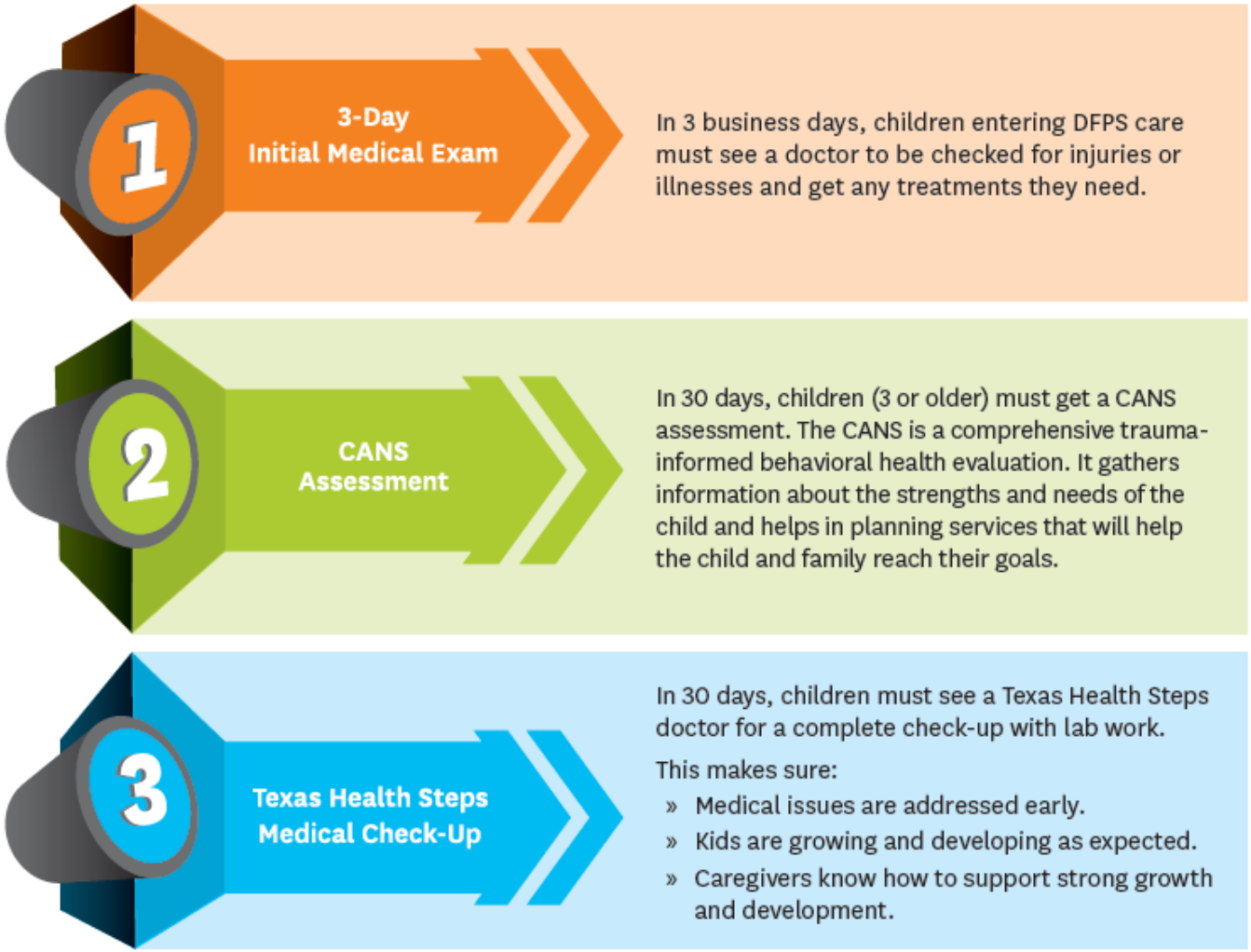
3 in 30

A Comprehensive Approach to Better Care for Children

Provider Training

3 in 30 Explained



3 in 30 Roll Out Plan

- April 1, 2018 – Regions 1, 7, 9, 10
- June 1, 2018 – Regions 2, 3E, 3W
- August 1, 2018 – Regions 4, 5, 6A, 6B
- October 1, 2018 – Regions 8, 11

Eligibility Verification

Verify Eligibility By:

- A completed DFPS 2085B Medical Consent Form
- A Superior HealthPlan Member ID Card
- Using the Superior HealthPlan Website: SuperiorHealthPlan.com
- Contacting Member Services: 1-866-912-6283

Required Exams

3-Day Medical Exam

- Applies to all youth entering foster care because it is in their best interest
- Medical screening for each child within 3 business days of removal
- Does not replace the Texas Health Steps (THSteps) medical checkup or the Child and Adolescent Needs and Strengths (CANS) Assessment

3-Day Medical Exam

- 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 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

3-Day Medical Exam Exceptions

- Child was removed from or while in a medical setting, such as a hospital
- Child was taken to the Emergency Room or Urgent Care Clinic due to emergent or urgent medical needs for immediate medical attention
- Child was removed from or while in a psychiatric or behavioral health setting

3-Day Medical Exam Components

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

Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 2.0 (Child Welfare) Assessment

- Multi-purpose tool developed with the primary objectives of permanency, safety and improved quality of life for youth in foster care
- Completed by a licensed clinician who is certified to administer the tool
- Children who are 3-17 years old at the time of removal are required to have a CANS assessment **within 30 days** of coming into care
- Children who turn 3 while in care are required to have a CANS within 30 days of their 3rd birthday
- CANS re-assessments are required annually while an eligible child remains in care
- Bill CANS assessments with 90791 and modifier TJ

What is a Texas Health Steps Medical Checkup?

- Texas Health Steps is a comprehensive preventive care program for all Medicaid-eligible children birth through age 20.
- Texas Health Steps Medical Checkups are to be performed by a licensed health practitioner who is enrolled in Texas Medicaid as a Texas Health Steps provider and in the STAR Health network. These initial screenings should also include, at a minimum:
  - Family History
  - Physical examinations
  - Dental assessment, checkup and treatments
  - Measurements (height, weight and infant head circumference)
  - Mental health assessment
  - Tuberculosis test (often called TB)
  - Laboratory tests
  - Vision and hearing screenings
  - Developmental and nutritional assessments
  - Lead screenings
  - Immunizations
  - ADHD assessments
- Reminder: Not all STAR Health PCPs are Texas Health Steps providers.

Texas Health Steps Medical Checkups

- Must be completed within 30 days:
  - When a child initially enters DFPS conservatorship
  - Does not apply to each time the child changes placement
- Texas Health Steps Medical Checkups must be completed by a STAR Health Texas Health Steps provider and documented in the Health Passport.
- Texas Health Steps Laboratory Services must be submitted to the DSHS Laboratory Services Section.

Ongoing Texas Health Steps Medical Checkups

- Children under 3 years of age require more frequent Texas Health Steps Medical Checkups.

3 – 5 days	6 months	18 months
2 weeks	9 months	24 months
2 months	12 months	30 months
4 months	15 months	

- Children 3-20 years old must have medical checkups scheduled one year after the previous checkup, and no later than the child's next birthday.
- Immunizations must be conducted according to the Advisory Committee on Immunization Practices (ACIP) routine immunization schedule.

Texas Health Steps Billing

New Client Codes	99381	99382	99383	99384	99385
Established Client Codes	99391	99392	99393	99394	99395
Follow-up Visit Code	99211				

Diagnosis Codes	
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 (18-20 yrs of age)
Z0001	General adult exam, abnormal (18-20 yrs of age)

- Refer to the Texas Health Steps Quick Reference Guide for the most up to date instructions on billing: http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf

Texas Health Steps Billing

- Use benefit code EP1
- Include 2-digit modifier to indicate practitioner
  - AM – Physician
  - SA – Nurse Practitioner
  - TD – Nurse
  - U7 – Physician Assistant
- FQHC Providers
  - Use modifier EP
- RHC Providers
  - Bill place of service 72

Additional Instructions & Billing Notes

Immunization Requirements:

- Use code Z23 to indicate when immunizations are administered
- Screen for immunization status at each checkup
- Must not refer to local health department for immunizations
- Obtain vaccines/toxoids through Texas Vaccines for Children (TVFC): www.dshs.state.tx.us/immunize/tvfc/default.shtm
- Report all vaccines to Texas Immunization Registry (ImmTrac): www.dshs.state.tx.us/immunize/immtrac/default.shtm

Additional Instructions & Billing Notes

Developmental Screenings:

- Use procedure code 96110 without a modifier
- Developmental Screening needs to be completed with either the Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS)
- ASQ is available at http://agesandstages.com/how-to-order/
- PEDS is available at www.pedstest.com/Ordering.aspx.

Autism Screenings:

- Use procedure code 96110 with modifier U6
- Autism Screening needs to be completed with the Modified Checklist for Autism in Toddlers (M-CHAT). The M-CHAT is available at: http://www2.gsu.edu/~psydlr/Diana_L._Robins,_Ph.D..html.

Additional Instructions & Billing Notes

Oral Evaluation and Fluoride Varnish:

- Bill with procedure code 99429 and modifier U5
- Must be billed on the same date as the Texas Health Step check-up, by the same provider, and is limited to 6 services per lifetime by any provider.
- Provider must be certified by the Department of State Health Services (DSHS)
- Training and registration information: www.dshs.state.tx.us/dental/OEFV_Training.shtm

Additional Instructions & Billing Notes

Documentation:

- All required components must be documented
- If unable to complete a component must document the reason and include plan for completing component
- Follow up visits must document reason(s) for visit and component(s) completed
- Screening tools should include results

Claims – Filing and Payment

Clean Claims

- Once a clean claim is received, Superior will either pay the total amount of the claim or part of the claim in accordance with the contract, or deny the entire claim or part of the claim, and notify the provider why the claim will not be paid within the 30-day claim payment period.
- Each claim payment check will be accompanied by an Explanation of Payment (EOP), which itemizes your charges for that reimbursement and the amount of your check from Superior.
- Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Superior, or the date of electronic transmission, if payment is made electronically.

Claims Filing: Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS):
  - Filed on CMS-1450/UB-04 or CMS 1500 (HCFA)
  - Filed electronically through clearinghouse
  - Filed directly through Superior's Provider Portal
- Claims must be completed in accordance with Medicaid billing guidelines.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.
- Mailing Address (paper claims):

  Superior HealthPlan
  Attn: Claims
  P.O. Box 3003
  Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Paper Claims Filing

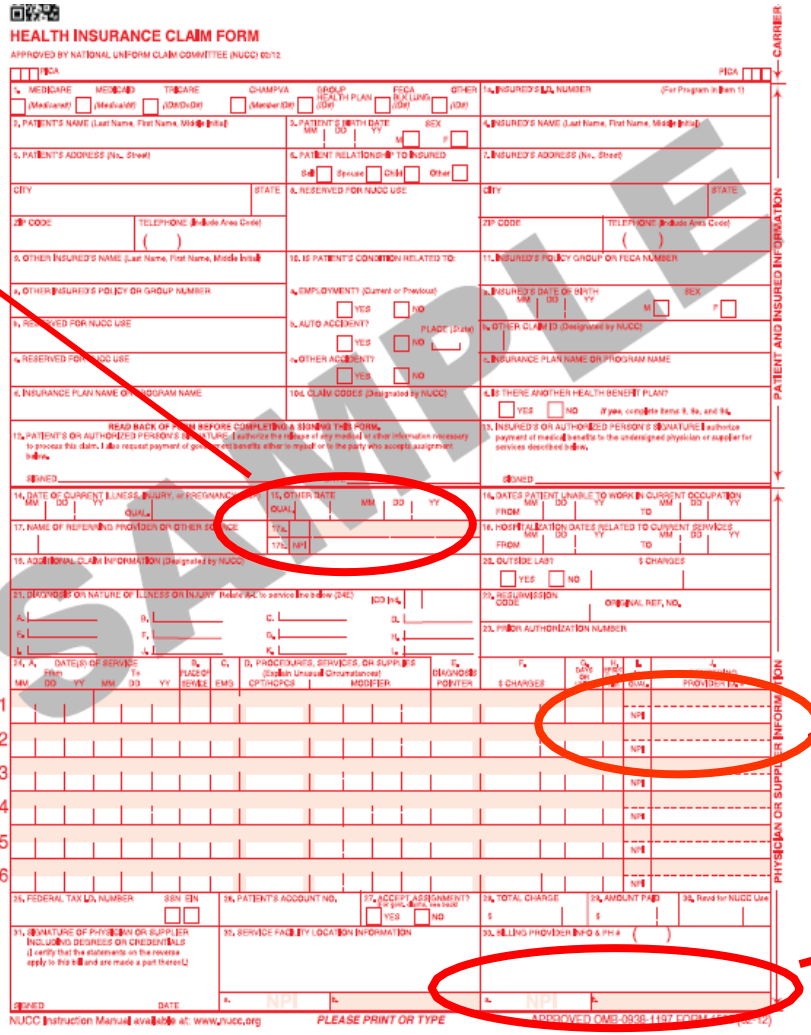
- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS 1450 or CMS 1500 red form (not a copy).
    - Handwritten claim forms are no longer accepted.
  - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

CMS 1500 (HCFA) Form

Referring Provider: [C]

17 Name of the referring provider and

17b NPI



Rendering Provider: [R]

Place your NPI (National Provider Identifier #) in box 24J (Unshaded) and Taxonomy Code in box 24J (shaded).

