to the receipt and response of complaints.

Appealing a Complaint Resolution

Provider complaint appeals must be submitted no later than 30 Days of the complaint response letter. The appeal will be settled in accordance with the commercial arbitration rules of the American Arbitration Association or the arbitration or litigation provisions as noted in the provider's contract with Superior.

Additional Filing Rights

Providers have the right to file a complaint through HHS:

Texas Health and Human Services
Managed Care Compliance and Operations
H-320 P.O. Box 85200
Austin, TX 78708-5200

Medical Appeals

The complaint process does not include medical necessity appeals that are directed to the Superior's Medical Management department. Please refer to Section 10 - Adverse Benefit Determinations, Actions and Appeals of this manual for details related to medical necessity denials and appeal.

Member Complaints

Superior understands that there are times when a member is not satisfied with Superior. In those instances, members have the right to file a complaint.

Member Advocacy

Superior designates member advocates to support and assist members filing a complaint and monitoring the complaint through Superior's complaint process until the issue is resolved. Superior also trains all staff who interact directly with members to advocate on the member's behalf including filing a complaint on their behalf. Many of the Member Services Representatives are bilingual in English and Spanish but can further utilize Superior's contracted language translation vendor for members speaking a language other than English or Spanish.

Member Rights in the Complaint Process

Superior works to preserve and protect the rights of members throughout the entire complaint process. Members have the right to:

- Designate an authorized representative who can file a complaint on their behalf. An "authorized representative" is any person or entity acting on behalf of the member and with the member's written consent. A provider may be an authorized representative. Members can print an Authorization to Disclose Health Information form at https://www.SuperiorHealthPlan.com/members/medicaid/resources/helpful-links.html.
- Have a language interpreter, including American Sign Language, available to them at any point in the process, free of charge.
- File a complaint directly with HHS or TDI once they member has exhausted Superior's complaint process.
- Receive an objective review and decision free of retaliation and discrimination.

Filing a Member Complaint

STAR+PLUS MMP Member Complaint

Superior offers a number of ways a member can file a complaint:

- Online through a link on Superior's website at https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.
- Filing a complaint in writing or by fax by printing the complaint form found at https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.
- The form may be mailed or faxed to:

  Appeals & Grievances
  Attn: Medicare Operations
  P.O. Box 10450
  Van Nuys, CA 91410-0450

- Calling the member hotline at 1-866-896-1844.

What a Member Can Expect When Filing a Complaint

When a complaint is received, a written acknowledgement letter is sent to the complainant within five Business Days of receipt. Superior then has 30 Days to resolve the complaint. The response to the complaint will be provided in writing in the form of a resolution letter. If the response is not satisfactory, a complaint appeal may be filed.

Member Appeal of a Complaint

Complaint appeals must be submitted no later than 30 Days of the complaint resolution response. The complaint-appeal involves the review by a complaint appeal panel during a scheduled meeting. The appeal panel is composed of an equal number of members, providers, and Superior employees. The doctors or other providers will be specialists in the area of care related to the complaint, and will not have reviewed the issue before. The meeting will be at a time and place that is acceptable and convenient to the member. The member may choose to send

an authorized or designated representative in their place and have the right to submit written documentation that can be presented during the panel hearing. The panel reviews all of the information presented and makes a recommendation to Superior. The recommendation is presented to Superior's Plan Product Leadership for a final decision. No later than 30 Days from receipt of the complaint appeal panel request, Superior will mail the complaint appeal response letter to the member.

Additional Filing Rights

If a STAR+PLUS MMP member is not satisfied with the outcome of their complaint appeal, they can file a complaint with the Health and Human Services Commission (HHS) at 1-866-566-8989 or by mail to:

Texas Health and Human Services
Managed Care Compliance and Operations – H-320
Attn: Resolution Services
P.O. Box 85200
Austin, TX 78708-520

STAR+PLUS MMP members can file a complaint through the Office of Long-Term Care Ombudsman by calling toll free at 1-800-252-2412, emailing ltc.ombudsman@HHS.state.tx.us or by visiting https://apps.hhs.texas.gov/news_info/ombudsman/index.cfm.

