STAR Kids

Provider Training

Introductions and Agenda

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Superior HealthPlan

Who is Superior HealthPlan?

- Superior HealthPlan:
  - Is a subsidiary of Centene Corporation providing healthcare for Medicaid and CHIP members across Texas.
  - Superior has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
  - Contracted with the State of Texas to provide all Medicaid lines of business, including:
    - STAR/CHIP
    - STAR Kids
    - STAR+PLUS
    - STAR Health (Foster Care)
    - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - 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.

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STAR Kids Overview

What is STAR Kids?

- STAR Kids is a health insurance program designed for children with disabilities, special needs or chronic conditions, who are age 20 or younger.
- Services include all Medicaid Benefits, including prescription drugs, primary and specialty care, hospital care, Personal Care Services (PCS), Private Duty Nursing (PDN), therapies, medical supplies and equipment, and behavioral health services.
- Superior offers STAR Kids in the following service areas: Bexar, Hidalgo, Lubbock, West, El Paso, Nueces, and Travis.

STAR Kids Program Objectives

- Provide Medicaid benefits that are customized to meet the health care needs of recipients through a defined system of care.
- Better coordinate care of recipients.
- Improve health outcomes.
- Improve access to health services.
- Achieve cost containment and cost efficiency.
- Reduce administrative complexity.
- Reduce potentially preventable events, including out-of-home residential care, through provision of care management and appropriate services.
- Establish a health home.
- Coordinate with long-term services and supports provided outside the health plan.
- Provide a plan for transitioning provision of benefits from STAR Kids to STAR+PLUS when the member turns 21.

STAR Kids Eligibility

- Medicaid populations who must participate in STAR Kids include children and young adults 20 years of age and younger who receive:
  - Social Security Income (SSI) and SSI-related Medicaid
  - SSI and Medicare
  - Medically Dependent Children Program (MDCP) waiver services
  - Youth Empowerment Services (YES) waiver services
  - Intellectual and Developmental Disabilities (IDD) waiver services (e.g., CLASS, DBMD, HCBS, TxHmL)
  - Those who reside in community-based Intermediate Care Facility/Individuals with an Intellectual Disability (ICF-IID) or in Nursing Facilities
- Individuals excluded from participating in STAR Kids include:
  - Adults 21 years of age or older
  - Children and young adults 20 years of age and younger enrolled in STAR Health
  - Children and young adults 20 years of age and younger who reside in the Truman Smith Children's Care Center or a state veteran's home

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STAR Kids Medicaid Managed Care Benefits

STAR Kids Program Benefits

- Include, but are not limited to:
  - Medical and Surgical Services
  - Hospital Services
  - Texas Health Steps
  - Transplants
  - Prescriptions (Unlimited)
  - Therapy – Physical (PT), Speech (ST), Occupational (OT)
  - Durable Medical Equipment (DME)
  - Mental and Behavioral Health Services
    - Mental Health Rehabilitation Services
    - Mental Health Targeted Case Management
  - Maternity Services
  - Long Term Services and Supports (LTSS)
  - Telemonitoring, Telehealth and Telemedicine Services

Behavioral Health Benefits

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

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
  - Texas Medicaid & Healthcare Partnership (TMHP) Texas Medicaid Provider Procedures Manual

STAR Kids LTSS Services

- LTSS services available to all STAR Kids members:
  - Community First Choice (CFC)
  - Day Activity Health Services (DAHS) (Only members 18 or older)
  - Financial Management Services
  - PCS
  - PDN
- LTSS services available to MDCP members only:
  - Adaptive Aids
  - Employment Assistance
  - Flexible Family Supports
  - Minor Home Modifications
  - Respite Care
  - Supported Employment
  - Transitional Assistance Services

Community First Choice

- CFC is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities.
- CFC services are available for members who:
  - Are eligible for Medicaid and enrolled in STAR Kids or STAR Health
  - Need an institutional level of care:
    - Intermediate Care Facility for Individuals with ICF/IID
    - Nursing Facility
    - Institution for Mental Disease (IMD)
  - Need services provided in the CFC program
- CFC services include
  - Personal Assistance Services (PAS)
  - Habilitation
  - Emergency Response Services (ERS)
  - Support Management

Community First Choice

- CFC assessments will be conducted by Superior or the Local Intellectual & Developmental Disabilities Authority (LIDDA).

