Nursing Facility Provider Manual

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TEXAS STAR PLUS
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TEXAS Health and Human Services

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INTRODUCTION

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

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

Superior Policies and Objectives

Superior conducts its business affairs in accordance with the standards and rules of ethical business conduct, and abides by all applicable federal and state laws. Superior's policies are designed to assist HHS in achieving an integrated delivery system of acute and LTSS through the following objectives:

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

Member Rights and Responsibilities

Member Rights:

1. Members have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that their medical records and discussions with providers will be kept private and confidential.
2. Members have the right to a reasonable opportunity to choose a health-care plan and Primary Care Provider (PCP). This is the doctor or health-care provider members will see most of the time and who will coordinate their care. Members have the right to change to another plan or provider. That includes the right to:
    a. Be told how to choose and change health plans and PCPs.
    b. Choose any health plan that is available in the member's area and choose a PCP from that plan.

c. Change PCPs.

d. Change health plans without penalty.

e. Be told how to change health plans or PCPs.

3. Members have the right to ask questions and get answers about anything they do not understand. That includes the right to:

   a. Have their provider explain their health-care needs to them and talk about the different ways their health-care problems can be treated.

   b. Be told why care or services were denied and not given.

4. Members have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

   a. Work as part of a team with providers in deciding what health care is best for them.

   b. Say yes or no to the care recommended by providers.

5. Members have the right to use each available complaint and appeal process through Superior and through Medicaid, and get a timely response to complaints, internal health plan appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

   a. Make a complaint to Superior or to the state Medicaid program about health care, providers or their health plan.

   b. Get a timely answer to complaints.

   c. Use the Superior appeal process and be told how to use it.

   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

   e. Ask for a State Fair Hearing with or without an External Medical Review 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 needed.

   b. Get medical care in a timely manner.

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

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

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

7. Members have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force the member to do something they do not want to do, or is to punish them.

8. Members have a right to know that doctors, hospitals, and others who care for them and can advise them about their health status, medical care, and treatment. Superior cannot prevent them from giving members

this information, even if the care or treatment is not a covered service.

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

j. Superior's practice guidelines.

Member Education

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

- Superior member handbooks
- Superior website: www.SuperiorHealthPlan.com
- Quarterly newsletters
- Special mailings
- Superior Provider Directory

To obtain a sample of any of the materials listed above, contact Member Services. All educational materials are available in written text, both English and Spanish, and can be made available in other languages or formats such as Braille or large print, if needed. These materials are written at or below a 6th grade reading level, as measured by

the appropriate score on the Flesch-Kincaid Readability Scale.

You may always refer your residents to our Member Services department at 1-877-277-9772 for personalized member education or to request information or materials.

Contacting Superior

Superior has staff to assist you with your day-to-day operations, questions and/or concerns. Every Nursing Facility provider will have a designated Account Manager that can coordinate an in-service/training for facility staff, provide face-to-face support in the facility and assist with answering questions about Superior's policies and procedures. You may also contact Superior's Provider Services department at 1-877-391-5921, Monday through Friday 8 a.m. to 5 p.m. (CST), for inquiries including program information or assistance with claims. During after hours, state-approved holidays, and weekends the Provider Services 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 Nursing Facility Account Manager or Service Coordinator, see Quick Reference Guide – Superior HealthPlan Office Locations. You can also go to https://www.SuperiorHealthPlan.com/providers/resources/nursing-facilities.html. Once there, go to Account Manager List (PDF).

Helpful numbers:

Provider Services	1-877-391-5921
Provider Portal Help Desk	1-866-895-8443
Member Services	1-877-277-9772
TTY/TDD	1-800-735-2989
Service Coordination	1-877-277-9772
24-Hour Nurse Advice Line	1-877-277-9772
DentaQuest	1-800-896-2374
Evolent (Formerly National Imaging Associates, Inc.)	1-800-642-7554
Express Scripts Pharmacy Help Desk	1-833-750-4508
Pharmacy Prior Authorization Requests	1-866-768-7147
Pharmacy Prior Authorization Fax	1-800-690-7030
For Clinician Administered Drugs (CAD)	1-866-768-7147 (prior authorization)
TurningPoint	1-855-336-4391

SECTION 2
PROVIDER ROLES

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

The Role of the Nursing Facility Provider

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

General Responsibilities

Providers must comply with each of the items listed below:

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

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

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

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

Coordination with Entities Providing Non-Capitated Services

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 or for services not directly provided by Superior. Providers must assist in these efforts. The Texas Medicaid Provider Procedures Manual (TMPPM) includes the following services:

- Tuberculosis (TB) services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- Hospice services provided by Home and Community Support Service Agencies contracted with HHS.
- PASRR Level 1 screenings, Level 2 evaluations and specialized services are provided by HHS-contracted LA and DSHS-contracted LMHA.
  - Specialized services provided by the LA include:
    1. Service coordination, alternate placement and vocational training.
    2. Mental health rehabilitative services and targeted case management.
    3. Specialized services provided by a Nursing Facility or Long-Term Care and Supports for individuals identified with intellectual and developmental disabilities (IDD), including physical therapy, occupational therapy, speech therapy and customized adaptive aids.
- LTSS for individuals who have IDD provided by HHS-contracted providers.

Hospice

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

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

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

Policy and program question may be directed to HHS at 1-512-438-3161. Questions regarding billing, claims and authorizations should be directed to HHS at 1-512-438-3550 or providers can refer to the TMPPM for further coordination.

Preadmission Screening and Resident Review (PASRR)

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

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

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

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

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

Reporting Abuse, Neglect, or Exploitation (ANE)

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

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

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

Contact HHS at 1-800-458-9858.

Report to the Department of Family and Protective Services (DFPS)

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

- An adult who is elderly or has a disability, receiving services from:
  - HCSSAs – also required to report any HCSSA allegation to 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), LMHAs, community center or mental health facility operated by the Department of State Health Services.
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services.
  - A managed care organization.
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above.
- An adult with a disability receiving services through the Consumer Directed Services option.

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement

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

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 & 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. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation or at a childcare center.

Fraud, Waste and Abuse Prevention

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

Reporting Fraud, Waste and Abuse

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

For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid.
- Using someone else's Medicaid.
- Not telling the truth about the amount of money or resources they have to get benefits.

Information Needed to Report Fraud, Waste and Abuse

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and select "Report Fraud" to complete the online form.
- Contact Superior's Corporate Special Investigative Unit directly at:

  Centene Corporation
  Superior HealthPlan Fraud and Abuse Unit
  1390 Timberlake Manor Pkwy, STE 450
  Chesterfield, MO 63017
  1-866-685-8664

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

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

Key Information for Nursing Facility Providers

The following are some helpful tips for Nursing Facility providers:

- Verify member eligibility to ensure the first date of enrollment with the plan.
- Ensure necessary authorizations have been obtained from Superior for all add-on services.
- Use in-network providers for add-on services.