For additional information on Ombudsman Complaint Process, visit https://hhs.texas.gov/about-hhs/your-rights/ombudsman-complaint-process.

SECTION 15
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

To improve the efficiency and effectiveness of the health-care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic health-care transactions and code sets, unique health identifiers and security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards
- National provider identifier standard
- Employer identifier standard

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html.

Privacy Regulations

The Privacy Rules regulates who has access to a member's/patient's personally identifiable health information (PHI), whether in written, verbal or electronic form. In addition, this regulation affords individuals the right to keep their PHI confidential and, in some instances, from being disclosed.

In compliance with the privacy regulations, Superior has provided each member with a privacy notice, which describes how Superior can use or share a member's health records and how the member can get access to the information. In addition, the member privacy notice informs the member of their health-care privacy rights and explains how these rights can be exercised. Superior's notice of privacy practice can be found at https://www.superiorhealthplan.com/privacy-practices.html.

As a provider, if you have any questions about Superior's privacy practices, contact Superior's compliance officer by calling 1-800-218-7453 or by emailing Superior.Compliance@SuperiorHealthPlan.com.

Members should be directed to Superior's Member Services department with any questions about the privacy regulations. Member Services can be reached at 1-866-896-1844.

Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used or maintained by Superior. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information.

The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

Breach Notification Rule

On January 25, 2013, the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) published in the Federal Register a Final Omnibus Rule (Final Rule) that revises certain rules promulgated under HIPAA. These revised rules were issued pursuant to changes enacted by Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination Act (GINA) of 2008. On March 23, 2013, the Final Rule implemented section 13402 of the HITECH Act requiring various notifications following a breach of unsecured protected health information.

The Final Rule eliminates the significant risk of harm standard from the Interim Rule for determining whether a breach has occurred. Covered entities and business associates must ensure compliance with regulatory definitions relating to breach notifications.

Transactions and Code Sets Regulations

Transactions are activities involving the transfer of health-care information for specific purposes. Under HIPAA, if Superior or a health-care provider engages in one of the identified transactions, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The Standards for Electronic Transactions and Code Sets, published August 17, 2000, and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any health-care provider that conducts a standard transaction also must comply with the Privacy Rule.

Version 5010 refers to the revised set of HIPAA electronic transaction standards adopted to replace the current standards. Every standard has been updated, including claims, eligibility and referral authorizations.

All HIPAA covered entities must be using version 5010 as of January 1, 2012. Any electronic transaction for which a standard has been adopted must have been submitted using version 5010 on or after January 1, 2012.

HIPAA Required Code Sets

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding. Only national standard codes can be used for electronic claims and/or authorization of services.

Nationally recognized code sets include:

1. Health Care Common Procedure Coding System (HCPCS) - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.
2. Current Procedure Terminology (CPT) codes - The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the AMA.
3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 and 2 (diagnosis codes) - These are maintained by the National Center for Health Statistics and Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) - Those are maintained by CMS.

5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM- This is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 and 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3, and two parts:
   - Part 1: ICD-10-CM for diagnosis coding. ICD-10-CM is for use in all U.S. health-care settings. Diagnosis coding under ICD-10-CM uses three to seven digits instead of the three to five digits used with ICD-9-CM, but the format of the code sets is similar.
   - Part 2: ICD-10-PCS for inpatient procedure coding. ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses seven alphanumeric digits instead of the three or four numeric digits used under ICD-9-CM procedure coding.

   The transition to ICD-10 occurred because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-10 affects diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims. Everyone covered by HIPAA who transmits electronic claims must also switch to Version 5010 transaction standards. The change to ICD-10 does not affect CPT coding for outpatient procedures.
6. National Drug Code (NDC) - The NDC is a code that identifies the vendor (manufacturer), product and package size of all medications recognized by the Federal Drug Administration (FDA). To access the complete NDC code set, see www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

HIPAA Regulated Transactions

Below are the eight electronic standardized transactions that are mandated by the HIPAA legislation.

