STAR Health

Provider Training

SHP_20228738

Agenda

- Foster Care and STAR Health
- 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])
  - Offering telehealth services
  - Providing emergency support and services

- Due to abuse and neglect, children and youth in foster care often have greater health-care needs, including:
  - A history of physical and/or emotional trauma
  - Not receiving proper dental and vision care
  - 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
  - Attorneys ad litem
  - Other involved parties from DFPS and other state agencies
  - Guardians ad Litem
  - Law Enforcement Officials
  - Providers
  - Single Source Continuum Contractors (SSCC) Staff / Community Base Care (CBC)
  - Integrated Care Coordination Vendor Staff
- To contact Service Coordination, call 1-866-912-6283.

STAR Health Membership

- Children and young adults:
  - In DFPS conservatorship
  - In kinship care
  - Young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement
  - Young adults aged 18 through the month of their 21st birthday, who are Former Foster Care Child Members or who are participating in the Medicaid for Transitioning Foster Care Youth Program
  - An infant born to a mother who is enrolled in STAR Health
  - Children through age 17 and young adults aged 18 through the month of their 21st birthday who are receiving Supplemental Security Income (SSI) or who were receiving Supplemental Income before becoming eligible for AA or PCA
  - Children through age 17 and young adults aged 18 through the month of their 21st who are enrolled in a 1915(c) Medicaid Waiver and AA or PCA

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 two separate programs based on their age:
  1. 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.
  2. 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: 1-877-787-8999
  - Online: https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman

Provider Roles and Responsibilities

Provider Roles and Responsibilities

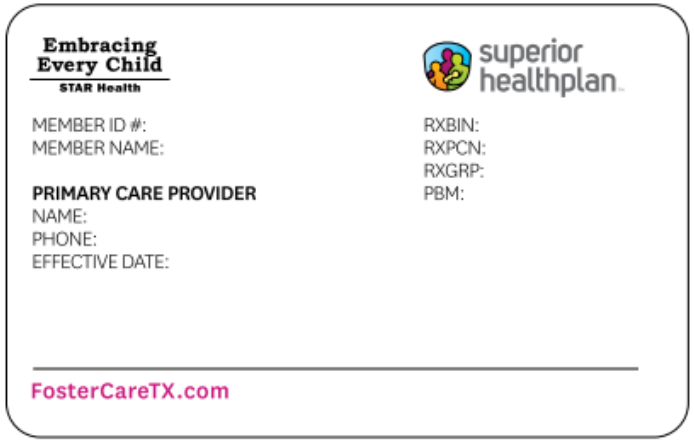
- Eligibility Verification
- PCP Responsibilities
- After-Hours Telephone Arrangements
- PCP Access to Care Requirements
- Referrals
- Member Self-Referral
- Cultural Competency

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 Provider.SuperiorHealthPlan.com.
  - 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 https://secure.tmhp.com/TexMedConnect.
  - 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:



- Disclaimer: Documentation in Health Passport is required* when caring for STAR Health members. For more information, please visit SuperiorHealthPlan.com/HealthPassport.

**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 these requirements 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 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 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 SuperiorHealthPlan.com/ProviderManuals.

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 SHP.Intake@SuperiorHealthPlan.com.
  - 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: SuperiorHealthPlan.com/ProviderForms

Specialty Care Provider Expectations

- Maintain contact with PCP by:
  - Supporting the medical home and integrated primary care
  - Sharing information
  - Ensuring that necessary referrals/authorizations have been obtained prior to the provision of services
  - 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 https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Psychotropic_Medications.asp.
- 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

- It is a contractual obligation that all behavioral health providers 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 when the service being court-ordered is a benefit of Texas Medicaid
  - Providing documentation (reports and/or reviews) as requested
  - Testifying in court

STAR Health Benefits

STAR Health Benefits

- 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
  - Transportation

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 Vendor Drug Program (txvendordrug.com).

Value-added Services

- Care Grants
- Over-the-Counter (OTC) Items
- Extra Vision Services
- Sports Physicals
- a2A My Health Pays
- $20 gift card and journal for completing 7-day follow-up visit after a behavioral health inpatient stay
- For more details or updates, please visit:
  - www.FosterCareTX.com/for-members/about-star-health/value-added-services.html

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 health-care providers are also kept private.
  - STAR Health follows all applicable state and federal confidentiality laws.

Advance Directives

- Federal and state law requires Managed Care Organizations (MCOs) and providers to maintain written policies and procedures for informing all members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives.
- 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.

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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
- Must use U2 modifier when billing the 3-Day Exam
- 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

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

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

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 3rd 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 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.

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
  - 2 weeks
  - 2 months
  - 4 months
  - 6 months
  - 9 months
  - 12 months
  - 15 months
  - 18 months
  - 24 months
  - 30 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 ages 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 non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms, visit https://www.dshs.state.tx.us/lead/child.shtm.