These are required fields when billing Superior claims.

If you do not have an NPI, place your API (Atypical Provider Identifier #/LTSS #) in Box 33b.

Billing Provider: [R]

Billing NPI# in box 33a and Billing Taxonomy # (or API # if no NPI) in 33b.

Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - Visit the web for a list of our Trading Partners: https://www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
  - Superior Emdeon ID 68069
  - Behavioral Health Emdeon ID 68068
  - For questions, contact EDI: EDIBA@Centene.com
- 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 3003
  Farmington, MO 63640-3803

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

Electronic Claims Filing

Superior will not pay any claim submitted by a provider, if the provider:

- Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- Is on payment hold under the authority of HHSC or its authorized agent(s).
- Has provided neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

**In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be reimbursed under state or federal law.*

Claims Filing: Deadlines

- First Time Claim Submission
  - 95 days from date of service
- Adjusted or Corrected Claims
  - 120 days from the date of Explanation of Payment (EOP) or denial is issued
- Claim Reconsiderations and Disputes
  - 120 days from the date of EOP or denial is issued

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 days from the date of adjudication or denial.
  - **Adjusted or Corrected Claim**: The provider is changing the original claim.
  - **Correction to a Prior Claim**: Finalized claim that was in need of correction as a result of a denied or paid claim.
  - **Claim Appeals**: Often require additional information from the provider.
    - **Request for Reconsideration**: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - **Claim Dispute**: Provider disagrees with the outcome of the request for reconsideration.
- Claim Adjustments/Corrections and Submissions can be processed through the Provider Portal or a paper claim.
  - Paper claims require a Superior Corrected Claim or Claim Appeal form.
    - Find claims forms under **Provider Resources>Forms** at: https://www.SuperiorHealthPlan.com/providers/resources/forms.html

Corrected Claims

- A Corrected Claim is a correction of information to a previously finalized clean claim.
  - For example – Correcting a member's date of birth, a modifier, Dx code, etc.
  - The original claim number must be billed in field 64 of the CMS 1450 form or field 22 of the CMS 1500 form.
  - The appropriate frequency code/resubmission code should also be billed in field 4 of the CMS 1450 form or field 22 of the CMS 1500 form.
  - A Corrected Claim Form, found in the Provider Manual, may be used when submitting a corrected claim.

Corrected Claims Filing

- A Corrected Claim is a correction or a change of information to a previously finalized clean claim in which additional information from the provider is required to perform the adjustment.
- Corrections can be made but are not limited to:
  - Patient Control Number (PCN)
  - Date of Birth (DOB)
  - Date of Onset
  - X-Ray Date
  - Place of Service (POS)
  - Present on Admission (POA)
  - Quality Billed
  - Prior Authorization Number (PAN)
  - Beginning DOS
  - Ending DOS or Discharge Date

Corrected Claims Filing

- Must reference original claim number on EOP within 120 days of adjudication paid date.
- Can be submitted electronically, through your clearinghouse/EDI software or through Superior's Provider Portal.
- Corrected or adjusted paper claims can also be submitted with a Corrected Claim Form attached and sent to:

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

Claims Appeal Form

- 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 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

Payspan

- Superior has partnered with 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 at: Payspan.com
- 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.
- Members do not have co-payments.
- Additional details can be found in your Superior provider contract.

Secure Provider Portal

Superior Website & Secure Provider Portal

SuperiorHealthPlan.com

Submit:

- Claims
- Prior Authorization Requests
- Request for EOPs
- Provider Complaints
- Notification of Pregnancy
- COB Claims
- Adjusted Claims

Verify:

- Member Eligibility
- Claim Status

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for Additional Provider Resources
- Claim Editing Software

How to Register for the Provider Portal

- Provider.SuperiorHealthPlan.com.
- Enter your provider/group name, tax identification number, individual's name entering the form, office phone number and email address.
- Create user name and password.
- Each user within the provider's office must create their own user name and password.
- The provider portal is a free service and providers are not responsible for any charges or fees.

Provider Portal: Eligibility

- Search for eligibility using:
  - Member's date of birth
  - Medicaid/CHIP/DFPS ID number or last name
  - Date of service
- View/print patient list:
  - Member panel
  - Member care gap alerts
  - Both can be downloaded in Excel or PDF format

Provider Portal: Authorizations

- Create Authorizations
  - Enter the patient's member ID/last name and DOB and click "Find."
  - Populate the six (6) sections of the authorization with the appropriate information starting with the service type section.
  - Follow the prompts and complete all required information.
  - Attach any required documentation, review and submit.
- Check Authorization Status
  - Enter web reference number and click "Search." Please allow at least 24 hours after submission to review status.
  - View authorization status, id number, member name, dates of service, type of service and more.
  - To view all processed authorizations, click "Processed" and to view any authorizations with errors, click "Errors."

Note: Authorizations update to the web portal every 24 hours.

Provider Portal: Claims

- Claim Status
  - Claims update to the web portal every 24 hours.
  - Status can be checked for a period of time going back 18 months.
- View Web Claims
  - Click on the claims module to view the last three (3) months of submitted claims.
- Unsubmitted Claims
  - Incomplete claims or claims that are ready to be submitted can be found under “Saved” claims.
- Submitted Claims
  - Status will show “in progress,” “accepted,” “rejected” or “completed.”

Provider Portal: Claims

- Create Claims
  - Professional, institutional, corrected and batch.
- View Payment History
  - Displays check date, check number and payment amount for a specific timeframe (data available online is limited to 18 months).
- Claim Auditing Tool
  - Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
  - Proactively determine the appropriate code/code combination representing the service for accurate billing purposes.
  - Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

Additional Provider Portal Information

- Online Assessment Forms
  - Notification of pregnancy
- Resources
  - Practice guidelines and standards
  - Training and education
- Contact Us (Web Applications Support Desk)
  - Phone: 1-866-895-8443
  - Email: TX.WebApplications@SuperiorHealthPlan.com

Provider Portal Highlights

- Manage all product lines and multiple TINs from one account
  - Office Manager accounts available
- PCP Panel - Texas Health Steps last exam date
- Eligibility section for providers
- Authorization detail & history
  - New display features: Authorization denial reason
- Submit batched, individual or recurring claims
- Download EOPs
- Secure messaging
- Refer members to Case Management
- Review member alerts/care gaps

Superior HealthPlan Departments

We're here to help you!

December 2016

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - Office visits to review quality performance reports
- Superior Account Management offers targeted billing presentations depending on the type of services you provide. For example, we offer general billing and Texas Health Steps trainings.

Note: You can find a map at https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html that can assist you with contact information for your Account Manager.

Provider Services

- Provider Services can help you with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims related questions, have your claim number, TIN and other pertinent information available to meet HIPAA validation requirements.
- Contact Provider Services, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time:
  - 1-877-391-5921

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Answering questions
    - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
      - **STAR Health: 1-866-912-6283**

Provider Contracting

- Network Development and Contracting is a centralized team that handles all contracting for new and existing providers to include:
  - New provider contracts
  - Adding providers to existing Superior contracts
  - Adding additional products (i.e. CHIP, STAR, STAR+PLUS) to existing Superior contracts
  - Amendments to existing contracts
- Contract packets can be requested at: https://www.SuperiorHealthPlan.com/providers/become-a-provider.html

Provider Credentialing

- Initial Credentialing:
  - Complete a TDI credentialing application form for participation
  - Complete an electronic application
  - Provide Council for Affordable Quality Healthcare (CAQH) identification number
  - Email applications to SHP.NetworkDevelopment-Medicaid@SuperiorHealthPlan.com
- Re-credentialing:
  - Completed every three (3) years from date of initial credentialing
  - Applications and notices are mailed at 180, 120, 90 and 30 days out from the last day of the credentialing anniversary month
  - Lack of timely submission can result in members being re-assigned and system termination
  - Email applications to Credentialing@SuperiorHealthPlan.com
- All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686, ext. 22281 or Credentialing@SuperiorHealthPlan.com.

Provider Complaints

- A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to the Superior. Superior offers a number of ways to file a complaint, as listed below:
  - Mail:

    Superior HealthPlan
    ATTN: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741

  - Fax:

    1-866-683-5369

  - Online:
    https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html

Requesting Assistance

- STAR Health 1-866-439-2042
- DentaQuest (Dental Services) 1-888-308-9345
- Envolve Benefit Options (Vision Services) 1-866-642-9488

Health Passport Clinical Training Guide

Provider Training

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.
- 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

Health Passport: Modules

- Face Sheet—An easy-to-read summary that includes member demographics, care gaps, Texas Health Steps (TH Steps) and last dental visit dates, active allergies, active medications and more.
- Contacts—Easily find a foster child's Primary Care Provider (PCP), medical consenter, caregiver, caseworker and service coordinator contact information in one place.
- Allergies—Providers can use interactive fields to add or modify allergies at the point-of-care. Once an allergy is charted, it's instantly checked for medication interactions.
- Assessments—Providers can document TH Steps, dental and behavioral health forms directly online. Mailing or faxing in documents critical to patient care for display is still available.
- Growth Chart—Providers can chart weight, height, length and head circumference at the point of care to track growth of infants and children.

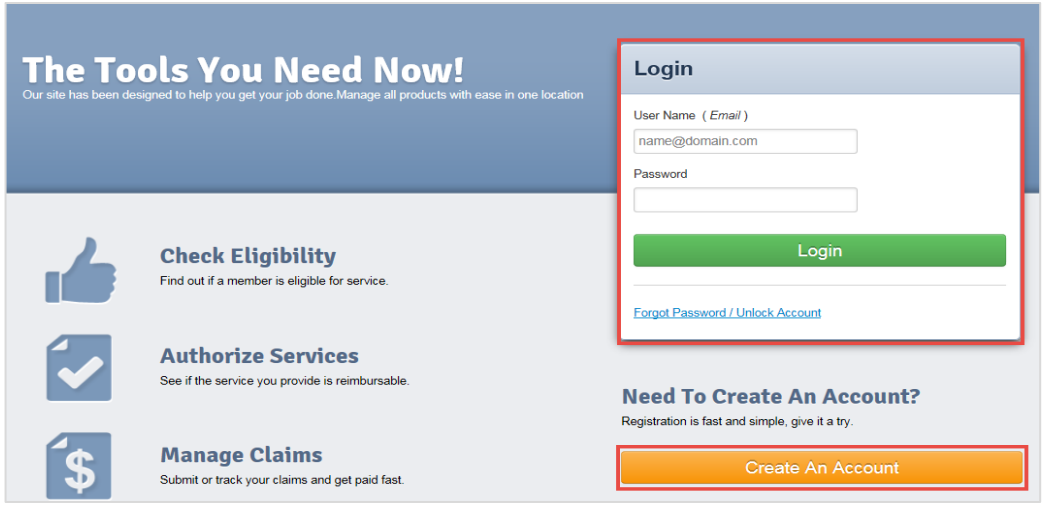
Health Passport: Modules

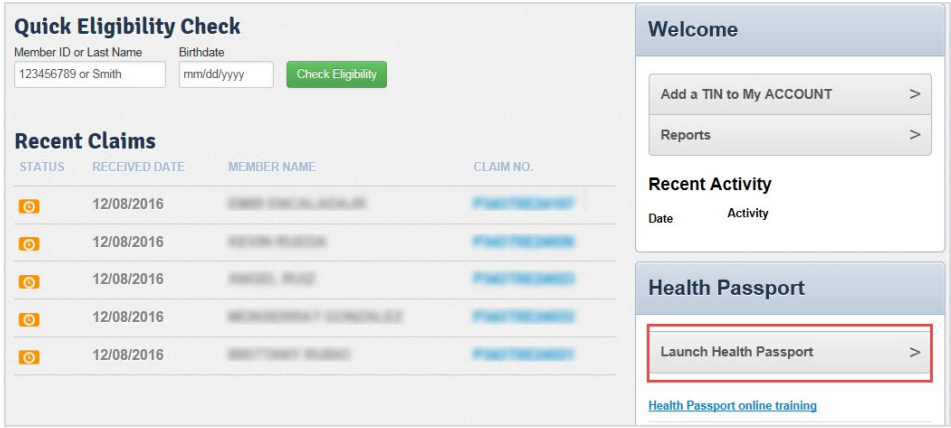
- Immunizations—A comprehensive list of a person's immunizations collected from ImmTrac.
- Labs—All lab results are made available, where providers typically only have access to the lab results they've requested.
- Medication History—A summary of medications filled and access to more detail, including name of the prescription, the prescribing clinician, date filled, and dosage. Indicators representing drug-drug, drug-allergy and drug-food interactions appear, when applicable, as soon as new medications or allergies are added to the member record.
- Patient History—Past visits with details that include the description of service, treating provider, diagnosis and the service date.
- Appointments—On this module, users are able to add, modify and cancel their own appointments entries.

Provider Access Setup

- **Step 1:** Go to Superior's Secure Provider Portal.
- **Step 2:** To **Login**, enter the **Username** (email) and **Password** you created during registration. If you need to create an account, click the **Create an Account** button to register.

