# STAR Health

*Provider Training*

# Agenda

- Superior HealthPlan
- STAR Health Basics
- Provider Roles and Responsibilities
- STAR Health Benefits
- 3 in 30
- Service Coordination
- Mental Health Rehabilitation and Targeted Case Management
- Medical Management
- Claims - Filing and Payment
- Electronic Visit Verification (EVV)
- Pharmacy
- Quality Improvement
- Abuse, Neglect and Exploitation
- Fraud, Waste and Abuse
- Health Passport
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# Superior HealthPlan

# Superior HealthPlan

Superior is:

- An HMO that contracts with the State of Texas to provide Medicaid covered services statewide.
- Contracted with the State of Texas to provide all Medicaid lines of business. Including:
  - STAR/CHIP
  - STAR Kids
  - STAR+PLUS
  - STAR Health
- Among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings.
- The only provider of health insurance for youth in Texas foster care (STAR Health) since 2008. STAR Health has helped set a framework for foster care programs at other health plans in the U.S.

# STAR Health Basics

# Children and Youth In Foster Care

- Children and youth that have been taken into conservatorship of the State have often experienced abuse and neglect.
- Scientific studies have documented the link between experiencing abuse and neglect and a wide range of medical, emotional, psychological and behavioral disorders such as:
  - Fetal Alcohol Syndrome
  - Shaken Baby Syndrome
  - Developmental Delays
  - Bonding and/or Attachment Disorders
  - Brain Trauma
  - Self/Sibling Abuse
  - Depression
  - Alcoholism
  - Drug abuse
  - Teen Pregnancy
  - Obesity

# Why STAR Health?

- STAR Health is a statewide contract that:
  - Provides access to health-care services across the state
  - Allows for coordination of care when children and youth enrolled in STAR Health change placements from one location to another
  - Establishes a Medical Home (Primary Care Provider [PCP])
  - Offers telehealth services to allow more flexibility in delivery of many service types
  - Provides emergency support and services
- Due to abuse and neglect, children and youth in foster care often have greater health-care needs, that include:
  - Treatment for physical and/or emotional trauma
  - Treatment due to developmental delays
  - Dental and vision care
  - Treatment for chronic conditions such as:
    - Asthma
    - Depression
    - Diabetes

# STAR Health's Commitment

The children and youth enrolled in STAR Health have unique needs. The Superior STAR Health team has a commitment to:

- Understand the foster care community.
- Be sensitive to the needs of the foster care population.
- Provide accessible and integrated care.
- Utilize Health Passport to better support coordination of care.
- Deliver appropriate education to all stakeholders.

# STAR Health Membership

- Children and young adults:
  - In Department of Family and Protective Services (DFPS) conservatorship
  - In kinship care
  - Young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement
  - Young adults aged 18 through the month of their 21st birthday, who are Former Foster Care Child Members or who are participating in the Medicaid for Transitioning Foster Care Youth Program. To learn more, visit HHSC's Medicaid for Transitioning and Former Foster Care Youth webpage.
  - An infant born to a mother who is enrolled in STAR Health

# STAR Health Membership

- Children through age 17 and young adults aged 18 through the month of their 21st birthday who are receiving Supplemental Security Income (SSI) or who were receiving Supplemental Income before becoming eligible for Adoption Assistance (AA )or Permanency Care Assistance (PCA).
- Children through age 17 and young adults aged 18 through the month of their 21st birthday who are enrolled in a 1915(c) Medicaid Waiver and AA or PCA. To learn more, visit HHSC's Adoption Assistance or Permanency Care Assistance webpage.
- STAR Health members under 21 years of age will be disenrolled from Superior upon election of hospice.
  - Hospice care and treatment services will be available to these individual through fee-for-service Medicaid.

# Coverage After Adoption or Permanency Care Placement

- After adoption or permanency care placement, children enrolled in STAR Health may remain in STAR Health if they receive Social Security Income (SSI) now or received SSI before their adoption or permanency care placement.
- They may also choose to enroll with a STAR Kids program.
- If the child did not receive SSI, they would need to choose to join a STAR Medicaid program.
- During the transition, STAR Health members will remain in STAR Health. There will be no gap in the member's coverage.
- For assistance with enrollment questions, members or providers may contact the Texas Health and Human Services Commission (HHSC) Ombudsman's Office:
  - By phone: 1-877-787-8999
  - Online: Visit HHS's Office of the Ombudsman webpage

# Provider Roles and Responsibilities

# PCP Responsibilities

- Serve as a “Medical Home”
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member.
- Develop an Integrated Primary Care (IPC), which involves the integration of behavioral health services into primary care, where appropriate.
- Be accessible to members 24 hours a day, 7 days a week, 365 days a year
- Responsible for the coordination of care and referrals to specialists
- Verify member eligibility prior to rendering services
  - Members just entering STAR Health may not be in the system yet. In these situations, providers should reference the member’s DFPS 2085 B (Designation of Medical Consenter) Form.
  - DFPS provides this form to caregivers when the child is placed in their care and updates it when there is a change in who can consent for the child.

# PCP Responsibilities

- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider. Please note:
  - PCPs are required to upload forms and documents related to the member's checkup to Health Passport, as well as complete the Texas Health Steps checkup steps and bill appropriately.
  - Specialists who serve as PCPs are encouraged, but not required, to be Texas Health Steps providers.
- Update contact information to ensure accurate information is available in Provider Directories.
- Sign Form 2601 to verify medical necessity for MDCP services.
- Report all encounter data on a CMS 1500 form or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Utilize the Health Passport to ensure continuity of care.

# PCP Responsibilities

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

# PCP's Role in Behavioral Health

- PCPs are responsible for coordinating the member's physical and behavioral health care, including making referrals to behavioral health practitioners when necessary.
- PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health.
  - To assist in making appropriate referrals, providers can access Superior's behavioral health assessment tools online visit Superior's Behavioral Health webpage.
- PCPs are required to send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must include, at a minimum:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.

# Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope, such as mental health referrals, including identification of Severe Emotional Disturbance (SED) or substance use disorder.
  - There may be times when a referral to an out-of-network may be appropriate. Superior will review the out-of-network request and make a medical necessity decision on the request.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.
- Members may self-refer for the following services:
  - Family planning
  - Texas Health Steps
  - Case management for children and pregnant women
  - Vision
  - Behavioral health
  - Substance Use Disorder
  - True emergency services
  - Well woman annual examinations

# Referrals for Non-Capitated Services

- Non-capitated services are excluded from covered services; however, STAR Health members may be eligible to receive them from Texas Medicaid providers on a Fee-for-Service basis.
- When it is determined that a member may need a non-capitated service, Superior staff will assist the member in requesting these services.
- Services include:
  - ECI Case Management
  - ECI Specialized Skill Training
  - Texas Health Steps environmental lead investigation (ELI)
  - Texas School Health and Related Services (SHARS)
  - HHSC Blind Children's Vocational Discovery and Development Program
  - Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
  - HHSC hospice services
  - Mental Health Targeted Case Management and Mental Health Rehabilitative Services for dual-eligible members
  - Texas DFPS Nurse-Family Partnership (NFP)
- Claims for non-capitated services should be submitted directly to the HHSC Claims Administrator for reimbursement.
  - Most STAR Health (foster care) claims are capitated services and must be submitted to Superior.

# Behavioral Health Care Provider Expectations

- Comply with the *Psychotropic Medication Utilization Parameters for Foster Children*
  - For more information, please visit DFPS Psychotropic Medications webpage.
- Expand the use of evidence-based practices, including:
  - Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Informed Care, Parent-Child Interaction Therapy (PCIT), Trust-Based Relational Intervention (TBRI), Post Traumatic Stress Disorder (PTSD) and Attention-Deficit/Hyperactivity Disorder (ADHD).
  - Cognitive behavioral therapy for sexually abused children
  - For more information, please visit Substance Abuse and Mental Health Services Administration (SAMHSA) Resources webpage.
- Provide services to targeted populations, including members with:
  - Abandonment issues
  - ADHD
- Provide documentation required for judicial review, including:
  - Initial assessments and monthly reviews

# Behavioral Health Care Provider Expectations

Superior must contractually require Behavioral Health (BH) providers to provide the following information in Health Passport:

1. Primary and secondary (if present) diagnosis;
2. Assessment information;
3. Brief narrative summary of clinical visits/progress;
4. Scores on each outcome rating form(s);
5. Referrals to other Providers or community resources;
6. Evaluations of each Member's progress at intake, monthly, and at termination of the Individual Service Plan (ISP) or as significant changes are made in the treatment plan; and
7. Any other relevant care information.

The BH provider must also submit an initial and monthly or more frequently, if a member's medical condition indicates, narrative summary report of a member's BH status for inclusion in Health Passport. This information will be available to the member's providers, the Superior Service Coordination team, and DFPS staff.
Health Passport training information is available on Superior's Health Passport webpage.

# Foster Care Court Orders

- All STAR Health providers must comply with court orders, including:
  - Rendering court-ordered health-care services for the child when the service being court-ordered is a benefit of Texas Medicaid
  - Providing documentation (reports and/or reviews) as requested
  - Testifying in court

# STAR Health Benefits

# STAR Health Benefits

superior healthplan

- General STAR Health Benefits include, but are not limited to:
  - Regular check-ups at the doctor, including Texas Health Steps exams
  - Dental and vision services
  - Prescription medicine and vaccines
  - Hospital care and services
  - X-rays and lab tests
  - Vision and hearing care
  - Access to medical specialists and behavioral health services
  - Treatment of special health needs and pre-existing conditions
  - Durable Medical Equipment (DME)
  - Therapy (physical, speech, and occupational)
  - Family planning services
  - Maternity services
  - A 24/7 nurse hotline for caregivers and caseworkers
  - Access to the Health Passport, a comprehensive, patient-centered and internet based electronic health record
  - Non-Emergent Medical Transport (NEMT)

# Value-added Services

- Care Grants
- Over-the-Counter (OTC) Items
- Extra Vision Services
- Sports Physicals
- a2A My Health Pays
- $20 gift card and journal for completing 7-day follow-up visit after a behavioral health inpatient stay
- For more details or updates, please visit:
  - Superior's Value-added Services webpage.

# My Health Pays® Rewards

- Members can earn My Health Pays® rewards for completing health activities.
- Rewards can be used to help pay for:
  - Utilities
  - Transportation
  - Telecommunications
  - Childcare services
  - Education
  - Rent
  - Rewards can also be used at Walmart stores to pay for everyday items (not including alcohol, tobacco or firearms products)
- Rewards can be earned for receiving a flu vaccine, completing Texas Health Steps checkups and for completing an annual well woman exam.

# 24-Hour Nurse Advice Line

The Nurse Advice line staff are Registered Nurses who are bilingual in English and Spanish.

They are:

- Available 24 hours a day, 7 days a week, 365 days a year
- Knowledgeable about the STAR Health Program including:
  - Covered Services
  - Non-capitated Services
  - Needs of the STAR Health Population and child welfare system
  - Medical Consenter requirements
  - Provider resources
- Able to provide clinical information and guidance on specialty referrals or requests for specialty provider consultations.
- Will transfer to the Behavioral Health Hotline as needed.

To contact the 24-Hour Nurse Advice Line, please call: 1-866-912-6283.

# Behavioral Health Services

Behavioral Health assistance can be provided by Behavioral Health professionals who are bilingual in English and Spanish.

They are:

- Available 24 hours a day, 7 days a week, 365 days a year.
- Qualified BH professionals who are trained to address routine, emergency and crisis calls.
- Knowledgeable in the process to access emergency prescriptions.
- Knowledgeable in the steps to take to immediately address Member issues when pharmacies do not provide a 72-hour supply of emergency medicines.
- Knowledgeable in the processes for obtaining services and how to address common problems.
- Able to triage calls and escalate issues to the appropriate Superior staff person by warm transfer.
- Trained regarding the availability of and access to Substance Use Disorder treatment services, including information on self-referral.

For Behavioral Health services, please call: 1-866-912-6283, then press 2.