- Adhere to HHS clean claim rules, as found under on page 35 of the Superior's Nursing Facility Provider Manual, Code of Federal Regulations, Title 42, §447.45(b).
- Notify the Service Coordinator whenever there is a change in the member's physical or mental condition, an inpatient admissions or an emergency room visit.
- Ensure that covered Medicare services are billed to Medicare as primary for members who are eligible for both Medicare and Medicaid.
- File claims for PASRR and hospice directly to the administrative services contractor for Medicaid fee-for-service.
- Continue submitting your MDS, 3618 and 3619 forms through the LTC online portal.

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's 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 14, 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 10, 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.

Superior may refuse to contract with a Nursing Facility seeking to participate in the STAR+PLUS program if the Nursing Facility does not meet the Nursing Facility minimum performance standards as described in Chapter 8 of the Uniform Managed Care Manual (UMCM). Superior may also refuse to renew a STAR+PLUS provider contract with a Nursing Facility that has failed to meet the STAR+PLUS Nursing Facility minimum performance standards as described in Chapter 8 UMCM for three or more consecutive years.

Practitioner 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 the address or email address listed below:

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 above.
  - 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.

The Role of a Primary Care Provider (PCP)

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

For Medicare covered services, please reference the Wellcare by Allwell (Medicare Advantage) provider manual at www.SuperiorHealthPlan.com/providers/training-manuals.html.

Who Can Serve as a PCP?

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

- Certified Nurse Midwife
- Family Practitioner
- Obstetrics and Gynecology (OB/GYN)
- General Practitioner
- Physician Assistant
- Internal Medicine Practitioner
- Specialist (when appropriate, as described below)
- Nurse Practitioner
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Pediatricians
- Geriatricians

A Specialist as a PCP

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

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

All requests for a specialist to serve as a PCP must be submitted to Superior on the Specialist as PCP Request Form located on the Superior website. The request should contain the following information:

- Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
- A statement signed by the specialist that 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 to the member of the decision no later than 30 Days after receiving the request. The effective date of the designation of a specialist as a member's PCP may not be applied retroactively. If the request is denied, Superior will provide a written notification to the member, which will include the reasons for the denial. The member may file an appeal if their request to have a specialist as a PCP is denied.

Roles of Specialty Care Providers (Specialist)

The specialist partners with the PCP to deliver specialty care to members. A key component of the specialist's responsibilities is to maintain ongoing communication with the member's PCP. Superior prefers that specialists are board-certified in their area of expertise, but it is not required. Specialty Care Providers and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services. To ensure continuity and coordination of care for the member, every Specialty Care Provider must:

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

Member's Right to Designate an OB/GYN

Superior HealthPlan members have the right to designate an OB/GYN within the Superior network of providers.

Attention Female Members

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

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

Network Limitations

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

Please note: All out-of-network services require prior authorization.

Continuity of Care

There are situations that arise when Superior may need to approve services out-of-network. Superior may need to provide authorization for continuity in the care of a member whose health condition could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

Prior Authorization (PA) for services may be requested in one of three ways:

1. Calling the Prior Authorization department at 1-800-218-7508.

2. Faxing the PA form to 1-800-690-7030. The form is available online at www.SuperiorHealthPlan.com.

3. Submitting the request via the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Newly Enrolled Members

Acute Care Services

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

- 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 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 enrolled with Superior.

Community Based Long-Term Services & Supports (LTSS)

Superior will consider an initial time frame of up to six months for LTSS or until a new assessment is completed and new authorizations 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 such time the member is disenrolled from Superior. Superior will be responsible for providing and coordinating services for the member until the member's eligibility with the new MCO is effective.

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.

In the event a Nursing Facility Change of Ownership (CHOW), please contact your Account Manager for assistance in coordinating the CHOW and termination of the previous tax ID number, or refer to Superior's website to provide notification at: www.SuperiorHealthPlan.com/providers/become-a-provider/change-of-ownership.html.

SECTION 3
ELIGIBILITY AND DISENROLLMENT

Health Plan Enrollment

HHS is responsible for determining Medicaid and CHIP eligibility. Contact Superior's Member Services department if you need to locate an HHS eligibility office.

The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the Medicaid and CHIP programs. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at 1-800-964-2777.

When a member's application is approved for Medicaid or CHIP, the state's Enrollment Broker sends the member an enrollment packet, informing the member of the health plan choices in their area. The packet will also instruct the member to select a health plan and a PCP within 15 Days. Members applying for CHIP will need to select a plan and a PCP within 15 Days of gaining eligibility.

Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits receives a "Your Texas Benefits Medicaid" card. However, having a card does not always mean a person has current Medicaid coverage. A provider should verify the member's eligibility for the date of service before rendering services. There are three ways to do this:

- Call Superior HealthPlan at 1-877-277-9772.
- Visit Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- Use TexMedConnect on the Texas Medicaid and Healthcare Partnership (TMHP) website at www.tmhp.com.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- Your Texas Benefits Medicaid Card
    1. Temporary ID (Form 1027-A).
    2. Superior Health Plan ID Card.
        - If the member also receives Medicare health insurance coverage, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's Superior ID card. The member receives long-term services and supports through Superior.

    Important: To request a Superior ID card, members can call 1-877-277-9772.

Pharmacies

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

Involuntary Disenrollment Due to Member Non-Compliance

There may be instances when a PCP feels that a member should be removed from 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; and
- 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; or
- 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.

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.

Hospice Enrollment

Pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), states are required to provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP who elect hospice care. Due to this change in federal law, a family that elects to receive hospice care for a child is no longer required to waive treatment for the child's terminal illness.

Concurrent treatment services include:

- Covered treatment services (including services related to the individual's terminal illness).
- Hospice care to include palliative care, including medical and support services related to the individual's terminal illness.

STAR+PLUS Program

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

The STAR+PLUS program operates under the federal Medicaid waiver Home and Community-Based Services in order to mandate participation and to provide Home and Community-Based Services. HHS is the oversight agency for the STAR+PLUS program.

Mandatory Members

The following Medicaid-eligible individuals MUST enroll in the STAR+PLUS program:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS (c) waiver eligibility.
- Dual eligible individuals who are 21 and over covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a Nursing Facility.

Voluntary Members

The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:

- Nursing Facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing Facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE).

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

- Nursing Facility residents who reside in the Truman W. Smith Children's Care Center or reside in a state veterans home.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Residents of Institutions of Mental Disease or State Hospitals.
- Children in the conservatorship of the Texas Department of Family and Protective Services (DFPS).
- Dual eligible (individuals who have both Medicare and Medicaid) who are residents of Intermediate Care. Facilities for Persons with IID (ICF/IID) Community Living Assistance and Support Services.
- Persons enrolled in a waiver program other than the HCBS STAR+PLUS(c) Nursing Facility waiver program.
- Individuals not eligible for full Medicaid benefits (e.g., frail elderly program, Qualified Medicare Beneficiary [QMB], Service Limited Medicare Beneficiary [SLMB], Qualified Disabled Working Individual [QDWI], undocumented immigrants).
- Individuals receiving long-term care services through non-Medicaid funded programs.

Dual Eligible Members

Dual eligible members have both Medicare and Medicaid health insurance coverage. Medicare or the member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare co-insurance and deductibles for dual eligible members unless enrolled in Superior's Medicare Advantage Special Needs Plans (SNP), Superior HealthPlan Medicare Advantage (HMO SNP).

