

#### STAR Health

**Provider Training** 

#### Agenda



- Foster Care and STAR Health Background
- STAR Health Basics
- Provider Roles and Responsibilities
- STAR Health Benefits
- 3 in 30
- Texas Health Steps Exams
- Superior Pharmacy Services
- Quality and Compliance

- Service Management
- Medical Management
- Claims Filing and Payment
- Electronic Visit Verification (EVV)
- Telemedicine and Telehealth
- Secure Provider Portal
- Health Passport Clinical Training Guide
- Superior HealthPlan Departments



# Foster Care and STAR Health Background

#### Who is Superior HealthPlan?



- Only health plan with statewide Health Maintenance Organization (HMO) license.
  - An HMO is an organization that provides or arranges managed care for health insurance.
- First health plan with child welfare experience nationally.
  - Superior has been the only provider of health insurance for youth in Texas foster care (STAR Health) since 2008. STAR Health has helped set a framework for foster care programs at other health plans in the U.S.
- Leader in Pay for Performance (P4P) programs.
  - P4P gives financial incentives to providers to improve health outcomes.
- Large provider network.
  - Superior has 90,000+ providers across Texas. This includes doctors, specialists, clinics and hospitals.

#### NCQA Accreditation



- National Committee for Quality Assurance (NCQA) awards accreditation to participating health plans.
  - NCQA is a private, non-profit organization. It was founded in 1990 to help improve health-care quality.
  - Superior is 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 for 2019-2020.
  - NCQA accreditation ratings are based on:
    - Health Effectiveness Data and Information Set (HEDIS) scores.
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
    - NCQA accreditation standard scores.





#### **STAR Health Basics**

### Foster Care Explained



- Victims of child abuse and neglect.
- Scientific studies have documented the link between the abuse and neglect of children and a wide range of medical, emotional, psychological and behavioral disorders.
- Abused and neglected child victims may be linked to:
  - Fetal Alcohol Syndrome.
  - Intrauterine Assault.
  - Shaken Baby Syndrome.
  - Developmental Delays
  - Bonding and/or Attachment Disorders.
  - Brain Trauma.
  - Domestic Violence.

- Self/Sibling Abuse.
- Depression.
- Alcoholism.
- Drug abuse.
- Teen Pregnancy.
- Obesity.
- Crime.

#### Why STAR Health?



- STAR Health better serves the needs of foster children by:
  - Providing greater access to health-care services.
  - Assisting in the coordination of health-care services.
  - Establishing a Medical Home (Primary Care Provider [PCP]).
  - Providing emergency support and services.
- Children in foster care often have greater health-care needs, including:
  - A history of physical and/or emotional trauma (due to abuse and neglect).
  - Not receiving proper dental and vision care (due to abuse and neglect).
  - Needing additional behavioral health services.
  - Needing assistance in treatment for asthma, depression, etc.
  - The presence of developmental delays.

#### STAR Health's Commitment



- Understanding the foster care community.
- Sensitivity to the needs of the foster care population.
- Providing accessible and integrated care.
- Providing an electronic Health Passport to better support coordination of care.
- Delivering appropriate education to all stakeholders.

### Service Management -Service Coordination



- Service Coordinators and Service Managers will act in the best interest of the child and coordinate care involving all the necessary parties, including:
  - Medical Consenters.
  - Caregivers.
  - Members.
  - Courts.
  - Department of Family and Protective Services (DFPS) Staff. - Integrated Care Coordination
  - Attorneys ad litem.
  - Other involved parties from DFPS and other state agencies.

- Guardians ad Litem.
- Law Enforcement Officials.
- Providers.
- Single Source Continuum Contractors (SSCC) Staff.
- Vendor Staff.

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

#### STAR Health Membership



- Children and young adults:
  - In foster care.
  - In kinship care.
  - Who choose to remain in a paid foster care placement (through the month of their 22nd birthday).
  - Who aged out of foster care at 18 years of age (through the month of their 21st birthday).
  - In the Adoption Assistance or Permanency Care Program.

# Former Foster Care Children Program (FFCC)



 Members under 26 years of age who were receiving Medicaid when they aged out of foster care at 18 years of age or older.

#### Eligibility:

- Were enrolled in foster care at the time of their 18th birthday.
- Must be 18-25 years of age.
- Were a Medicaid recipient when they left foster care.
- Must be a U.S. citizen or legal immigrant.

### FFCC Coverage and Benefits



- FFCC members will receive health-care benefits in 2 separate programs based on their age:
  - Members who are 18-20 years of age will continue to get their benefits in the STAR Health program unless they want to change to a STAR plan.
  - Members who are 21-25 years of age will get their Medicaid benefits through a STAR plan of their choice.

Note: There are no income, asset or educational requirements to qualify for the FFCC program.

## Coverage After Adoption or Permanency Care Placement



- After adoption or permanency care placement, children enrolled in STAR
  Health may remain in STAR Health if they receive Social Security Income
  (SSI) now, or received SSI before their adoption or permanency care
  placement.
- They may also choose to enroll with a STAR Kids program.
- If the child did not receive SSI, they would need to choose to join a STAR Medicaid program.
- During the transition, STAR Health members will remain in STAR Health.
   There will be no gap in the member's coverage.
- For assistance, members or providers may contact the Texas Health and Human Services (HHS) Ombudsman's Office:
  - By phone: 1-866-566-8989
  - Online: https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman



# Provider Roles and Responsibilities

#### Provider Roles and Responsibilities



- Eligibility Verification
- PCP Responsibilities
- After-Hours Telephone Arrangements
- PCP Access to Care Requirements
- Referrals
- Member Self-Referral
- Cultural Competency

### STAR Health Eligibility Verification



- Providers should verify member eligibility prior to delivering service at each visit by:
  - Logging on to Superior's Secure Provider Portal at <u>Provider.SuperiorHealthPlan.com</u>.
  - Viewing the member's Superior issued ID card (Member ID card is not a guarantee of enrollment or payment).
  - Contacting Superior's Member Services Department at 1-866-912-6283.
  - Viewing the member's "Your Texas Benefits" Medicaid Card.
  - Visiting TexMedConnect at <a href="https://secure.tmhp.com/TexMedConnect">https://secure.tmhp.com/TexMedConnect</a>.
  - Reviewing the member's DFPS 2085B (Designation of Medical Consenter) Form.
    - DFPS provides this form to caregivers when the child is placed in their care, and updates
      it when there is a change in who can consent for the child.

#### Member ID Card



The STAR Health Member ID Card contains the following information:



Member Services: 1-866-912-6283
Available 24 hours a day/7 days a week
Service Coordinator: 1-866-912-6283 Vision Services: 1-866-642-8959
Behavioral Health: 1-866-912-6283 Dental Services: 1-888-308-4766
In case of emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24 hours or as soon as possible.

Servicios para Miembros: 1-866-912-6283
Disponible 24 horas al día/7 días de la semana
Coordinandora de Servicios: 1-866-912-6283
Servicios de Salud del Comportamiento: 1-866-912-6283
Servicios de la Vista: 1-866-642-8959
Servicios Dentales: 1-888-308-4766
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible.

 Disclaimer: Documentation in Health Passport is required\* when caring for STAR Health members. Please visit <u>www.SuperiorHealthPlan.com/providers/resources/health-passport.html</u> for more information.

<sup>\*</sup>May not apply to members over 18 years of age.

### PCP Responsibilities



- Serve as a "Medical Home."
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member.
- 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.
- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider.

#### PCP Responsibilities



- Ensure accurate information in Provider Directories by updating contact information, including:
  - Address.
  - Phone number.
  - Provider listing.
  - Hours of operation.
- Report all encounter data on a CMS 1500 form or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.

#### PCP Accessibility



- PCPs must arrange coverage with another Superior provider if one is not available.
- Office phones must be answered during normal business hours.
- After-hours calls should be documented in an after-hour call log and transferred to the member's medical record.
- Contact Superior Account Management if requirement cannot be fulfilled.

# PCP or Medical Home After Hours Availability



#### Acceptable

- Phone answered by an answering service must be returned within 30 minutes by the PCP or other designated provider.
- Phone answered by an answering machine that directs members to call another number where someone must be available to answer the designated number.
- Phone transferred to another location where someone will answer the phone and contact the PCP or on-call provider, who can return call within 30 minutes.

#### Unacceptable

- Phone only answered during office hours or directs members to leave a message.
- Phone message directs members to the Emergency Room (ER).
- Answering machine or answering service is not bilingual (English and Spanish).
- Returning after-hours calls outside of 30 minutes.