Missed Appointments

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

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 SuperiorHealthPlan.com/ProviderPharmacy
- Prior authorization can be requested through Superior's Pharmacy Benefit Manager (PBM), CVS Caremark:
  - Phone: 1-800-364-6331

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:
  - SuperiorHealthPlan.com/ProviderForms
- Note: Members, care givers or medical consenters are not required to pay for medication just because the child was newly enrolled.
  - If they are at the pharmacy, they should be directed to call Superior and request to speak to a Member Advocate.
  - Superior can utilize the DFPS ID Number to pay for the medication even though the member is not showing as eligible in the system.
  - Superior will need a copy of the 2085B form showing the member is in state conservatorship.

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 http://www.hhs.gov/ocr/privacy.
- 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:
  - An act or failure to act by a person responsible for a child's care, custody, or welfare evidencing the person's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger, rather than a substantial risk, to the child's physical health or safety.
- Exploitation:
  - Misuse of a child with disabilities for personal or monetary benefit. This includes taking Social Security or SSI checks, abusing a joint checking account and taking property and other resources.

How to Report ANE

- Providers must report any allegation or suspicion of ANE to the appropriate entity:
  - 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 psychotropic 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 medium-risk 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:
  - SuperiorHealthPlan.com/ProviderForms
- Call in your request to 1-800-218-7508.
- Log on to the Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- Receive a Reference Number for Inpatient Hospitalization or Outpatient authorizations.
  - For the most up-to-date PA List, visit SuperiorHealthPlan.com/MedicaidPriorAuth.

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 SuperiorHealthPlan.com/ProviderResources under "*Therapy Documents and Policy Clarification*."

Therapy Services - No Prior Authorization Needed

- Prior authorization is not required for initial evaluations or re-evaluations for Physical Therapy, Occupational Therapy, Speech Therapy (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 two Business Days once a disability or developmental delay is identified/suspected.
  - Superior will work with contracted providers to provide ECI services to members who have been determined eligible.
  - For more information, please visit https://hhs.texas.gov/services/disability/early-childhood-intervention-services.

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

Prior Authorization Incomplete Clinical Information

- 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.

Prior Authorization 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.

- 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

Prior Authorization Incomplete Clinical Information

- Medical Management provides notice of the determination of approval or denial of the PA request within three 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 Business 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: SuperiorHealthPlan.com/ProviderBehavioralHealth
  - 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 www.radmd.com, 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 www.radmd.com, 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 RadMD.com 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.

NIA Genetic and Molecular Testing

- Utilization review for genetic and molecular testing services is delegated to NIA for Medicaid, CHIP, and STAR+PLUS MMP members.
- Authorization requests for out-of-network providers should continue to be submitted to Superior.
- Claims should be submitted to Superior for processing
- NIA's Genetic and Molecular Testing clinical guidelines can be found on NIA's Genetic Testing Policies webpage.

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

**This is not an all-inclusive list. For a detailed list of impacted CPT codes, visit TurningPoint's Web Portal or SuperiorHealthPlan.com/PriorAuth.*

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 SuperiorHealthPlan.com/ProviderResources.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
  - Web Portal Intake: http://www.myturningpoint-healthcare.com
  - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
  - Facsimile Intake: 1-214-306-9323

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Medicaid External Appeal Rights - External Medical Review and State Fair Hearing

Medicaid Member New External Appeal Rights – May 2022

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for:
  - Superior service denials and reductions (Phase I – effective 5/1/2022).
  - Eligibility denials for certain programs based on medical or functional necessity (Phase II implementation date not yet scheduled).
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 days of Superior's appeal decision letter.
- If requested, the External Medical Review through an IRO is completed before a State Fair Hearing.

Medicaid Member New External Appeal Rights – May 2022

- There are two types of EMR requests – standard and expedited:
  - Standard EMR Request – IRO Review is completed no later than 10 days following receipt of Superior's records related to the service denial or reduction determination.
  - Expedited EMR Request – IRO review is completed the next business day following receipt of Superior's record for urgent requests.
- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services: Upheld, Partially Overturned or Fully Overturned.
- The IRO will send written notification of its EMR decision to the member, the member's authorized representative or member's LAR (if applicable), Superior and the HHSC EMR Intake Team.
- Superior will implement any partial or full overturn by the IRO within 72 hours.

Medicaid Member New External Appeal Rights – May 2022

- Withdrawal of EMR or State Fair Hearing Requests:

  EMR – The member, the member's authorized representative, or the member's LAR must initiate an EMR request withdrawal communication to Superior before the IRO Review is initiated.

  State Fair Hearing – If the EMR decision is to overturn Superior's adverse determination, the State Fair Hearing will proceed unless the member or member's representative withdraws the request. If the request is not withdrawn, regardless of the EMR decision, the member, the member's authorized representative or the member's LAR is required to attend the State Fair Hearing.