Transaction Name	HIPAA Transaction Number
Claims and Encounters	837
Enrollment and Disenrollment	834
Health Plan Eligibility Solicitations and Response	270/271
Payment and Remittance Advice	835
Premium Payment	820
Claim Status Solicitation and Response	C276/277
Coordination of Benefits	837
Referral and Authorization	278

Though it is standard operating process, Superior does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets, is made available to Superior's providers via various alternative capabilities, such as online tools. Superior currently offers an alternative through the online web tool, Superior's Secure Provider Portal, for the following transactions:

- ASC X12 270 Eligibility Status Inquiry.
- ASC X12 271 Eligibility Status Response.
- ASC X12 276 Claim Status Inquiry.
- ASC X12 277 Claim Status Response.
- ASC X12 278 Referral Certification and Response.

For more information on conducting these transactions electronically, contact the EDI Department at 1-800-225-2573 ext. 25525 or by email at EDIBA@centene.com.

National Provider Identifier

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health-care providers. Covered health-care providers and all health plans and health-care clearing houses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health-care providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in all electronic HIPAA standards transactions.

As outlined in the federal regulation, covered providers must also share their NPI with other providers, health plans, clearinghouses and any entity that may need it for billing purposes.

All Superior providers must attest a valid NPI upon requesting an application for network participation with Superior. For any questions about NPI, please contact Superior's Provider Services department.

SECTION 16
Secure Provider Portal

Provider Portal

Superior provides a Secure Provider Portal that offers tools to assist your office staff any time of day. It is available for providers at Provider.SuperiorHealthPlan.com.

Registering for the Provider Portal

In order to use Superior's Secure Provider Portal, you must first register online at Provider.SuperiorHealthPlan.com.

- You will be asked to enter your tax identification number, first name, last name, email address and to create a password. Your email address will also serve as your username.
- Once you submit the registration form, you will receive an email confirmation to validate your account.
- Your request for access will be reviewed and additional validation will be sent to your TIN's Account Manager for confirmation.

Each TIN is allowed to designate Account Manager(s). This role is responsible for managing access permissions to their TIN, including adding and removing accounts and allowing users to access the modules with in the Secure Provider Portal (claims, authorizations, eligibility, etc.). If registering for an Account Manager role, additional validation will be required.

Logins and passwords are unique, requiring each staff member within one office or group to register separate user accounts. Sharing accounts between staff is not permitted.

Please note, the Secure Provider Portal will randomly launch the Challenge Survey on a quarterly basis to users with an account management role. This survey is a new tool to verify provider demographic data and monitor provider adherence to state requirements. The tool gives providers access to update or confirm their demographic information prior to accessing the Secure Provider Portal modules.

Benefits of the Provider Portal

Here are some of the features currently available in the Secure Provider Portal:

- Verify Patient Eligibility: Identify patient coverage, and program copays, if applicable, by simply entering the necessary search criteria (DOB, member ID, or patient name).
- Print Member-Patient Panel Reports: For Primary Care Providers (PCPs), login to your account and print a list of members assigned to you for primary care services. Other features included on the PCP Panel Report are:
  - Date of last wellness exam.
  - Preventive visits due, including last mammogram.