- If the PCP determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination and request an assessment.

- CFC services should be billed either directly to Superior or through TMHP if Electronic Visit Verification (EVV) validation is required. Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the Texas Health and Human Services Commission (HHSC) STAR Kids billing matrix.

Home and Community-Based Services (HCS) Waiver

- Provides individualized services to individuals who qualify for ICF/IID level of care.
- Services include adaptive aids, minor home modifications, dental treatment, nursing, supported home living, respite, day habilitation, residential services, employment assistance, supported employment and professional therapies.
- Professional therapies include PT, OT, ST and language pathology, audiology, social work, behavioral support, dietary services and cognitive rehabilitation therapy.
- Financial management services and support consultation are available to individuals who use the Consumer Directed Services (CDS) option.

Community Living and Assistance Support Services (CLASS) Waiver

- Provides home and community-based services to persons having a diagnosis of a “related condition” by a licensed physician qualifying them for placement in an ICF/IID.
  - A related condition is a disability other than an intellectual disability (ID) or mental illness which originates before 22 years of age, and is found to be closely related to the ID because the condition substantially limits life activity; similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID.
  - Services in the CLASS Waiver include Skilled Nursing, Support Family services, Employment Assistance and Specialized Therapies
- Financial management services and support consultation are available to individuals who use the CDS option.

Deaf, Blind, Multiple Disability (DBMD) Waiver

- Provides home and community-based services as an alternative to residing in an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness and who have an additional disability.
- Services available to individuals receiving the DBMD waiver include:

Case Management	Day Habilitation	Residential Habilitation	Respite
Supported Employment	Prescriptions	Financial Management Services	Adaptive Aids/Medical Supplies
Assisted Living	Audiology Services	Behavioral Support	Chore Services
Dental Treatment	Dietary Services	Employment Assistance	Intervener
Minor Home Modifications	Nursing	Orientation and Mobility	Physical, Speech, Hearing and Language Therapy
Transition Assistance Services			

- Support consultation is also available to individuals who use the CDS option.

Medically Dependent Children Program (MDCP) Waiver

- Available to members who meet income, resource and medical necessity requirements for nursing facility level of care, include services unavailable under the state plan, as a cost-effective alternative to living in a nursing facility.
- Support families caring for children and young adults who are medically dependent.
- Encourage de-institutionalization of children in a nursing facility.
- MDCP waiver services:
  - Adaptive aids*
  - Minor home modifications*
  - Transition assistance services
  - Employment assistance*
  - Flexible family support services*
  - Financial management services*
  - Respite services*
  - Supported employment*

**These services are available through the CDS option. Pursuant to SB 1207, all services will soon be available through CDS.*

Texas Home Living (TxHML) Waiver

- Provides selected services and supports for individuals who qualify for ICF/IID level of care and live in their family homes or their own homes.
- Services provided through the TxHML waiver includes:

Adaptive Aids	Minor Home Modifications	Behavioral Support	Dental Treatment
Nursing	Community Support	Respite	Day Habilitation
Employment Assistance	Supported Employment	Specialized Therapies	Physical Therapy
Occupational Therapy	Speech and Language Pathology	Audiology	Dietary Services

- Financial management services and support consultation are available to individuals who use the CDS option.

Youth Empowerment Services (YES) Waiver

- Program for children and young adults 3 to 19 years of age that are at risk of hospitalization because of serious emotional disturbance.

- Allows for more flexibility in the funding of intensive community-based services for children and adolescents 3 to 19 years of age with serious emotional disturbances and their families.