- **Step 3:** To access Health Passport, click the **Launch Health Passport** button from your account homepage.

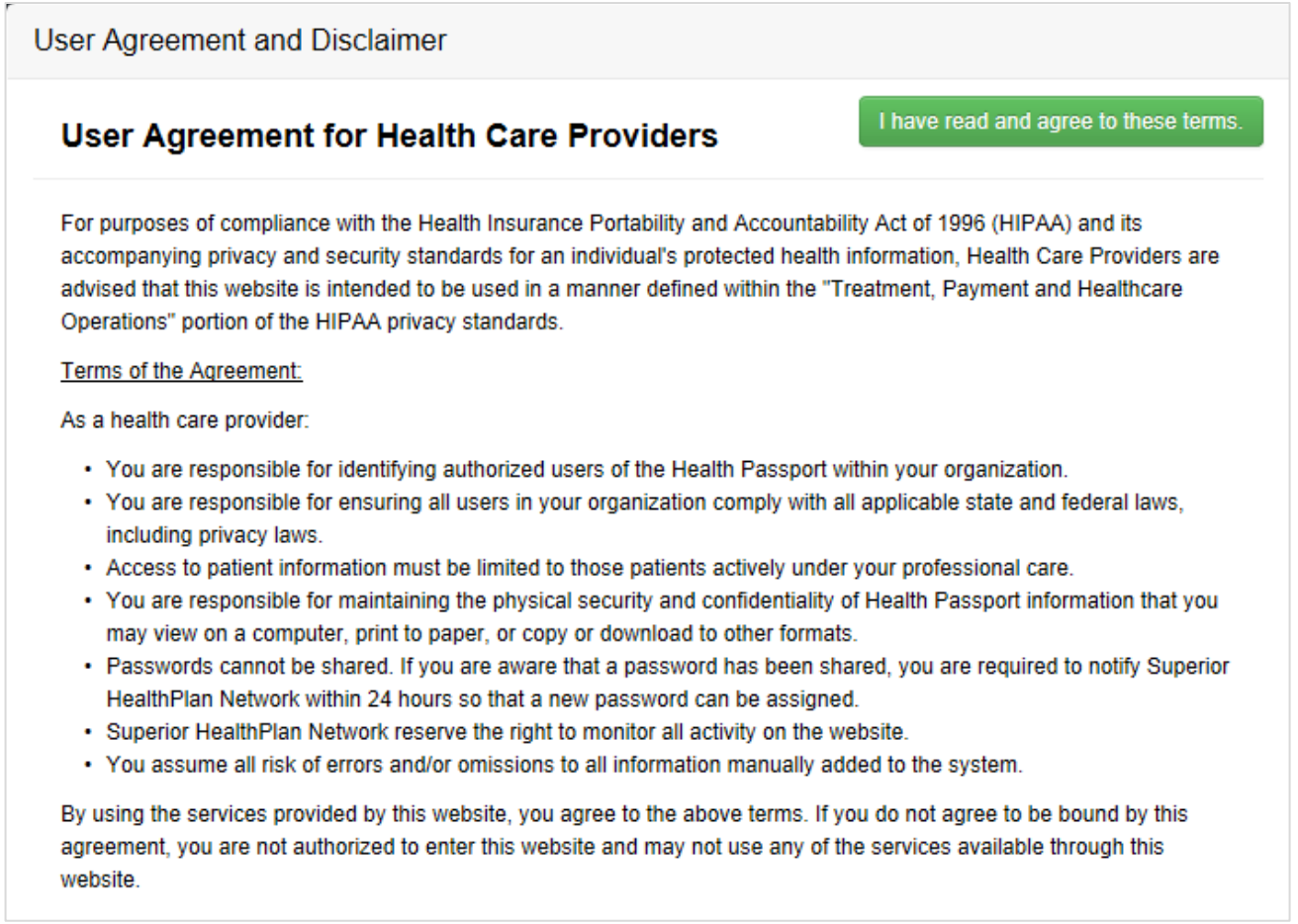




Disclaimer

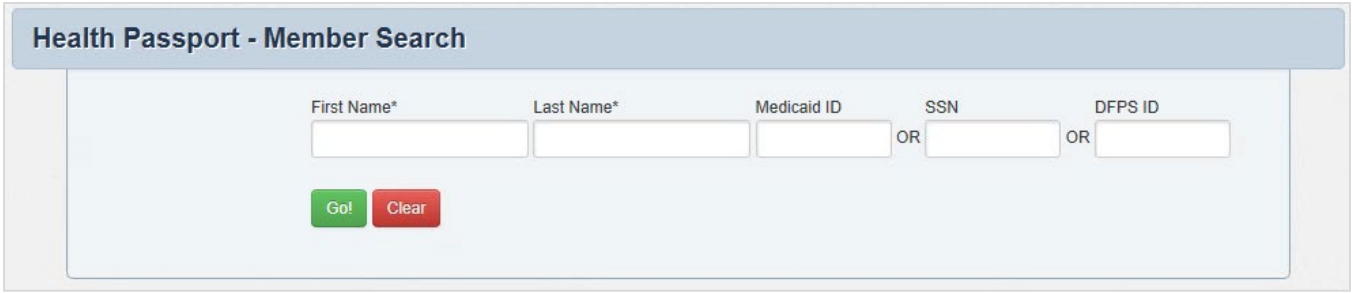
The User Agreement and Disclaimer will appear.

Once you have read the agreement, click **I have read and agree to these terms** to continue.



Member Search

- To search a member, enter the first few letters of the first and last name and one of the three ID numbers (Medicaid ID, SSN, or DFPS ID) and click **Go**.

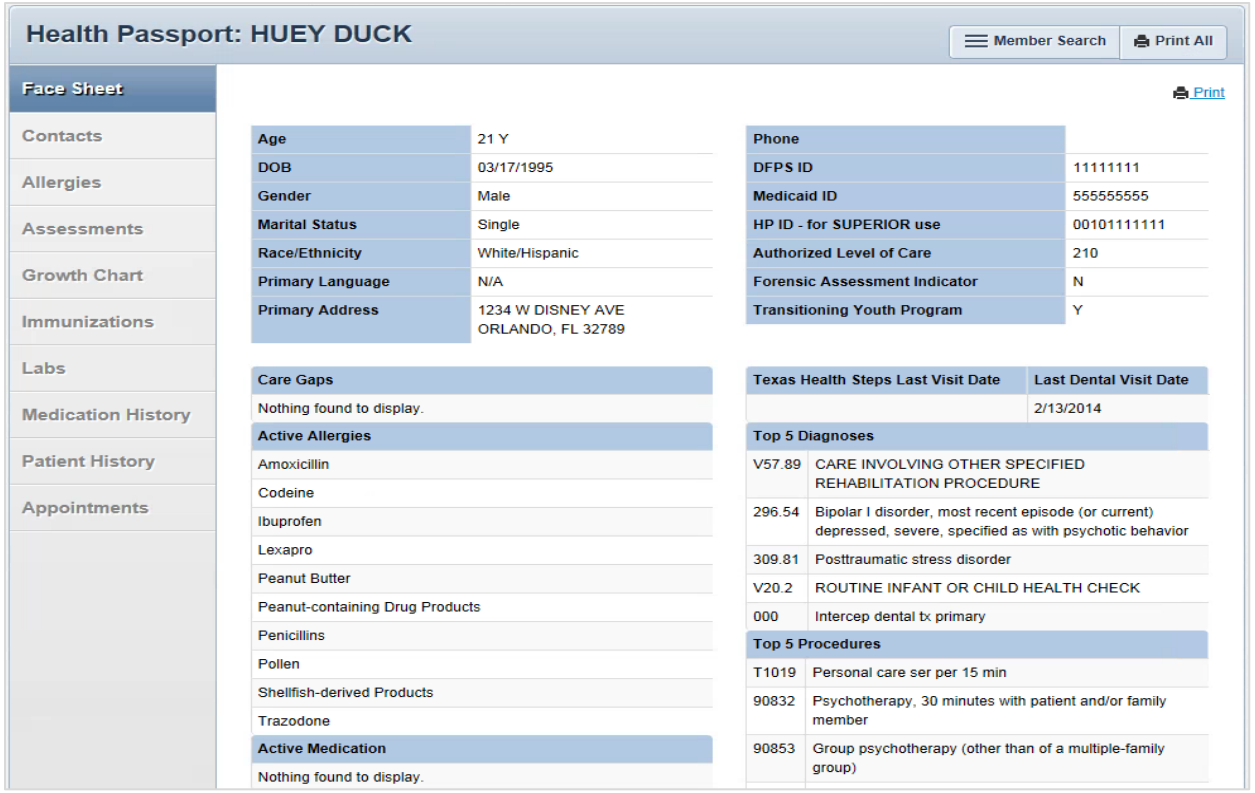


- The search results will display the full name of the member and other demographic information.

- Click the member name to access the member's health record.

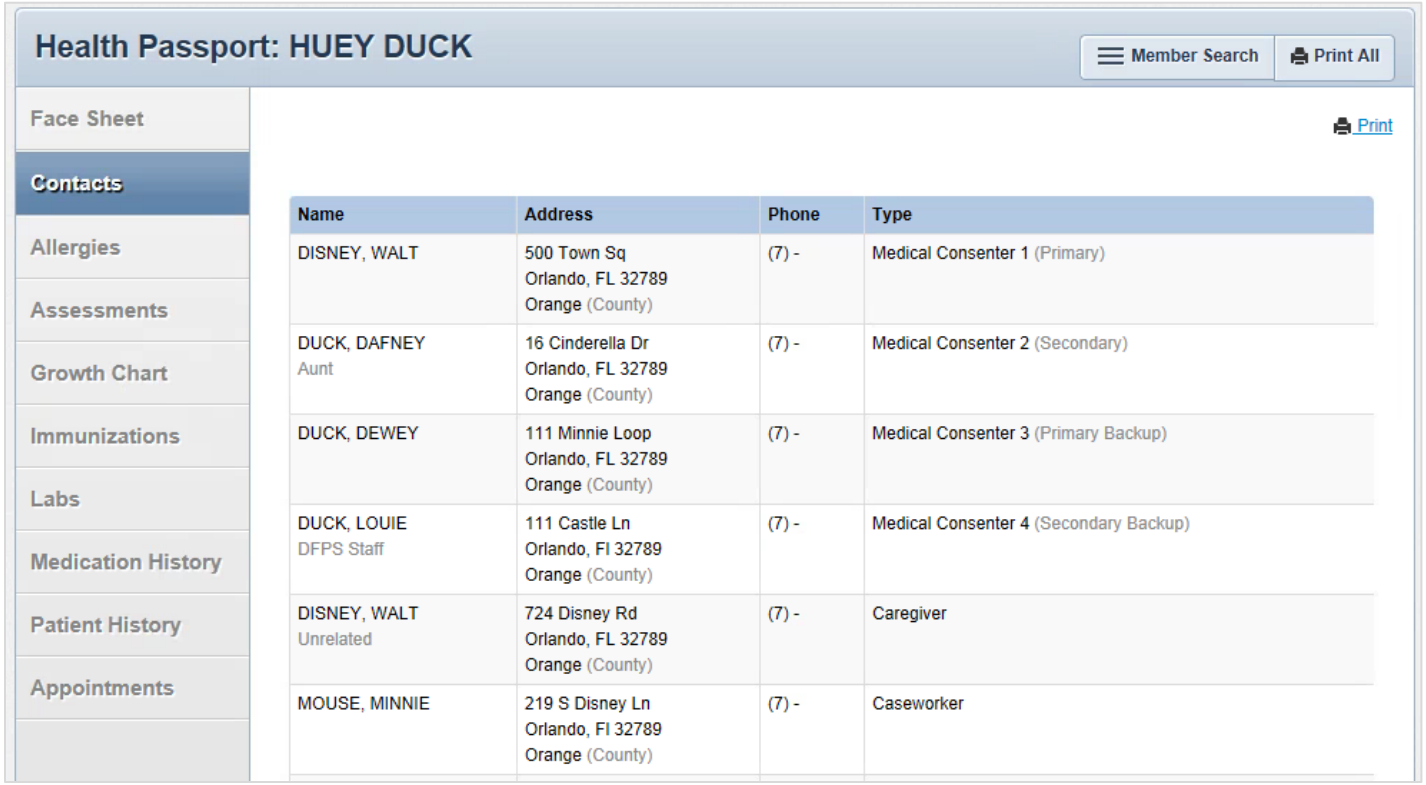
Face Sheet

This module provides a quick overview of the member's health record, including common diagnoses and procedures, active medications, active allergies, care gaps and member demographics.



Contacts

This module displays a member's medical and personal contacts.