### **Appointment Availability**



- Superior requires that a provider's hours of operation for Medicaid members be no less than those offered to commercial patients.
- Appointment availability standards:
  - Routine Exam: Within 14 calendar days of request.
  - Urgent Care: Within 24 hours of the request, including urgent specialty care.
  - Emergency Care: Immediate (Neither prior authorization, nor medical consenter approval is required for this type of care).
  - Routine Specialty Care: Within 21 calendar days of request.
- Additional timeframes can be found within the Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual, located at <a href="https://www.SuperiorHealthPlan.com/providers/training-manuals.html">www.SuperiorHealthPlan.com/providers/training-manuals.html</a>

# PCP or Medical Home Expectations



- Communicate member needs with Service Management:
  - Physical
  - Behavioral
  - Vision
  - Dental
  - Specialty and/or Diagnostic Assessments
  - Other organizations (Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Durable Medical Equipment [DME], etc.)
- Provide referrals and secure authorizations.
- Deliver member education healthy lifestyles and wellness.
- Ensure emergency care follow-up.

### Early Childhood Intervention (ECI)



PCP or Medical Home Compliance – Early Childhood Intervention (ECI):

- Assist in ensuring mandated timelines for ECI are adhered to.
- Early Childhood Intervention (Texas Department of Assistive and Rehabilitative Services [DARS] Inquiries): 1-800-628-5115
  - All health-care professionals are required under Federal and State regulations to refer children (under 3 years of age) to ECI within 2 business days of identification of a disability or suspected developmental delay.
  - Works with child, family, medical consenter and provider to develop an Individual Family Service Plan (IFSP) which can include physical, occupational and speech therapies (PT, OT, ST).
  - Medical consenters may self-refer to a local ECI provider without a referral from the PCP.

#### **Health-Care Providers**



- PCP or Medical Home Expectations:
  - Assure heightened attentiveness to potential abuse or neglect and reporting requirements.
  - Use and support the update of Health Passport information for continuity of care.
  - Use of valid screening and assessment instruments to identify members with mental health needs (Texas Health Steps Behavioral Health Forms).
  - Identify members suffering trauma to the brain and referring to appropriate specialty provider.

### Physician Certification (2601)



- HHS requires a Screening and Assessment Instrument (SAI) assessment to be conducted when a STAR Health member is released from the HHS interest list for Home and Community-Based Services (HCBS) in the Medically Dependent Children Program (MDCP).
- Following the assessment, Superior will supply the medical provider with the Physician Certification (2601) (Medical Necessity [MN] Form), certifying that the 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 include, but are not limited to, Minor Home Modifications (MHM), Respite Services, Flexible Family Support Services, Transition Assistance Services, Adaptive Aids, Supported Employment, Community First Choice (CFC) Services, Employment Assistance.

## Physician Certification (2601)



- The medical provider's signature is required only at initial request of STAR
  Health MDCP services, and any significant Change in Condition (CIC). Texas
  Medicaid & Healthcare Partnership (TMHP) will grant final approval for 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)



- Forms can be returned electronically or via fax.
  - Forms using an Adobe Sign e-signature can be returned to <u>SHP.Intake@SuperiorHealthPlan.com</u>.
  - Forms can be faxed to 1-866-703-0502
- 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 is received, the member is notified and Superior will notify the Program Support Unit at HHS.
- For additional information, please call 1-866-912-6283 or reference the Physician Certification (2601 Form) FAQs (STAR Kids and STAR Health) (PDF) found under "Member Management" on Superior's Forms webpage: www.SuperiorHealthPlan.com/providers/resources/forms.html

# Specialty Care Provider Expectations



- Maintain contact with PCP by:
  - Supporting the medical home and integrated primary care.
  - Sharing information.
  - Adopting and interacting with the member's Health Passport.

# Behavioral Health Care Provider Expectations



- Comply with the Psychotropic Medication Utilization Parameters for Foster Children.
  - For more information, please see <a href="https://www.dfps.state.tx.us/Child\_Protection/Medical\_Services/Psychotro-pic\_Medications.asp">https://www.dfps.state.tx.us/Child\_Protection/Medical\_Services/Psychotro-pic\_Medications.asp</a>.
- Expand the use of evidence-based practices, including:
  - Trauma focused cognitive behavioral therapy.
  - Cognitive behavioral therapy for sexually abused children.
- Provide services to targeted populations, including members with:
  - Abandonment issues.
  - Attention Deficit Hyperactivity Disorder (ADHD).
- Provide documentation required for judicial review, including:
  - Initial assessments and monthly reviews.

# Behavioral Health Care Provider Expectations



- Provide monthly progress notes from behavioral health exams or treatments and upload in Health Passport for the member's file.
- Notes should include the following:
  - Member's diagnosis.
  - Assessment information.
  - Summary of the member's progress.
  - Referrals and/or community resources provided.
  - Any other relevant care information.
- Participate in Health Passport training, which includes a refresher of how to view and submit assessments through Health Passport.

#### **Foster Care Court Orders**



- All STAR Health providers must comply with court orders, including:
  - Rendering court-ordered health-care services for the child.
  - Providing documentation (reports and/or reviews) as requested.
  - Testifying in court.



#### **STAR Health Benefits**

#### STAR Health Benefits



- Benefits include, but are not limited to:
  - Dental and vision services.
  - Doctor and clinic visits.
  - Durable Medical Equipment (DME).
  - Family planning services.
  - Hospital services (inpatient and outpatient).
  - Laboratory.
  - Maternity services.
  - Medical and surgical services.
  - Mental and behavioral health services.
  - Non-Emergent Medical Transport (NEMT).
  - Prescriptions (unlimited).
  - Texas Health Steps.
  - Therapy (physical, speech and occupational).
  - Transplants.

# Family Planning: Long Acting Reversible Contraception



- Providers, including hospital/facility providers, Federally Qualified Health
  Centers (FQHCs) and Rural Health Clinics (RHCs), may be reimbursed for the
  insertion of the Long Acting Reversible Contraception (LARC), along with the
  device itself.
  - LARCs may be reimbursed to the hospital/facility, in addition to the facility reimbursement, when insertion is performed immediately postpartum.
    - Insertion within 10-15 minutes of placental delivery for IUDs.
    - Insertion prior to discharge for implantable contraceptive capsules.
  - FQHCs and RHCs may receive reimbursement for covered LARC devices in addition to the encounter rate paid for the visit.
- Providers can prescribe and obtain LARC products on the Medicaid formulary from certain specialty pharmacies that work with LARC manufacturers. Additional information on the pharmacy benefit can be located at <a href="https://www.txvendordrug.com/formulary/information/long-acting-reversible-contraception-products">https://www.txvendordrug.com/formulary/information/long-acting-reversible-contraception-products</a>.

#### Value-added Services



- Care Grants
- Over-the-Counter (OTC) Items
- Extra Vision Services
- Sports Physicals
- Boys and Girls Club Membership
- For more details or updates, please visit <u>www.FosterCareTX.com/for-members/about-star-health/value-added-services.html</u>.

### My Health Pays® Rewards



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

#### 24-Hour Nurse Advice Line



- Available 24 hours a day, 7 days a week, 365 days a year.
- Staff is bilingual in English and Spanish.
- All Texas licensed Registered Nurses (RNs).
- Will transfer behavioral health crisis calls to the Behavioral Health Hotline.
- To contact the 24-Hour Nurse Advice Line, please call 1-866-912-6283.

### STAR Health Transportation Benefits



- Superior's Medical Ride Program (NEMT Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- Transportation includes rides to the doctor, dentist, hospital, pharmacy and other places members receive Medicaid services.
- Transportation services are provided by SafeRide.
- Superior's Medical Ride Program will cover the cost of an attendant for members needing assistance while traveling.
  - Providers may receive a request to provide proof of documentation of medical necessity.
- Children 14 years of age and younger must be accompanied by a parent, guardian or other authorized adult.

### Medical Ride Program Services



- Services offered by Superior's Medical Ride Program include, but are not limited to:
  - Passes or tickets for mass transit within and between cities or states.
  - Commercial airlines transportation.
  - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
    - The enrolled ITP can be the member, the member's family member, friend or neighbor.
  - Car, van or private bus services, including wheelchair-accessible vehicles, if necessary.
  - 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.

### Requesting NEMT Services



- Superior members should request rides as early as possible, and at least two Business Days before they need the ride.
- It is the responsibility of the member to coordinate all information needed from both the provider and Superior timely, in order for Superior or SafeRide to consider the request.
- Appointments can be requested Monday through Friday, 8:00 a.m. 5:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).
- For questions, concerns or complaints about SafeRide, Superior medical providers and nursing facilities can contact 1-855-932-2322 (Monday through Friday, 8:00am 6:00pm CST) for assistance.