- Provider training on the new EMR process is available at:

  https://attendee.gotowebinar.com/recording/4623254401546558726

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Claims

Filing and Payment

Claims Filing: Submitting Claims

- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - For a list of our Trading Partners visit SuperiorHealthPlan.com/Billing.
  - 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.*

- 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; 4th or 5th 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 www.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.
- 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
  - Prior Authorization
  - 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: uperiorHealthPlan.com/PriorAuth

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.

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 in-person 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 (www.TMHP.com).
  - 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 www.SuperiorHealthPlan.com.

- 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 Provider.SuperiorHealthPlan.com.
- 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: TX.WebApplications@SuperiorHealthPlan.com

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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.

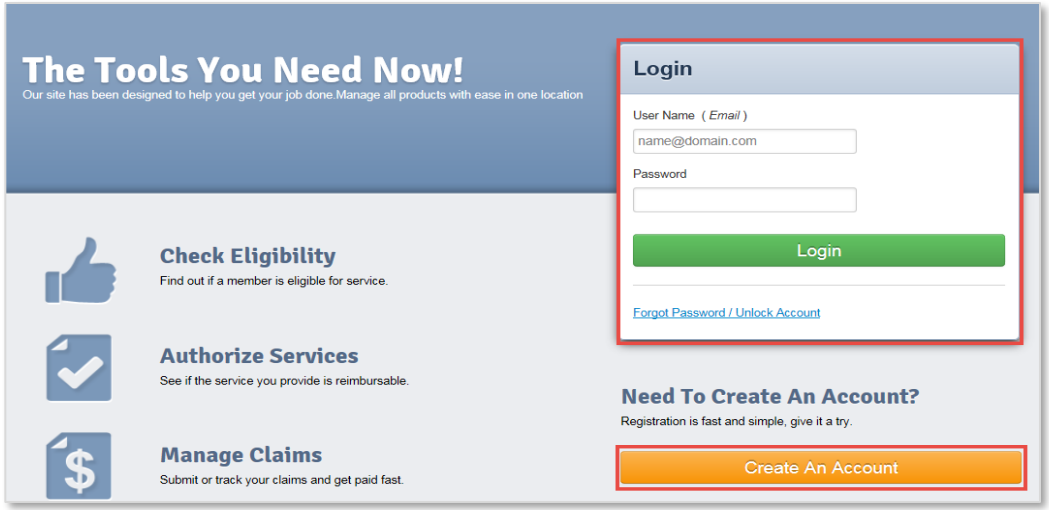
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination
  - Eliminate waste
  - Reduce errors
- To log on to Health Passport, visit Provider.SuperiorHealthPlan.com.
- For additional information, visit www.FosterCareTX.com/for-providers/health-passport.html.