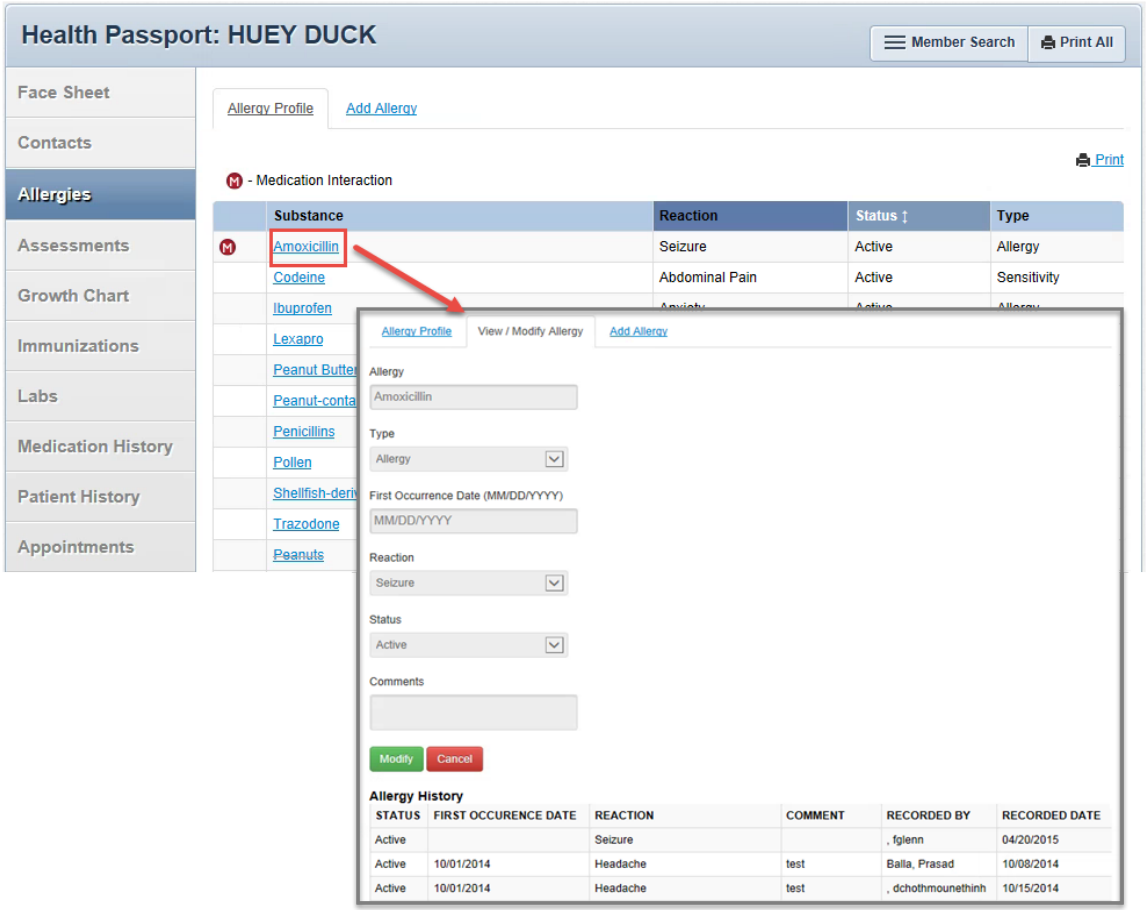


Note: Caregivers are not necessarily considered medical consenters.

Allergies

This module contains all allergies for a member entered by providers.

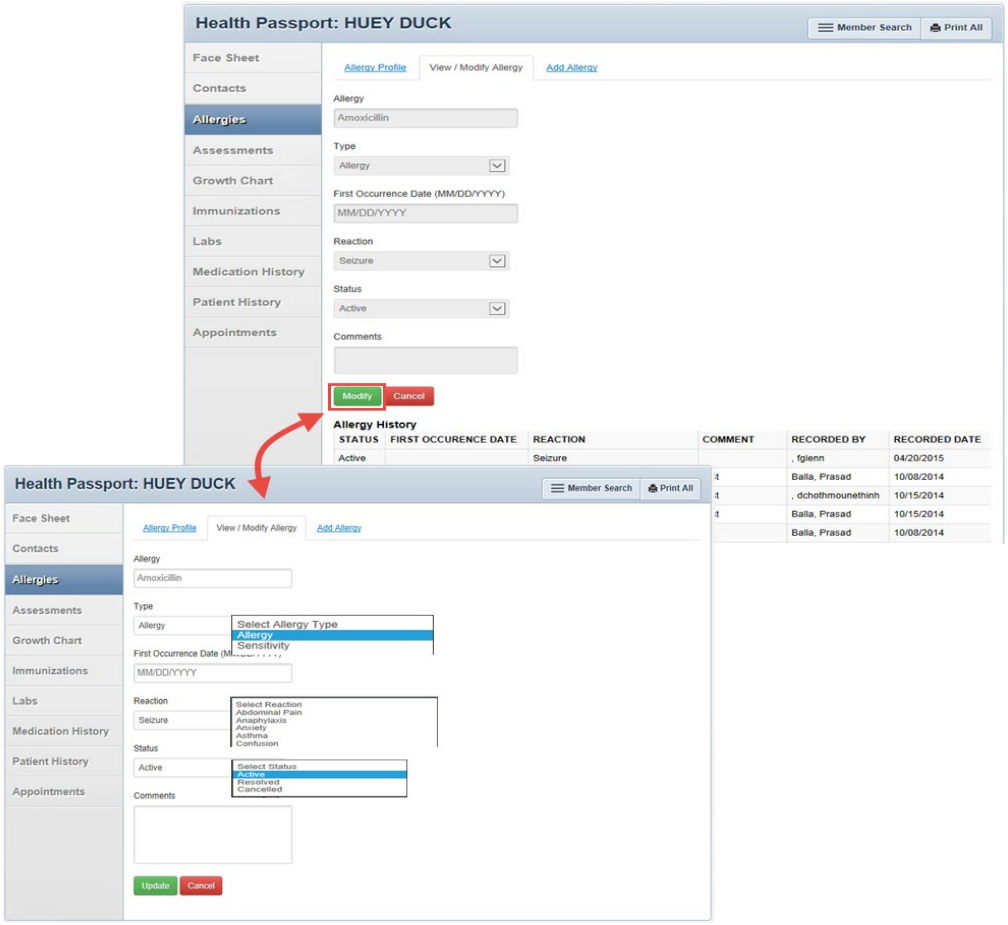
- Click the allergy name to view the allergy history.
- Ⓜ Indicates an interaction with a prescribed medication.
- If an allergy has a comment associated with it, an asterisk (*) appears next to the allergy name.
- The strikethroughs indicate:
  - Resolved status—an allergy the member no longer experiences.
  - Canceled status—an allergy that could be mistakenly entered.



Modify Allergy

Providers have the ability to modify allergies.

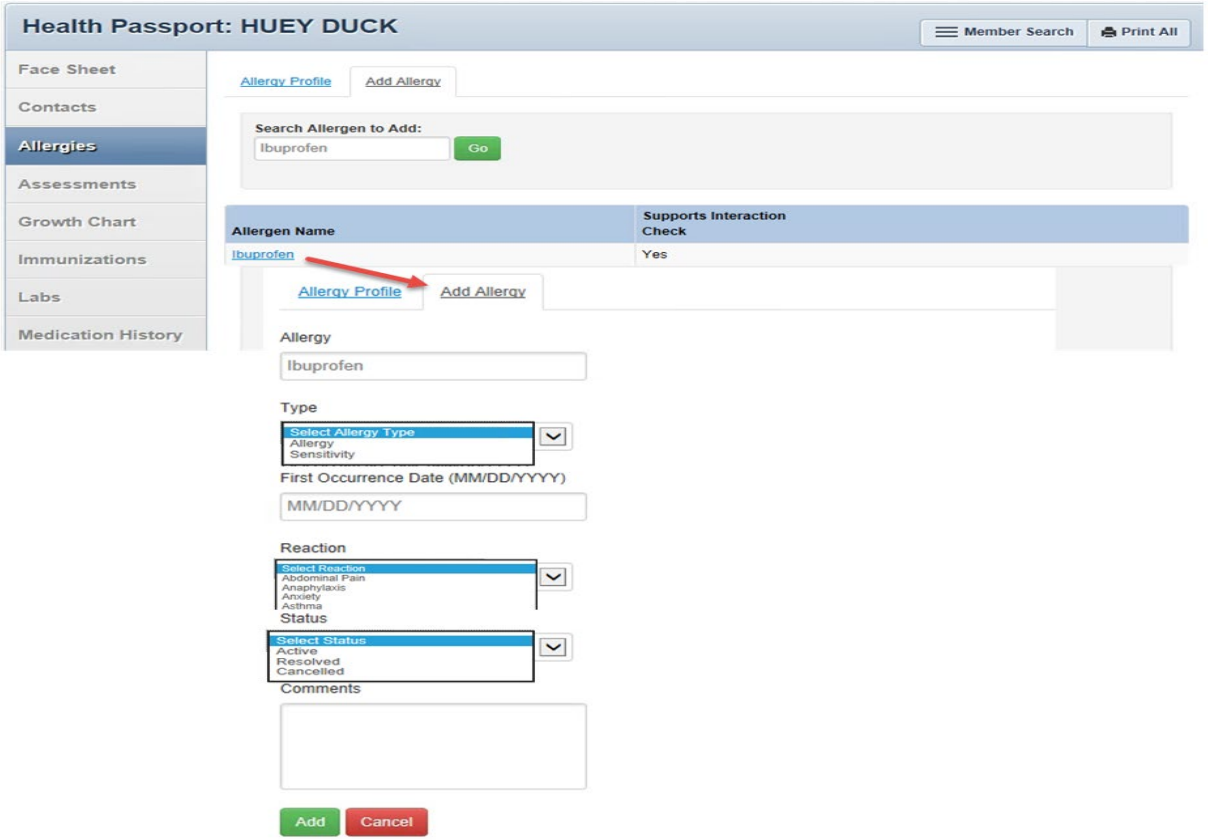
- **Step 1:** Click **Modify**.
- **Step 2:** Modify allergy name, type, occurrence date, reaction, status, or comments.
- **Step 3:** Click **Update** to save changes.



Add Allergy

Providers have the ability to add an allergy.

- **Step 1:** Search for an allergen and click **Go**. If not found, use the **Add Free Text Allergen** box.
- **Step 2:** Select allergy name, type, occurrence date, reaction, status and include comments, as applicable.
- **Step 3:** Click **Add** to save changes.

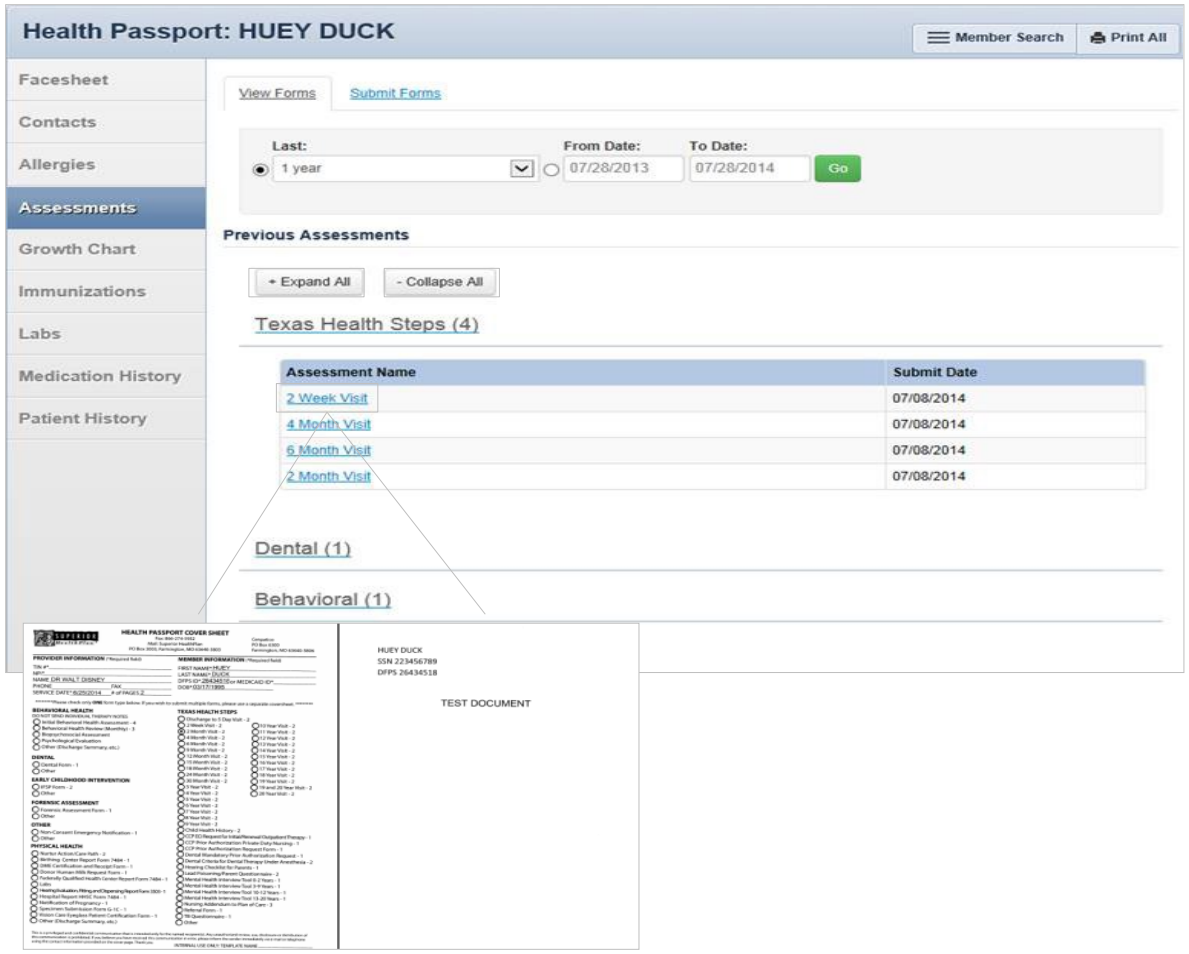


Assessments

This module allows providers to document Texas Health Steps, Dental and Behavioral Health forms directly online. Mailing or faxing in documents critical to patient care for display is also available.