Value-Added Services (VAS)

- Over-the-Counter (OTC) quarterly benefit
- Home Delivered Meals following discharge from acute inpatient hospital stay
- Extra-Curricular Activity
- In Home Respite care services (Non-MDCP)
- Sports/School physicals
- CDS Reward for members in Bexar and Hidalgo
- My Health Pays® Rewards Program
- 24/7 Nurse Advice Line

Restrictions and limitations may apply. For a complete and up-to-date list of VAS, please review the **Value-Added Services for Superior STAR Kids Members** section found on Superior's Plan Benefits, Services, & Co-Pays webpage.

STAR Kids Transportation Benefits

- Superior's Medical Ride Program provides transportation to non-emergency health-care appointments for STAR Kids 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.

Call Center:	1-855-932-2318
Hours:	8:00 a.m. – 5:00 CST p.m. Monday-Friday
Where's My Ride:	1-855-932-2319
Hours:	4:00 a.m. – 8:00 p.m. CST Monday-Saturday
Medical Providers ONLY:	1-855-932-2322
Hours:	8:00 a.m. – 6:00 p.m. Monday-Friday

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

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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.
- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider.

PCP Responsibilities

- Update contact information to ensure accurate information is available in Provider Directories.
- Report all encounter data on a CMS 1500 form or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Sign Form 2601 to verify medical necessity for MDCP services.
- 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.
  - 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
  - True emergency services
  - Case management for children and pregnant women
  - Behavioral Health
  - Vision
  - Well woman annual examination

Referrals for Non-Capitated Services

- Non-capitated services are excluded from covered services; however, STAR Kids members may be eligible to receive from 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 Department of Family and Protective Services (DFPS) Nurse-Family Partnership (NFP)
- Claims for non-capitated services should be submitted directly to the HHSC Claims Administrator for reimbursement.

Physician Certification (2601) – STAR Kids

- HHSC requires a Screening and Assessment Instrument (SAI) assessment to be conducted when a STAR Kids or STAR Health member is released from the HHSC interest list for HCBS in the MDCP.
- Following the assessment, Superior will supply the medical provider with the Physician Certification (2601) (Medical Necessity [MN] Form), certifying that the STAR Kids or STAR Health member meets nursing facility level of care.
- The MN Form is the physician's certification of medical necessity for the member's need for ongoing services under the supervision of a physician.
- Services can be provided in the home, community-based setting or a nursing facility.
- Services include, but are not limited to, Minor Home Modifications (MHM), Respite Services, Flexible Family Support Services, Transition Assistance Services, Adaptive Aids, Supported Employment, CFC Services and Employment Assistance.

Physician Certification (2601) – STAR Kids

- The medical provider's signature is required only at initial request of STAR Kids or STAR Health MDCP services, and any significant Change in Condition (CIC). TMHP will grant final approval for STAR Kids or STAR Health MDCP services.
- The MN Form must be signed and obtained from a Physician (MD), Osteopathic Medicine (DO) or Military Physician, who has examined the member and reviewed the medical record within the last 12 months. The provider must be a Medicaid provider.
- The physician is certifying that the member meets the nursing facility level of care, and that the member would benefit from the additional services that are provided under the HCBS program.

Physician Certification (2601) – STAR Kids

- Providers have 5 Business Days from the initial request to submit the form.
  - If not received within the timeframe, Superior will complete additional attempts to obtain the signature
  - If no response if received, the member is notified, and Superior will notify the Program Support Unit at HHSC
- For additional information:
  - Call 1-844-433-2074
  - Review the *Physician Certification (2601 Form) FAQs (STAR Kids and STAR Health) (PDF)*, located in the *Member Management* section of Superior's Provider forms webpage.

Behavioral Healthcare Provider Expectations

- 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.
- Refer members with known or suspected physical health problems or disorders to their PCP for examination and treatment.
  - Behavioral health providers may provide physical health services if they are within the scope of their license.
- Contact members who have missed appointments within 24 hours to reschedule.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities.
- 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.

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Texas Health Steps Requirements

Texas Health Steps Overview

- Comprehensive preventive care program that combines diagnostic screenings, communication and outreach, and medically necessary follow-up care, including dental, vision and hearing examinations for Medicaid-eligible children, adolescents and young adults under 21 years of age.
- Age-appropriate screenings must include but are not limited to:
  - Nutrition
  - Developmental
  - Autism
  - Mental Health
  - Vision
  - Hearing
  - Tuberculosis
  - Lead
  - Sexually Transmitted Diseases
- For complete Texas Health Steps exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule webpage.