# Screening, Brief Intervention and Referral to Treatment

- Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidenced-based practice to address substance use disorder and related issues.
- SBIRT successfully reduces healthcare costs, severity of drug and alcohol use and risk of trauma.
- **Screening** is a quick, simple method of identifying patients who use substances at at-risk or hazardous levels, and who may already have substance use-related disorders.
- **Brief Intervention** is a time-limited, patient-centered strategy that focuses on changing a patient's behavior by increasing insight and awareness regarding substance use. It is designed to motivate patients to change their behavior and prevent the progression of substance use.
- **Referral to Treatment** is done when a more advanced treatment option is necessary, and the member is referred to a higher level of care. The referral to treatment process consists of helping patients access specialized treatment, select treatment facilities and facilitate the navigation of any barriers.
- Additional information on SBIRT can be found using the following resources:
  - SAMHSA's Screening, Brief Intervention, and Referral to Treatment webpage
  - TMHP Texas Medicaid Provider Procedures Manual

# STAR Health
# Medical Ride Benefit

- Superior's Medical Ride Program provides transportation to non-emergency health-care appointments for STAR Health who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.
- Transportation services for Superior members will be provided by SafeRide.
- Members must request rides at least two business days in advance and it is the responsibility of the member to coordinate all information needed from both the provider and Superior for SafeRide to consider the request.

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

# Medical Ride Program Services

- There are many types of transportation services offered by Superior's Medical Ride Program, including:
  - Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
  - Commercial airline transportation services.
  - Car, van, private bus services, including wheelchair-accessible vehicles, if necessary. These are types of rides where you are picked up and dropped off at the entrance/exit of your home or clinic.
  - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
    - The enrolled ITP can be you, a responsible party, a family member, a friend, or a neighbor
- Superior's Medical Ride Program will cover the cost of an attendant for members needing assistance while traveling.
- Children 14 years of age and younger must be accompanied by a parent, guardian or other authorized adult.
- Members 20 years of age and younger requiring long-distance trips may be eligible to receive the cost of meals and/or lodging to obtain a covered health-care service.

# Intellectual Developmental Disabilities (IDD)

- Service Coordination seeks to identify and support those with a diagnosis of Developmental Delay, Intellectual Disability and Autism Spectrum Disorder through the following steps:
  - Assessment of need related to the IDD diagnosis
  - Coordination of services and supports with providers who are knowledgeable about developmental disabilities
  - Referrals to appropriate waiver programs
  - Communication and coordination with the DFPS Developmental Disability Specialists
  - Education of caregivers about the diagnosis and appropriate treatment interventions

# Community First Choice (CFC)

- Community First Choice (CFC) is part of Senate Bill 7 from the 2013 Texas Legislature requiring the HHSC to put in place a cost-effective option for attendant and habilitation services for people with disabilities.
- CFC services are available for STAR Health members who:
  - Need help with activities of daily living (dressing, bathing, eating, etc.).
  - Meet an institutional level of care, such as a hospital, an Intermediate Care Facility (ICF) for individuals with an Intellectual Disability (ID), Nursing Facility or Institution for Mental Disease (IMD).
  - Currently receive Personal Care Services (PCS).
  - Are individuals on the waiver interest list or are already getting services through a 1915(c) waiver.

# Community First Choice (CFC)

- CFC is a Medicaid benefit that provides services for people with IDD and/or physical disabilities, and/or individuals who meet the institutional level of care for an IMD.
  - CFC will include PAS, Habilitation (HAB), Emergency Response Services and Support Management.
  - CFC assessments for MDCP waiver members or PCS members will be conducted by Superior and submitted to TMHP to determine medical necessity.
  - For members with an IDD diagnosis or related condition, the LIDDA will complete the assessment and submit to HHSC who makes the LOC determination.
  - If the PCP determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination at 1-800-218-7508 and request an assessment.
  - CFC services should be billed directly to Superior through the Secure Provider Portal, through your clearinghouse or on paper.
  - Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the Uniformed Managed Care Manual (UMCM).

# Communication and Confidentiality

- STAR Health will assist with coordination and sharing of health information between caregivers, medical consenters, DFPS workers, courts and providers (as appropriate) to ensure that the health-care needs of children in foster care are being met.
- STAR Health, by law, will keep all health records and medical information private. Discussions with the doctors or other health-care providers are also kept private.
  - STAR Health follows all applicable state and federal confidentiality laws.

# Advance Directives

- Federal and state law requires Managed Care Organizations (MCOs) and providers to maintain written policies and procedures for informing all members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives.
- Members and/or their medical consenter have the right to informed consent. Providers must tell members and/or their medical consenter about all the good and bad things of any procedures, tests or treatments and members must give permission to be treated.
- STAR Health does not require a member to have an advance directive as a condition for receiving health care, nor does STAR Health discriminate against a member based on whether the member has or does not have an advanced directive.

# 3 in 30

# 3 in 30

- 3 Day Initial Medical Exam
  - Within 3 Business Days, children with certain conditions entering DFPS care must see a doctor to be checked for injuries or illnesses and get any treatments they need.
    - The child's caseworker will decide if the 3-day initial medical exam is needed.
- Texas Child and Adolescent Needs and Strengths (CANS) 3.0 Assessment
  - Within 30 Days, children (3-17 years of age) must get a CANS 3.0 assessment. The CANS 3.0 is very similar to the CANS 2.0 in that it is still a comprehensive, trauma informed behavioral health evaluation. It gathers information about the strengths and needs of the child and helps in planning services that will help the child and family reach their goals. The difference is that there are two additional modules – Medical Health and Exploitation.
- Texas Health Steps Medical Check-Up (also known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
  - Within 30 Days, children must see a Texas Health Steps doctor for a complete check-up with lab work. This ensures:
    - Medical issues are addressed early
    - Children are growing and developing as expected
    - Caregivers know how to support strong growth and development
- For more information, visit Superior's STAR Health Provider Resources webpage.