- Click on form name to open the document.
- Expand or collapse all forms by clicking the **Expand All** and **Collapse All** buttons.

Fax: 1-866-274-5952
Mail: Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

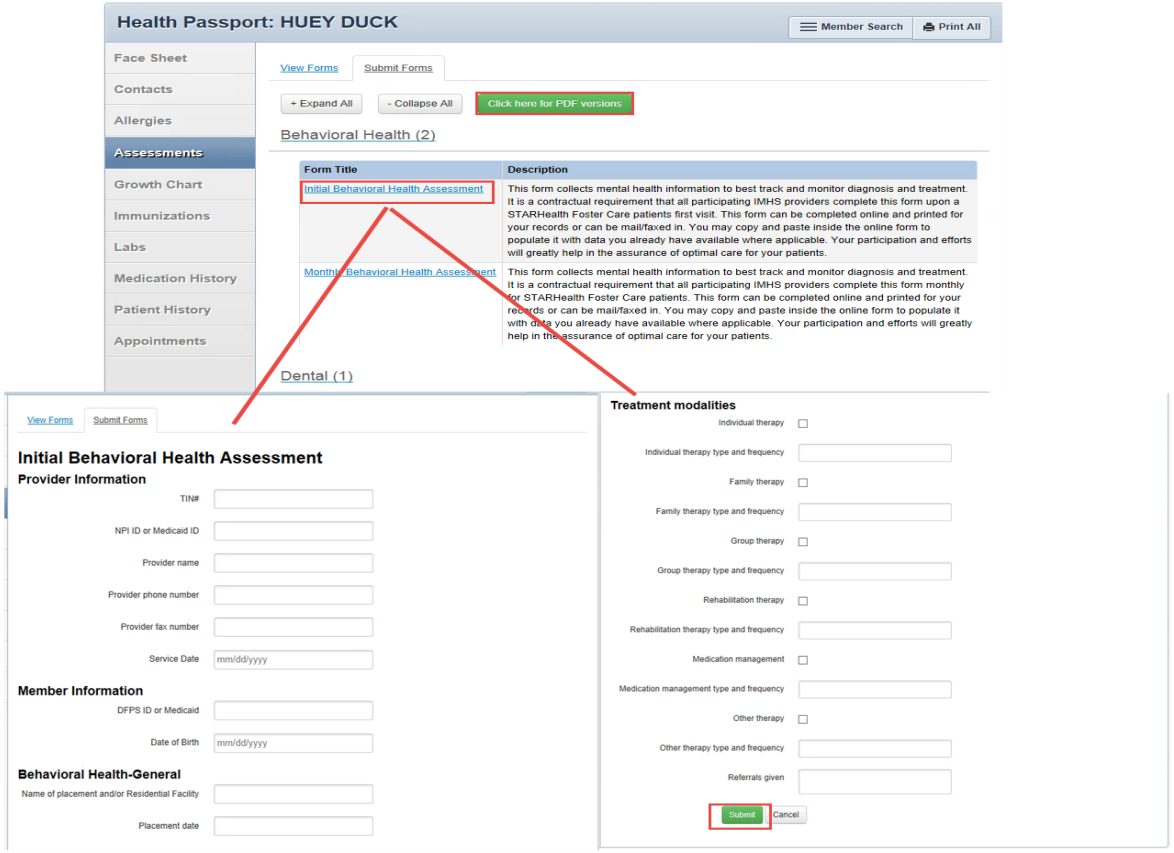


Submit Forms

To complete and submit forms, click on the **Submit Forms** tab.

- **Step 1**: Open a form by selecting the **Form Title**.
- **Step 2**: Fill in all relevant information.
- **Step 3:** Click the **Submit** button.

Click **PDF versions** to be directed to the Health Passport Forms section on the FosterCareTX.com, where a blank form can be printed.

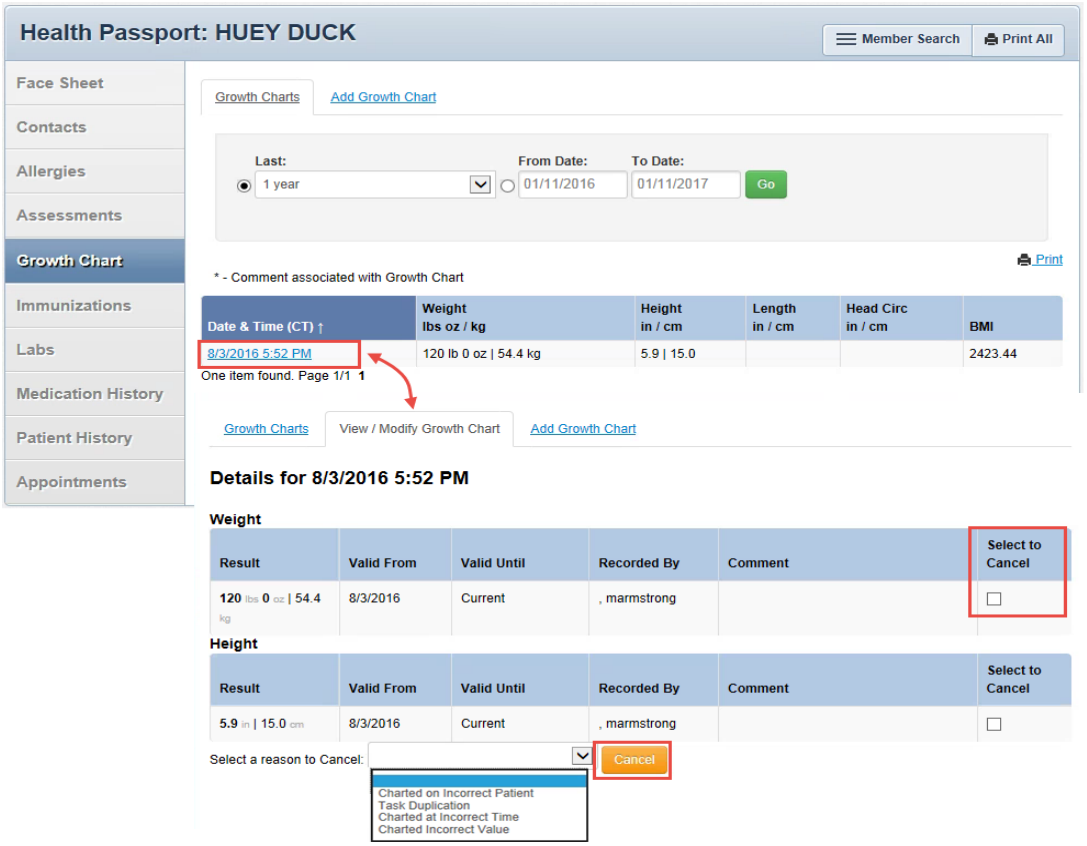


Growth Chart

This module contains height, weight, length, and head circumference entered by providers and calculates BMI, when applicable.

- Click a date and time to view details for that date.
- An asterisk (*) indicates there is a comment associated with the entry.

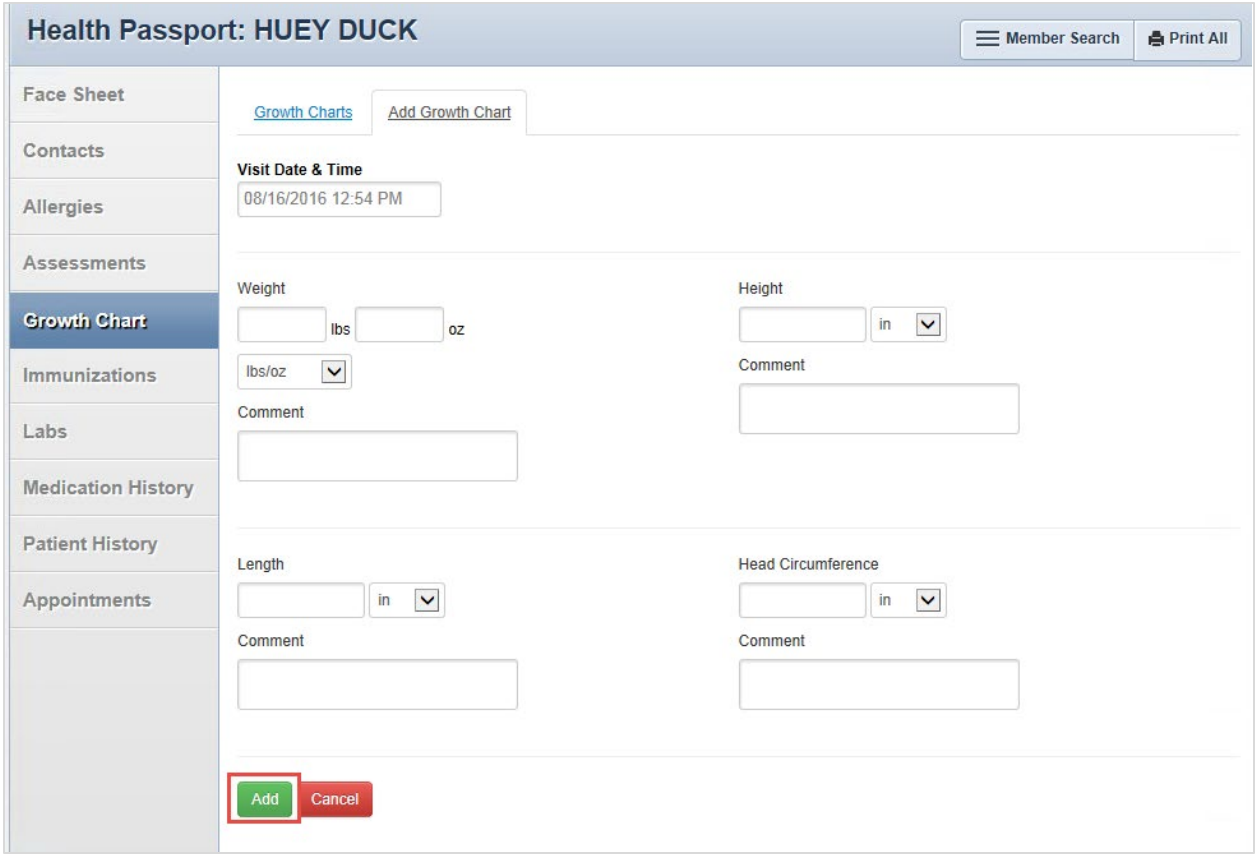
Modify chart by clicking the box **Select to unchart**, select a reason to unchart, and then click **Unchart**. A strikethrough will appear in place of uncharted entries.



Add a Growth Chart

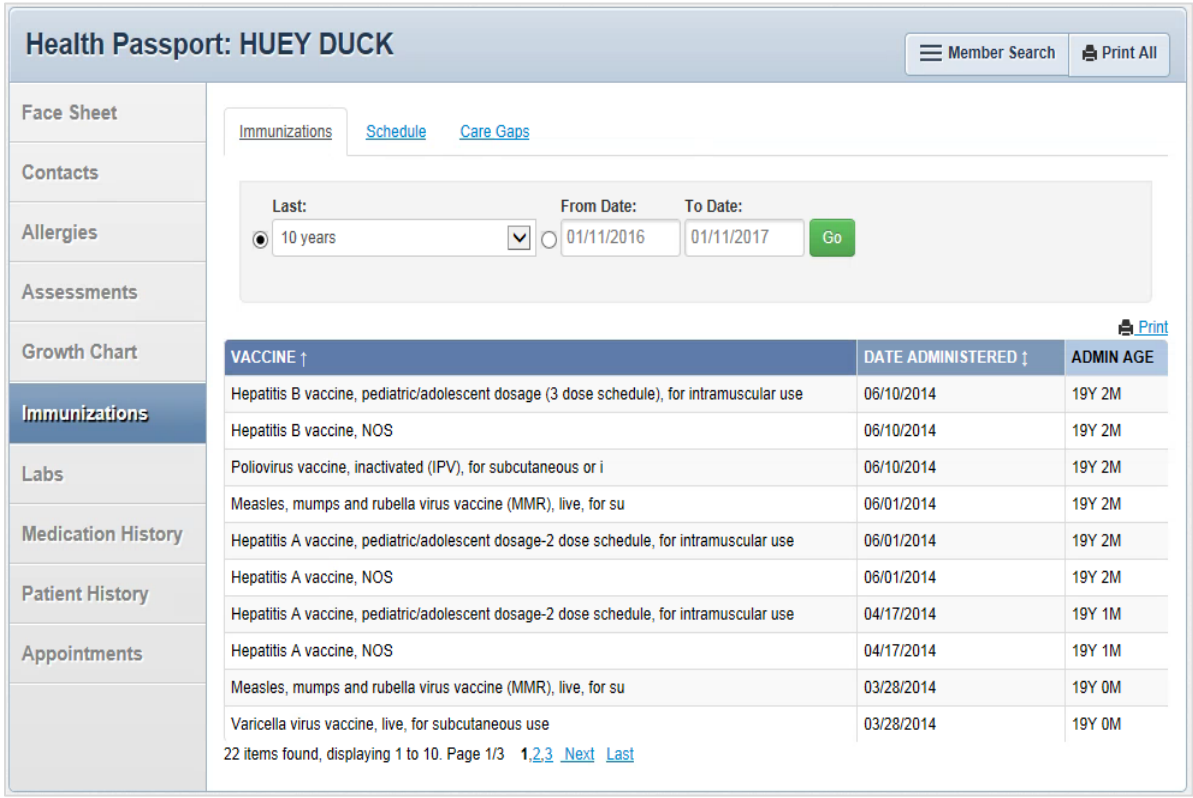
Click the **Add Growth Chart** tab to add new growth measurements.