# Intellectual Developmental Disabilities (IDD)



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

### Community First Choice (CFC)



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

### Community First Choice (CFC)



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

## Coordination with Service Organizations



- ECI
- Texas School Health and Related Services (SHARS)
- Texas Department of State Health Services (DSHS) Mental Health Targeted Case Management
- DSHS Case Management for Children and Pregnant Women
- Local Mental Health Authorities (LMHA)
- WIC
- NEMT

#### Communication and Confidentiality



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

#### **Advance Directives**



- Federal and state law requires Managed Care Organizations
   (MCOs) and providers to maintain written policies and procedures
   for informing all members 18 years of age and older about their
   rights to refuse, withhold or withdraw medical treatment and mental
   health treatment through advance directives.
- STAR Health does not require a member to have an advance directive as a condition for receiving health care, nor does STAR Health discriminate against a member based on whether or not the member has or does not have advanced directive.



3 in 30

### 3 in 30 Explained



- 3 Day Initial Medical Exam
  - Within 3 business days, children entering DFPS care must see a doctor to be checked for injuries or illnesses, and get any treatments they need.
- Texas Child and Adolescent Needs and Strengths (CANS) 2.0 Assessment
  - Within 30 days, children (3 years of age or older) must get a CANS 2.0
     assessment. The CANS 2.0 is a comprehensive, trauma informed behavioral health
     evaluation. It gathers information about the strengths and needs of the child, and
     helps in planning services that will help the child and family reach their goals.
- Texas Health Steps Medical Check-Up (also known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
  - Within 30 days, children must see a Texas Health Steps doctor for a complete check-up with lab work. This ensures:
    - Medical issues are addressed early.
    - Children are growing and developing as expected.
    - Caregivers know how to support strong growth and development.

#### 3-Day Medical Exam



- Applies to all children and youth entering foster care
- Exceptions to the 3-Day exam requirement are:
  - Members with emergent or urgent visit.
  - Members discharged from an inpatient (IP) medical admit.
  - Members with a documented physical at admit for a behavioral health IP stay.
- Medical screening for each child within 3 business days of removal.
- Does not replace the Texas Health Steps medical checkup of the CANS 2.0 Assessment.

### 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.

### 3-Day Medical Exam - Billing



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

New Client Codes	99201	99202	99203	99204	99205
<b>Established Client Codes</b>	99211	99212	99213	99214	99215

### 3-Day Medical Exam Exceptions



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

#### **CANS 2.0**



- DFPS assesses with the Family Strengths and Needs Assessment (FSNA).
- Children who are 3-17 years of age at the time of removal are required to have a CANS 2.0 assessment within 30 days of entering care.
- Children who turn 3 while in care are required to have a CANS 2.0 assessment with in 30 days of their 3<sup>rd</sup> birthday.
- CANS 2.0 re-assessments are required annually while an eligible child remains in care.
- Bill CANS 2.0 assessments with 90791 and modifier TJ.



### Texas Health Steps Exams

## What is a Texas Health Steps Medical Checkup?



- For Medicaid-eligible children, adolescents and young adults under 21 years of age, the comprehensive preventive care program combines:
  - Diagnostic screenings.
  - Communication and outreach.
  - Medically necessary follow-up care, including:
    - Dental.
    - Hearing examinations.
    - · Vision.
  - Age-appropriate screenings must include, but are not limited to:
    - Autism.
    - Developmental.
    - Hearing.
    - Lead.
    - Mental Health.

- Nutrition.
- Sexually Transmitted Diseases.
- Tuberculosis.
- Vision.
- Reminder: Not all STAR Health PCPs are TH 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.

Note: There may be other licensing requirements for different placements.

### 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 months12 months30 months

4 months15 months

- Children 3 years of age through 20 years of age 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 Dental Checkups



- All children 6 months of age and over who are newly enrolled in the STAR Health program need a dental checkup within 60 days.
- For children already in foster care, the dental checkup should be scheduled within 30 days of the child turning 6 months of age.
- No referral is needed from a child's provider for regular dental checkups or other dental services.
- Please contact DentaQuest for assistance:
  - 1-888-308-4766

# Texas Health Steps Dental Checkups



- Ongoing Texas Health Steps Dental Checkups:
  - Dental checkups for children 3 years of age through 20 years of age are due every 6 months.
  - Children age 6 months through 35 months of age who are likely to develop early childhood tooth decay should have dental checkups as often as every three months. The child's dentist will let you know the frequency.

## 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 nonelevated, 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 <a href="https://www.dshs.state.tx.us/lead/child.shtm">https://www.dshs.state.tx.us/lead/child.shtm</a>.

### Missed Appointments



- Complete a Missed Appointment Form and fax it to MAXIMUS for member follow-up.
- The Missed Appointment Form is available at <a href="https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1235-notice-appointment-or-delay">https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1235-notice-appointment-or-delay</a>.
- More information is available through your local regional Texas Health Steps Provider Relations Representative: <a href="https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-regional-contacts.pdf">https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-regional-contacts.pdf</a>



### Superior Pharmacy Services

#### **Pharmacy Benefits**



- Superior utilizes the Vendor Drug Program (VDP) formulary and the Preferred Drug List (PDL) to determine whether a prior authorization is required for Medicaid and CHIP. Authorization requirements may be determined on the PDL.
  - To view the VDP formulary and PDL, visit <u>www.SuperiorHealthPlan.com/providers/resources/pharmacy.html</u>.
- Prior authorization can be requested through Superior's Pharmacy Benefit Manager (PBM), Envolve Pharmacy Services, at 1-866-399-0928.

### **Specialty Drugs**



- Medications on the HHS specialty drug list may be obtained from AcariaHealth or CVS Caremark if not under limited drug distribution.
- Contact Information:

AcariaHealth	CVS Caremark
Phone: 1-855-535-1815	Phone: 1-800-237-2767
Fax: 1-877-541-1503	Fax: 1-800-323-2445
Web: www.AcariaHealth.com	Web: www.CVSSpecialty.com

### 72-Hour Emergency Prescription



- State and Federal law requires that a pharmacy dispense a 72-hour (3 day) supply of medication to any member awaiting a prior authorization or medical necessity determination.
- If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should dispense an emergency 72-hour prescription.
- 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**



- The Superior Pharmacy department can assist with questions and concerns from prescribers and members.
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: www.SuperiorHealthPlan.com/contact-us
- In-Clinic Rx Administration (Authorizations department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeals (Appeals department)
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168
  - Appeals Requests Fax: 1-866-918-2266

#### **Pharmacy Contact Information**



- Pharmacy Complaints:
  - STAR Health Complaint Hotline: 1-866-912-6283
- E-forms:
  - www.SuperiorHealthPlan.com/providers/resources/forms.html



### **Quality and Compliance**

### **Quality Improvement**



- Superior works with our provider community to:
  - Manage and review annual HEDIS rates to identify interventions to improve HEDIS scores.
  - Maintain compliance with quality related areas of HHS regulations.
  - Generate, distribute and analyze selected provider profiles.
  - Coordinate office site visits related to complaints regarding physical appearance, physical accessibility, adequacy of wait time and adequacy of treatment record.
  - Conduct provider satisfaction surveys annually.
  - Review, investigate and analyze quality of care concerns (member complaints).

### **Cultural Sensitivity**



- 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.
- 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.

### HIPAA / Fraud, Abuse and Waste



- Health Insurance Portability Accountability Act (HIPAA) of 1996
  - Providers and contractors are required to comply with HIPAA guidelines.
     For more information, please see <a href="http://www.hhs.gov/ocr/privacy">http://www.hhs.gov/ocr/privacy</a>.
- Fraud, Abuse and Waste (Claims/Eligibility)
  - Providers and contractors are all required to comply with state and federal provisions that are set forth.
  - To report fraud, waste and abuse, call the numbers listed below:
    - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
    - Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664

# 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:
  - Department of Family and Protective Services (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 Consumer Directed Services (CDS) option.
  - Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free at 1-800-252-5400.

### How to Report ANE



- HHS
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities.
    - Assisted living facilities.
    - HCSSAs also required to report any HCSSA allegation to DFPS.
    - Day care centers.
    - Licensed foster care providers.
  - Phone: 1-800-647-7418
  - 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.



### Service Management

### Clinical and Non-Clinical Support



- 24 hours a day, 7 days a week, 365 days a year accessibility to STAR Health staff through the STAR Health Member Services hotline:
  - 1-866-912-6283
- Identification and assistance with meeting member needs.
- Referrals/pre-authorizations/certifications.
- Communicate with doctor and other providers to develop a "Health Care Service Plan" to address the unique needs of the client.
- Coordinate services with other entities to ensure integration of care (ECI, WIC, DME, etc.).