# 3-Day Medical Exam

- Children who meet certain criteria should receive a 3-day exam. These criteria are:
  - Removal due to physical abuse
  - Removal due to sexual abuse
  - Obvious physical injury
  - Chronic medical condition
  - Complex medical condition
  - Diagnosed mental illness
    - The child's caseworker will determine if a 3-day exam is necessary and inform the person caring for the child.
- Children who have a need for a sick visit or urgent care exam can see a doctor at any time.
- Must use U2 modifier when billing the 3-Day Exam
- Does not replace the Texas Health Steps medical checkup or the CANS 3.0 Assessment

# 3-Day Medical Exam Components

- Vital signs (including growth parameters)
- History
- Physical exam
- Tests (laboratory, imaging, etc.) as medically necessary
- Treatment as necessary
- Discharge recommendations

# 3-Day Medical Exam - Billing

- Vaccinations ***cannot*** be given at the 3-Day Exam unless the medical professional determines that a tetanus vaccination is necessary.
- To show confirmation that the exam has been completed, providers should bill with one of the following Evaluation and Management (E&M) codes along with the **U2 modifier** in the last position:

| | | | | | |
|---|---|---|---|---|---|
| **New Client Codes** | **99201** | **99202** | **99203** | **99204** | **99205** |
| **Established Client Codes** | **99211** | **99212** | **99213** | **99214** | **99215** |

# Effective 1/1/25 – CANS 3.0

- On January 1, 2025, DFPS will be ready to have the first child placements made into the Texas Child-Centered Care (T3C) System, with IMPACT 2.0 updates ready and residential childcare providers that have been credentialed.
- As part of the T3C System, the CANS 2.0 Assessment will be discontinued and replaced by an enhanced CANS 3.0 Assessment on January 1, 2025.
  - A child or youth who has had a CANS 2.0 does not automatically need to get a CANS 3.0 assessment simply due to the updated tool.
- The CANS 3.0 will look very similar to the CANS 2.0 with the addition of two new modules, Medical Health and Exploitation.
  - To view a side-by-side comparison of the CANS 2.0 and CANS 3.0, please view the Texas CAN 2.0 vs. Texas CANS 3.0 (YouTube).

# Effective 1/1/25 – CANS 3.0

- Current providers who administer the CANS may continue to complete CANS 3.0 Assessments under their current CANS 2.0 certification.
  - These providers will be required to re-certify with the CANS 3.0 through the TCOM website when their next annual CANS certification is due.
- As children begin moving into T3C placements, CANS 3.0 assessments will become the responsibility of either DFPS or Single Source Continuum Contractor (SSCC) CANS Assessors, based on the child's legal DFPS region or SSCC catchment area.
  - DFPS or SSCC CANS Assessors will reach out directly to the child's caregiver to schedule and complete the CANS 3.0 assessment.
  - For children who have NOT moved into a T3C placement, caregivers will follow the normal process of scheduling a CANS assessment through STAR Health, though the CANS 3.0 tool will be used.

# Texas Health Steps Medical Checkups

A Texas Health Steps Check up must be completed within 30 Days:

- When a child initially enters DFPS conservatorship
- The requirement does not apply to each time the child changes placement
- Regular Texas Health STEPS exams should occur per the Texas Health Steps periodicity schedule on an ongoing basis.

- Texas Health Steps Medical Checkups must be completed by a STAR Health Texas Health Steps provider and documented in the member's medical record and Health Passport.
  - *There may be other licensing requirements for different placements.*
- Use of the Texas Health Steps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components.
  - Use is optional, but recommended
  - Forms are available online in the resources section at HHSC's Texas Heath Steps webpage.
- Access the Texas Health Steps catalog online at HHSC's Texas Health Steps Catalog. Materials can be printed or ordered at no cost.
  - To request an account email txmailhouse@maximus.com.

# Texas Health Steps Medical Checkups

- Checkups must include:
  - Comprehensive health and developmental history including:
    - Nutritional assessment
    - Developmental assessment
    - Tuberculosis screening
    - Autism screening
    - Mental health assessment
  - Comprehensive unclothed physical examination that includes an oral assessment, measurements and sensory screening.
  - Immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) schedule.
  - Health education/anticipatory guidance.
  - Laboratory tests (including blook lead level assessments).
    - Please note that Texas Health Steps Laboratory Services must be submitted to the DSHS Laboratory Services Section.
  - Referral services (e.g., CCP services, WIC, family planning and dental services).

# Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- The most important step that parents and caregivers, healthcare providers and public health professionals can take, is to prevent lead exposure before it occurs. The Centers for Disease Control (CDC) has both primary and secondary prevention guidelines.
  - For more information, please visit CDC's Childhood Lead Poisoning Prevention webpage.
- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
  - The Centers for Medicare and Medicaid Services (CMS) requires all children enrolled in Medicaid to get tested for lead at ages 12 and 24 months, or age 24–72 months if they have never been tested.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.

# Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- If a blood lead level test confirms to be positive, the CDC recommends that healthcare providers use a venous draw to confirm the test; however, if the first test was via a venous, an additional venous test is not needed. Additional guidance on follow-up testing as well as treating children based on their blood lead levels, can be found on CDC Testing for Lead Poisoning in Children webpage.
  - Children 35 months and younger with blood lead levels ≥ 5mcg/dL should be referred to ECI for evaluation of support and specialized services for developmental disabilities or delays. For more information, visit HHSC's ECI Services webpage.
  - If a child's lead levels meet the ELI requirement, the provider will complete the TXCLPPP request for ELI form (PB-101) and fax it to the EXCLPPP Environmental Specialist
    - The form can be found on HHSC's Reporting Forms webpage.
- Providers are expected to ensure follow up testing and treatment guidelines are followed as identified and recommended.
- For more information and forms, visit the Texas DSHS TXCLPPP webpage.