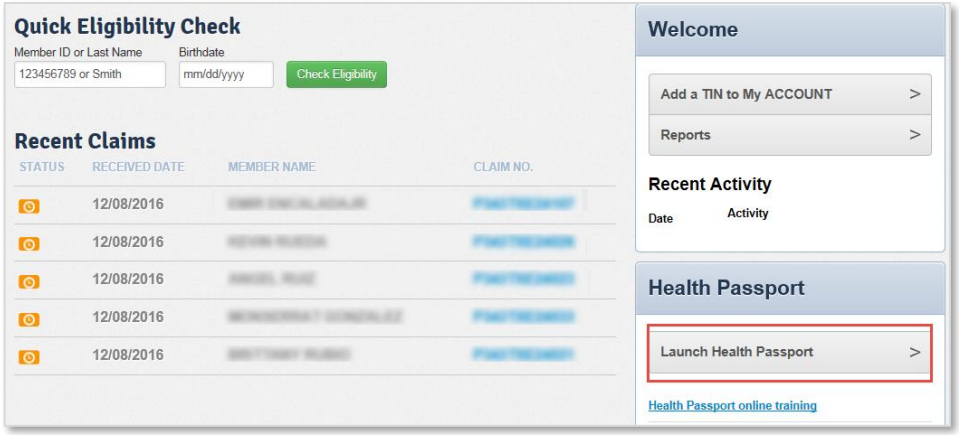
Provider Access Setup

1. Go to Superior's Secure Provider Portal.

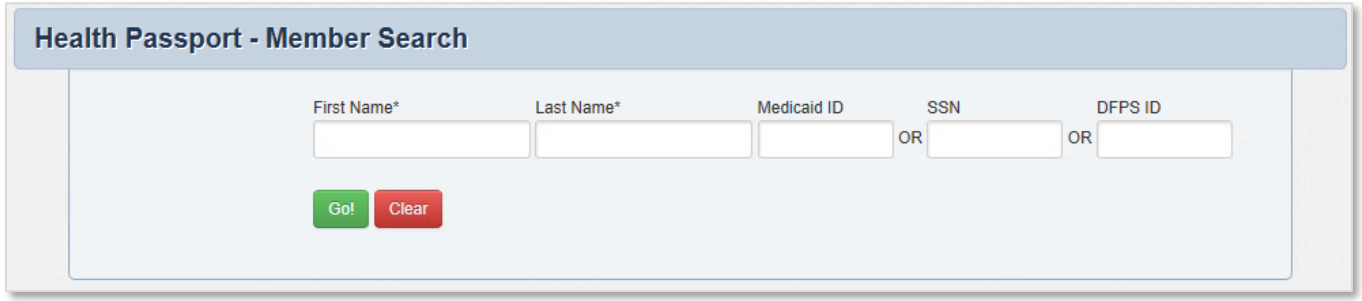
2. To log in, enter the **Username** (email) and **Password** you created during registration. If you need to create an account, click the **Create an Account** button to register.

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.

Health Passport - Member Search

First Name*	Last Name*	Medicaid ID		SSN		DFPS ID
hu	du		OR	223456789	OR	

Go! Clear

ELIGIBLE	NAME	AGE	DOB	GENDER	MEDICAID ID	DFPS ID
	HUEY DUCK	21	03/17/1995	M	555555555	11111111

Face Sheet

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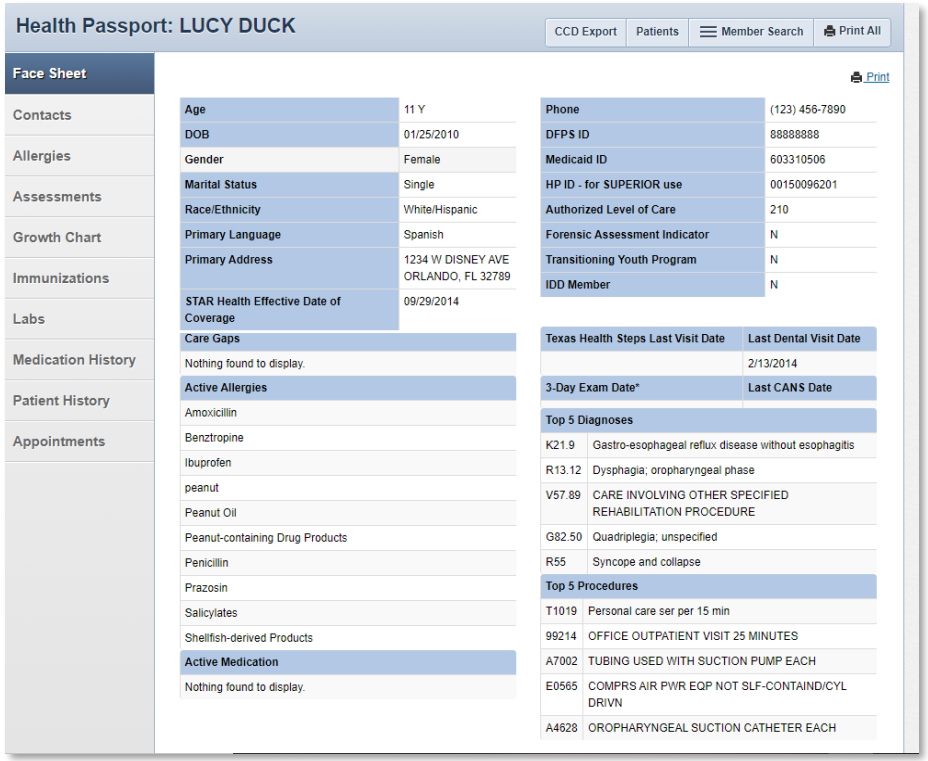
- This module provides a quick overview of the member's health record, including common diagnoses and procedures, active medications, active allergies, care gaps and member demographics.
- New features:
  - Providers have the ability to export the Continuity of Care Document (CCD), allowing providers 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.



Health Passport: LUCY DUCK

CCD Export | Patients | Member Search | Print All

- Face Sheet
- Contacts
- Allergies
- Assessments
- Growth Chart
- Immunizations
- Labs
- Medication History
- Patient History
- Appointments

Print

Age	11 Y
DOB	01/25/2010
Gender	Female
Marital Status	Single
Race/Ethnicity	White/Hispanic
Primary Language	Spanish
Primary Address	1234 W DISNEY AVE ORLANDO, FL 32789
STAR Health Effective Date of Coverage	09/29/2014

Phone	(123) 456-7890
DFPS ID	88888888
Medicaid ID	603310506
HP ID - for SUPERIOR use	00150096201
Authorized Level of Care	210
Forensic Assessment Indicator	N
Transitioning Youth Program	N
IDD Member	N

Texas Health Steps Last Visit Date	Last Dental Visit Date
	2/13/2014
3-Day Exam Date*	**Last CANS Date**

Care Gaps
Nothing found to display.

Active Allergies
Amoxicillin
Benztropine
Ibuprofen
peanut
Peanut Oil
Peanut-containing Drug Products
Penicillin
Prazosin
Salicylates
Shellfish-derived Products

Active Medication
Nothing found to display.