Required Elements of Checkup

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

Please note: Each of the components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule must be completed and documented in the member's medical record. Any component or element not completed must also be noted in the medical record along with the reason why and the plan to complete it.

Checkup Requirements

- Members new to Superior:
  - Within first 90 calendar days (unless documentation of previous checkup is provided).
- Existing members:
  - Follow periodicity schedule on the Texas Health Steps Medical Checkups Periodicity Schedule webpage.
  - Members under 3 years of age have multiple checkups within each year; 6 outpatient checkups in the first year.
  - Members over 3 years of age have an annual checkup which must occur within 364 days following their birth date.

Texas Health Steps Medical Checkups

- Children may need more frequent medical checkups when:
  - The physician determines the checkup is “medically necessary.”
  - There is a high risk of the child getting sick (e.g., if another child in the home has a high level of lead in the blood).
  - A child enters Head Start, day care, foster care or pre-adoption.
  - The child needs anesthesia for required dental services.

Missed Appointments

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

Texas Health Steps Outreach and Informing

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

Children of Traveling Farm Workers

- HHSC defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health-care needs, provide direct education about the health care system and the services available, and arrange appointments and transportation.
- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed helpful pieces of information to ensure these children get the health-care services they need.
- The referral process for providers who provide care to Superior members who are children of traveling farm workers is to direct the parent to call Member Services for assistance on program benefits or to help schedule an appointment by calling 1-844-590-4883.

Refusal of Exam

- Superior is required to log all member refusal for service to HHSC.
- The refusal should be recorded in the member's medical record and communicated to Superior's Member Services department at:
  - 1-844-590-4883
- If a member indicates that their exam was previously done, Superior will:
  - Look for that claim in our system, and if there is no claim on file, will contact the provider of service to verify the member's statement.

Oral Evaluation and Fluoride Varnish

- This program will allow STAR Kids members who are 6 months to 35 months of age to receive an oral evaluation and fluoride varnish during medical checkups.
  - Limited to 10 fluoride treatments.
  - Providers must be certified to provide oral evaluations and fluoride varnishes.
  - Once a provider has completed the training, he or she will need to submit certification to his or her Superior Account Manager.
  - The training information is available on the, along with the registration form on HHSC's Oral Health Program webpage.
  - The provider should bill with procedure code 99429 and modifier U5 with the diagnosis codes Z00121 or Z00129.

Blood Lead Level Reporting

Texas Childhood Lead Poisoning Prevention Program (TXCLPPP):

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms visit Texas Health Steps Medical Checkups Periodicity Schedule webpage.

Enrollment and Training

- Enrollment as a Texas Health Steps Provider must be completed through TMHP's website.
- Training from the HHSC is mandatory for Texas Health Steps Providers.
- Free continuing education hours are available at Texas Health Steps webpage.

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Service Coordination and Transition Planning

Service Coordination

- Service Coordinator role
  - Clinical and non-clinical support
    - 24/7/365 accessibility to STAR Kids staff via the Member Services at: 1-844-590-4883
    - Identification of member's needs
    - Referrals/pre-authorizations/certifications
    - Communicate with doctor and other providers to develop an Individual Service Plan (ISP)
    - Conduct mandatory telephonic and/or face to face contacts
    - Coordinate care with other entities to ensure integration of care
  - Direct support
    - Coordinate care for members with special health-care needs
    - Monitor adherence to treatment plan
    - Coordinate discharge planning
    - Assist with transition plan
    - Promote best practice/evidence-based services
    - Identify and report potential abuse/neglect

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
- LMHA
- WIC
- NEMT

Transition Planning

- STAR Kids Members have more complex needs and may need extra assistance to prepare for being an adult. In addition to having to face the same transition issues as their peers, transition issues for these youth can also include:
  - What will their level of independence allow?
  - Are they receiving any services that end at age 21?
  - Do they receive services from pediatric providers?
  - What kind of guardianship documentation is needed starting at age 18?
  - Is there a back up plan for critical service?
- A Transition Specialist will assist the Member/LAR in thinking through all the issues in transitioning to adulthood, setting goals, and planning for life as an adult. They will also build a timeline of specific actions to address the priorities of the member (such as finding a job, going to college, making friends, etc.)