- **Step 1:** Fill in weight, height, length, head circumference, and add comments, if applicable.
- **Step 2:** Click **Add**.



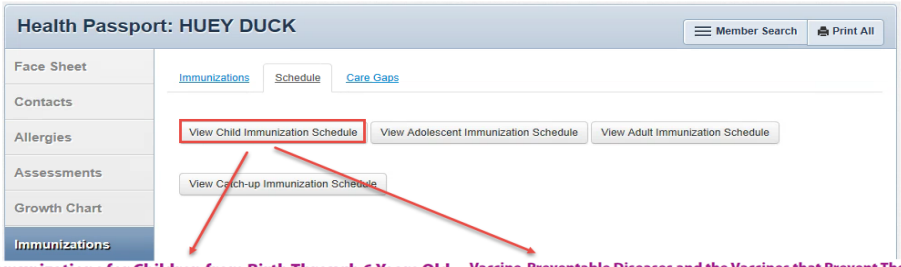
Immunizations

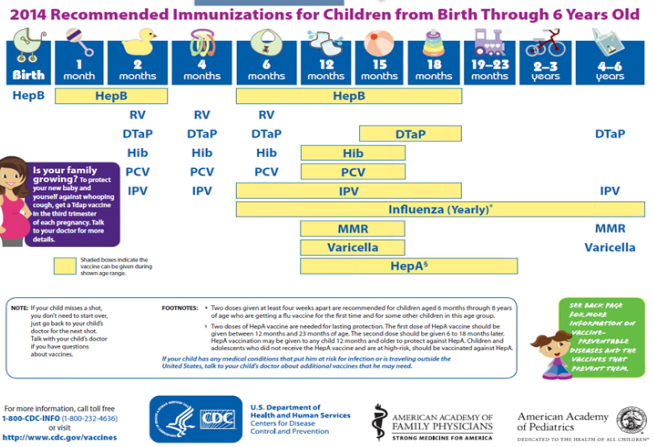
- This module presents a comprehensive list of a member's immunizations that have been reported to ImmTrac, the Texas Immunization Registry.
- Additionally, there is a tab that displays immunization schedules for the Centers for Disease Control and Prevention. The "Care Gaps" tab shows any gaps in care, including missing immunizations.



Immunizations: Schedule Tab

This tab offers child, adolescent, adult and catch-up immunization schedules. Click the “Respective Schedule” to open the document.





Vaccine-Preventable Diseases and the Vaccines that Prevent Them

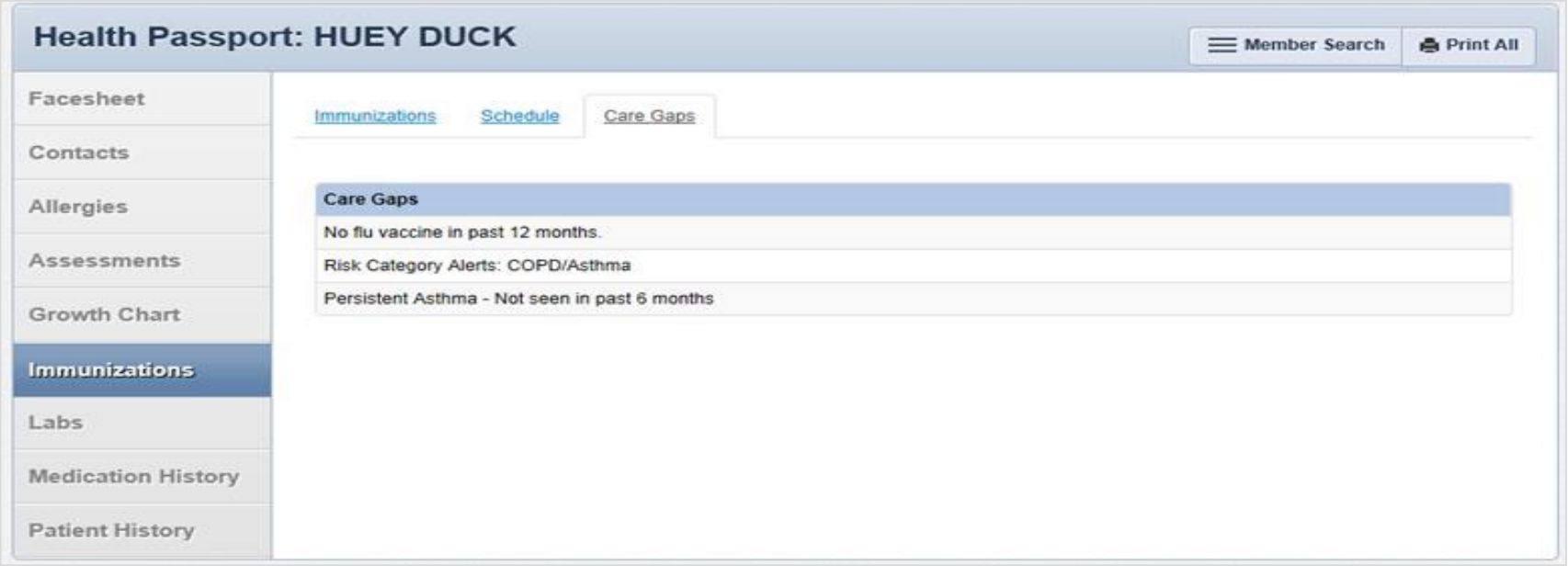
Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 2014 • CS245366-A

Immunizations: Care Gaps Tab

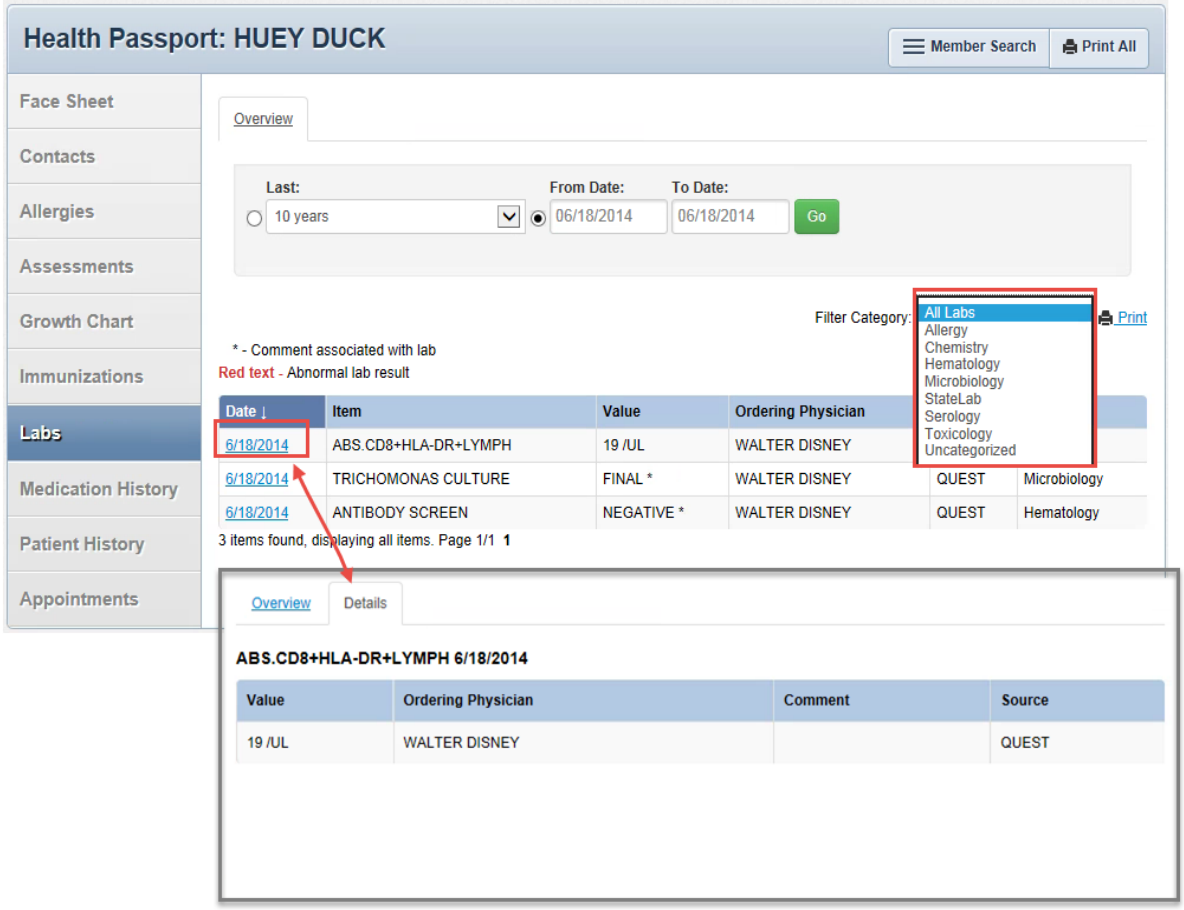
This tab allows you to gaps in care, including missing immunizations.



Labs

This module contains a list of a member's lab results.

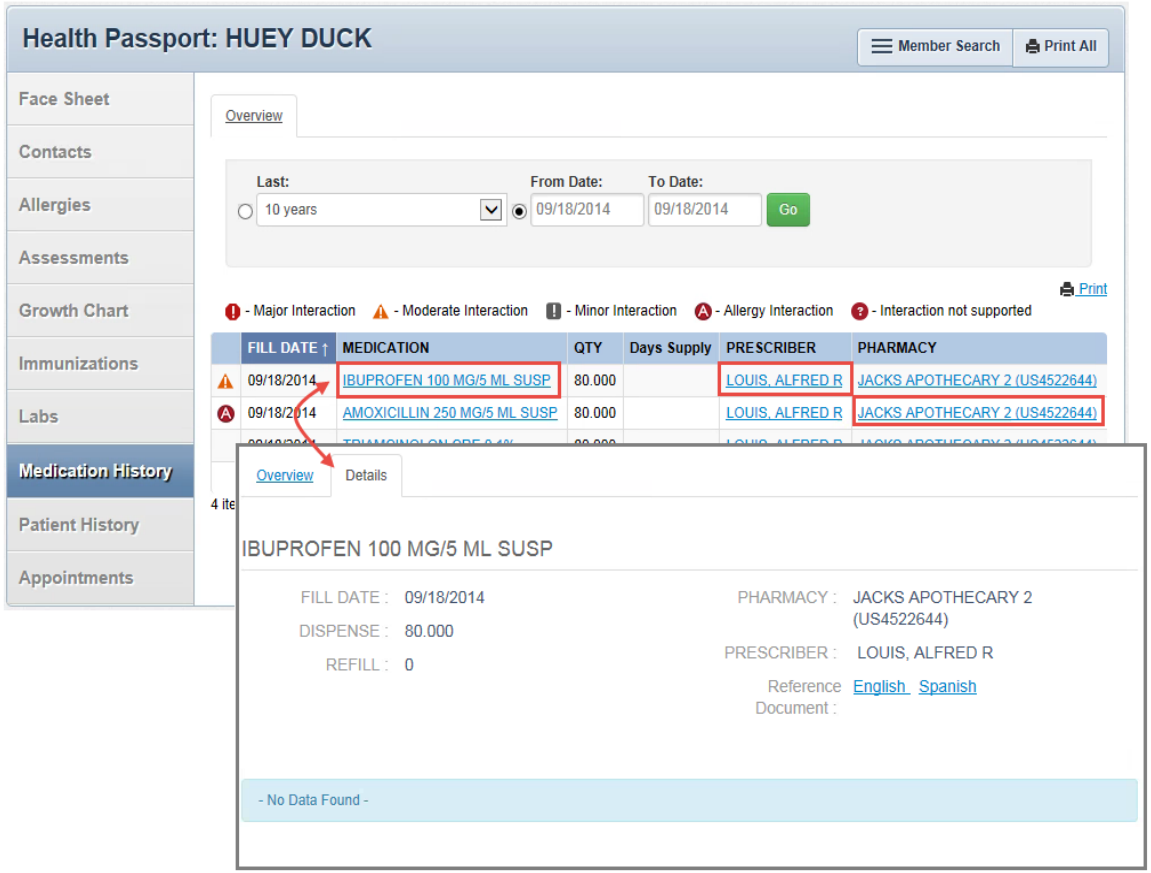
- Click on a **date** and **time** to view details of labs.
- By selecting **Filter Category**, you can filter by lab type.