### **Direct Support**



- Support members with special health-care needs, including:
  - Following up and documenting reported results.
  - Complex case management.
  - Specialty program(s).
  - IDD management.
  - Asthma disease management.
- Monitor adherence to treatment plan to promote permanency.
  - Follow-up and document reported results.
- Promote best practice/evidence-based services.
  - Includes compliance with psychotrophic medications on utilization standards.
- Identify and report potential abuse/neglect.

### Asthma Disease Management



- STAR Health's Asthma Management program is an interaction designed program to identify and treat asthma patients by:
  - Conducting an initial telephonic assessment.
  - Educating low-risk members.
  - Providing an initial visit by phone and self-management tools for mediumrisk members.
  - Providing home interaction for high-risk members.
  - Coordinating referral services.



### Medical Management

# How to Obtain a Referral/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:
  - www.SuperiorHealthPlan.com/providers/resources/forms.html
- Call in your request to 1-800-218-7508.
- Log on to the Superior's Secure Provider Portal at <u>Provider.SuperiorHealthPlan.com</u>.
- Receive a Reference Number for Inpatient Hospitalization or Outpatient authorizations.
  - For the most up-to-date PA List, visit <u>www.SuperiorHealthPlan.com/providers/preauth-check.html</u>.

### **Therapy Treatment Authorizations**



- Providers must include specific information when submitting therapy prior authorization requests for Medicaid and CHIP 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 at <a href="https://www.SuperiorHealthPlan.com/providers/resources.html">www.SuperiorHealthPlan.com/providers/resources.html</a> under "Therapy Documents and Policy Clarification."

# Therapy Services - No Prior Authorization Needed



- Effective June 1, 2021 prior authorization is no longer required for initial evaluations or re-evaluations for PT/OT/ST.
- 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
     <a href="https://hhs.texas.gov/services/disability/early-childhood-intervention-services">https://hhs.texas.gov/services/disability/early-childhood-intervention-services</a>.

### Incomplete Prior Authorization Essential Information



- When Superior receives a request for PA for a STAR Health member and the request does not contain all essential information to set up an authorization or it is illegible, the request will be returned to the provider, outlining the information that is missing/must be submitted.
  - Essential Information is prescribed in the HHS UMCM, Chapter 3.22, II.
     A., and includes all elements below:
    - Member name, Medicaid ID number and date of birth.
    - Requesting and rendering/servicing provider name, National Provider Identifier (NPI) and Tax Identification Number (TIN).
    - Service requested Current Procedural Terminology (CPT), Healthcare Common Procedure (HCPCS).
    - Service requested start and end date(s).
    - Quantity of service units requested.



- An incomplete Medicaid PA request is a request in which clinical information/documentation is incomplete or insufficient.
  - Superior's Medical Management department will communicate the request to supply the missing but required clinical information to proceed with the medical necessity review through a faxed request to the provider's office. Providers may also receive a phone call requesting missing clinical information, as necessary and appropriate.
  - The written or verbal notice containing the details of the incomplete/insufficient clinical documentation is delivered to the provider via fax or phone, within 3 business days after receipt of a PA request containing all essential information.
    - The member receives a written notice of the request for submission of the incomplete clinical information.



- Providers must supply the requested clinical information/documentation within 3 business days after the request. If the clinical information/documentation is not received within the required timeframe, the case will be reviewed with the incomplete or insufficient information received with the PA request.
- The requested clinical should be faxed to Medical Management, using the appropriate fax number for the service for which authorization is requested.



- The exceptions for faxing clinical information for STAR Health services are denoted in the listing below:
  - STAR Health Prior Authorization Fax Lines:
    - Physical Health Acute Care Services: 1-866-918-2268
    - Outpatient DME: 1-800-521-8836
    - Behavioral Health Services: 1-866-570-7517
    - Biopharmacy Services: 1-866-683-5631
    - PT, OT, ST: 1-844-218-1157



- Medical Management provides notice of the determination of approval or denial of the PA request within 3 business days after receipt of a complete PA request.
- Reasonable opportunity for physician peer-to-peer discussion is offered prior to adverse determination on all PA requests, including incomplete PA requests. To schedule a peer-to-peer discussion, the referring physician may contact 1-877-398-9461, option 3.
- For STAR Health members, outreach to the medical consenter or DFPS case worker will be made prior to adverse determination.

### Referrals/Authorizations Tips



- PCP must initiate the referral.
- Specialist may NOT refer to another specialist, unless the specialist chooses to act as the member's PCP.
- Reminder: The following information must be provided to the referral specialist at least 5 working days in advance for non-emergent services:
  - Demographics.
  - Provider Information (NPI, TIN, fax number and contact number).
  - Requested services, HCPCS and CPT codes (if applicable), and dates of service, using the 2021 Outpatient Medicaid Authorization Form located in the "Prior Authorization" section of Superior's Behavioral Health webpage:
     <a href="https://www.SuperiorHealthPlan.com/providers/resources/behavioral-health.html">www.SuperiorHealthPlan.com/providers/resources/behavioral-health.html</a>
  - Clinical information needed to process request.

# National Imaging Associates – Radiology Authorizations



- National Imaging Services (NIA) is contracted with Superior to perform utilization review for High-Tech Imaging Services, including:
  - Coronary Computed Tomography Angiography (CCTA)
  - Computerized Tomography (CT)/
- Computed Tomography Angiography (CTA)
  - Cardiology/Myocardial Perfusion Imaging (MPI)
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
  - Nuclear
  - Positron Emission Tomography (PET)Scan
  - Stress Echo
- The ordering physician is responsible for obtaining an authorization by:
  - Accessing <u>www.radmd.com</u>, or calling 1-800-642-7554.
- Emergency room, observation and inpatient imaging procedures do not require authorization.
- Servicing providers and imaging facilities may access status of authorizations by:
  - Accessing <u>www.radmd.com</u>, or accessing Integrated Voice Response (IVR) at 1-800-642-7554.

### NIA - Interventional Pain Management (IPM) Authorizations



- NIA also manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR Health members 21 years of age and older.
- It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined on the following slide.
- Authorizations are valid for 30 days from the date of the request.

# NIA - Interventional Pain Management (IPM) Authorizations



- Outpatient IPM procedures requiring prior authorization include:
  - Spinal Epidural Injections.
  - Paravertebral Facet Joint Injections or Blocks.
  - Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis).
  - Sacroiliac Joint Injections.
- Note: A separate prior authorization number is required for each procedure ordered.
- To obtain authorization through NIA, visit <u>RadMD.com</u> or call 1-800-642-7554.
- Note: Prior authorization is not required through NIA for services performed in the emergency department or on an inpatient basis.
  - Authorization and/or notification of admission is still required through Superior.

### TurningPoint HealthCare Solutions



- TurningPoint is responsible for processing PA requests for medical necessity and appropriate length of stay for Musculoskeletal surgical procedures.
- PA is required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings\*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Acromioplasty and Rotator Cuff Repair	Cervical
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Hip Arthroplasty and Arthroscopy	Laminectomy/Discectomy
Knee Arthroplasty and Arthroscopy	Lumbar
Osteochondral Defect Repair	Spinal Fusion Surgeries
Uni/Bi-compartmental Knee Replacement	Thoracic

<sup>\*</sup>This is not an all-inclusive list. For a detailed list of impacted CPT codes, visit TurningPoint's Web Portal or <a href="https://www.SuperiorHealthPlan.com/providers/preauth-check.html">www.SuperiorHealthPlan.com/providers/preauth-check.html</a>.