Superior HealthPlan Medicare Advantage will coordinate the payment of the Medicare Advantage cost sharing amounts for dual eligible members up to the Medicaid fee schedule. Under Superior HealthPlan Medicare Advantage, there is no copayment for services received at a Skilled Nursing Facility. Superior will reimburse Long-Term Services and Supports (LTSS) covered under the STAR+PLUS program. Superior STAR+PLUS benefits will not change or reduce any Medicare benefits for which a member is eligible.

Members with traditional Medicare coverage may choose to use their existing Primary Care Providers (PCP), and may access specialty services without prior approval from Superior. Dual eligible members do not have to select a separate PCP through Superior for their LTSS services. The Service Coordinator will communicate and coordinate services with the member's Medicare PCP to ensure continuity of care. Dual eligible members should notify their Service Coordinators that they have Medicare coverage, and will provide the name of their chosen PCP.

Dual eligible members have identification cards that indicate Long-Term Care (LTC) services only, and must show their ID cards each time they receive Superior STAR+PLUS covered services. Dual eligibles enrolled in Superior HealthPlan Medicare Advantage must show their ID cards each time they receive physician or hospital services. Dual eligible members do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

For dual eligible members, claims will process according to the member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid. For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over-the-counter medications), some products used in symptomatic relief of cough and colds, limited home health supplies (LHHS) and some prescription vitamins and mineral products, which are identified on the HHS Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (TXVDP) formulary. Please note:

- A member with a Medicare Advantage plan will not affect the coverage of wrap benefits.
- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be covered by Medicaid without a prescription).

Note: If a STAR+PLUS dual eligible member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's ID card.

Disenrollment

When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR+PLUS program and from Superior. HHS is solely responsible for determining if and when a member is disenrolled from the Medicaid program. Members can be disenrolled from Superior, but still be eligible for Medicaid through another

health plan or program, so it is important to check eligibility before considering a member as eligible or ineligible.

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

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

Renewal

Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to re-certify with HHS each year. To maintain SSI benefits, the SSA may require information from the member related to their SSI benefits. The member or their representative payee may call the SSA. 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 time frame 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.

Members Who Move to a Facility Outside of the Service Area

Members may transfer to another Nursing Facility at any time. Members are required to notify the State Enrollment Broker of their change of address. The member may transfer to a Nursing Facility in a different geographic area. For MMP members that transfer from one Nursing Facility to another – the member must elect to enroll in MMP in that new county (Bexar, Dallas, Hidalgo). If Superior is approved by HHS in the area the Nursing Facility resident is transferred to, the member may remain enrolled with Superior. If the member is transferred to a Nursing Facility that is not in a geographic area that HHS has approved Superior to provide services, then the member will be asked to select a new Managed Care Organization (MCO). The effective date of the new MCO will be prospective will follow the member's admission to the new Nursing Facility. Superior will be responsible for providing and coordinating services for the member until the enrollment with the new MCO is completed. Members are encouraged to report any change of address to 211 as well as to the SSA office.

SECTION 4
COVERED BENEFITS AND SERVICES

Direct Access to Care - Medicaid Members Only

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

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

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

Telemedicine and Telehealth Services

Any provider in the Superior HealthPlan network can offer telehealth services to Superior members (except for STAR+PLUS dual members) for certain health-care needs. "Telehealth services" are virtual healthcare 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.
- A telehealth visit with an in-network Superior provider is subject to the same co-payments, co-insurance and deductible amounts as an in-person visit with an in-network provider.

Providers may be reimbursed for a patient site facility fee when services are performed by a:

- County Indigent Health Care Program
- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Outpatient Hospital

Please note: A facility fee is not available if the patient site is the patient's home.

- Providers interested in providing telemedicine, telemonitoring and telehealth services to eligible Superior members should reference the Texas Medicaid Provider Procedures Manual, located at https://www.tmhp.com/resources/provider-manuals.

For more information, contact the Member Services department at 1-877-277-9772.

STAR+PLUS Spell of Illness Limitation

The Medicaid 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.

Exceptions to the spell of illness limitation for inpatient admissions are listed below:

- A prior approved solid organ transplant. The 30 Day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- Texas Health Steps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- Applicable diagnoses exempt from the spell of illness limitation include the following as described in the DSM-V (parenthetical codes are corresponding ICD-10 codes): Schizophrenia (F20), Schizoaffective disorder (F25), Schizophreniform (F20), Bipolar I and Bipolar II Disorder (F31) with any severity or status, and Major Depressive Disorder (F32 and F33) with any variation or subtype. However, the diagnosis must be a specific condition rather than a general behavioral health condition. For example, MCOs are not required to exempt "unspecified" or "not classified" diagnoses. Examples of diagnoses that are unspecified include (but are not limited to) F31.9 (bipolar disorder, unspecified), F20.9 (schizophrenia, unspecified type), F20.89 (other specified types of schizophrenia, unspecified).

Nursing Facility Add-On Services

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

Add-on services are limited to the following:

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

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

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

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

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

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

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

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

Initial treatment requests should include:

- Date of evaluation.
- Member's age and birthdate.
- A brief statement of the member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment.
- Relevant review of systems.
- Pertinent physical assessment including a description of the member's current deficits and the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
- A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
- A description of the member's functional impairment with a comparison of prior level of function to current level of function.
- A statement of the prescribed treatment modalities and their recommended frequency/duration.
- Proposed patient and/or caregiver education.
- 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.
- Treatment plan may not be more than 90 Days old.
- If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

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

- Number of therapy visits authorized and number of therapy visits attended.
- A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant

progress.

- A description of the member's current deficits and the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
- Objective demonstration of the member's progress towards each prior functional treatment goal. For all unmet functional treatment goals, baseline and current function must be submitted so that the member's progress towards goals may be measured. As the treating therapist has set the functional treatment goals for a specified time period, it would be expected that functional treatment goals would be met within the specified time frame. If the functional treatment goals are unmet, it is the treating therapist's responsibility to objectively describe any barriers to progress that were encountered and appropriate modifications to the treatment plan in order to meet the member's needs.
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
- A brief prognosis with clearly established discharge criteria.
- Updated 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.
- Updated treatment plan/progress summary may be no older than 90 Days old.
- Treatment plan must be signed and dated by the treating therapist.

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

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

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

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

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

Utilization Management Criteria

Utilization Management decisions are made in accordance with currently accepted medical or health-care practices. The criteria used for review of medical necessity, provider peer-to-peer review takes into account the special circumstances of each case that may require an exception to the standard, as stated in the screening

criteria. The medical director may review all potential adverse determinations for medical necessity; and the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria.

InterQual criteria are used to determine medical necessity. InterQual was developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. A Superior Utilization Management clinician will review clinical documentation to determine medical necessity and the appropriateness for Nursing Facility add-on and acute care services, including setting of care, are met according to the InterQual criteria. Superior also utilizes the Texas Medicaid Provider Manual (TMPPM) as a guideline for Medicaid covered services. Providers may request a copy of the criteria used to make a specific decision by contacting Provider Services at 1-877-391-5921. 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 Utilization Management decision makers do not encourage decisions that result in underutilization.