Top 5 Diagnoses	
K21.9	Gastro-esophageal reflux disease without esophagitis
R13.12	Dysphagia; oropharyngeal phase
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
G82.50	Quadriplegia; unspecified
R55	Syncope and collapse

Top 5 Procedures	
T1019	Personal care ser per 15 min
99214	OFFICE OUTPATIENT VISIT 25 MINUTES
A7002	TUBING USED WITH SUCTION PUMP EACH
E0565	COMPRS AIR PWR EQP NOT SLF-CONTAIND/CYL DRIVN
A4628	OROPHARYNGEAL SUCTION CATHETER EACH

Contacts

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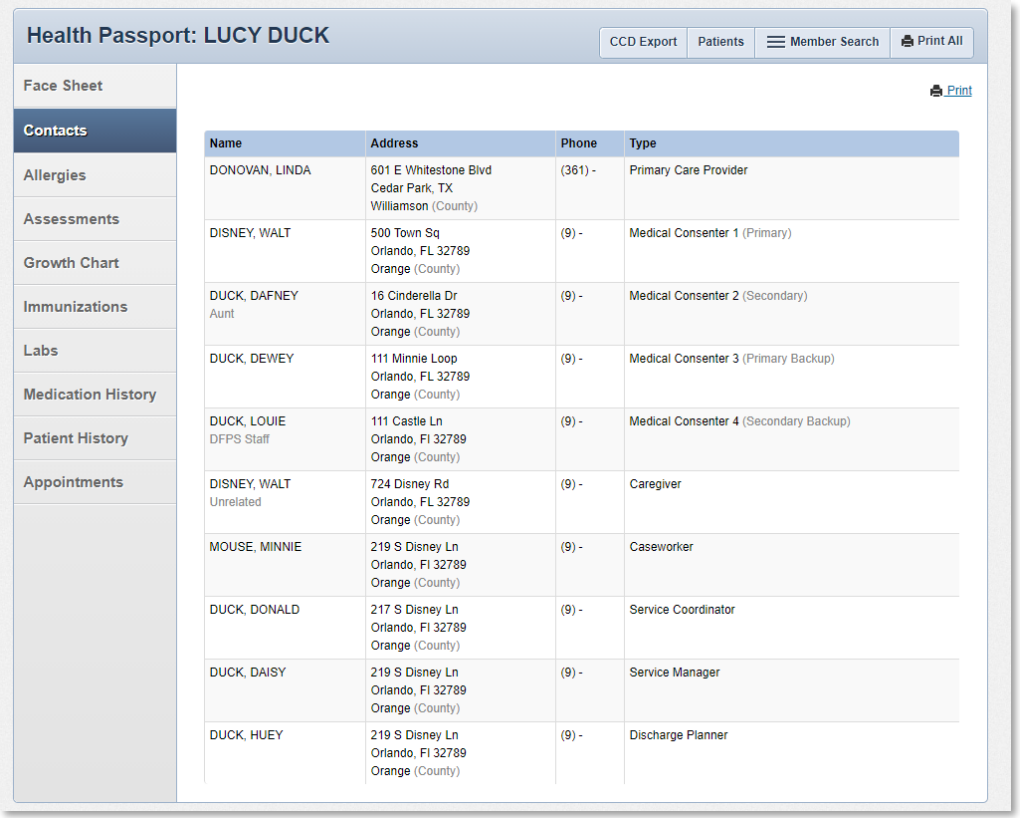
- This module displays a member's medical and personal contacts.
  - Contact information for the Service Manager, Service Coordinator and Discharge Planner are now included to enhance care coordination for the foster care member.