Transition Planning

- Members receiving MDCP Services, CFC, PCS, or PDN have additional transition considerations.
- Each year beginning at age 15, the transition specialist will discuss with members receiving PDN or MDCP that these pediatric services are not available to adults.
  - For those receiving PDN the STAR+PLUS HCBS program or an IDD waiver will need to cover medically necessary nursing services that are not intermittent or part time beginning at age 21.
  - The level of nursing the member may be able to receive may not be the same as they received through STAR Kids.
- Twelve months prior to the member turning 21, the transition specialist will meet face to face with STAR Kids MDCP members and those receiving >50 hours of PDN per week to discuss the STAR+PLUS HCBS program and explain that PCS are available through STAR+PLUS.
  - All other members receiving services will still be contacted on a quarterly basis.
- Nine Months prior to the member turning, 21, the Program Support Unit (PSU) will mail a STAR+PLUS enrollment packet with a list of MCOs and a comparison chart. The member will then need to select the MCO with which they want to enroll.
- The Service Plan will be monitored every 90 days until the member turns 21.

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Prior Authorizations

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 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 & Phamracy Policies webpage.

Therapy Treatment Authorizations

- Prior authorization is not required for initial evaluations or re-evaluations for Physical Therapy, Occupational therapy or Speech Therapy (PT/OT/ST).
- Providers must include specific information when submitting therapy prior authorization requests for Medicaid 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 on the *Therapy Documents and Policy Clarification* section of Superior's Provider Forms 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 2 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.

Acute Care Services Requiring PA

- Some common acute services that require authorization are:
  - DME items with a purchase price > $500
  - Enteral nutrition
  - Home health/Skilled Nursing/Private Duty Nursing
  - Hearing aids
  - Orthotics/prosthetics
  - Non-emergent ambulance transportation
  - Pre-scheduled admissions for elective procedures
  - Therapy (physical, occupational and speech)
- Existing authorizations for acute services will be honored for up to 90 Calendar Days or until the end of the authorization or until Superior conducts a new assessment.
- Hospitals must notify Superior of all emergent admissions no later than the close of the next Business Day.
  - Prior authorization is not required for emergency services, urgent care services and post-stabilization services.
- For a full and current list of acute services that require authorization, visit Superior's Provider Forms webpage.

LTSS Authorizations

- All LTSS require authorization:
  - Personal Attendant Services (PAS)
  - Day Activity and Health Services (DAHS) (available for > 18 years of age)
  - MDCP - Employment assistance/supported employment
  - Cognitive Rehabilitative Therapy
  - CFC
  - PDN
  - PCS
- Existing authorizations for LTSS will be honored for 6 months, or until Superior conducts a new assessment.

Evolent/National Imaging Associates (NIA)

- Evolent, formerly known as National Imaging Associates (NIA), is contracted with Superior to perform utilization review for:
  - High-Tech Imaging Services
  - Genetic and Molecular Testing
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
- 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 authorization has been obtained. Failure to do so may result in non-payment of claims.
- Prior authorization requirements for facility and radiology may also be applicable.
- Turning Point's Procedure Coding and Medical Policy Information can be located under *Billing Resources* on 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

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Pharmacy Benefits

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 prior authorization of 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 HHSC's VDP formulary webpage.
- For more information, review the *Pharmacy Resource Guide and Benefit Overview (PDF)* in the *Pharmacy Resources* section of Superior's Pharmacy webpage .

How to Access the Formulary/PDL

- Superior utilizes the Texas VDP formulary which is available on smartphones, tablets or similar technology on the epocrates website.
- for Preferred Drug List and clinical PA criteria please visit the Texas VDP Website.
- A copy of the criteria is available online at the PA XPRESS website.

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 are covered.