# Documentation and Reporting of Texas Health Steps Elements

- Each of the 6 components of the Texas Health Steps exam reviewed previously and their individual elements must be completed and documented in the member's medical record.
  - Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete it.
  - The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings.
  - The results of these screenings and any necessary referrals must be documented in the medical record.
- All laboratory specimens, (including newborn screenings, blood lead level assessments and anemia) collected as a required component of a Texas Health Steps checkup (depending on age-specific requirements) must be submitted to the DSHS Laboratory Services webpage, or to a laboratory approved by the department under Health and Safety Code for analysis.
- When an immunization is given providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac).
- Texas Health Steps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

# Texas Health Steps Billing

- Texas Health Steps Medical checkups should be billed with procedure codes 99381-99385 for existing patients and 99391-99395 for new patients.
  - If a follow-up visit is required, use code 99211
- Claims should be billed with the following ICD-10 diagnosis codes:

| Diagnosis Code | Description |
|---|---|
| Z00110 | Routine newborn exam, birth through 7 days |
| Z00111 | Routine newborn exam, 8 through 28 days |
| Z00129 | Routine child exam |
| Z00121 | Routine child exam, abnormal |
| Z0000 | General adult exam |
| Z0001 | General adult exam, abnormal |

- Use benefit code EP1 and the appropriate modifier for the performing provider.
- The condition indicator code is required whether a referral is made or not.
- Additional billing guidelines can be found on the ***Texas Health Steps Quick Reference Guide (QRG)*** found by visiting TMHP's Texas Health Steps webpage.

# Texas Health Steps Outreach and Informing Unit

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

# Missed Appointments

- Providers should complete a Missed Appointment form and fax it to MAXIMUS, who will then contact the members to determine what prevented them from keeping the appointment (lack of transportation, childcare, money for gasoline, etc.).
- The Missed Appointment Form is available at HHSC's Notice of Appointment or Delay webpage.
- More information is available through your local regional Texas Health Steps Regional Provider Relations Representatives (PDF).

# Service Coordination

# Service Coordination

Offers support for enrolled members including:

- Facilitation of access to primary, dental and specialty care and support services
- Scheduling of assessments with expediting as needed
- Clarify and provide access to information regarding the PA process
- Clarify program requirements and processes, including the Member Appeals
- Assist DFPS and court staff in obtaining the member's medical information timely
- Coordination with DFPS Case Management Services, to facilitate referrals and access to services provided by other agencies and community resources
- Coordinate the sharing of health information between Providers and other Programs, such as ECI
- Assist Members, Caregivers and Medical Consenters with other coordination needs when needed
- Ensure coordination with and referral to DSHS Case Management
- Ensure Members with transportation needs for medical appointments receive assistance through Safe Ride
- Share information with DFPS Forensic Assessment Centers
- Development of a Individual Service Plan (ISP)
- Monitor adherence to treatment plan and progress towards goals
- Promote best practice/evidence-based services
- Identify and report potential abuse/neglect

# Service Coordination

- Service Coordinators will act in the best interest of the child and coordinate care involving all the necessary parties, including:
  - Medical Consenters
  - Caregivers
  - Members
  - Courts
  - Caseworkers
  - DFPS Staff
  - Attorneys' ad litem
  - Other involved parties from DFPS and other state agencies
    - Guardians' ad litem
  - Law Enforcement Officials
  - Providers
  - Single Source Continuum Contractors (SSCC) Staff / Community Base Care (CBC)
  - Integrated Care Coordination Vendor Staff

- To contact Service Coordination, call: 1-866-912-6283.

# Clinical and Non-Clinical Support

- Clinical and non-clinical support is available 24 hours a day, 7 days a week, 365 days a year
  - For assistance contact STAR Health Member Service at: 1-866-912-6283
- STAR Health Member Services can help with:
  - Questions about the health plan
  - Finding a doctor
  - Scheduling an appointment
  - Getting a new ID card
  - Accessing benefits and services
  - Accessing interpreter services
  - And much more

# Coordination with Service Organizations

- Service Coordination coordinates services with other entities to ensure integration of care. Entities include, but are not limited to:
  - ECI
  - Texas School Health and Related Services (SHARS)
  - Texas Department of State Health Services (DSHS) Mental Health Targeted Case Management
  - DSHS Case Management for Children and Pregnant Women
  - Local Mental Health Authorities (LMHA)
  - WIC
  - NEMT

# Disease Management

**Superior STAR Health offers the following disease management programs:**

**Attention Deficit Hyperactivity Disorder -** The Attention Deficit Hyperactivity Disorder (ADHD) program provides telephonic outreach, education, and support services to assist members and families to improve self-management skills for effective management of ADHD symptoms and optimize their quality of life. Members who are eligible are aged six and older, have one or more medical or pharmacy claims indicating an ADHD diagnosis, and with symptoms of ADHD reported by their caregiver.

**Asthma -** The asthma DM program assists members with a diagnosis of asthma to make progress towards their asthma-related goals to reduce exacerbations and decrease ED utilization and inpatient admissions and readmissions through collaborative management between STAR Health and Envolve People Care (EPC). Members receive an asthma action plan, education on medications and their specific plan of care, referrals to appropriate specialists, community resource information, and ongoing telephonic follow-up to identify further gaps in care.

# Disease Management

**Depression -** The Depression DM program provides telephonic outreach, education, and support services to assist members with depression to improve self-management skills to effectively manage depression and optimize their quality of life. Eligible members include those who are age 12 or older and who have one or more medical or pharmacy claims indicating a depression diagnosis and with symptoms of depression or reported depression.

**Diabetes** - The Diabetes program provides telephonic outreach, education and support services to optimize blood glucose, blood pressure and lipid control to minimize the development and/or progression of diabetic complications; optimize nutrition, healthy-eating options, and self-care behaviors; improve self-management skills to increase compliance associated with HbA1c, lipids, and blood pressure testing; and Promote statin therapy for patients with cardiovascular disease and diabetes.

# Disease Management

**Start Smart for Your Baby (SSFB) -** All pregnant STAR Health members are eligible for SSFB Care Management which promotes education and support designed to reduce the risk of pregnancy complications, premature delivery, and infant disease resulting from high-risk pregnancies. The SSFB program's focus is on prenatal and post-partum members, developmental milestones, and linkage to community resources, and is provided through a pregnancy Care Management team.

**Weight Management** - The lifestyle management program provides telephonic outreach, education, and support services to members in support of changing unhealthy behaviors and motivating individuals on risk reduction and achievement of health goals. to the list of Disease Management programs. I'd like to keep them in alphabetical order.