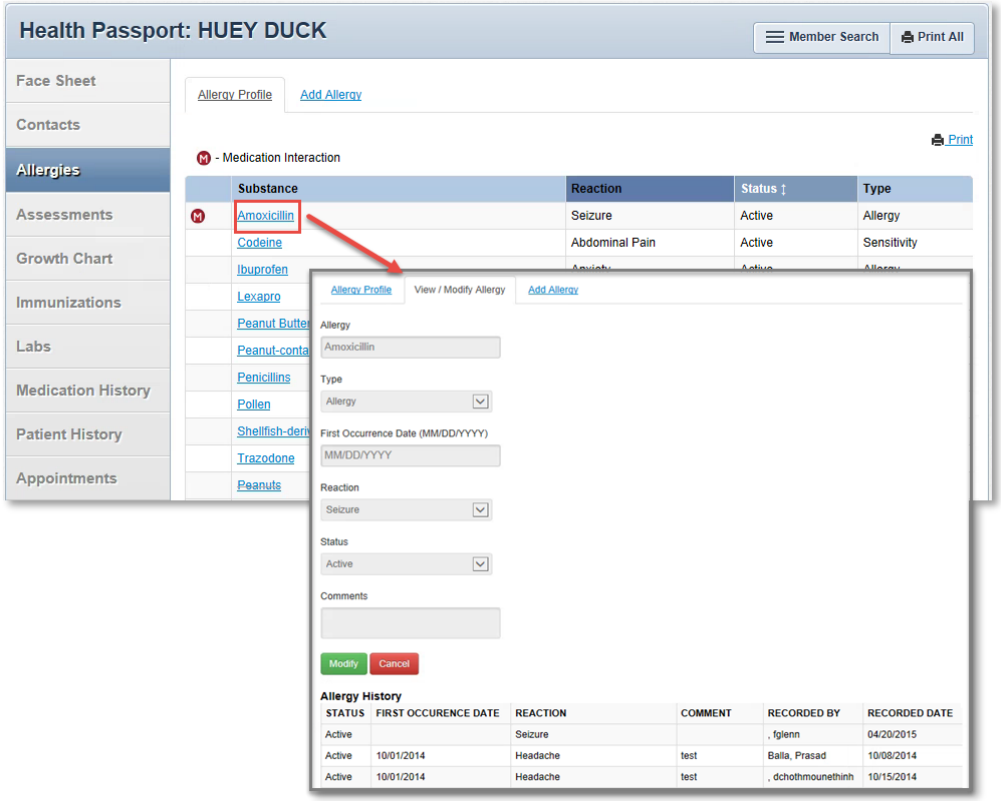


Name	Address	Phone	Type
DONOVAN, LINDA	601 E Whitestone Blvd Cedar Park, TX Williamson (County)	(361) -	Primary Care Provider
DISNEY, WALT	500 Town Sq Orlando, FL 32789 Orange (County)	(9) -	Medical Consenter 1 (Primary)
DUCK, DAFNEY Aunt	16 Cinderella Dr Orlando, FL 32789 Orange (County)	(9) -	Medical Consenter 2 (Secondary)
DUCK, DEWEY	111 Minnie Loop Orlando, FL 32789 Orange (County)	(9) -	Medical Consenter 3 (Primary Backup)
DUCK, LOUIE DFPS Staff	111 Castle Ln Orlando, Fl 32789 Orange (County)	(9) -	Medical Consenter 4 (Secondary Backup)
DISNEY, WALT Unrelated	724 Disney Rd Orlando, FL 32789 Orange (County)	(9) -	Caregiver
MOUSE, MINNIE	219 S Disney Ln Orlando, Fl 32789 Orange (County)	(9) -	Caseworker
DUCK, DONALD	217 S Disney Ln Orlando, Fl 32789 Orange (County)	(9) -	Service Coordinator
DUCK, DAISY	219 S Disney Ln Orlando, Fl 32789 Orange (County)	(9) -	Service Manager
DUCK, HUEY	219 S Disney Ln Orlando, Fl 32789 Orange (County)	(9) -	Discharge Planner

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

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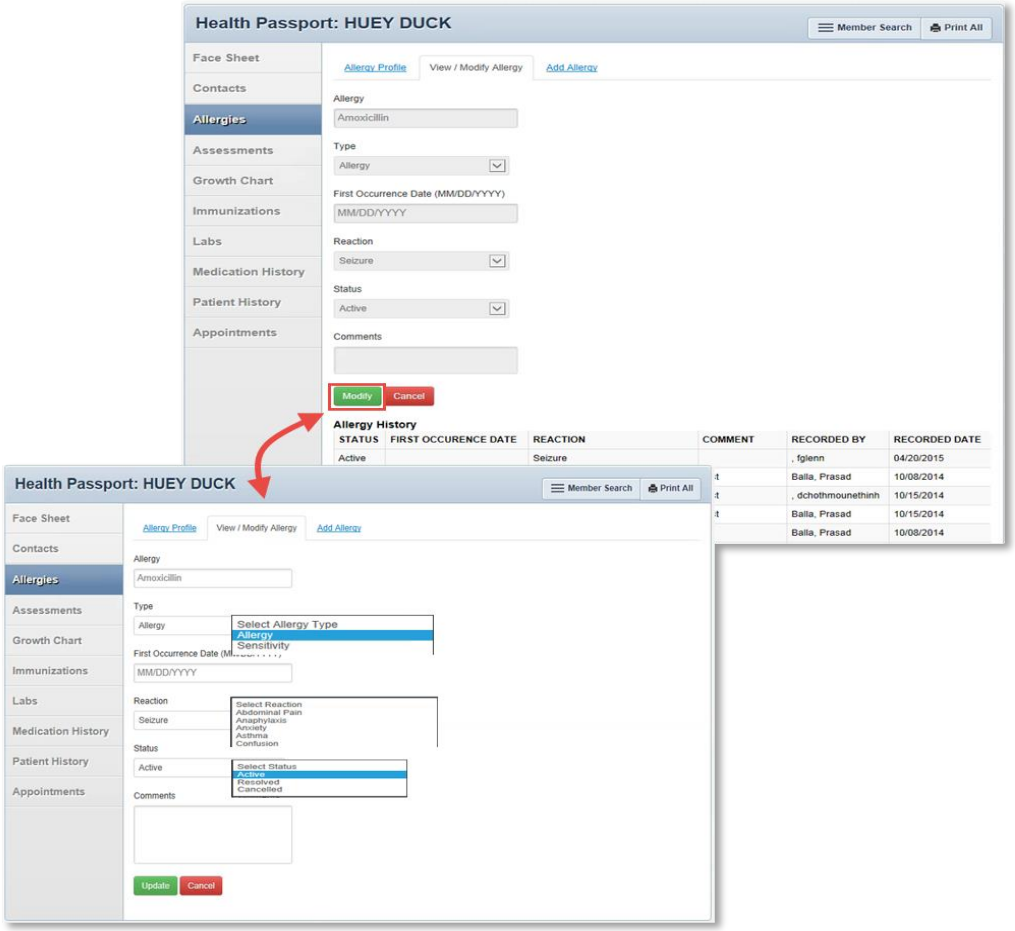
- Providers have the ability to modify allergies.