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

Coordination with Other State Program Services

Coordination with Public Health

Superior coordinates with other State Health and Human Services (HHS) programs regarding the provision of essential public health services. Providers must assist Superior in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving members.
- Reporting Tuberculosis (TB) and all confirmed cases of STD/HIV to the public health entity for investigation and evaluation, and preventive treatment of persons whom the member has come into contact within one Business Day of identification:
    1. Bill all TB-related services to TMHP.
    2. Reporting to the local public health entity for TB contact investigation and evaluation, and preventive treatment of persons whom the member has come into contact within one Business Day of identification.
    3. Ensure all members who have TB or are at-risk are screened for TB.
    4. Access procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/forms.
- Properly maintaining confidential information about members who have received STD/HIV services.
- Properly referring for Women, Infant and Children (WIC) services and information sharing for the purposes of eligibility determination.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Referring lead screening tests to the 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.

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

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

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

Refer to the TMPPM for further coordination.

Additional Benefits

Prescriptions

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

Pharmacy Compounds

Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Compounds should contain medication(s) that are covered by the Texas Vendor Drug formulary.

Providers should bill a compound using the compound indicator code.

Roles of a Pharmacy

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

Superior is required to adhere to the Preferred Drug List (PDL) which is created and maintained by the Texas VDP. Members have the right to obtain Medicaid covered medications from any Superior network pharmacy. These pharmacies are located on Superior's website. Providers and members can also call Superior's Member Services department to locate a network pharmacy.

Network pharmacies are required to perform Prospective and Retrospective Drug Utilization Reviews, coordinate with the prescribing physician, ensure members receive all medications for which they are eligible and ensure adherence to the state mandated Medicaid formulary PDL. The pharmacy must coordinate the benefits when a member also receives Medicare Part D services or has other benefits.

Behavioral Health

Superior 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.

Behavioral health providers agree to:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Only provide physical health services if such services are within the scope of the network provider's clinical licensure.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the consent of the member or the member's legal guardian.
- Schedule outpatient follow up and/or continuing treatment prior to discharge for all members that have received inpatient psychiatric services.
- Ensure outpatient treatment occurs within seven Days from the date of hospital discharge, inpatient psychiatric facility discharge or Nursing Facility discharge.
- Contact members who have missed appointments within 24 hours to reschedule appointments.
- Coordinate with LMHA and state psychiatric facilities.
- Complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA).
- Use Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Uniform Managed Care Manual, Chapter 15 as the medical necessity criteria for Mental Health Rehabilitative services (MHR) and Mental Health Targeted Case Management (TCM) services.
- As part of the credentialing process, provide an attestation to Superior that provider/facility has the ability to provide, either directly or through sub-contract, Superior members with the full array of MHR and TCM services as outlined in the RRUMG and the Uniform Managed Care Manual, Chapter 15.
- Abide by the Qualified Mental Health Professionals for Community Services (QMHP-CS) the requirement minimums for a QMHP-CS are as follows:
  - Demonstrate competency in the work to be performed; and medical record documentation and referral information must be documented using the Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Value-added Services

Superior offers coverage beyond the traditional Medicaid benefits. Collectively, this additional coverage is referred to as Value-added Services (VAS). VAS may be actual health-care services, benefits or positive incentives that HHS determines will promote healthy lifestyles and improve health outcomes. Superior contracts with companies to provide VAS. Those companies will bill Superior directly for the services they provide.

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

- Superior's Member Handbook.
- Superior's website at www.SuperiorHealthPlan.com.
- Superior's Member Services department by calling 1-877-277-9772.

SECTION 5
SERVICE COORDINATION

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

The Service Coordinator participates in person and family-centered[1] service planning[2] with the Nursing Facility staff, Primary Care Provider, vendors and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources. In addition, the Service Coordinator attends meetings, assists in the development of the Nursing Facility's plan of care for the member, and serves as the primary resource or advocate for the member ensuring that the member, the member's family or representative, Nursing Facility staff and other members of the interdisciplinary team are involved. On a quarterly basis, the Service Coordinator conducts a face-to-face visit with the Nursing Facility member, or more frequently, as determined by the member's condition, situation and level of care. Providers may request a Service Coordinator by calling 1-877-277-9772, Monday through Friday 8 a.m. to 5 p.m. (CST). 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.

Service Coordinator Responsibility

The Service Coordinator is responsible for:

- Provide the Service Plan to the member and the member's authorized representatives and providers in the language and format requested.

  Note: Providers can access Service Plans and ISP documents on the Provider Portal using the Assessment tab.
- Coordinating services when a member transitions into a Nursing Facility.
- Developing a service plan that includes services provided through the Nursing Facility, add-on services, acute medical services, behavioral health services and primary or specialty care.
- Participating in Nursing Facility care planning meetings telephonically or in person, provided the member does not object.
- Comprehensively reviewing the member's service plan, including the Nursing Facility plan of care, at least annually, or when there is a significant change in condition.
- Visiting members living in Nursing Facilities at least quarterly. Visits should include, at a minimum, a review of the member's service plan and, when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the member's service plan and any other aspect of the member's life or situation that may need to be addressed.
- Promoting a meaningful quality of life and autonomy for members.

- Assisting with the collection of applied income when a Nursing Facility has documented unsuccessful efforts, per the state-mandated Nursing Facility requirements.
- Cooperating with representatives of regulatory and investigating entities including HHS Regulatory Services, the LTC Ombudsman program, Adult Protective Services, the Office of the Inspector General and law enforcement.
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) as described in UMCC Section 8.3.9.2. The quarterly in-person visits required can include assessments required under the PII, and the Service Coordinator can serve as the designated point of contact for an individual referred to return to the community under PII.
- Coordinating with the Nursing Facility discharge planning staff to plan discharge and transition from the Nursing Facility.
- Notifying the Nursing Facility within 10 Days of a change to Superior's assigned service coordinator.
- Returning a call from a Nursing Facility within 24 hours after the call is placed by the Nursing Facility.

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

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

Nursing Facility Responsibility

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

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

How a Provider Can Access a STAR+PLUS Member's Service Coordinator

Service Coordination provides members with initial and ongoing assistance with identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance the member's well-being, independence, and integration in the community. STAR+PLUS providers may access assigned Service Coordinator through Member Services by calling 1-877-277-9772.

SECTION 6
ROUTINE, URGENT AND EMERGENCY SERVICES

Routine, Urgent and Emergency Services Defined

Superior requires that medically necessary health services are safely provided in the most appropriate and least restrictive setting without adversely affecting a member's physical health or their quality of life. Members are encouraged to contact their Primary Care Provider (PCP) prior to seeking care. In the case of a true emergency, members are encouraged to visit their nearest emergency department. The following are definitions for routine, urgent and emergency care:

Routine Care

Health care for covered preventive and medically necessary health-care services that are non-emergent or non-urgent, designed to prevent disease altogether, to detect and treat it early or to manage its course most effectively. Some examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.

