

STAR Health

Member Handbooks Updates Effective 5/1/2022

The updates below replace the information in your Member Handbook.

NEW: MDCP/DBMD Escalation Helpline
UPDATED: Appeals
NEW: External Medical Reviews
UPDATED: State Fair Hearings
UPDATED: Member Rights & Responsibilities

MDCP/DBMD Escalation Helpline

This is new information and does not appear in the Member Handbook.

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about State Fair Hearings and continuing services during the appeal process.

When should members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call **1-844-999-9543** and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back

Appeals

The following Appeals information below replaces pages 45-47 in your Member Handbook.

How will I find out if Medicaid covered services are denied or limited? What can I do if my doctor asks for a service for me that's covered by Superior, but Superior denies or limits it?

Superior will send you a letter if a requested service is denied or limited. If you disagree with the decision, you may file an appeal.

You have the right to appeal Superior's decision if Medicaid covered services are denied, reduced, suspended or ended. You may also appeal Superior's denial of a claim, in whole or in part. Superior's denial is called an "Adverse Benefit Determination." You can appeal the Adverse Benefit Determination if you think Superior:

- Is stopping coverage for care you think you need.
- Is denying coverage for care you think should be covered.
- Provides a partial approval of a request for a covered service.

When do I have the right to ask for an internal health plan appeal?

You can ask for an internal health plan appeal within 60 Days of the date of Superior's Notice of Adverse Benefit Determination letter.

Can someone from Superior help me file an internal health plan appeal?

You, your doctor, your Medical Consenter, lawyer or another Legally Authorized Representative can request an appeal of an Adverse Benefit Determination. A Superior Member Advocate can help you with any questions you have about filing an appeal. Just call Member Services at 1-866-912-6283. Interpreter services are provided free of charge. Please call Member Services at 1-866-912-6283 (TTY 1800-735-2989) for assistance.

What are the timeframes for the internal health plan appeal process for denied Medicaid covered services?

You will have sixty (60) Days from the date of Superior's Notice of Adverse Benefit Determination letter to appeal the decision. Superior will acknowledge your appeal by sending you a letter within five (5) Business Days of receipt of your appeal, complete the review of the appeal and send you an appeal response letter within 30 Days after receipt of the initial written or oral request for appeal. Superior must complete the entire standard appeal process within 30 Days after receipt of the initial written or oral request for appeal. An additional 14 Days may be added to process the appeal, if you request an extension or Superior shows that there is a need for additional information and how the delay is in the member's interest. If more time is needed for Superior to gather facts about the requested service, you will receive a letter with the reason for the delay. If you

do not agree with Superior's decision to extend the timeframe for the decision on your appeal, you can file a complaint.

How can I continue my current authorized services while my appeal is being processed?

You can ask to continue current authorized services when you appeal Superior's Adverse Benefit Determination. To continue receiving a service that is being ended, suspended or reduced, your request to continue a service must be made within ten (10) Calendar Days of the date of Superior's Notice of Adverse Benefit Determination letter, or before the date previously authorized services will be discontinued, whichever is later.

Superior will keep providing the benefits while your appeal is being reviewed, if:

- Your appeal is sent in the needed time frame.
- Your appeal is for a service that was denied or limited that had been previously approved.
- Your appeal is for a service ordered by a Superior-approved provider.

If Superior continues or reinstates benefits at your request and the request for continued services is not approved on appeal, Superior will not pursue recovery of payment for those services without written permission from HHS.

Does my internal health plan appeal request have to be in writing?

You can call or request in writing to let us know you want to appeal Superior's Adverse Benefit Determination. You, your provider, Medical Consenter, lawyer or another Legally Authorized Representative can request an appeal and complete the appeal form on your behalf. If you have questions about the appeal form, Superior can help you. Call Superior at 1-866-912-6283 for more information.

What is an internal health plan emergency appeal?

An emergency appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your health or life.

How do I ask for an internal health plan emergency appeal? Does my request have to be in writing?

You, your provider, or your legal authorized representative can ask for an emergency appeal by calling Superior at 1-877-398-9461. Internal health plan emergency appeals do not have to be in writing.

You can ask for an internal health plan emergency appeal in writing and send it to:

Superior HealthPlan
Attn: Medical Management
5900 E. Ben White Blvd.
Austin, Texas 78741
Fax: 1-866-918-2266

What are the timeframes for an internal health plan emergency appeal? What happens if Superior denies my request for an emergency appeal?

We will notify you of the internal health plan emergency appeal decision within 72 hours, unless your appeal is related to an ongoing emergency or denial of continued hospitalization. If your appeal is about an ongoing emergency or denial of a continued hospital stay, you will be notified of the appeal decision within one (1) Business Day. If Superior determines that your emergency appeal request does not meet the emergency appeal criteria, Superior will let you know right away. Your appeal will be processed as a standard appeal with a response provided within thirty (30) Days.

Who can help me file an internal health plan emergency appeal?