# TurningPoint Healthcare Solutions Expansion



- Superior has expanded the partnership with TurningPoint to process PA requests for medical necessity and appropriate length of stay for certain Cardiac procedures, ENT surgeries and sleep study procedures for STAR Health members.
- PA is required for the following Cardiac surgical procedures in both inpatient and outpatients settings:
  - Arterial Procedures
  - Coronary Angioplasty/Stenting
  - Coronary Artery Bypass Grafting
  - Implantable Cardioverter
     Defibrillator (ICD)
  - ICD Revision or Removal
  - Left Atrial Appendage Occluders

- Loop Recorders
- Non-Coronary Angioplasty/Stenting
- Pacemaker
- Pacemaker Revision or Removal
- Valve Replacement
- Wearable Cardiac Defibrillator

# TurningPoint Healthcare Solutions Expansion



• PA is required for the following Ear, Nose and Throat (ENT) surgeries and sleep studies performed in the inpatient, outpatient, physician's office and in-home settings:

#### **Sleep Study Procedures**

Actigraphy

Home Sleep Study

Multiple Sleep Latency and Maintenance of Wakefulness Testing

Polysomnography

#### **ENT Surgeries**

Balloon Dilation Esophagoscopy

**Cochlear Implant Device** 

Laryngoscopy and Laryngoplasty

Rhinoplasty and Septoplasty

Sinus Surgery

Thyroidectomy and Parathyroidectomy

Tonsillectomy (with or without Adenoidectomy)

Tympanostomy and Tympanoplasty

### TurningPoint HealthCare Solutions



- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services listed on the previous slides should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under "Billing Resources" at <u>www.SuperiorHealthPlan.com/providers/resources.html</u>.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:

Web Portal Intake: <a href="http://www.myturningpoint-healthcare.com">http://www.myturningpoint-healthcare.com</a>

Telephonic Intake: 1-469-310-3104 or 1-855-336-4391

Facsimile Intake: 1-214-306-9323



### Claims

Filing and Payment

### Claims Filing: Submitting Claims



- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - Visit <u>www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html</u> for a list of our Trading Partners.
  - Superior Emdeon ID: 68069
    - 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 63640-3803

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

• Effective January 1, 2020, medical eye services provided by an ophthalmologist will be submitted to Superior for processing.

### 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.

#### **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, diagnosis (Dx) code, etc.
  - The original claim number must be billed in field 64 of the Center for Medicare and Medicaid Services (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 Superior STAR, CHIP,
     STAR+PLUS, STAR Health and STAR Kids Provider Manual, may be used when submitting a corrected claim.

### Common Billing Errors



- Member date of birth or name does not match ID card/member record.
- Code combinations not appropriate for demographic of member.
- Not filed timely.
- No itemized bill provided when required.
- Diagnosis code not to the highest degree of specificity; 4<sup>th</sup> or 5<sup>th</sup> digit when appropriate.
- Illegible paper claim.

### 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 <u>www.PaySpan.com</u>.
- For further information contact 1-877-331-7154, or email <a href="mailto:ProviderSupport@PaySpanHealth.com">ProviderSupport@PaySpanHealth.com</a>.

### Member Balance Billing



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

### 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.
  - Medical Necessity Appeals.
  - PA.
  - Provider Complaints Related to Medical Eye Care Services.
  - Provider Relations/Account Management.
  - Provider Services.
  - Retrospective Utilization Review.
  - 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 PA, refer to Superior's Prior Authorization tool: <a href="https://www.SuperiorHealthPlan.com/providers/preauth-check.html">www.SuperiorHealthPlan.com/providers/preauth-check.html</a>



# Electronic Visit Verification (EVV)

# 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 attendants or CDS employees providing covered services to an individual or health plan member must use the EVV system to record visit arrival and departure times.
- The program provider, Financial Management Services Agency (FMSA) or CDS employer will use the time recorded in the EVV system to determine billable units/hours.
- The EVV system:
  - Electronically verifies the occurrence of authorized personal attendant service visits.
  - Electronically documents the precise time a service delivery visit begins and ends.

# Services Requiring EVV



- Personal Care Services (PCS)
- Community First Choice Personal Assistance Services (CFC-PAS) and Habilitation (CFC-HAB)
- In-home Respite Services
- Flexible Family Support Services

### **EVV Claims**



- Providers, FMSAs or CDS employers will verify EVV visits using their selected EVV vendor system.
- All EVV claims must match to an accepted EVV visit in the EVV Aggregator (the state's centralized EVV database) in order to receive payment.
- Superior will only pay for verified units of service aligning with EVV data.
- To avoid denials, claims for multiple dates of service should be billed on a separate line for each day with the number of units per day.

### **EVV Claims**



- EVV claims must be billed to TMHP and will be subject to the EVV claims matching process.
- The info 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 EVV will result in denials
    - Providers or FMSAs will be required to resubmit any denials to TMHP.

# Personal Care Services Oversight



- Effective September 1, 2020, HHS mandated MCOs to require PCS agencies to conduct unannounced visits to validate that services are rendered and billed correctly.
- This requirement was put into place for the STAR+PLUS, STAR Health and STAR Kids programs.
- To comply with this new requirement, Superior has initiated audits of randomly selected PCS agencies to validate agency compliance with program integrity policies and procedures.
- Upon receipt of Superior's PCS oversight audit request, all requested documentation should be submitted to <u>Statewide.AM@SuperiorHealthPlan.com</u> within the specified timeframe.



# Telemedicine and Telehealth

### What is Telemedicine?



- Telemedicine services are medical services delivered by a physician to a member at a different physical location. Using telecommunications or information technology, providers are able to see and hear the member in "real" time.
- Providers must be licensed in Texas or be under the supervision of a licensed provider licensed in Texas. Provider types able to practice telemedicine include:
  - Physicians.
  - Clinical Nurse Specialists.
  - Nurse Practitioners.
  - Physician's Assistants.
  - Certified Nurse Midwifes.
- Providers must receive informed consent to treat using telemedicine services from the member, or the member's parent or guardian.

### What is Telehealth?



- Telehealth services are health-care services, other than telemedicine medical services, delivered to a patient at a different physical location.
- Telehealth is a benefit when provided by these provider types:
  - Licensed Professional Counselor.
  - Licensed Marriage and Family Therapists (LMFT).
  - Licensed Clinical Social Workers (LCSW).
  - Psychologist.
  - Licensed Psychological Associate.
  - Provisionally Licensed Psychologist.
  - Licensed Dietitian.

# Covered Benefits of Telemedicine and Telehealth



- Telemedicine and telehealth may be delivered via:
  - Synchronous (real time) audiovisual interaction between the provider and the client in another location using a mobile app or live online video.
  - Asynchronous technology (i.e. member sends information to the provider and provider responds after review). Documentation may include:
    - Clinically relevant photographic or video images, including diagnostic images.
    - The member's medical records (i.e. medical history, lab results and prescriptive histories).
  - Other forms of audiovisual communication that allow the provider to meet the inperson visit standard of care.
- Reimbursement may not be provided for audio-only interactions such as:
  - Telephone consultations.
  - Text-only email messages.
  - Facsimile transmissions.

# Covered Benefits of Telemedicine and Telehealth



- For a list of CPT codes that are covered under telemedicine and telehealth, please see pages 6 and 10 of the TMHP Telecommunication Services Handbook (<u>www.TMHP.com</u>).
  - The codes listed must be billed with modifier 95.
  - Procedure codes for behavioral health services are subject to the same benefits and limitations as in-person visits.
- For behavioral health services, Q3014 must be billed with modifier 95.
- Patient site providers may be reimbursed for Q3014 in a facility setting;
   however, it is not a benefit of telehealth services.
- Texas Health Steps checkups are not a benefit under telemedicine or telehealth.
- Distant site providers issuing prescriptions must follow the same standards as would be applied during an in-person visit.



### Secure Provider Portal

# Superior Website and Secure Provider Portal



#### Visit <u>www.SuperiorHealthPlan.com</u>.

- Submit:
  - Claims
  - PA Requests
  - Request for EOPs
  - Provider Complaints
  - Notification of Pregnancy
  - COB Claims
  - Adjusted Claims

- Verify:
  - Member Eligibility
  - Claim Status
- View:
  - Provider Directory
  - Provider Manuals
  - Provider Training Schedule
  - Links for Additional Provider Resources
  - Claim Editing Software

# How to Register for the Provider Portal



- Visit <u>Provider.SuperiorHealthPlan.com</u>.
- Enter your provider/group name, TIN, 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: Authorizations



#### Create Authorizations

- Enter the member's member ID/last name and date of birth, then click Find.
- Populate the 6 sections of the authorization with the appropriate information, starting with 1. Provider Request
- Follow the prompts and complete all required information.
- Attach any required documentation, review and submit.

#### Check Authorization Status

- Enter confirmation 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. 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 18 months prior.

#### View Web Claims

- Click on the claims module to view submitted claims.
- Claims can be viewed in a 1 month date range.