Urgent Condition

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

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity including severe pain, such that a PCP or practitioner could reasonably expect the absence of immediate medical care could result in:

- Placing the member's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Access to Routine, Urgent and Emergent Care

Superior requires the hours of operation that providers offer to Medicaid members be no less than those offered to commercial patients. Members must have access to covered services within the timelines specified by HHS and Texas Department of Insurance (TDI). "Day" is a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

Covered Services	Timelines
Routine primary care	14 Days
Routine specialty care	21 Days
Initial outpatient behavioral health visits	14 Days
Urgent care, including urgent specialty care	24 hours
Emergency services, including at non-network out-of-area facilities	Must be provided upon member presentation at the service delivery site

Emergency Pharmacy Services - Medicaid Only

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

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

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

For more information about the 72-hour emergency prescription supply policy, please contact the Pharmacy Help Desk at 1-800-460-8988.

Emergency Transportation

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

Reimbursement is limited to basic life support ambulance services. Emergency transportation does not require PA.

Non-Emergency Ambulance Transportation

The Nursing Facility is responsible for providing routine non-emergency transportation services. The cost of such

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

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

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

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

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

Prior authorization may be obtained by:

- Calling the Medical Management department at 1-800-218-7508.
- Faxing a request for PA to 1-800-690-7030 using the Texas Department of Insurance Standard Prior Authorization Form or the Superior Prior Authorization Form found at www.SuperiorHealthPlan.com.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Authorization Tips

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

1. A physician or physician extender writes an order for non-emergency transport.
2. Nursing Facility staff should contact Superior's Member Services line, Utilization Management department or the assigned Service Coordinator to find an ambulance company that is in-network.
3. The Nursing Facility staff contacts the ambulance company to get their necessary information to complete the PA form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI and other business information.
4. The ambulance provider will document the request was initiated by the Nursing Facility staff and include name, time and date.
5. The Nursing Facility must sign and submit the form to Superior for review along with documentation to support medical necessity.
6. The ambulance company and Nursing Facility will coordinate the scheduling of the appointment.

Approvals/Denials for Non-Emergent Transportation Services

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

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

STAR+PLUS Non-Urgent Transportation

Superior HealthPlan's Medical Ride Program is designed to serve community-based STAR+PLUS members that have no other means of transportation for medical appointments. This program is only available to members residing in a nursing facility for dialysis appointments.

- To request transportation to dialysis appointments, members, advocates and providers can call SafeRide provided by Superior HealthPlan toll free at 1-855-932-2318.

SafeRide's transportation specialists are available to take requests by telephone on weekdays from 8:00 a.m. to 5:00 p.m.

SafeRide requires at least two Business Day’s advance notice for most requests, but will attempt to accommodate urgent requests. Members should call in their request as far in advance as possible. Superior's Medical Ride Program may also reimburse mileage for the client, a caregiver/medical consenter, friend or someone else to take the client to health-care services if the trip is scheduled in advance and the driver abides by Superior's Medical Ride Program guidelines. In situations where Superior does not provide transportation, additional transportation assistance may be available to qualifying Superior members. Please refer residents to the Value-added Services section of their member handbook for specific information on transportation-related benefit. Providers can also direct members to contact Member Services to see if additional benefits are available to them.

Emergency Dental Services-Medicaid only

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

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

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling.
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration).
- Open or closed reduction of fracture of the maxilla or mandible.
- Repair of laceration in or around oral cavity.
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts.
- Incision and drainage of cellulitis.
- Root canal therapy. However, payment is subject to dental necessity review and pre and post-operative x-rays are required.

- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Non-Emergency Dental Services

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

SECTION 7
PRIOR AUTHORIZATION

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, care management/ complex care management and disease management components, 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 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

Prior Authorization Requirements

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

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

Superior has adopted a PA process for specific procedures and/or services. These procedures and/or services are listed on Superior's PA list. The PA list is available on Superior's website at SuperiorHealthPlan.com/PriorAuth. To look up by code, refer to the prior authorization look up tool found on SuperiorHealthPlan.com/MedicaidPriorAuth.

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

If you have any questions about prior authorizations, please call Provider Services, 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.

Prior Authorizations/Clinical Prior Authorization Edits

Superior will utilize the Texas Vendor Drug Program prior authorization criteria for non-preferred medication requests. A copy of the criteria is available online at the PA XPRESS website via https://paxpress.txpa.hidinc.com. It is helpful to include all pertinent medical information in the original request to facilitate this process.

In addition, the Texas VDP provides clinical prior authorization criteria to managed care organizations to ensure medications follow the latest FDA-approved product labeling, nationals guidelines and peer-reviewed literature via evidence-based clinical criteria. Please refer to our website for a link to the Clinical Prior Authorization criteria applied to Superior members, as well as forms to assist providers with prior authorization requests: https://www.SuperiorHealthPlan.com/providers/resources/pharmacy/clinical-prior-authorization.html.

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 shall 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.

Radiology

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

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

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

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

Interventional Pain Management

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

Outpatient IPM procedures requiring prior authorization include:

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

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**: 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 Medicaid and CHIP 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 Medicaid and CHIP 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.

Span of Coverage — Nursing Facility

The following tables describe payment responsibility for Medicaid enrollment changes that occur during a Nursing Facility stay for both STAR+PLUS and STAR+PLUS MMP members, beginning on the member's effective date of coverage with the new Managed Care Organization (MCO).

STAR+PLUS Payment Responsibility for Enrollment Changes during a Nursing Facility Stay

	Scenario	Nursing Facility Charge	All Other Covered Servics
1	Member moves from FFS to STAR+PLUS or STAR+PLUS MMP	New STAR+PLUS or STAR+PLUS MMP MCO	New STAR+PLUS or STAR+PLUS MMP MCO
2	Member moves between STAR+PLUS MCOs	New STAR+PLUS MCO	New STAR+PLUS MCO
3	Member moves from STAR+PLUS to STAR+PLUS MMP	New STAR+PLUS MMP MCO	New STAR+PLUS MMP MCO
4	Member moves from STAR+PLUS MMP to STAR+PLUS	New STAR+PLUS MCO	New STAR+PLUS MCO

STAR+PLUS MMP Payment Responsibility for Enrollment Changes during a Nursing Facility Stay

	Scenario	Nursing Facility Charge	All Other Covered Servics
1	Enrollee moves from Medicaid FFS to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP
2	Enrollee moves from other Texas Medicaid MCO to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP
3	Enrollee moves between STAR+PLUS MMPs	New STAR+PLUS MMP	New STAR+PLUS MMP

STAR+PLUS MMP Skilled Nursing Facility

Payment for Skilled Nursing Facility (SNF) stays for STAR+PLUS MMP members who change enrollment is treated differently than for inpatient hospital stays. The SNF payment is split by the day. SNFs follow the requirements of the agreement they have with the STAR+PLUS MMP. In cases where the member may have enrolled or disenrolled from STAR+PLUS MMP during the billing period, the SNF will split the bill and send the STAR+PLUS MMP's portion to it and the remaining portion to the new Medicare Advantage plan or Medicare Administrative Contractor for Original Medicare.

SECTION 8
CLAIMS AND ENCOUNTERS ADMINISTRATION

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

Claim Filing Guidelines

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

HHS Clean Claim Criteria:

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

Note: Any claim that does not meet the definition of a clean claim is considered a "non-clean claim." Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim. Members and providers will not be held responsible for claims adjudication or transaction fees.