# Mental Health Rehabilitation and Targeted Case Management Services

# Mental Health Rehabilitation (MHR)

- Services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.
- MHR services include:
  - Crisis Intervention Services (H2011)
  - Medication Training and Support Services (H0034)
  - Psychosocial Rehabilitative Services (H2017)
  - Skills Training and Development Services (H2014)
  - Day Program for Acute Needs (H2012)

*Please note: The information above and on the following slides comes from the Texas Medicaid Provider Procedures Manual (TMPPM), which is updated monthly. For the latest information, please visit TMHP's Texas Medicaid Provider Procedures Manual webpage.*

# Mental Health Rehabilitation (MHR)

- A Medicaid provider may only bill for medically necessary MHR services that are provide face-to-face to:
  - A Medicaid-eligible person
  - The Legally Authorized Representative (LAR) of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person)
  - The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person)
- Rehabilitative services delivered via group modality are limited to an 8-person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

# Targeted Case Management (TCM)

- Targeted Case Management (T1017)
  - Assist persons in gaining access to needed medical, social/behavioral educational and other services and supports.
  - Include monitoring of service effectiveness as frequently as necessary (at least annually).
  - TCM is a Medicaid billable service provided separate from Superior Service Coordination.
    - Service Coordinators coordinate with providers to ensure integration of behavioral and physical health needs of enrollees.
    - Service Coordinators refer non-eligible enrollees to Local Mental Health Authorities (LMHAs) that can provide indigent mental health care.
- Mental Health Targeted Case Management is not payable when delivered on the same day as psychosocial rehabilitative services.

# Targeted Case Management (TCM)

- Routine case management services are primarily office-based activities that assist a person, caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the person's needs.
- Intensive case management services are predominantly community-based case management activities provided to the child or youth or to the LAR on behalf of the child or youth (who may or may not be present) to assist a child or youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the child or youth's needs.
- Intensive case management and routine case management are not payable on the same day.

# Medical Management

# How to Obtain an Authorization

- Use the Prior Authorization (PA) Request Form and submit via fax to:
  - Medical Outpatient: 1-800-690-7030
  - Medical Inpatient: 1-877-650-6942
  - Behavioral Health Outpatient: 1-866-570-7517
  - Behavioral Health Inpatient: 1-800-732-7562
- PA Form:
  - To access this form please visit Superior's Provider Forms webpage.
- Call in your request to 1-800-218-7508.
- Log on to the Superior's Secure Provider Portal .
- For the most up-to-date PA List, visit Superior's Authorization Requirements webpage.

# Utilization Management Criteria

- Utilization management decisions are made in accordance with currently accepted medical or health-care practices, taking into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria.
- The following are used for the review of medical necessity, as well as provider peer-to-peer review:
  - Federal and/or State law/guidelines
  - Utilization management clinical policies
  - Proprietary clinical guidelines
  - Interqual® criteria
- The medical director reviews all potential Adverse Benefit Determinations for medical necessity.
- Providers can contact Provider Services at 1-877-391-5921 to request a copy of the criteria used to make a specific decision or review the clinical policies by visiting Superior's Clinical, Payment & Pharmacy Policies webpage.

# Therapy Treatment Authorizations

- Prior authorization is not required for initial evaluations or re-evaluations for Physical Therapy, Occupational Therapy, Speech Therapy (PT/OT/ST).
- Providers must include specific information when submitting therapy prior authorization requests for STAR Health members.
- The following clinical documentation must be submitted when requesting a prior authorization for therapy:
  - Current objective assessment
  - Treatment goals
  - Progress reporting
  - Frequency and duration
- Documentation must be dated within the last 60 Calendar Days.
- MD signatures must be dated the day of the evaluation or after and specify the frequency and duration of the service.
- Providers must follow and adhere to practice standards for all clinical treatment areas. The details for each of the four criteria can be found online under "*Therapy Documents and Policy Clarification*" on Superior's Provider Resources webpage.

# Early Childhood Intervention (ECI)

- ECI
  - Therapy services for members under 3 years of age do not require prior authorization for contracted providers.
  - Health-care professionals are required, under federal and state regulations, to refer children under 3 years of age to ECI within two Business Days once a disability or developmental delay is identified/suspected.
  - Superior will work with contracted providers to provide ECI services to members who have been determined eligible.
  - For more information, please visit HHSC's ECI Services webpage.

# Evolent

- Evolent is contracted with Superior to perform utilization review for:
  - High-Tech Imaging Services
  - Interventional Pain Management (IPM)
  - Genetic and Molecular Testing
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
- For IPM, a separate prior authorization number is required for each procedure ordered.
- The ordering physician is responsible for obtaining authorizations.
- Emergency room and inpatient procedures do not require prior authorization; however, notification of admission is still required through Superior.
  - Observation Imaging Services do not require authorization
- To obtain authorization through Evolent, visit Evolent's website or call 1-800-642-7554.
- Claims should still be submitted to Superior for processing.

# TurningPoint Healthcare Solutions


- TurningPoint Healthcare Solutions is contracted with Superior to process prior authorization requests for medical necessity and appropriate length of stay for:
  - Certain Cardiac procedures
  - ENT surgeries
- Emergency related procedures do not require prior authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services should verify that the necessary prior authorizations have been obtained. Failure to do so may result in non-payment of claims.
- Prior authorization requirements for facility and radiology may also be applicable.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under *Billing Resources* at Superior's Provider Resources webpage.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
  - Web Portal Intake: TurningPoint Provider Login
  - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
  - Facsimile Intake: 1-214-306-9323

# Claims Filing and Payment

# Claims Submission

- Secure Provider Portal:
  - Visit Superior's Secure Provider Portal
- Electronic Claims:
  - For a list of our trading partners visit Superior's Billing and Coding webpage
  - Superior Emdeon ID
    - Medical Claims: 68069
    - Behavioral Claims: 68068
- Paper Claims:

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

# Claims Submission

- Clean Claim – A claim submitted by a provider for healthcare services rendered to a member that contains accurate and compete data in all claim fields required to adjudicate and accurately report and finalize the claim.
- First time claims must be submitted within 95 calendar days from the date of service.
- Rejected Claims – An unclean claim that does not contain all elements necessary to process the claim, and/or is not the responsibility of the health plan for adjudication.
  - All rejected claims must be corrected and resubmitted within 95 Calendar Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.
- Superior's Provider Manual provides guidelines on how to submit Clean Claims and highlights the requirements for completing CMS 1450 or CMS 1500 forms.
  - National Provider Number (NPI) of a referring or ordering physician on a claim.
  - Appropriate two-digit location code must be listed.
  - Appropriate modifiers must be billed, when applicable.
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician
    - ZZ qualifier for CMS 1500 or B3 qualifier for CMS 1450 to indicate taxonomy.