#### 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."

# Additional Provider Portal Information



- Online Assessment Forms
  - Notification of Pregnancy (NOP)
- Resources
  - Practice Guidelines and Standards
  - Training and Education
- Contact Us (Web Applications Support Desk)
  - Phone: 1-866-895-8443
  - Email: <u>TX.WebApplications@SuperiorHealthPlan.com</u>



# Health Passport Clinical Training Guide

## Health Passport

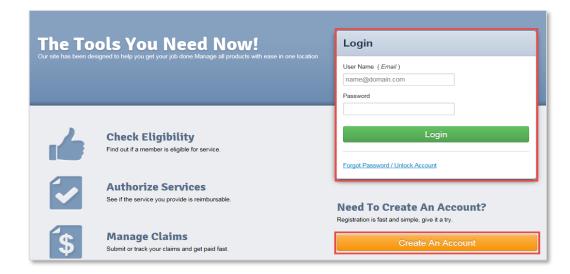


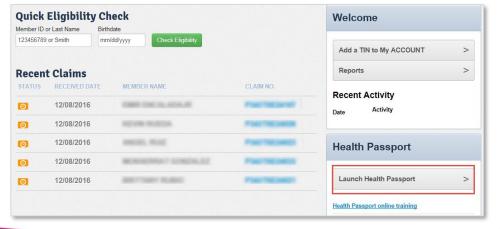
- Health Passport is a secure web-based application built using core clinical and claims information to deliver relevant health-care information when and where it is needed.
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination.
  - Eliminate waste.
  - Reduce errors.
- To log on to Health Passport, visit <u>Provider.SuperiorHealthPlan.com</u>.
- For additional information, visit <a href="www.FosterCareTX.com/for-providers/health-passport.html">www.FosterCareTX.com/for-providers/health-passport.html</a>.

## Provider Access Setup



- Go to Superior's Secure Provider Portal.
- To log in, 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.
- 3. To access Health Passport, click the Launch Health Passport button from your account homepage.





### Member Search



 To search for a member, enter the first few letters of the first and last name and one of the three ID numbers (Medicaid ID, Social Security Number [SSN] or DFPS ID) and click Go.



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

### Member Search



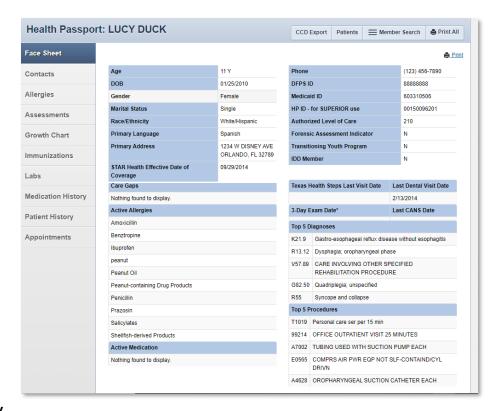
Click the member name to access the member's health record.



### **Face Sheet**



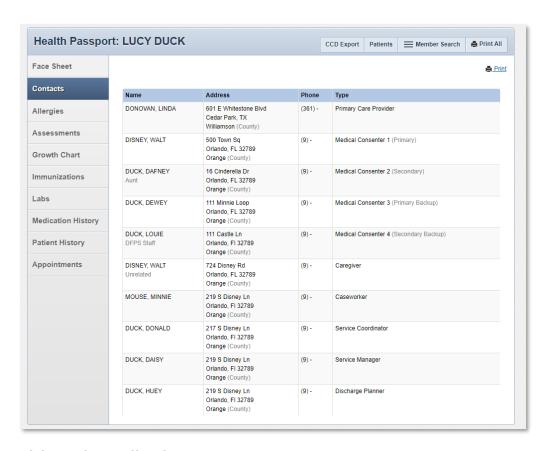
- This module provides a quick overview of the member's health record, including common diagnoses and procedures, active medications, active allergies, care gaps and member demographics.
- New features:
  - Providers have the ability to export the Continuity of Care Document (CCD), allowing providers to upload the complete health record for the member to their Electronic Medical Record (EMR) system.
  - The STAR Health Effective Date, IDD Member Flag, Last CANS Date and 3-Day Exam Date were recently added.



### Contacts



- This module displays a member's medical and personal contacts.
  - Contact information for the Service Manager, Service Coordinator and Discharge Planner are now included to enhance care coordination for the foster care member.

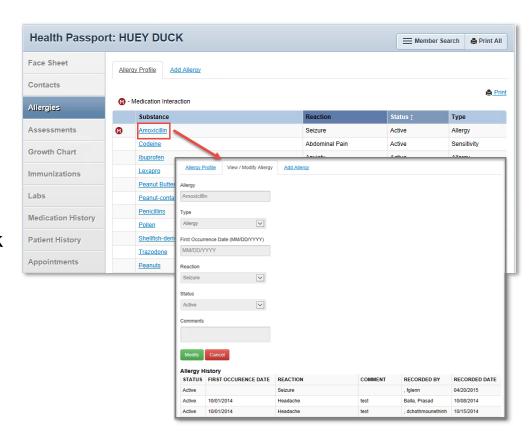


Note: Caregivers are not necessarily considered medical consenters.

# Allergies



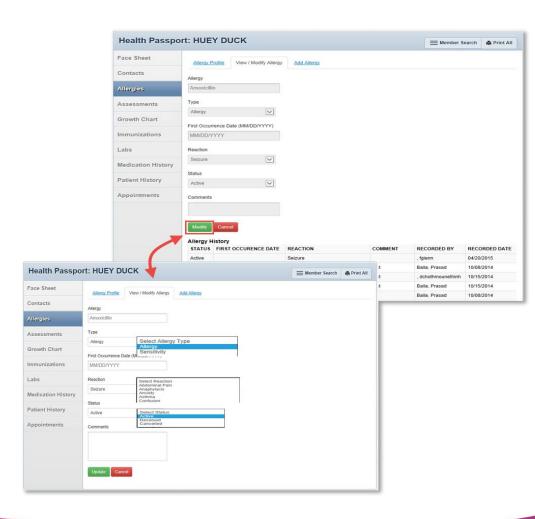
- This module contains all allergies for a member entered by providers.
  - Click the allergy name to view the allergy history.
  - indicates an interaction with a prescribed medication.
  - If an allergy has a comment associated with it, an asterisk (\*) appears next to the allergy name.
  - The strikethroughs indicate:
    - Resolved status: an allergy the member no longer experiences.
    - Canceled status: an allergy that could be mistakenly entered.



# Modify Allergy



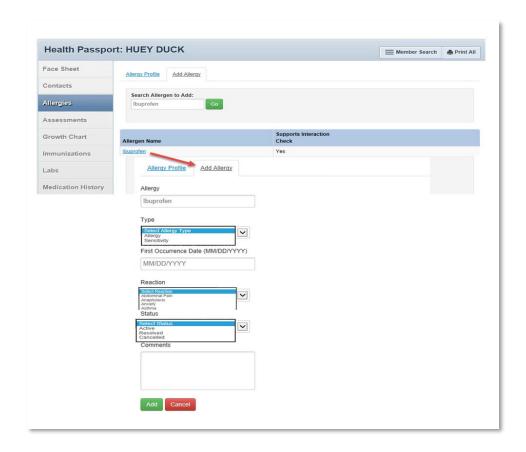
- Providers have the ability to modify allergies.
  - 1. Click Modify.
  - 2. Modify allergy name, type, occurrence date, reaction, status or comments.
  - 3. Click **Update** to save changes.



## Add Allergy



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



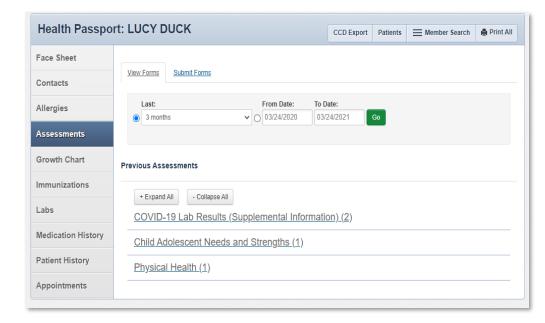
### **Assessments**



- This module allows providers to document Texas Health Steps, Dental and Behavioral Health forms directly online. Providers can also see if the member has been tested for COVID-19. Click on form name to open the document.
  - Expand or collapse all forms by clicking the Expand All and Collapse All buttons.
- Mailing or faxing in documents critical to member care for display is also available.