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

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

Providers should contact Superior's Provider Services at 1-877-391-5921 for questions related to claims procedures, filing complaints or appeals.

Timely Filing Requirements

Nursing Facilities must file room and board first time claims within 365 Days from the date of service. If a claim is not received by Superior within the 365 Days, Superior will deny the claim unless there is an exception from the filing deadline.

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

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

A claim should not be filed with different RUG or split authorized service levels. Each claim must only bill for one RUG or service authorized date span which may result in a separate claim. If a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next Business Day following the weekend or holiday.

Payment Requirements

Superior must administer an effective, accurate and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the contract, including Uniform Managed Care Manual Chapter 2.3. Superior may not directly or indirectly charge or hold a member or network or non-network provider responsible for a fee to adjudicate a claim.

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

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

A claim should not be filed with different RUG or split authorized service levels. Each claim must only bill for one RUG or service authorized date span which may result in a separate claim. No later than 10 Days after the Submission Received Date of a Clean First Time Claim, Superior must: (1.) pay the total amount due of the claim or part of the claim or (2.) deny the entire claim, or part of the claim and notify the provider defining the reasons why the claim will not be paid.

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

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. For retroactive loss of enrollment where the date of service falls outside of the 24 month period and there have been no updates to HHS SAS data removing authorization/coverage, recoupment cannot take place.

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.

Durable Medical Equipment (DME) and Other Common Pharmacy Products

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

- Nebulizers, ostomy supplies or bed pans and medical accessories.

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

Nursing Facility Unit Rate

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

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

It is important to note that HHS will continue to authorize the daily rate as well as make the medical necessity determinations. Nursing Facilities are required to submit the Minimum Data Set (MDS) form to Centers for Medicare and Medicaid Services (CMS) and Long-Term Care Medicaid Information (LTCMI) form to the LTC Online Portal. For additional information on Texas Minimum Data Set (MDS) visit https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/texas-minimum-data-set-mds.

Providers should contact Superior's Provider Services at 1-877-391-5921 for questions related to claims procedures. Please submit a Medicaid Eligibility Service Authorization Verification (MESAV) for any discrepancies identified. Please note that SAS information is obtained by Superior after it is posted to the TMHP website. Delays can be expected between data appearing on the TMHP website and Superior's Secure Provider Portal. The uniform billing requirements can be found in the HHS Uniform Managed Care Manual (UMCM), Chapters 2 Texas Claims Procedures: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/2-0.pdf.

Adjusted Claims-Daily Unit Rate

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

- Nursing Facility daily rates
- Provider contracts
- Service authorizations
- Applied income
- Level of service/Resource Utilization Group (RUG)
- Non-compliance with spending and staffing requirements as dictated by HHS's Direct Care Rate Enhancement Program.

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

When a subsequent claim submission is necessary as result of a SAS related claim denial, please submit as a corrected claim within 120 Days of the applied SAS denial (vs. a first time time claim).

Applied Income – Nursing Facility Unit

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

Coordination of Benefits for STAR+PLUS Members with Medicare

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

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

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

MMP members have their Medicare and Medicaid benefits coordinated under one health plan. Superior STAR+PLUS MMP will reimburse providers for acute care services, including behavioral health (statewide, including Dallas SDA) as well as the SNF approved amounts. In the case of SNF, providers must file two claims: one claim with the standard Medicare revenue code for SNF and a separate claim for the Medicaid coinsurance revenue code 101. It is not required that providers file their claims for coinsurance with a copy of the Superior (Medicare) EOP. The Nursing Facility must file a room and board first time claim with Superior within: (1.) 365 Days after the date of service or (2.) 95 Days after the date on the EOP from the Medicare payment.

Acute Care Service

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

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

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

Coordination of Benefits

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

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

Out-of-Network Reimbursement

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

Claims Filing Guidelines for Add-On Services

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

Please use the ANSI ASC X12 837P 5010 format for PT, OT, ST, Customized Power Wheelchairs (CPWC) and Augmentative Communication Devices (ACD) and ANSI ASC X12 8371 5010 format for Ventilator and Tracheostomy

Care add-on services. Claims filed for add-on services must conform to national billing standards and Medicaid billing guidelines. Claims may be filed in one of three ways:

1. Submitting an ANSI X12N 837 professional transaction through an EDI partner. For a full list of the trading partners who work with Superior (Centene), visit https://www.superiorhealthplan.com/providers/resources/electronic-transactions.html. The EDI Department can also be contacted for assistance at EDIBA@centene.com. *Note: Submission of a claim to the clearinghouse does not guarantee that the claim was transmitted or received by Superior. Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports.*
2. Providers may also submit claims directly to Superior through the Secure Provider Portal at Provider.SuperiorHealthPlan.com. To reach the web applications support desk, call 1-866-895-8443 or email them at TX.WebApplications@SuperiorHealthPlan.com.
3. Claims for add-on services can be submitted on paper to:
   Superior HealthPlan Claims Department
   PO Box 3003
   Farmington, MO 63640-3803

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

Timely Filing Requirements

Claims for add-on services must be filed with Superior within: (1.) 95 Days after the date of service, or (2.) 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.

However, if a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next Business Day following the weekend or holiday.

Payment Requirements

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

Billing Codes

Please reference to the most current LTSS Crosswalk for the list of codes and modifiers located in the HHS MMC: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/long-term-care-bill-code-crosswalks.

Claims Reconsiderations

A corrected claim is the replacement of a previously submitted claim and occurs when a provider has submitted a claim and received a denial due to incorrect or missing information. A corrected claim must be received within 120 Days of the initial claim disposition. To submit a claim form on paper, please use the required standard red and white UB-04 or HCFA 1500 claim form.

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

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

Submitting a Claim Appeal

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

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

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

Corrected Claim

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

- An original claim that was either denied or rejected as being deficient, as it did not contain all required elements to appropriately process the claim.
- An original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission were erroneous.
- Providers may correct, but are not limited to, the following:
    1. Patient control number (PCN)

2. Date of birth
3. Place of service (POS)
4. Quantity billed
5. Date of service (DOS)
6. Modifier missing or incorrect

Filing a Corrected Claim

Corrected paper claims should clearly indicate the corrections. Electronic or paper corrected claims must be submitted within 120 Days of the initial claim disposition. When a subsequent claim submission is necessary as result of a SAS related claim denial, please submit as a corrected claim vs. first time claim.

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

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

SECTION 9
COMPLAINT PROCEDURES

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

Filing a Provider Complaint

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

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

Resolving a Complaint

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

Appealing a Resolution

If a resolution/response is not satisfactory, a provider may ask that their appeal be reviewed and settled in accordance with the commercial arbitration rules of the American Arbitration Association or the arbitration or litigation provisions as noted in the individual provider's contract with Superior.

Additional Filing Rights

After exhausting Superior's complaint procedures, Medicaid providers may also file a complaint with HHS by submitting the complaint to:

Texas Health and Human Services

HPM Complaints
P.O. Box 85200, MC H-320
Austin, TX 78758

Member Complaints

Filing a Complaint

Superior offers a number of ways a member can file a complaint.