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



Add Allergy

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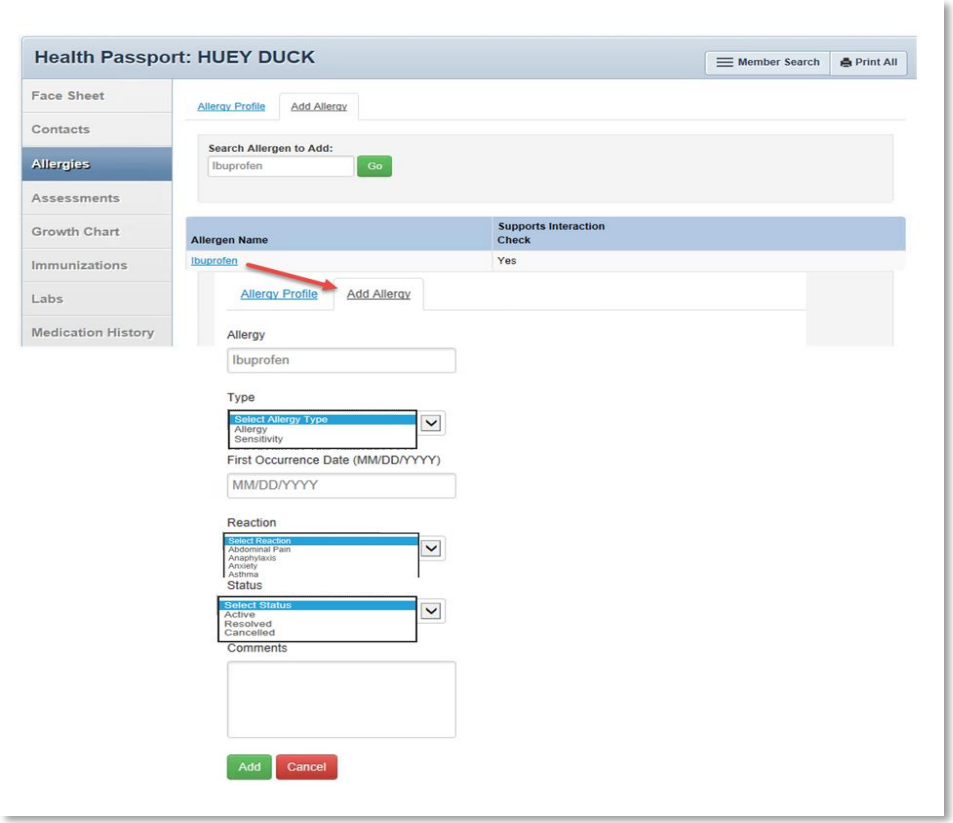
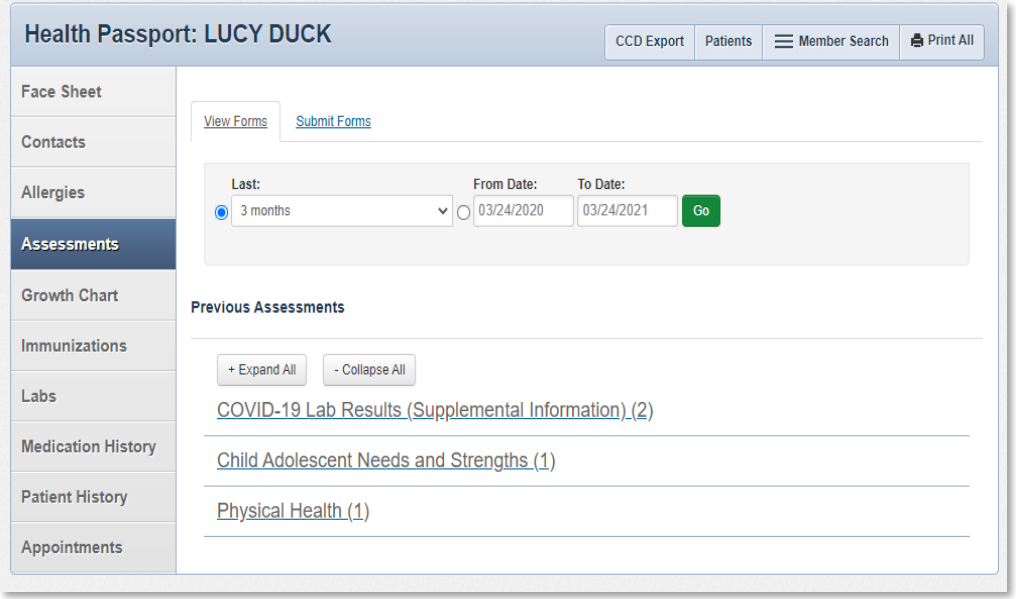
- Providers have the ability to add an allergy.
  1. Search for an allergen and click **Go**. If not found, use the **Add Free Text Allergen** box.
  2. Select allergy name, type, occurrence date, reaction, status and include comments, as applicable.
  3. Click **Add** to save changes.