Medication History

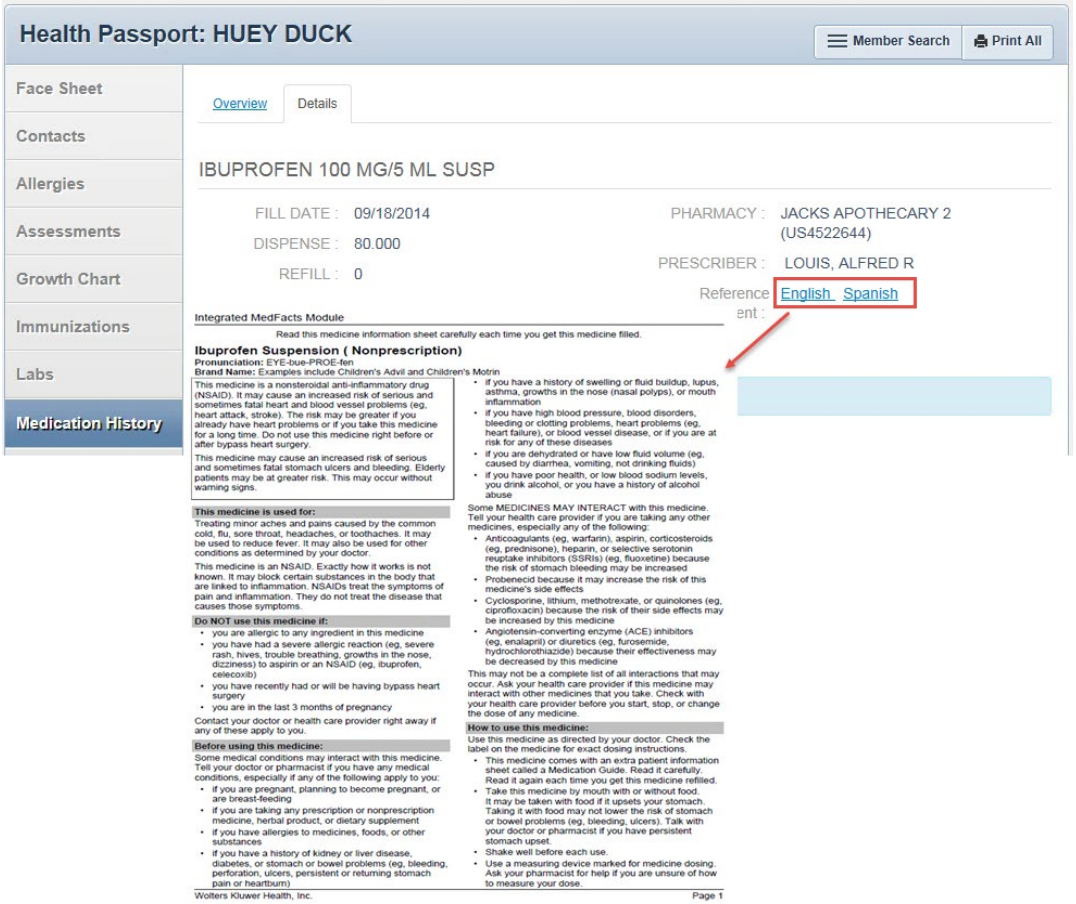
This module contains a detailed list of medications.

- Click **medication name** to view more details.
- Scroll over **Prescriber** and **Pharmacy** to view contact information.
- The legend of icons ( ) denote different medication interactions. Major interactions are potentially life threatening.



Medication History: Details Tab

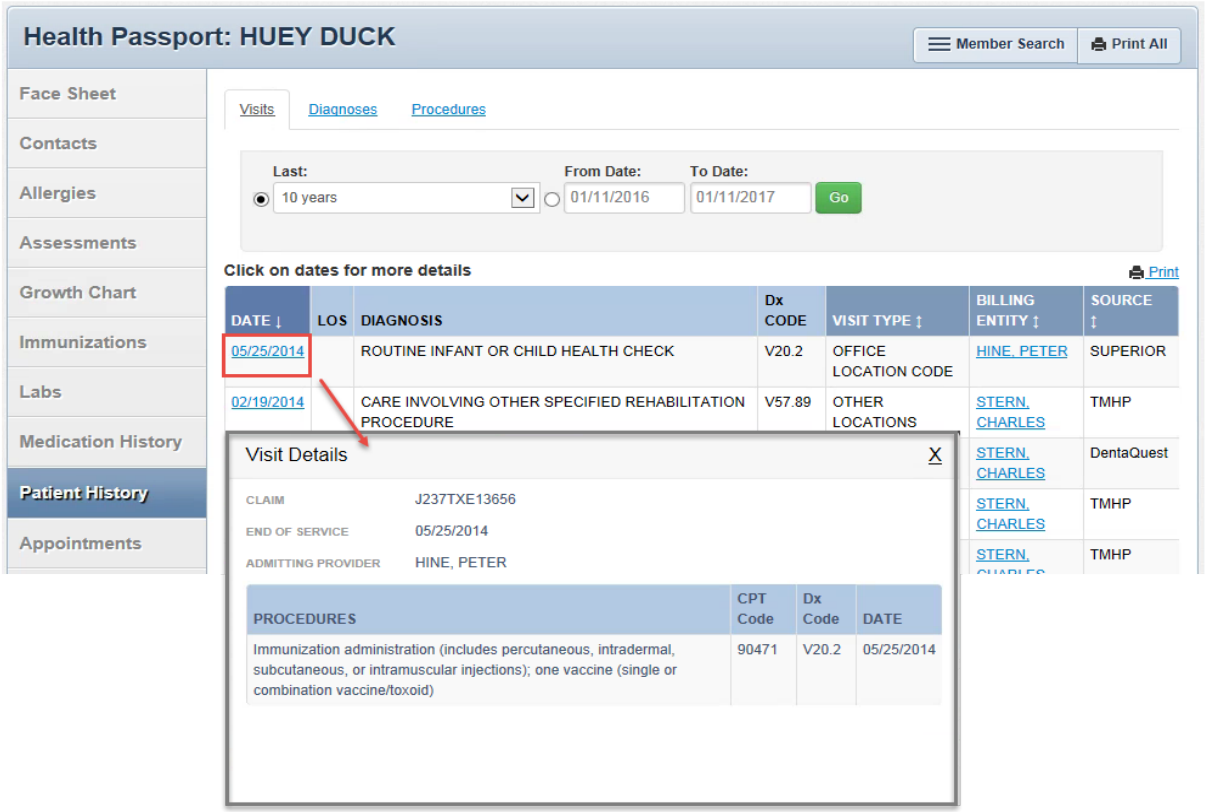
Select **English** or **Spanish** to open a reference document for the given medication.



Patient History

This module contains visit information from claims data on all services rendered, whether paid or denied. Claims come from all provider types and providers do not need to do anything extra for this data to load.

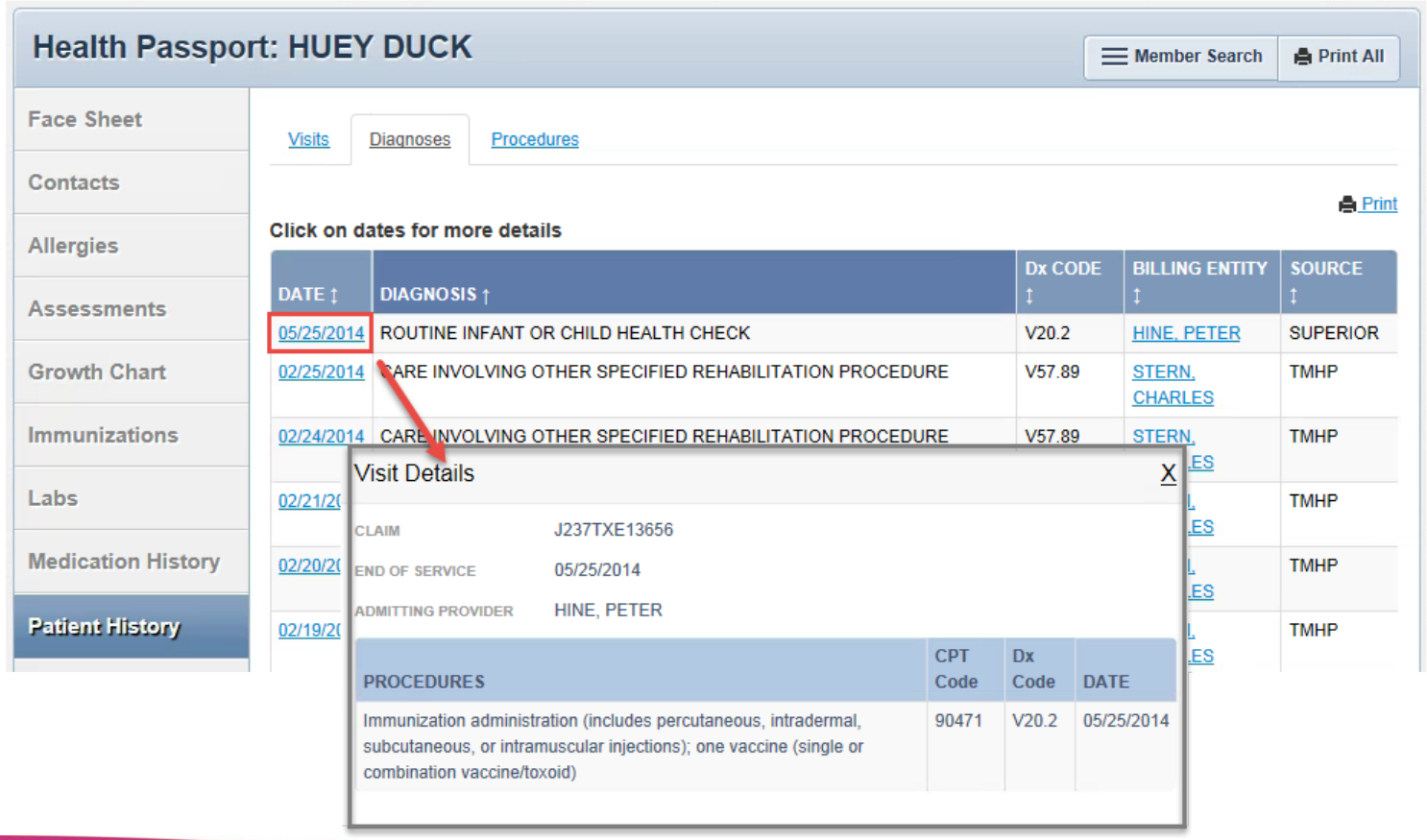
- Click the **date** to view more visit details.



Note: This module should not be used as a tool for claims payments. There is lag time before data is loaded as providers have 95 days to bill and Superior has 30 days to process.

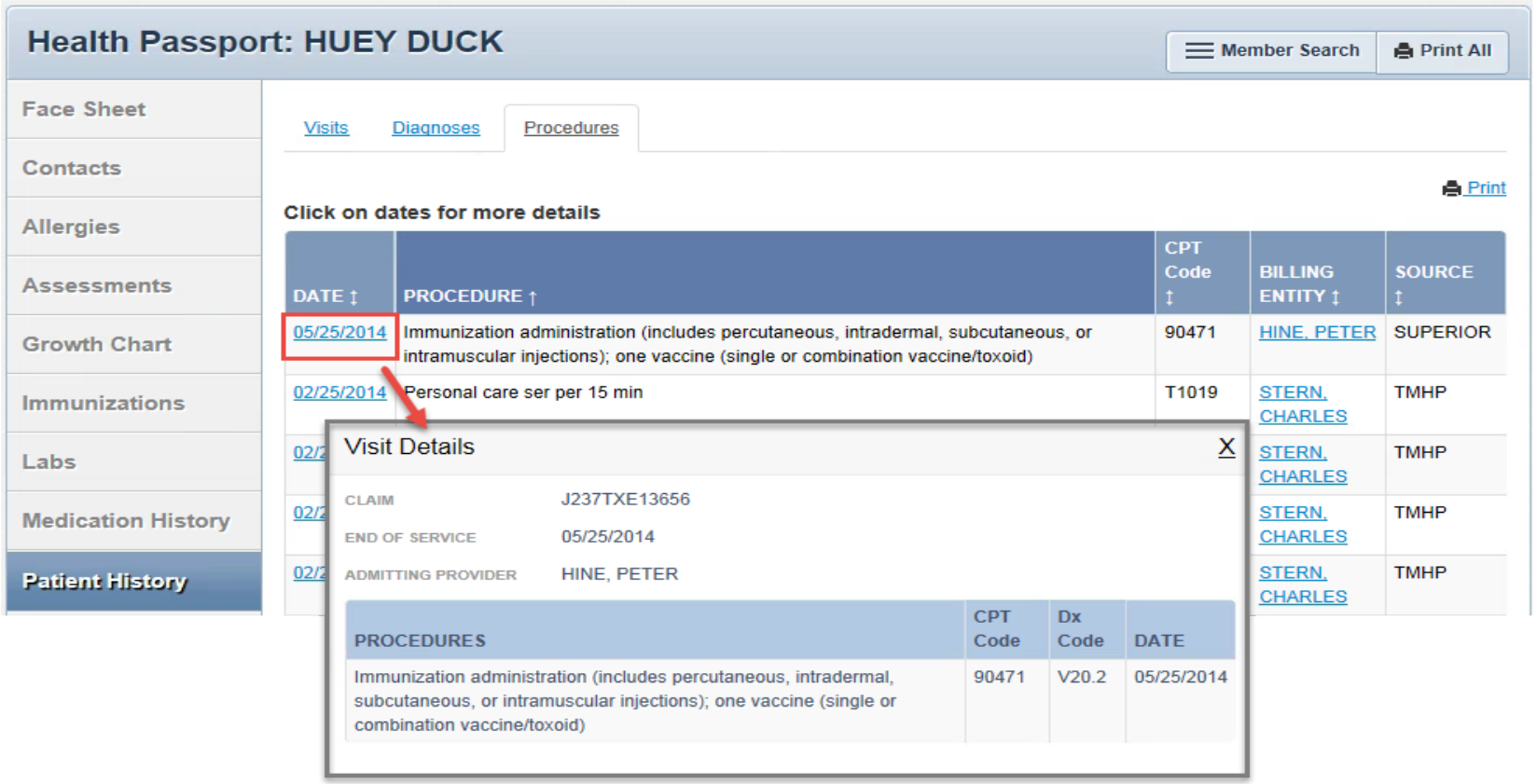
Patient History: Diagnoses Tab

This tab lists visits by diagnoses. Click the **date** to view by diagnoses.