- Calling Customer Service to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Superior employee.
- Completing the online Complaint Form found on Superior HealthPlan's website at: https://www.SuperiorHealthPlan.com/members/medicaid/resources/complaints-appeals.html
- Mailing a written complaint to:
  Superior HealthPlan
  Complaints Department
  5900 E. Ben White Blvd.
  Austin, TX 78741
- Faxing a complaint to: 1-866-683-5369

What a Member Can Expect When Filing a Complaint

When a complaint is received, a written acknowledgment letter is sent to the complainant within five 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 resolution/response is not satisfactory, a complaint appeal may be filed.

Member Appeal of a Complaint Resolution

Complaint appeals must be submitted no later than 30 Days of the complaint resolution response. The complaint appeal involves the review by a complaint appeal panel during a scheduled meeting. The appeal panel is composed of an equal number of members, providers and Superior employees. The doctors or other providers will be specialists in the area of care related to the complaint, and will not have reviewed the issue before. The meeting will be at a time and place that is acceptable and convenient to the member. The member may choose to send an authorized or designated representative in their place and have the right to submit written documentation that can be presented during the panel hearing. The panel reviews all of the information presented and makes a recommendation to Superior. The recommendation is presented to Superior HealthPlan Plan Product Leadership for a final decision. Superior will mail the complaint appeal response letter to the member no later than 30 Days from receipt of the complaint appeal panel request.

Additional Filing Rights

If a Medicaid member is not satisfied with the outcome of Superior's resolution of the complaint, they may file a complaint with HHS at 1-877-787-8999 or by mail at the address below.

Texas Health and Human Services Commission
ATTN: Office of the Ombudsman, MC H-700
P.O. Box 13247
Austin, Texas 78711-3247
Fax: 1-888-780-8099 (Toll-Free)

How Superior Can Assist the Member with Filing Complaints or Appeals

Superior Member Advocates are available to assist members with the complaint or appeal process. A Member Advocate may be reached by calling Member Services at 1-877-277-9772. STAR Health Members can also complain to the Texas Health and Human Services Commission (HHSC) by emailing STAR.Health@hhsc.state.tx.us.

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 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, of payment for a service; the failure to provide services in a timely manner; the failure of STAR+PLUS or the STAR+PLUS MMP to act within the required timeframes for the standard resolution of Appeals and Grievances (STAR+PLUS MMP); 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,

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.

Adverse Benefit Determinations

Adverse benefit determinations occur when a service is denied for not meeting medical necessity. Superior will request all necessary information, including pertinent clinical information and consult with the physician providing treatment as appropriate in making Utilization Management determinations.

A peer-to-peer discussion is available to the ordering physician at any time during the prior authorization, adverse determination or appeal process. 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 a adverse benefit determination is rendered.

STAR+PLUS will notify the member and provider of the adverse determination in writing. The notification describes the services that are being denied, the full clinical explanation for the adverse determination and the steps a member or authorized representative can take to appeal the decision and how to access subsequent steps of the appeal process which includes a State Fair Hearing with or without External Medical Review.

STAR+PLUS MMP will notify the member and provider 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, free 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 continued benefits, and under what circumstance.

Medicaid Peer-To-Peer Discussion and Opportunity to Discuss

For Medicaid covered services that require prior authorization, a peer-to-peer discussion is offered to the requesting provider prior to an adverse determination, 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 60 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 60 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 to:

Superior HealthPlan
ATTN: Medical Management Appeals
5900 E. Ben White Blvd.
Austin, Texas 78741
FAX: 866-918-2266

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 internal appeal, State Fair Hearing, and member complaint rights but are not eligible for External Medical Review rights.

Medical Necessity Denial Claim Disputes for Contracted Providers

Superior contracts with out of network physicians to review claims disputes related to medical necessity denials that remain unresolved subsequent to a provider appeal. The physician resolving the dispute is not an employee of Superior. The determination of the physician resolving the dispute is binding on Superior and our contracted provider. The physician resolving the dispute is licensed in the State of Texas and the same specialty or a related specialty as the appealing provider.

Appeal of an Adverse Benefit Determination

STAR+PLUS and STAR+PLUS MMP Nursing Facility members have the right to appeal an adverse benefit determination in whole or in part, for for any of the following reasons:

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

A person authorized by the member to act on their behalf, or their provider or other health-care provider may request an appeal of an adverse benefit determination.

STAR+PLUS Nursing Facility Member Medicaid internal health plan appeal requests can be requested orally or in writing, within 60 Days from the receipt of the Adverse Benefit Determination letter. Superior will acknowledge an internal appeal request within 5 Business Days of receipt. Superior must complete the entire appeal process within 30 Days after receipt of the initial written or oral request for appeal. Any additional information that may be used in consideration of the appeal will be requested, and 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, or if Superior shows that there is a need for additional information and how the delay is in the member's interest. The extension would be in the best interest of the member. The extension of the timeframe to resolve the appeal will be confirmed in writing to the member or member’s authorized representative.

Medicaid members, a person acting on their behalf with the member's written consent, or their physician or other health care provider may request an expedited appeal of an Adverse Benefit Determination if waiting 30 Days for a standard resolution could seriously jeopardize the member's life or health.

Superior will review the request to expedite the appeal review. If the request to expedite the appeal review is not medically necessary, Superior will transfer the appeal to the standard appeal timeframe of 30 Days and provide notice to the member and appellant of the decision, including complaint rights to dispute the denial of the expedited review.

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 the internal appeal is denied, Nursing Facility members, an authorized representative or the member's provider have External Appeal Rights through the CMS Independent Review Entity (IRE) for Medicare covered services, or the HHS State Fair Hearing office for Medicaid covered services. See information in this Section on External Appeals for STAR+PLUS and STAR+PLUS MMP Nursing Facility 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

To continue services while the appeal is pending, the denial must involve the termination, suspension or reduction of a previously authorized course of treatment and have been ordered by an authorized provider.

- The member or their representative must submit a request for an appeal on or before the later of 10 Calendar Days from the the postmarked date of the Superior denial notice or the day your service will be reduced or end.
- The time period covered by the original authorization must not have ended.

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

- The member cancels the appeal.
- The denial is upheld on internal health plan appeal, unless the member requests external review.
- The time period covered by the original authorization has ended.

External Appeals

After a Nursing Facility member has completed the internal health plan appeal process related to an adverse benefit determination, more appeal rights are available to a member if they are not satisfied with the health plan's appeal decision. After the health plan's appeal decision is completed, members have additional external appeal rights, including a State Fair Hearing, with or without an External Medical Review for STAR+PLUS nursing facility members, and External Appeal Rights through the CMS Independent Review Entity (IRE), or the HHS State Fair Hearing office for STAR+PLUS MMP nursing facility members. The details for External appeal rights and procedures are included in the sections below.

External Medical Review

Can a Member ask for an Medicaid External Medical Review?

If a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for an External Medical Review. This includes a State Fair Hearing, with or without External Medical Review. An External Medical Review is an optional, extra step the member can take to get the case reviewed for free before the State Fair Hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative. A member cannot request only an External Medical Review. The member must exhaust the internal health plan appeal process prior to requesting an External Medical Review. The member or the members' representative, including the member's provider, must ask for the External Medical Review within 120 Days of the date Superior mails the letter with the internal appeal decision. If the member does not ask for the External Medical Review within 120 days, the member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the member or the member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the member Notice of Internal Appeal Decision letter and mail or fax it to Superior by using the address or fax number at the top of the form; or
- Call Superior at 1-877-398-9461.