Your provider, your Medical Consenter, lawyer or another Legally Authorized Representative can file an emergency appeal on your behalf. A Superior Member Advocate can help you with any questions you have about filing an emergency appeal.

External Appeals

This is new information and does not appear in the Member Handbook.

After a Medicaid member has completed the internal health plan appeal process related to an adverse benefit determination, more appeal rights are available to a member if he/she is not satisfied with the health plan's appeal decision. After the health plan's appeal decision is completed, members have additional external appeal rights, including a State Fair Hearing, with or without an External Medical Review. The details for both the State Fair Hearing and External Medical review appeal rights and process are included in the sections below.

External Medical Review

Can I ask for an External Medical Review?

If you, as a member of Superior, disagree with our internal appeal decision, you have the right to ask for an External Medical Review. An External Medical Review is an optional, extra step you can take to get the case reviewed before the State Fair Hearing occurs. You may name someone to represent you by writing a letter to Superior telling us the name of the person you want to represent you. A provider may be your representative. You or your representative must ask for the External Medical Review within 120 days of the date Superior mails the letter with the internal appeal decision. If you do not ask for the External Medical Review within 120 days, you may lose your right to an External Medical Review. To ask for an External Medical Review, you or your representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Superior's Internal Appeal

Decision letter and mail or fax it to Superior by using the address or fax number at the top of the form; or

- Call Superior at 1-877-398-9461.

If you ask for an External Medical Review within 10 days from the time you get the appeal decision from Superior, you have the right to keep getting any service Superior denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If you do not request an External Medical Review within 10 days from the time you get the appeal decision from Superior, the service Superior denied will be stopped.

An Independent Review Organization is a third-party organization contracted by HHS that conducts an External Medical Review related to Adverse Benefit Determinations based on functional necessity or medical necessity. You may withdraw your request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing your External Medical Review request. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, you have the right to withdraw the State Fair Hearing request. If you continue with the State Fair Hearing, you can also request the Independent Review Organization be present at the State Fair Hearing. You can make both of these requests by contacting Superior at 1-877-398-9461 or the HHS Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If you continue with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase your benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Superior HealthPlan. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHS, you must first complete Superior's internal appeals process.

State Fair Hearings

The State Fair Hearing information below replaces page 48 in your Member Handbook.

How can I ask for a State Fair Hearing?

You must complete the internal health plan appeal process through Superior HealthPlan prior to requesting a State Fair Hearing. **If you disagree with Superior's appeal**

decision, you have the right to ask for a State Fair Hearing from Texas Health and Human Services (HHS), with or without an External Medical Review through an Independent Review Organization (IRO). You can ask for an External Medical Review and a State Fair Hearing, but you cannot request only an External Medical Review. You may also request a State Fair Hearing with or without an External Medical Review if Superior does not make a decision on your appeal within the required time frame. You may represent yourself at the State Fair Hearing, or name someone else to be your representative. This could be a provider, your Medical Consenter, lawyer, or any other Legally Authorized Representative. You may name someone to represent you by writing a letter to Superior telling us the name of the person that you want to represent you.

You or your representative must ask for a State Fair Hearing within 120 Days of the date of the notice telling you that we are denying your internal health plan appeal.

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped.

If Superior continues or reinstates benefits at your request and the request for continued services is not approved by the State Fair Hearing officer, Superior will not pursue recovery of payment for those services without written permission from HHS.

To ask for a State Fair Hearing, you or your representative should call or write Superior:

Superior HealthPlan
ATTN: State Fair Hearings Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
1-877-398-9461

You can ask for a State Fair Hearing without an External Medical Review.

What happens after I request a State Fair Hearing?

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. You can also contact the HHS State Fair Hearing Officer if you would like the hearing to be held in-person.

During the hearing, you or your representative can tell why you need the service or why you disagree with Superior's Adverse Benefit Determination. You have the right to examine, at a reasonable time before the date of the State Fair Hearing, the contents of your case file and any documents to be used by Superior at the State Fair Hearing. Before the State Fair Hearing, Superior will send you all of the documents to be used at the State Fair Hearing. It is important that you or your representative attend the State Fair Hearing in person or by phone.

HHS will give you a final decision within 90 Days from the date you asked for the hearing.

Can I ask for an emergency State Fair Hearing?

To qualify for an emergency State Fair Hearing through HHS, you must first complete Superior's internal appeals process. If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling us at 1-877-398-9461. The State Fair Hearing officer will provide a response on your emergency State Fair Hearing request within three (3) Business Days.

Rights and Responsibilities

The following Member Right was updated and replaces the information in your Member Handbook on page 49.

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

- a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
- b. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
- c. Get a timely answer to your complaint.
- d. Use the plan's appeal process and be told how to use it.
- e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
- f. Ask for a State Fair Hearing with or without an External Medical Review from the state Medicaid program and receive information about how that process works.

The following Member Right was updated and replaces the information in your Member Handbook on page 51.

As a member of Superior HealthPlan, you can ask for and get the following information each year:

- Information on complaint, internal health plan appeal, External Medical Review and State Fair Hearing procedures.