  - View member care gap alerts. When a member has a “gap in care” (i.e. a preventive service not rendered within the allotted time frame) an alert symbol will appear. When a provider clicks on the member’s name, the screen will revert to the member eligibility details page, which will display the care gap details (for example, “No Flu Vaccine in past 12 months.”).
- Online Claims Submission:
  - Individual Claim Submissions - Submit both professional and institutional claims online for quicker payment. Claim corrections can also be submitted through the Secure Provider Portal.
  - Copy Claim Feature - Recreate claims without entering data twice.
  - Recurring Claims Tool - Quickly and easily submit repetitive, long-term care claims for multiple members.
  - Batch Claim Submissions - Avoid paying clearing house fees and submit batch claims online! Please note: Currently we only accept formatted 837 claims files. We apply HIPAA level 5 edits. Files must be in .dat, .edi or .txt formats and no larger than 25MB.
  - Claims Reconsiderations - Submit a request for review if it is believed a claim was incorrectly paid or denied.
  - Attachments - Attach additional documentation necessary during the online claim or appeal submission.
- Check Claims Status Online: Confirm the status of submitted claims and easily reconcile your patient accounts.
- Authorizations:
  - Submissions - Submit authorization requests directly.
  - Attachments - Attach clinical information needed.
  - Authorization Status - Check authorization status.

Note: Currently, Long-Term Support Services (LTSS) providers are unable to use this feature for authorization submission for PAS, DAHS and Assisted Living.

- Explanation of Payments: Explanation of payments are available in the Secure Provider Portal.
- Update Demographic Information: Update provider demographics such as, address, phone number and office hours.
- Medicaid Authorization Pre-Screening: Find the tool on our website under Provider Resources. Simply enter a valid procedure code, and the system will display the authorization requirements for that procedure. Non-participating providers will always require an authorization for non-emergent services.

Other valuable content made available at www.SuperiorHealthPlan.com includes an online provider directory and provider resource section containing bulletins, Frequently Asked Questions (FAQs), Provider Manuals, training presentations for all Superior products and other helpful website links.

Provider Portal Help Desk

For assistance with accessing the Secure Provider Portal, contact the Web Applications Support Desk at 1-866-895-8443 or email TX.WebApplications@SuperiorHealthPlan.com.

SECTION 17
PHARMACY SERVICES

Pharmacy Services Responsibilities

Superior Pharmacy Services promotes the most effective use of medications for our members. Pharmacy Services is charged with oversight of administering the pharmacy benefit, ensuring member access to needed medications, employing appropriate utilization management tools and supporting the care management model. Superior works with the Pharmacy Benefits Manager (PBM) to ensure that medications are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally-recognized standards of pharmaceutical care. In addition, Pharmacy Services seeks to educate providers regarding the cost effective use of drugs and to provide useful feedback about current prescribing patterns to improve the quality of patient care. Responsibilities of Pharmacy Services include, but are not limited to:

- Ensure that pharmacy benefit services provided are medically appropriate.
- Promote safe and effective drug therapy.
- Manage pharmacy benefit resources effectively and efficiently while ensuring that quality care is provided.
- Ensure that members can easily access prescription services at any network pharmacy.
- Actively monitor utilization to guard against over-utilization of services and fraud or abuse and to address gaps in care or under-utilization of needed medications.
- Participate with care management to promote optimal use of medication, focusing on ER and hospitalization avoidance.
- Manage tools for members that assist them in managing and taking their medications.
- Assist providers with the coordination of prescription services.
- Work with quality initiatives and manage programs that increase the quality of pharmaceutical care for members.

Formulary Management

Superior will manage the provision of medications to STAR+PLUS MMP members via the Medicare formulary. Medications not covered by Medicare Part D may be covered by Texas Vendor Drug Program (VDP) as a Medicaid benefit via the wrap benefit. A link to the STAR+PLUS MMP formulary is available on the Superior website. A link to the VDP formulary is also available on the Superior website.

The majority of prescriptions will be covered based on the Medicare Part D formulary. In addition, Superior will assist with the following:

- Transitions of prescription drugs
- Out of network coverage
- Quality assurance
- Exceptions and appeals
- Utilization management (prior authorization requirements)
- Location of pharmacies in proximity to members
- Information about any formulary changes

Prior Authorizations (PA)

Certain medications Superior covers have limits or other rules. Please refer to the most current formulary posted on SuperiorHealthPlan.com for guidance on which medications have limitation(s) that may require additional authorization. Superior must make a decision within 72 hours of receiving the request. Requests may be expedited if the member's health is in danger. If a request for a expedited authorization is allowed, Superior must inform the provider of the authorization decision within 24 hours of receiving the request.