# Corrected Claims

- Corrected Claims – A resubmission of 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 required corrections.
  - For example: Correcting a member's date of birth, a modifier, diagnosis (Dx) code, etc.
  - The original claim number must be billed in field 64 of the UB-04 form or field 22 of the CMS 1500 form.
  - The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 form or field 22 of the CMS 1500 form.
- Must be submitted within 120 Calendar Days from the date on the Explanation of Payment (EOP).
- A Corrected Claim form may be used when submitting a Corrected Claim and mailing it to:

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

# Claims Appeals

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

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

# Pre- and Post-payment Claims Monitoring

- Prepayment Code Editing
  - Superior uses code editing software to assist in improving accuracy and efficiency in claims processing, payment, reporting and to meet HIPAA compliance. The code editing software will detect, correct (when applicable), and document coding errors on provider claims prior to payment.
  - When a change is made on your submitted code(s), we will provide a general explanation of the reason for the change on your EOP (or remittance advice). The code-editing software will make a change on submitted codes for unbundling, fragmentation and age or gender.
- Post-payment Claim Audit
  - Superior will complete all audits of a provider claim no later than two years after receipt of a clean claim.
    - This limitation does not apply in cases of provider Fraud, Waste or Abuse that Superior did not discover within the two-year period following receipt of a claim.
  - If an additional payment is due to a provider as a result of an audit, Superior will make the payment no later than 30 Calendar Days after it completes the audit.
  - If the audit indicates that Superior is due a refund from the provider, Superior will send the provider written notice of the basis and specific reasons for the recovery no later than 30 Calendar Days after it completes the audit

# PaySpan/Zelis

- Superior has partnered with Zelis, formerly known as PaySpan to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs)
  - Online remittance advices (ERAs/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register on the Zelis website.
- For further information contact 1-877-331-7154, or email ProviderSupport@PaySpanHealth.com.

# Member Balance Billing

- Providers may NOT bill STAR Health members directly for covered services.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Providers may inform members of costs for non-covered services and secure a private pay form prior to rendering.
- Members do not have co-payments.
- Additional details can be found in your Superior provider contract.

# Claims – Electronic Visit Verification (EVV)

# Electronic Visit Verification

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Service providers or Consumer Directed Services (CDS) employees providing covered services to an individual or health plan member must use one of the three HHSC approved methods to clock in and out.
- The EVV system electronically documents and verifies service delivery information, such as date, time, service type and location for certain Medicaid service visits.
- Once a provider or Financial Management Services Agency (FMSA) has ensured an EVV visit passes all validation edits they may reference the time recorded in the EVV system to determine billable units/hours.

# EVV Claims

- For STAR Health, EVV is required for Personal Care Services and CFC PAS and Habilitation.
  - For a list of all current programs and services requiring EVV refer to:
    - State-Required Personal Care Services (PDF)
    - Cures Act Home Health Care Services (PDF)
- EVV-relevant claims for programs required to use EVV, must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and are subject to the EVV claims matching process performed by the EVV Aggregator.
- Providers and FSMAs must verify all data elements on EVV claims, including times entered in the EVV system, prior to submitting to EVV Aggregator.
- Providers and FMSAs must ensure the appropriate authorization has been received prior to services being rendered and billed on the claim.
- TMHP submits daily files directly to Superior for all accepted EVV transactions and claims.
- EVV Claims are analyzed by the EVV Aggregator in accordance with EVV data matching requirements before claim adjudication.

# EVV Claims

- Bill Units Using the rounded “Pay Hours” calculated in the EVV vendor System.
  - Example: If client was serviced for 48 minutes, .75 units (rounds down to 45 minutes) should be billed. If a client was serviced 52 minutes (round up to 1 hour), 1 full unit should be billed for the respective visit.
- All Unit Increments should be billed in the following format after rounding:

| Service Time | Units |
|---|---|
| 60 minutes | 1 |
| 45 minutes | .75 |
| 30 minutes | .50 |
| 15 minutes | .25 |
| 0 minutes | 0 |

# EVV Claims

- The EVV Aggregator conducts validation on data from the EVV visit transaction verifying the data on the billed claim matches the visit data in the EVV portal before forwarding the claim to Superior for adjudication.
- To prevent claim denials, providers and FMSAs should verify the EVV visit transaction is accepted before billing.
- When billing claims, providers and FMSAs must verify the data elements billed match the data listed in the EVV portal.
- EVV claim line items must display a match status code of EVV01, listed in the EVV Portal, in order for EVV claims to be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.

# EVV Claims

- EVV claims must match an accepted EVV transaction with the following data elements:
  - NPI or Atypical Provider Identifier (API)
  - Date of Service
  - Medicaid ID
  - HCPCS Codes
  - Modifier(s), if applicable
  - Units (a requirement only for program providers, not CDS)
- All CDS claim line items billed without matching EVV visit transactions will result in denials.

# Pharmacy

# Pharmacy Benefits

- Pharmacy Benefit Manager (PBM)
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
- Centene Pharmacy Services (CPS)
  - Responsible for review of prior authorizations for prescriptions, as applicable.
- Superior utilizes the Vendor Drug Program (VDP) formulary and the Preferred Drug List (PDL) to determine whether a prior authorization is required. Authorization requirements may be determined on the PDL.
  - View the VDP Formulary webpage.
- For more information, please see the *Pharmacy Resource Guide and Benefit Overview (PDF)* on Superior's Provider Pharmacy Resources webpage.