Fax: 1-866-274-5952

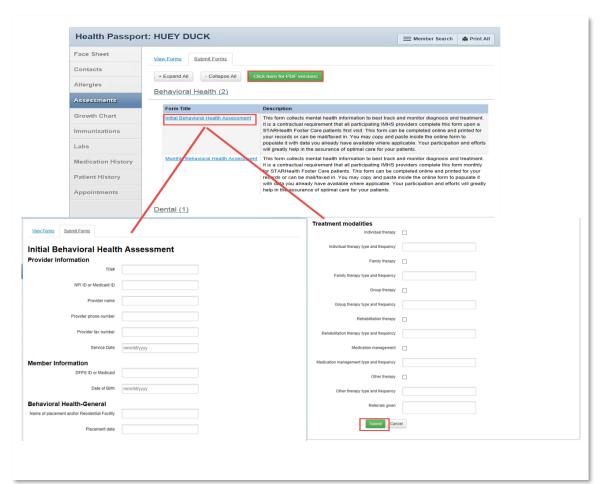
Mail: Superior HealthPlan
 P.O. Box 3003
 Farmington, MO 63640-3803



### Submit Forms



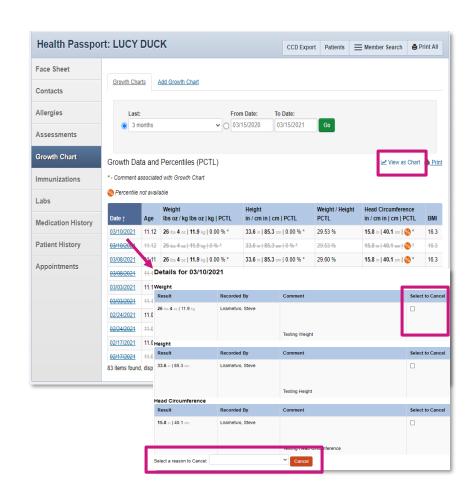
- To complete and submit forms, click on the Submit Forms tab.
  - 1. Open a form by selecting the **Form Title**.
  - 2. Fill in all relevant information.
  - 3. Click the **Submit** button.
- Click PDF versions to be directed to the Health Passport Forms section on FosterCareTX.com, where a blank form can be printed.



### **Growth Chart**



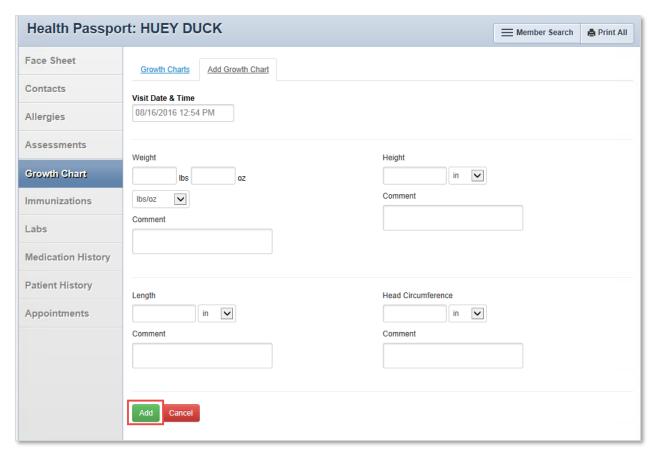
- This module contains height, weight, length and head circumference entered by providers. and calculates Body Mass Index (BMI) when applicable.
  - Click a date and time to view details for that date.
  - An asterisk (\*) indicates there is a comment associated with the entry.
- Modify chart by clicking the box
   Select to unchart, select a reason to
   unchart, then click Unchart. A
   strikethrough will appear in place of
   uncharted entries.
- The module also now offers the ability to view the information entered as a chart by clicking View as Chart.



### Add a Growth Chart



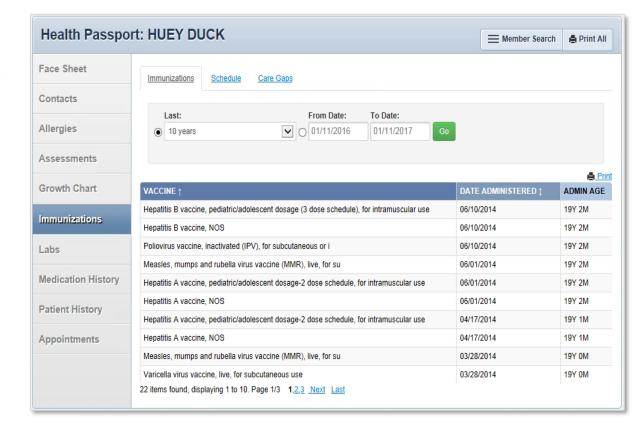
- Click the Add
   Growth Chart tab
   to add new growth
   measurements.
  - 1. Fill in weight, height, length, head circumference, and add comments, if applicable.
  - 2. Click Add.



### **Immunizations**



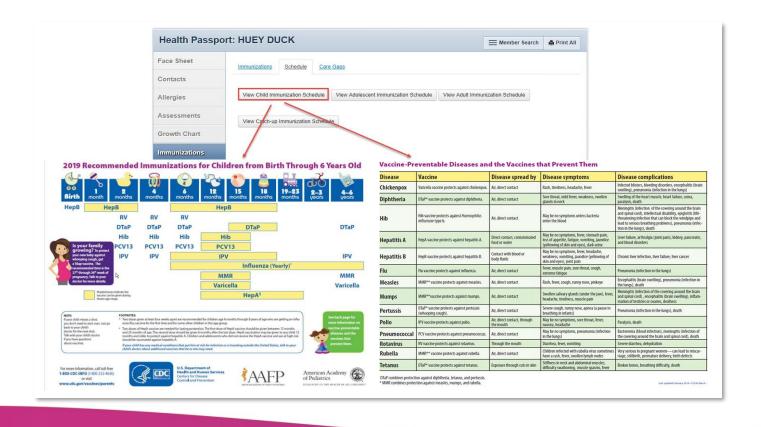
- This module presents a comprehensive list of a member's immunizations that have been reported to ImmTrac, the Texas Immunization Registry.
- Additionally, there is a tab that displays immunization schedules for the Centers for Disease Control and Prevention (CDC). The "Care Gaps" tab shows any gaps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



## Immunizations: Care Gaps Tab



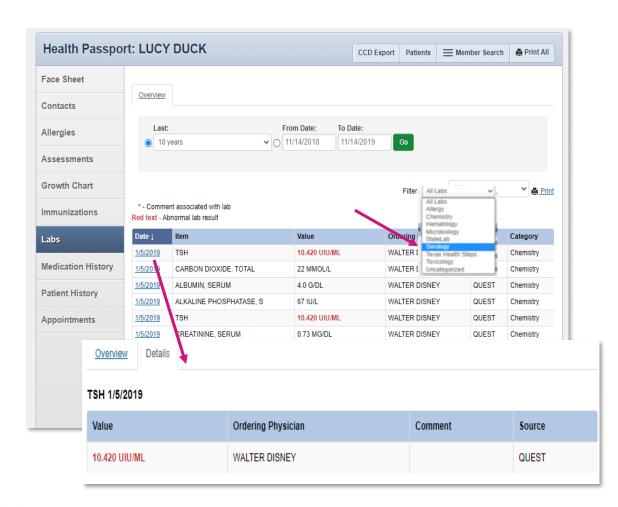
• This tab allows you to identify gaps in care, including missing immunizations.



### Labs



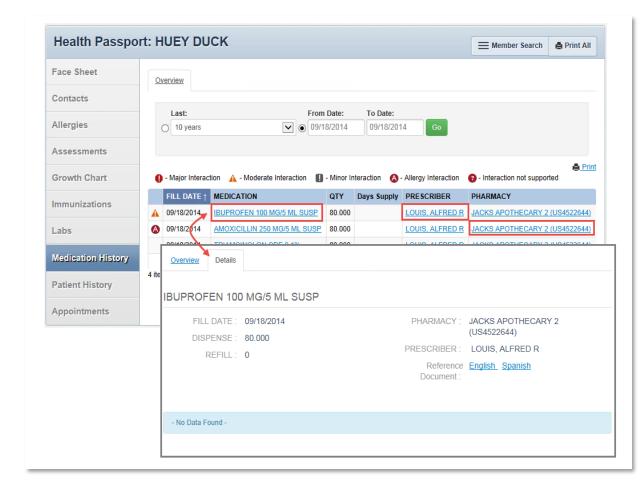
- This module contains a list of a member's lab results.
  - Click on a date and time to view details of labs.
  - By selecting Filter
     Category, you can filter by lab type.



# **Medication History**



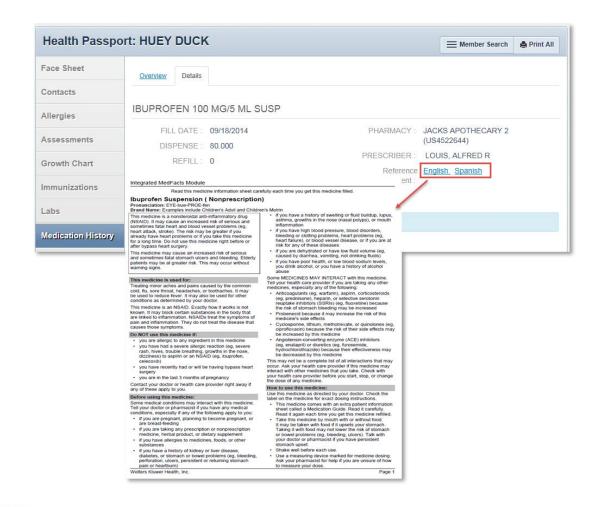
- This module contains a detailed list of medications.
  - Click medication name to view more details.
  - Scroll over
     Prescriber and
     Pharmacy to view
     contact information.
  - The legend of icons
     (① A ② ②) denote
     different medication
     interactions. Major
     interactions are
     potentially life
     threatening.