To request a coverage determination (exception) to our coverage limitation rules, providers may contact the Medicare Pharmacy Prior Authorization department at 1-800-867-6564.

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication that is wrapping to the Medicaid benefit is needed without delay and PA is not available. This applies to all drugs requiring a PA, under the Medicaid wrap benefit (tier 3 drugs) because they are non-preferred drugs on the Texas Vendor Drug Program (VDP) Preferred Drug List (PDL).

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the VDP formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit 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.

To be reimbursed for a 72-hour emergency prescription supply, the pharmacy may follow the point of sale messaging which allows the 72-hour supply to be adjudicated electronically (immediately) or the pharmacy may call the PBM help desk line for additional assistance.

For more information about the 72-hour emergency prescription supply policy, call the PBM help desk at 1-833-750-0202.

Appeals

In the event that a prior authorization is denied a written notification will be sent to the provider and member. This notification will provide additional information regarding the reason for the denial. The provider is encouraged to read over the denial notification and consider for example a preferred product, change in dose, etc. which may have led to the original denial. The denial notification will also contain instructions for contacting the appeals department and outline the appeals process. Contact information for the Superior Appeals department is also available on our website at: https://mmp.superiorhealthplan.com/appeals-grievances.html.

Pharmacy Benefits

STAR+PLUS MMP members have access to a large network of pharmacies for prescription needs. The pharmacy network includes retail chains, independent pharmacies, specialty pharmacies and mail order pharmacies. Members may receive up to a 100-Day supply of certain drugs. Members have the right to obtain medications from any network pharmacy. For a full listing of pharmacies in Superior’s network go to ProviderSearch.SuperiorHealthPlan.com.

Pharmacy Claims Processing

Pharmacy claims adjudicate through the PBM's online adjudication system. Claims submitted electronically have an 18-Day clean claim window. Claims submitted non-electronically have a 21-Day clean claim window.

Durable Medical Equipment

Superior reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans and other supplies and equipment.

To be reimbursed for DME, a pharmacy must submit their claim through Superior under the following guidelines:

- All documentation must be legible.
- Claims must use EDI version 5010 guidelines as mandated by HIPAA rules.
- Primary Care Providers (PCPs) and all participating providers must submit claims or encounter data for every patient visit, even though they may receive a monthly capitation payment.
- All claims and encounter data must be submitted on either a form CMS 1500 or UB-04 (see Section 9 - Claims and Encounters Administration) or on electronic media in an approved HIPAA compliant format.

Call 1-800-460-8988 for more information about DME. Physicians will have the option to prescribe incontinence supplies without obtaining prior authorization from Superior for payment. To do so, the incontinence supplies must be dispensed through one of Superior's nationally contracted DME providers.

The waiver of authorization will only apply when ordering incontinence supplies through one of Superior's nationally contracted DME providers. The prior authorization requirement will remain in effect for incontinence supplies whenever a nationally contracted DME provider is not used.

Contact Information

Prior authorization forms can be found on the Secure Provider Portal at Provider.SuperiorHealthPlan.com. The provider may submit a web authorization request, or fax the form to Superior at 1-877-941-0840.

SECTION 18
DENTAL SERVICES

Emergency Dental Services

Superior is responsible for emergency dental services provided to Medicaid members in a hospital, free-standing emergency room or ambulatory surgical center setting. Superior will pay for devices for hospital, physician and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

Superior is not responsible for paying for routine dental services provided to Medicaid members.