If the member asks for an External Medical Review within 10 Days from the time Superior mails the appeal decision, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the member does not request an External Medical Review within

10 Days from the time the member gets the appeal decision from Superior, the service Superior denied will be stopped.

The member, the member's authorized representative, or the member's Legally Authorized Representative (LAR) may withdraw the member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's External Medical Review request. The member, the member's authorized representative, or the member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail or fax; or (2) orally, by phone or in person.

An Independent Review Organization is a third-party organization contracted by HHS that conducts an External Medical Review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency Medicaid External Medical Review?

If a member believes that waiting for a standard External Medical Review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Superior. To qualify for an emergency External Medical Review and emergency State Fair Hearing the member must first complete Superior's internal appeals process.

State Fair Hearings

Can a Member Ask for a Medicaid State Fair Hearing?

If a Medicaid member disagrees with Superior's appeal decision, the member may request a State Fair Hearing with or without External Medical Review. The member must exhaust Superior's internal health plan appeal process prior to requesting an External appeal review. A provider may request a State Fair Hearing with or without External Medical Review, on behalf of the member/patient. The member or the member's representative must request a State Fair Hearing with our without an External Medical Review no later than 120 Days after Superior mails the appeal decision notice. The member or the member's representative must ask for the State Fair Hearing within 120 Days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the State Fair Hearing within 120 Days, the member may lose his or her 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, providers, the member or the member's representative should either send a letter to Superior at the address below or call the Member Services Department at 1-877-277-9772.

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 State Fair Hearing is requested within 10 Days from the time the member receives the hearing notice from Superior, the member has the right to keep getting any service that Superior has denied, at least until the final hearing decision is made.

If a State Fair Hearing is requested, 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 State Fair Hearings

Medicaid members, or their authorized representatives, may 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. However, in order to qualify for an expedited State Fair Hearing, the member must have exhausted Superior's internal appeal procedures. If the final decision is adverse to the member, it is possible that the member may be required to pay the cost of continued services while the appeal is in progress.

An expedited State Fair Hearing can be requested in one of two ways:

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

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

Resolving a Level of Care Determination

Medical necessity determinations for the daily unit rate are the responsibility of the HHS' administrative services contractor, Accenture. Accenture will review the information received on the MDS form and use the information to assign a Resource Utilization Groups (RUG) level. The MDS form will provide a comprehensive summary of the member's mental and physical issues which should be completed by the fifth Day after admission to a Nursing Facility. Superior also assesses the member in the Nursing Facility upon initial admission (within 30 Days and then 90 Days thereafter). After each assessment, Superior reviews the MDS from Accenture and utilizes the MDS to assist in meeting the needs of the member during their stay or at relocation.

The determination of the RUG level is based on facility considerations, including facility needs, nursing care and the amount of therapy provided per week. The RUG level determines the amount of money per Day that Medicare will pay for a member's stay at the Nursing Facility. If a member is informed that medical necessity is denied by an Accenture physician, the member has the right to appeal that decision. The member or the member's licensed authorized representative (LAR) or physician may file an appeal directly to Accenture:

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

STAR+PLUS MMP Nursing Facility Member External Appeal Rights

STAR+PLUS MMP Nursing Facility 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 HHS 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 mmber 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.

Other Available Provider and Member Resources

Consumer Rights and Services

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

- A complaint allegation is an assertion that a requirement of licensure or certification has been violated. This allegation can be reported orally or in writing and can come directly from individuals or residents, family members, health-care providers, advocates, law enforcement or other state agencies.

- A self-reported incident is an official notification to the state survey and licensing agency from an HHS-regulated provider that the physical or mental health or welfare of an individual or resident has been, or may be adversely affected by mistreatment, neglect or abuse. These reports may also include injuries of unknown source and exploitation or misappropriation of individual or resident property. In addition, reports are required to be filed on staff drug diversions or situations that pose a threat to residents, employees or the public, including calling the police or the local fire authority to maintain safety.

Contact information:

- CRS website: https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
- Telephone Number: 1-800-458-9858

Long-Term Care (LTC) Ombudsman

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

Contact information:

- The Office of the LTC Ombudsman can be contacted at 1-800-252-2412.
- LTC Ombudsman website: https://apps.hhs.texas.gov/news_info/ombudsman/
- A list and contact information of the 28 Area Agencies on Aging can be found at: https://apps.hhs.texas.gov/contact/aaa.cfm

Health Plan Management

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

HHS Office of the Ombudsman

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

Contact information:

- Online submission form found on their website at https://www.hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman.
- Telephone: 1-877-787-8999 or Relay Texas/TTY (hearing Impaired) or 1-800-735-2989.

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 Quality Improvement (QI) 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. 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.

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 the Secure 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://SuperiorHealthPlan.com/providers/resources/quality-improvement/practice-guidelines.html
  - Online via the Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - 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 Outcomes
5900 E. Ben White Blvd.
Austin, Texas 78741
1-800-218-7453

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

SECTION 12
CULTURAL COMPETENCY IN SERVING SUPERIOR'S MEMBERS

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 and a Cultural Competency Plan, 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 difference between culturally acceptable behaviors and 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 (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 through the 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:

- The Health and Human Services Culturally Effective Health Care online course - https://www.txhealthsteps.com/courses-list.
- "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, such as 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 available in English and Spanish.

To access interpreter services for your patients, contact Superior's Member Services department.

SECTION 13
SUPERIOR'S PROVIDER PORTAL

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

Registering for the Provider Portal

In order to use our Secure Provider Portal, you must register at Provider.SuperiorHealthPlan.com. You will be asked to enter your tax identification number, first name, last name, email address and create a password. Your email address will also serve as your username.

Once you submit the registration form, you will receive an email confirmation to validate your account.

After your email address has been validated, your request for access will be reviewed and additional validation will be sent to your TIN's Account Manager for confirmation.

Each TIN is allowed to designate an 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.

Benefits of the Provider Portal

Here are some of the features available to you:

- Verify Member Eligibility: Determine a member's coverage by simply entering the necessary search criteria, such as date of birth, member number and member name.
- Online Claims Submission features:
  - Individual Claim Submissions: Submit both professional claims for add-on services and institutional claims for the daily unit rate.
  - Copy Claim Feature: Recreate claims without entering data twice.
  - Recurring Claims Tool: Quick and easy way to submit repetitive, long-term care claims for multiple members.
  - Corrected Claims: Resubmit through the Secure Provider Portal.
  - Batch Claim Submissions: Avoid paying clearinghouse fees and submit batch claims online. Currently, formatted 837 claims files are only accepted. We apply Health Insurance Portability and Accountability Act (HIPAA) level five edits. Files must be .dat, .edi or .txt formats and no larger that 25MB.

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

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

Provider Portal Help Desk

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

5900 E. Ben White Blvd.
Austin, TX 78741

1-877-391-5921
SuperiorHealthPlan.com