## Medication History: Details Tab



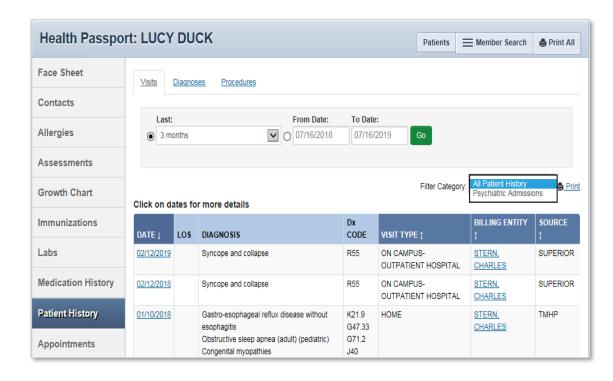
 Select English or Spanish to open a reference document for the given medication.



### **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.

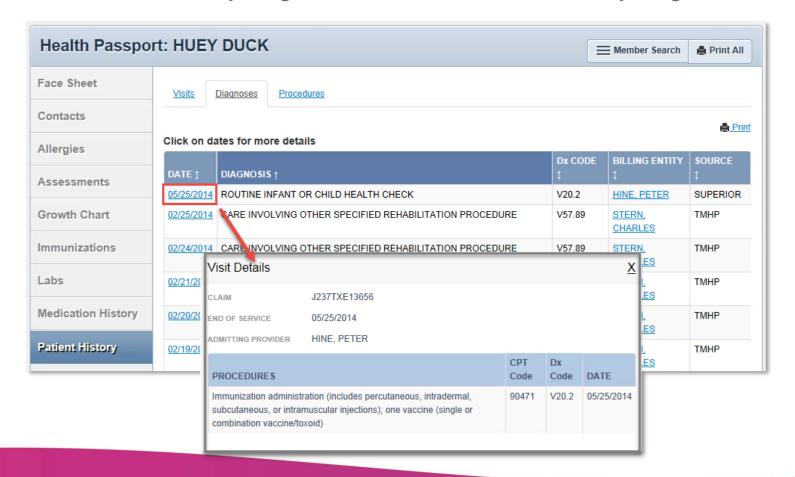


Note: This module should not be used as a tool for claims payments. There is lag time before data is loaded as providers have 95 days to bill and Superior has 30 days to process.

## Patient History: Diagnoses Tab



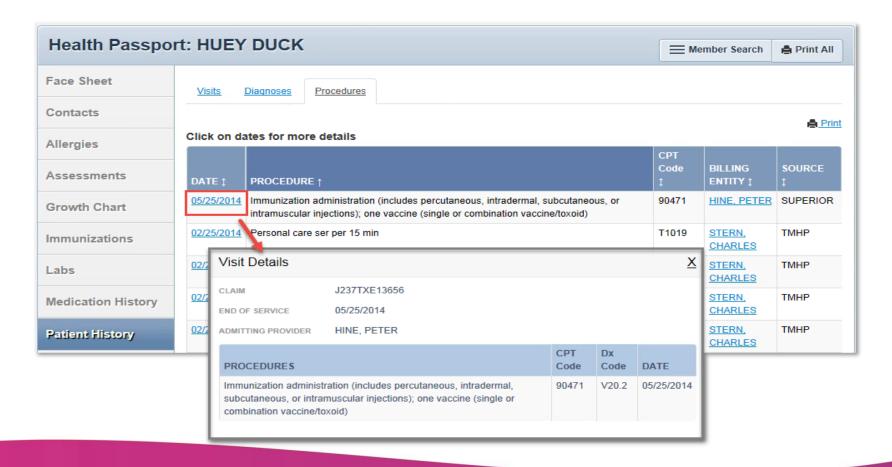
This tab lists visits by diagnoses. Click the date to view by diagnoses.



## Patient History: Procedures Tab



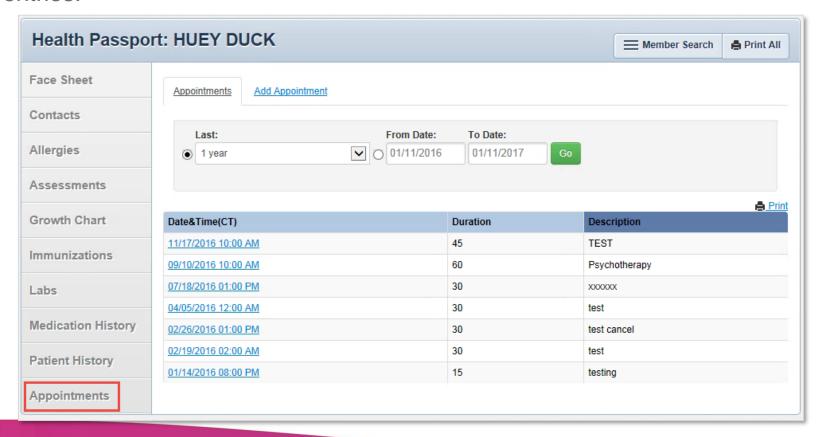
Click the Procedures tab to view visits by procedures.



### **Appointments**



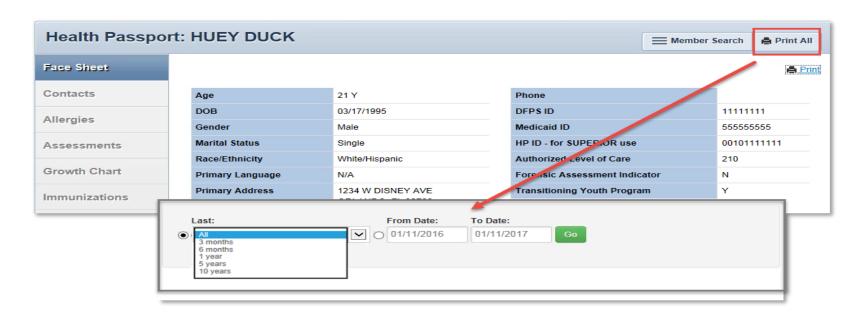
 On this module, users can create, modify and cancel their own appointment entries.



### Other Tools



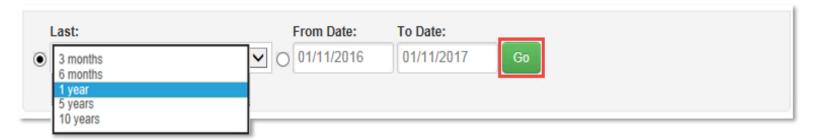
- Member Search: Return to search screen.
- **Print All**: Print complete health record by either (1) selecting a time frame or (2) selecting a date range and clicking **Go**.
- Print: Print single module.
- Demo Info: Hover over member name to view core demographic information.



#### Other Tools



- To filter, select the time frame and date range, then 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.

27 items found, displaying 1 to 10. Page 1/3 1,2,3 Next Last

### 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



- If you are interested in a live demo, contact your Account Manager to schedule a visit.
- If you need additional Health Passport help, contact the Health Passport Support Desk:

- Call: 1-866-714-7996

Email: <u>Tx.PassportAdministration@SuperiorHealthPlan.com</u>



# Superior HealthPlan Departments

We're here to help you!

## 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 and LTSS billing clinics.

Note: You can find a map at <u>www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html</u> to assist you with contact information for your assigned 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 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 <u>www.SuperiorHealthPlan.com/providers/become-a-provider.html</u>.

## Credentialing



- Initial Credentialing
  - Complete a Texas Department of Insurance (TDI) credentialing application form for participation.
  - Complete an electronic application.
  - Provide Council for Affordable Quality
     Healthcare (CAQH) identification number.
  - Complete the Central Registry Check Request for Abuse/Neglect (Form 1600).
  - Email applications to <u>SHP.NetworkDevelopment@Superior</u> HealthPlan.com.

- Re-credentialing
  - Completed every 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 <u>Credentialing@SuperiorHealthPlan.com</u>.
- 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:

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

## Thank you for attending!



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

- For additional STAR Health member information, please visit <u>www.SuperiorHealthPlan.com/for-members/programs/star-health/</u>.
- For questions, please contact your local Account Manager or click on "Contact Us" at <a href="https://www.SuperiorHealthPlan.com">www.SuperiorHealthPlan.com</a>.

Let us know what we can do to help.