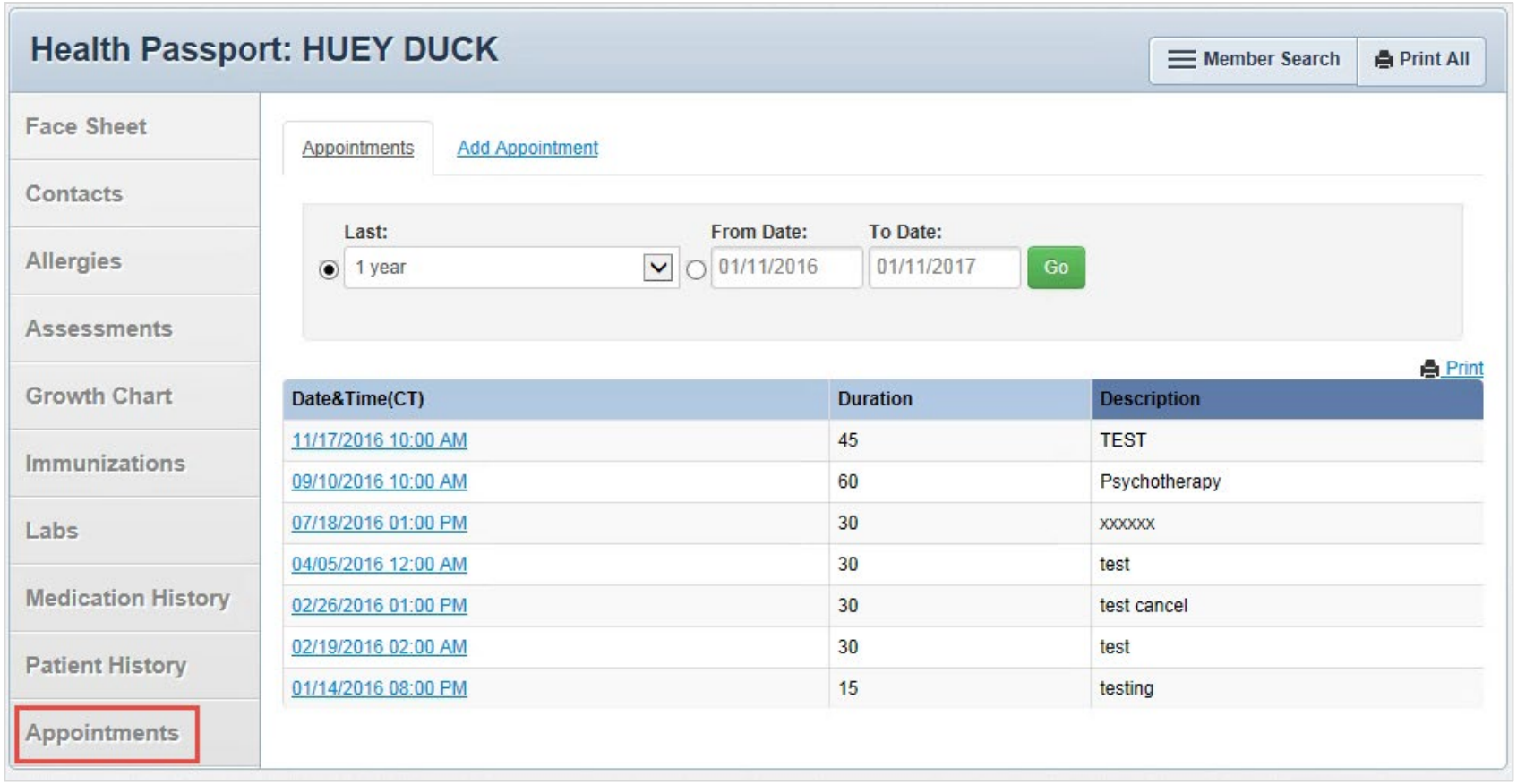
Patient History: Procedures Tab

Click the **Procedures tab** to view visits by procedures.



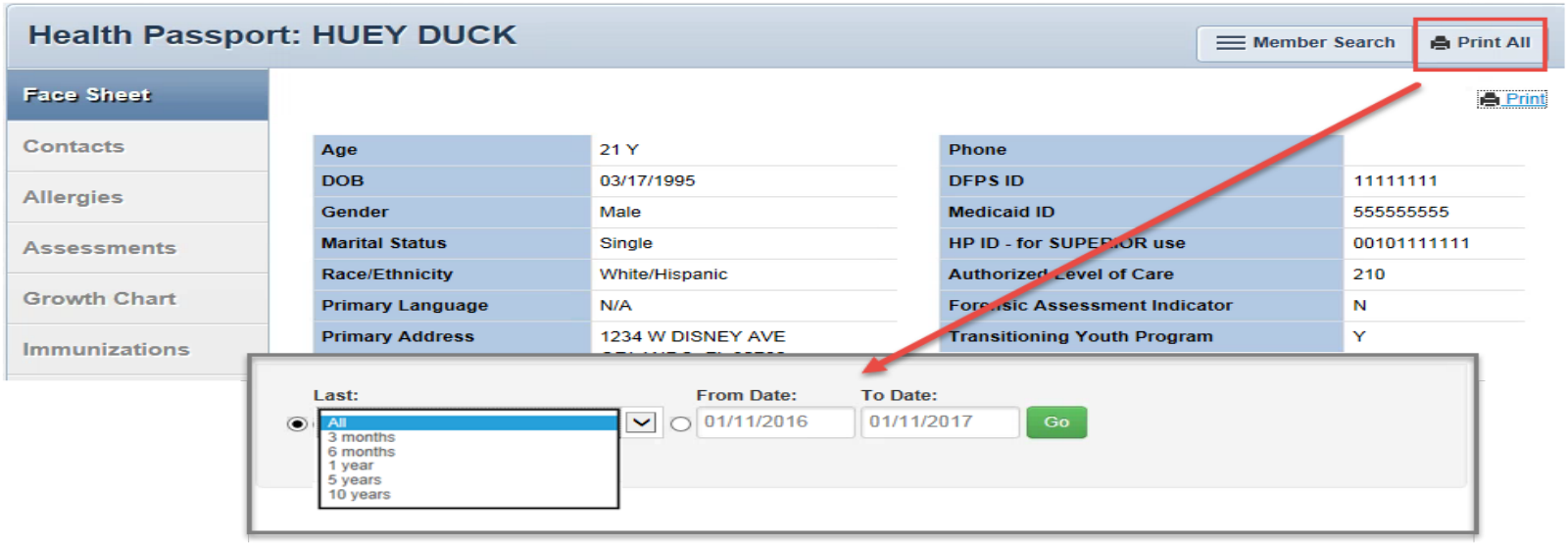
Appointments

On this module users can create and modify and cancel their own appointment entries.



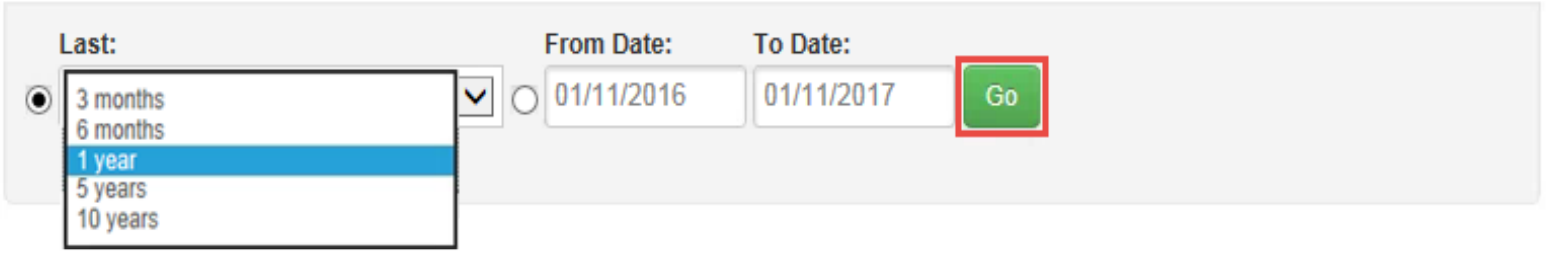
Other Tools

- **Member Search**: Return to search screen.
- **Print All**: Print complete health record by either (1) selecting a time frame or (2) selecting a date range and click **Go**.
- **Print**: Print single module.
- **Demo Info**: Hover over member name to view core demographic information.

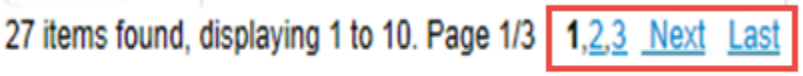


Other Tools

- To filter, select the **time frame** and **date range** and click **Go**.
- Found on modules: **Assessments, Growth Chart, Immunizations, Labs, Medication History** and **Patient History**



- View more by clicking the **Page** or the **Next** and **Last** buttons.

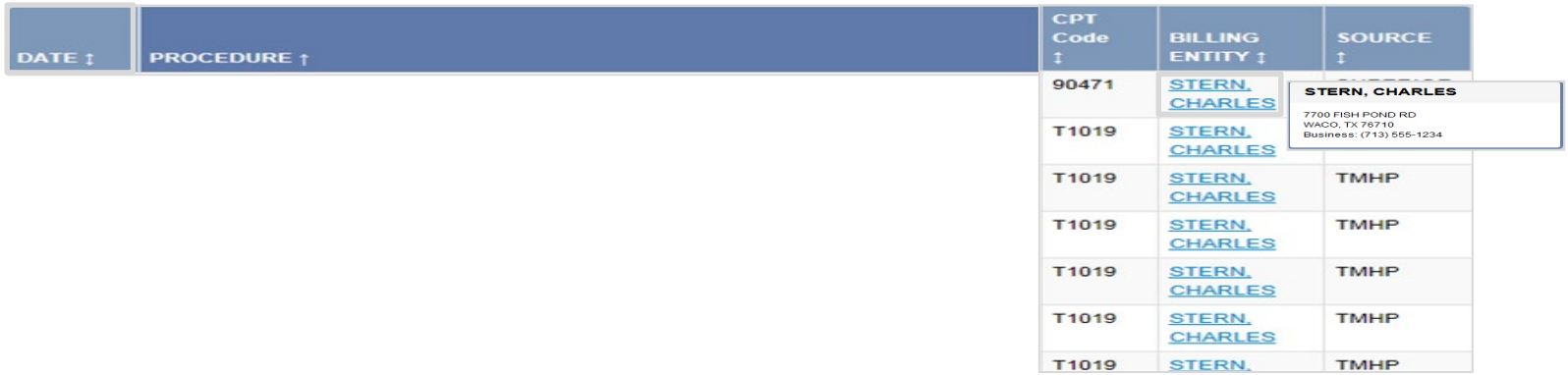


- **Allergies, Growth Chart, Immunizations, Labs, Medication History** and **Patient History** can be found on modules.

Other Tools

- Sort information by clicking on the titles labeled with arrows.
  - Found on modules: **Allergies, Growth Chart, Immunizations, Labs, Medication History** and **Patient History**

- Hover over **Billing Entity** to view contact information for providers.
  - Found on module: **Patient History**



Contact Us

- Interested in a Live Demo? Call your Account Manager to schedule a visit!
- Need additional Health Passport Help? Contact the Health Passport Support Desk:
  - Call: 1-866-714-7996
  - Email: TX.PassportAdministration@SuperiorHealthPlan.com

Thank You For Attending!

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

If you have additional questions, please contact your local Account Manager or select “Contact Us” at SuperiorHealthPlan.com

Let us know what we can do to help.