SECTION 20
ELECTRONIC VISIT VERIFICATION (EVV)

Electronic Visit Verification (EVV) applies to providers in the STAR+PLUS MMP program providing Texas Medicaid attendant or attendant-like services or habilitation services. EVV is a computer-based system that electronically verifies when service visits occur and documents the precise time service provision begins and ends. The purpose of EVV is to verify that individuals are receiving the services authorized for their support and for which the state is being billed.

Providers who contract with Superior on or after April 1, 2016 and provide services required to use EVV, must select and enroll with an HHS approved EVV system prior to furnishing services to Superior members.

EVV Requirements

As a part of EVV compliance, providers must ensure Electronic Visit Verification data, including any necessary visit maintenance within 95 Days from the date of service is accurately documented in the EVV system, in order to be properly reimbursed by Superior. EVV compliance and claim submissions are independent processes. EVV data must be captured and confirmed in the EVV system prior to billing.

Providers can verify that their visits have been transmitted to Superior by utilizing the EVV Visit Log in the EVV portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom as well as to verify that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available in the EVV portal to check for unsent transmissions and/or inaccurate visit data.

General Information About EVV

What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the service provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHS determines is necessary to ensure the accurate adjudication of Medicaid claims.

Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHS to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To

comply with these statutes, HHS required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHS plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

Which services must a service provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHS EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHS EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

To learn more, please review the EVV Service Bill Codes Table found on the HHS website: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification#service-bill-codes-table.

Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an Superior to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an Superior to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV Systems

Do providers and FMSAs Have a Choice of EVV Vendors?

Yes. A provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHS Claims Administrator, on behalf of HHS, that a provider or FMSA may opt to use instead of an EVV proprietary system. For additional information, please visit: https://www.tmhp.com/topics/evv/evv-vendors
- EVV proprietary system. An EVV proprietary system is an HHS-approved EVV System that a provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a provider or an FMSA.
  - Is used to exchange EVV information with HHS or Superior; and
  - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.
  - More information on proprietary systems can be found at TMHP: https://www.tmhp.com/topics/evv/evv-proprietary-systems

What is the process for a provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.
- To access state approved vendors and contact information, please visit: https://www.tmhp.com/topics/evv/evv-vendors. To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHS EVV Proprietary System approval process.
- For more information about the EVV proprietary system and onboarding process, please visit: https://www.tmhp.com/topics/evv/evv-proprietary-systems

What requirements must a provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. To see state approved vendor information, please visit: https://www.tmhp.com/topics/evv/evv-vendors.
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHS to use an EVV proprietary system to comply with HHS EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer in the EVV Training section below; and
  - Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data;
    - Enter or verify member service authorizations;
    - Setup member schedules (if required); and
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

Does a provider or FMSA pay to use the selected EVV System?

- If a provider or FMSA selects an EVV vendor system, the provider or FMSA uses the system free of charge.
- If a provider or FMSA elects to use an EVV proprietary system, the provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

Can a provider or FMSA change EVV Systems?

Yes. A provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a provider or FMSA is transferring to an EVV proprietary system, the provider or FMSA, TMHP, and HHS will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A provider or FMSA must complete all required EVV System training before using the new EVV System.
- A provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

EVV Service Authorizations

What responsibilities do Providers and FMSAs have regarding service authorizations issued by Superior for an EVV required service?

A provider and FMSA must do the following regarding service authorizations issued by Superior for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service,

including:

- Name of the MCO;
- Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV Clock In and Clock Out Methods

What are the approved methods a service provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A service provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A service provider or CDS Employee may use one method to clock in and a different method to clock out.

1. Mobile method
   - A service provider must use one of the following mobile devices to clock in and clock out:
     - The service provider's personal smart phone or tablet; or
     - A smart phone or tablet issued by the provider.
   - A service provider must not use a member's smart phone or tablet to clock in and clock out.
   - A CDS Employee must use one of the following mobile devices to clock in and clock out:
     - The CDS Employee's personal smart phone or tablet;
     - A smart phone or tablet issued by the FMSA; or
     - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
   - To use a mobile method, a service provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the service provider or CDS Employee has downloaded to the smart phone or tablet.
   - The mobile method is the only method that a service provider or CDS Employee may use to clock in and clock out when providing services in the community.