Pharmacy Contact Information

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: 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 (Superiors Appeals Department)
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168

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Quality Improvement

Quality Improvement

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, 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 website 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 is a website containing 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 more information about cultural and linguistic competency and available language services visit Superior's Health Equity webpage.

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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 or CHIP ID

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:
  - Failure to provide a child with food, clothing, shelter and/or medical care; and/or leaving a child in a situation where the child is at risk of harm. This may result in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care and personal hygiene.
- 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 Texas 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
    - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DFPS
    - Day care centers
    - Licensed foster care providers
    - Report online on DFPS's Texas Abuse Hotline website or call:
      - DADS: 1-800-458-9858
      - DFPS/APS/CPS: 1-800-252-5400
- 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.
- Superior
  - In addition to reporting to HHSC and DFPS, a care provider must report the findings within 1 Business Day to Superior.

Claims – Filing and Payment

Claims Submission

- Clean Claim – A claim submitted by a provider for healthcare services rendered to a member that contains accurate and complete 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

Claims Submission

- Visit Superior's Secure Provider Portal
- Electronic Claims:
  - For a list of our Trading Partners visit Superior's Billing and Coding webpage
  - Superior Payer ID
    - Medical Claims: 68069
    - Behavioral Health Claims: 68068
- Paper Claims - Initial and Corrected*
  - Superior HealthPlan,
    P.O. Box 3003
    Farmington, MO 63640-3803
- Paper Claims - Requests for Reconsideration* and Claim Disputes*
  - Superior HealthPlan,
    P.O. Box 3000, Farmington
    MO 63640-3800

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

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 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.

Claim Appeals

- Claim 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 received 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.

Zelis/PaySpan

- 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 (Electronic 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, call 1-877-331-7154 or email ProviderSupport@PaySpanHealth.com.

Member Balance Billing

- Providers may NOT bill STAR Kids 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 provider contract with Superior.

Ophthalmology for Medical Eye Care Services

- Superior manages all functions for ophthalmologists providing medical eye care services, including but not limited to:
  - Claim Processing and Appeals
  - Contracting/Credentialing
  - Prior Authorization
  - Retrospective Utilization Review
  - Medical Necessity Appeals
  - Provider Complaints Related to Medical Eye Care Services
  - Provider Relations/Account Management
  - Provider Services
  - Secure Provider Portal
- Envolve Vision continues to manage routine eye care services and full-scope of licensure optometric services for Superior.
- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool at Superior's Authorization Requirements webpage.

Claims – Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Service providers or 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 records the time the service provider or CDS employee begins providing services and the time the service provider or CDS employee stops providing services.
- 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 Kids, EVV is required for PCS, In-Home Respite, Flexible Family Support Services and CFC PAS and Habilitation.
  - For a list of all current programs and services requiring EVV refer to the Programs, Services and Service Delivery Options Required to Use EVV:
    - 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 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

- Units should be billed using the rounded “Pay Hours” calculated in the EVV vendor System.
  - Example: If a client was services for 48 minutes, this should be rounded down to 45 minutes and .75 units should be billed.
  - If a client was serviced for 52 minutes, this would be rounded up to 1 hour and a full unit should be billed for the 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.
- Only EVV claims with claim line items displaying a match result code of EVV01, listed in the EVV Portal, may be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.

EVV Claims

- The information on EVV claims must match EVV transactions along 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 EVV claims lines billed with mismatches between these data elements will result in denials.
    - Providers or FMSAs will be required to resubmit any denials to TMHP.

Superior's Website and Secure Provider Portal

Superior's Website and Secure Provider Portal

Visit Superior's website

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for additional Provider Resources

Visit Superior's Secure Provider Portal

Submit:

- Claims
- Request for EOPs
- Provider Complaints
- Coordination of Benefits (COB) Claims
- Corrected Claims

Verify:

- Member Eligibility
- Claim Status

Superior HealthPlan Departments

We're here to help you!

Contact Us

- Account Management:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - For any questions, please contact your Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services: 1-877-391-5921
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time
- Member Services: 1-844-590-4883
  - 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. local time

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Questions and Answers