# 72-Hour Emergency Prescription

- A pharmacy may dispense a 72-hour (3 day) supply of medication to any member awaiting a prior authorization or medical necessity determination if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy may dispense an emergency 72-hour prescription if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

# DME and Medical Supplies – Pharmacy Providers

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

# Pharmacy Contact Information

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - Online Form: Visit Superior's Contact Us webpage
- Pharmacy benefit prior authorization requests (Centene Pharmacy Services)
  - Authorization Requests Phone: 1-866-399-0928
  - Authorization Requests Fax: 1-833-423-2523
- Biopharmacy/Clinician Administered Drugs (CAD) Rx administration (Superior Authorizations Department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superior Appeals Department)
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168

# Quality Improvement

# Quality Improvement

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

# Cultural Sensitivity

- Superior encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with members, and the health and wellness of the members themselves.
- Providers and their staff should address Medical Consenters, Caregivers, DFPS staff and members with dignity sensitivity and respect.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
  - Knowledge
    - Provider's self-understanding of race, ethnicity and influence
    - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns
  - Skills
    - Ability to communicate effectively with the use of cross-cultural interpreters
    - Ability to utilize community resources
  - Attitudes
    - Respect the importance of cultural forces
    - Respect the importance of spiritual beliefs

# Resources

- Complimentary Interpretation Services
  - Superior offers interpretation services to providers at no cost.
  - To access telephonic interpreters for your members or to schedule an in-person interpreter, please contact Superior's Member Services department.
    - Contact information can be found on Superior's Phone Directory webpage.
- Trainings and Information:
  - The Culture, Language and Health Literacy provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions and special populations.
    - For more information visit Health Resources & Services Administration (HRSA) Addressing Health Literacy webpage
  - EthnoMed contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
    - For more information visit the EthnoMed website
  - For information about cultural and linguistic competency and available language services visit Superior's Health Equity Program webpage.

# Abuse, Neglect and Exploitation

# Abuse, Neglect and Exploitation (ANE)

- Abuse:
  - Intentional mental, emotional, physical or sexual injury to a child with disabilities or failure to prevent such injury.
- Neglect:
  - An act or failure to act by a person responsible for a child's care, custody, or welfare evidencing the person's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger, rather than a substantial risk, to the child's physical health or safety.
- Exploitation:
  - Misuse of a child with disabilities for personal or monetary benefit. This includes taking Social Security or SSI checks, abusing a joint checking account and taking property and other resources.

# How to Report ANE

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

# How to Report ANE

- HHSC
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities
    - Assisted living facilities
    - HCSSAs – also required to report any HCSSA allegation to DFPS
    - Day care centers
    - Licensed foster care providers
  - Phone: 1-800-458-9858
  - Local Law Enforcement:
    - If a provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.

# Fraud, Waste and Abuse

# Fraud, Waste and Abuse

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
  - Visit the HHSC OIG website 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
    7700 Forsyth Boulevard
    Clayton, MO 63105
    1-866-685-8664

- Examples of fraud, waste and abuse include:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid of CHIP ID

# Health Passport

# Health Passport

- Health Passport is a secure web-based application built using core clinical and claims information to deliver relevant health-care information when and where it is needed.
- Medical Consenters, providers, DFPS caseworkers and STAR Health staff may have access to the information.
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination
  - Eliminate waste
  - Reduce errors
- It is important to note that the data in the Health Passport is not a person's complete medical record, but it does contain information on patient demographics such as: doctor visits for which claims have been submitted, allergies, lab test results, immunizations, and filled medications.
- To log on to Health Passport, visit Superior's Secure Provider Portal.
- For additional information and access to training, visit Superior's Health Passport webpage.

# Health Passport Benefits

There are many benefits to using Health Passport, including:

- Improving care coordination by connecting authorized providers, state agencies, and medical consenters with health information from various facilities and clinicians.
- Allowing providers and other appropriate persons to monitor compliance with prescription regimens.
- Reducing risk of harmful interactions between medication, allergies, and/or chronic health problems.
- Increasing communication between the main stakeholders in the patient's care plans.
- Allowing non-clinical member advocates (selected state employees and medical consenters) to review portions of a patient's general health history and doctor visits to best understand and respond to the child's needs — physical, behavioral health, and medication needs.

# Health Passport Features

Once you are logged in, you will be able to see:

- **Face Sheet** – An easy-to-ready summary that includes member demographics, care gaps, Texas Health Steps and Dental last visit dates, active allergies, active medications, etc.
- **Contacts** – Find a member's PCP, Medical Consenter, Caregiver, assigned Caseworker and Service Coordinator's contact information in one place.
- **Allergies** – View allergies that are available at the point of care.
  - Once an allergy is charged, it is instantly checked for medication interactions.
- **Assessments** - Upload and view documents including, but not limited to Texas Health Steps, Dental and Behavioral Health online.
- **Growth Chart** - View the weight, height, length, and head circumference to track growth of infants and children.
- **Immunizations** – Access a comprehensive list of a patient's immunizations collected from ImmTrac.
- **Labs –** Access all patient lab results.
- **Medication History –** A summary of medications filled along with indicators representing drug-drug, drug allergy and drug-food interactions.
- **Patient History** – Past visits with details that include the description of service, treating provider, diagnosis, and the service date.
- **ADT Notifications Module** – Access Admit Discharge and Transfer (ADT) data.
- **Appointments** – View appointments for patients.

# Health Passport Contact Information

- If you are interested in a live demonstration, contact your Account Manager to schedule a visit.
- If you need additional Health Passport help, contact the Health Passport Support Desk:
  - Call: 1-866-714-7996
  - Email: Tx.PassportAdministration@SuperiorHealthPlan.com

# Superior HealthPlan Departments

# Contact Us

- Account Management:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - For questions, please contact your designated Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services: 1-877-391-5921
  - Questions on claim payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 6:00 p.m. CST
- Member Services: 1-866-912-6283
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Available Monday – Friday, 8:00 a.m. to 5:00 p.m. CST

# Thank you for attending!

Thank you for your commitment to serving the needs of Children in Texas Foster Care.

- For additional information, please visit Superior's STAR Health website.

- For questions, please contact your local Account Manager. To access their contact information visit, Find My Account Manager or on the *Contact Us* section of Superior's website.

Let us know what we can do to help!