2. Home phone landline
   - A service provider or CDS Employee may use the member's home phone landline, if the member agrees, to clock in and clock out of the EVV System.
   - To use a home phone landline, a service provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
   - If a member does not agree to a service provider's or CDS Employee's use of the home phone landline or if the member's home phone landline is frequently not available for the service provider or CDS Employee to use, the service provider or CDS Employee must use another approved clock in and clock out method.
   - The provider or FMSA must enter the member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.
3. Alternative device
   - A service provider or CDS Employee may use an HHS-approved alternative device to clock in and clock out when providing services in the member's home.
   - An alternative device is an HHS-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
   - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
   - The alternative device codes are active for only seven Days after the date of service and must be entered into the EVV system before the code expires.
   - The service provider or CDS Employee must follow the instructions provided by the provider or CDS Employer to use the alternative device to record a visit.
   - An alternative device must always remain in the member's home even during an evacuation.

What actions must the provider or FMSA take if a service provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a service provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the provider must manually enter the visit in the EVV System.
- If a service provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if Superior approves a Visit Maintenance Unlock Request.

- The EVV Policy Handbook requires the provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV Visit Maintenance

Is there a timeframe in which providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHS EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHS to accommodate providers impacted by circumstances outside of their control.

Are providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
- For more information, please review the Current HHSC EVV Reason Codes found on the HHS website: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification

EVV Training

What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHS or Superior.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;

    - Clock in and clock out methods; and
    - EVV Policy training provided by HHS, Superior or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHS, Superior or FMSA.
  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHS, Superior or FMSA.
- Providers and CDS Employers must train service providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.
- For more information on Superior's EVV Training Requirement, please attend an EVV Training found on SuperiorHealthPlan.com/ProviderCalendar.

Compliance Reviews

What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by Superior to ensure providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- Superior will conduct the following reviews and initiate contract or enforcement actions if providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review - meet the minimum EVV Usage Score;
  - EVV Required Free Text Review – document EVV required free text; and
  - EVV Landline Phone Verification Review - ensure valid phone type is used.
- The Superior EVV Compliance Plan is located by visiting SuperiorHealthPlan.com/ProviderResources, and clicking on EVV Provider Compliance Requirements.

EVV Claims

Are providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by Superior. Superior may deny or recoup an EVV claim that does not match an accepted visit transaction.

Where does a provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHS Claims Administrator in accordance with Superior's submission requirements.

Providers must follow the standards outlined within the existing appeals process and include supporting EVV attendant data as applicable in order to substantiate claims payment. All EVV claims being appealed must be submitted to TMHP. Please see Claim Appeal Process within section 10 for more information.

EVV Claims Matching

What happens if a provider or FMSA submits an EVV claim to Superior instead of the HHS Claims Administrator?

If a provider or FMSA submits an EVV claim to Superior instead of the HHS Claims Administrator, Superior will reject or deny the claim and require the provider or FMSA to submit the claim to the HHS Claims Administrator.

What happens after the HHS Claims Administrator receives an EVV claim from a provider or FMSA?

The HHS Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHS Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHS Claims Administrator forwards the claim to Superior for final processing.

How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to Superior once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. Superior will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHS implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- Superior will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- Superior may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHS, Superior may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

How can a provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and Superior's system. Superior's Provider Portal also provides additional claims status information, such as whether Superior has paid or denied the claim. In addition, Superior provides an Explanation of Payment (EOP) to providers and FMSAs to inform them of whether Superior paid or denied the claim, and if denied, the reason for denial.

For more information, please review the EVV Portal Job Aids section on the TMHP EVV Training webpage: https://www.tmhp.com/topics/evv/evv-training

Could Superior deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. Superior may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a member's loss of program eligibility or the provider's or FMSA's failure to obtain prior authorization for a service.

Is EVV Required for CDS Employers?

With the passage of the 21st Century Cures Act, the use of EVV will be required for individuals using the SRO/CDS option effective January 1, 2021. CDS employers have the option to choose from the following three options:

- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your CDS employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS employee will call in when they start work and call out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- No EVV Participation: If you do not have access to a computer, assistive devices or other supports, you do not feel you can fully participate in EVV, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

EVV Due Process Procedures for Recoupment of Overpayments: Missing EVV Information

Superior may periodically perform audits of EVV claims for a rolling 24 month lookback period.

In the event Superior identifies EVV claim overpayments Superior will provide written notice of the intent to recoup to the provider or FMSA within 30 Days from the completion of the audit. If the provider or FMSA intends to dispute Superior's findings, a response to the written notice must be received by Superior within 30 Business Days.

Providers and FMSAs have 60 Calendar Days from the notice date to correct and explain the deficiencies related to EVV claims identified in the audit before Superior may begin recovery effort for the identified overpayments. Superior may only recover for claims where deficiencies have not been corrected within 60 Calendar Days.

Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the provider or FMSA is using a proprietary system, the Service provider, CDS Employer or CDS Employee must contact the provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV Vendors

HHAeXchange

Contact:	Email:	Phone: 1-833-430-1307
Tech Support	TXsupport@hhaexchange.com	
Website: https://www.hhaexchange.com/info-hub/texas		

For additional questions, contact Superior's Provider Services department at 1-877-391-5921.

Other EVV Notes

- Providers can verify that their visits have been transmitted to Superior by utilizing the EVV Visit Log in the EVV portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom as well as to very that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available to the providers in the EVV system to check for unsent transmissions and/or inaccurate visit data.
- In the event of a retroactive authorization that may impact EVV visit data, providers should submit the HHS approved request form for visit maintenance unlock. In extenuating circumstances, unlock requests that Electronic Visit Verification (EVV) exceed the 95 Day timeline will be reviewed to determine if the retroactive authorization had an impact on the EVV visit data for the specific member and authorization time period in question. Superior will work directly with a provider to gather the necessary information to determine if visit maintenance is necessary due to a retroactive authorization. Visit maintenance unlock approval will be considered on a case-by-case basis, and visit maintenance updates should be applied as appropriate per policy guidelines.
- Unlock requests that are received after the 95 Day timeline will be reviewed to determine if there were extenuating circumstances outside of the provider's control that would warrant approving the unlock request. Possible examples of an "extenuating circumstance" would be a retroactive change to a member's eligibility or vendor portal outage. In cases like these, Superior will work directly with a provider to gather the required information to determine if visit maintenance is necessary. Visit maintenance unlock approval will be considered on a case-by-case basis, and visit maintenance updates should be applied as appropriate per policy guidelines.

  In the case that a Visit Maintenance Unlock Request is denied, reason for denial will be provided to the program provider, FMSA or CDS employer. Any additional information or documentation that can be given from the program provider, FMSA or CDS employer will be considered and will require resubmission of the Visit Maintenance Unlock Request form . Once resubmission is received, it will be reviewed as an appeal request for visit maintenance unlock.
- For additional information relating to EVV please refer to the Superior Provider Resources page, located at: https://www.superiorhealthplan.com/providers/resources.html.
- EVV does not eliminate the need to obtain prior authorization. Providers still need to secure prior authorizations for these services prior to rendering services. If a provider has not received prior authorization for services, they must contact Superior at 1-877-391-5921.

  - Please refer to the Superior HealthPlan website (www.SuperiorHealthPlan.com) for a list of services that require prior authorization.
- For EVV complaints regarding EVV approved vendors, providers can contact SHP_EVV@centene.com.
- For general EVV questions, providers may contact:
  - Superior Provider Services at 1-877-391-5921.
  - HHS at EVV@hhs.texas.gov.

superior healthplan™

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