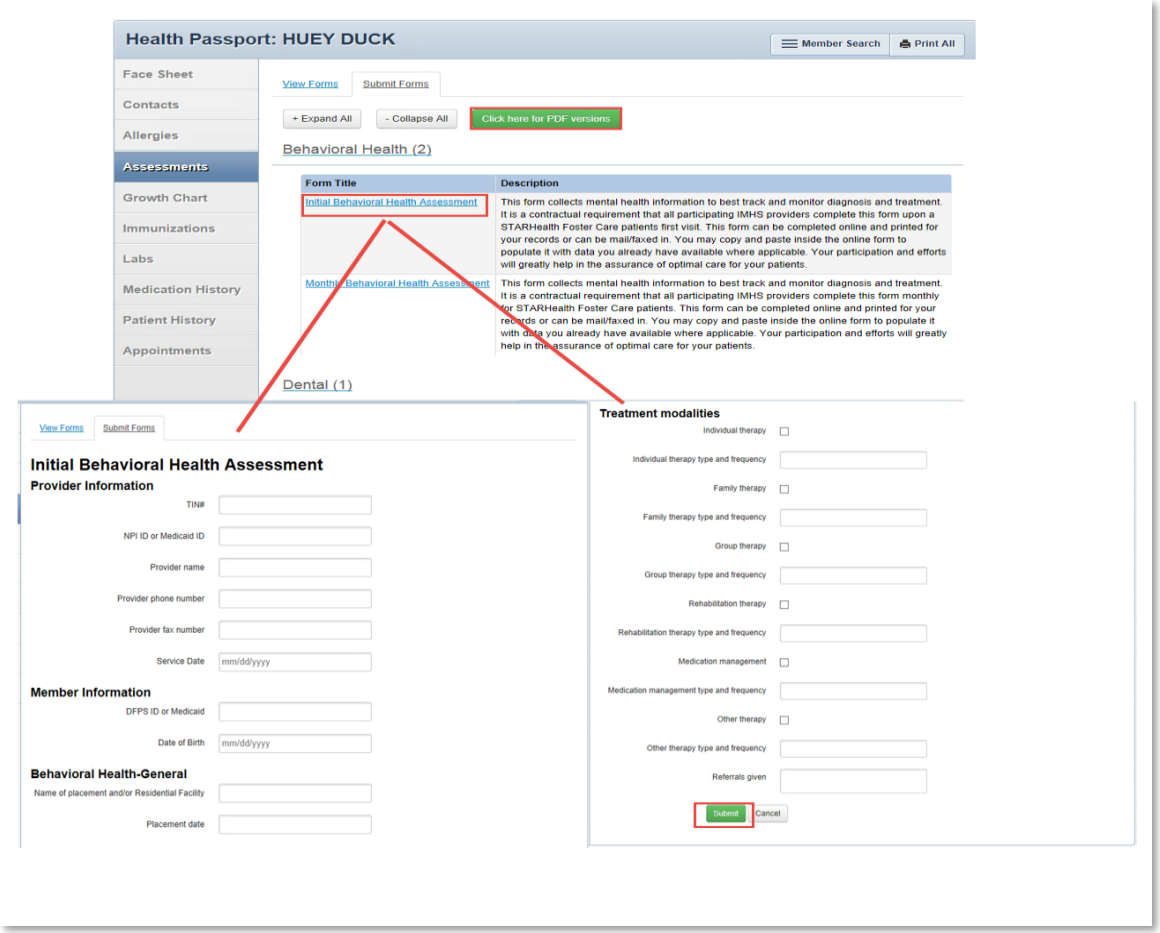
Assessments

- 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



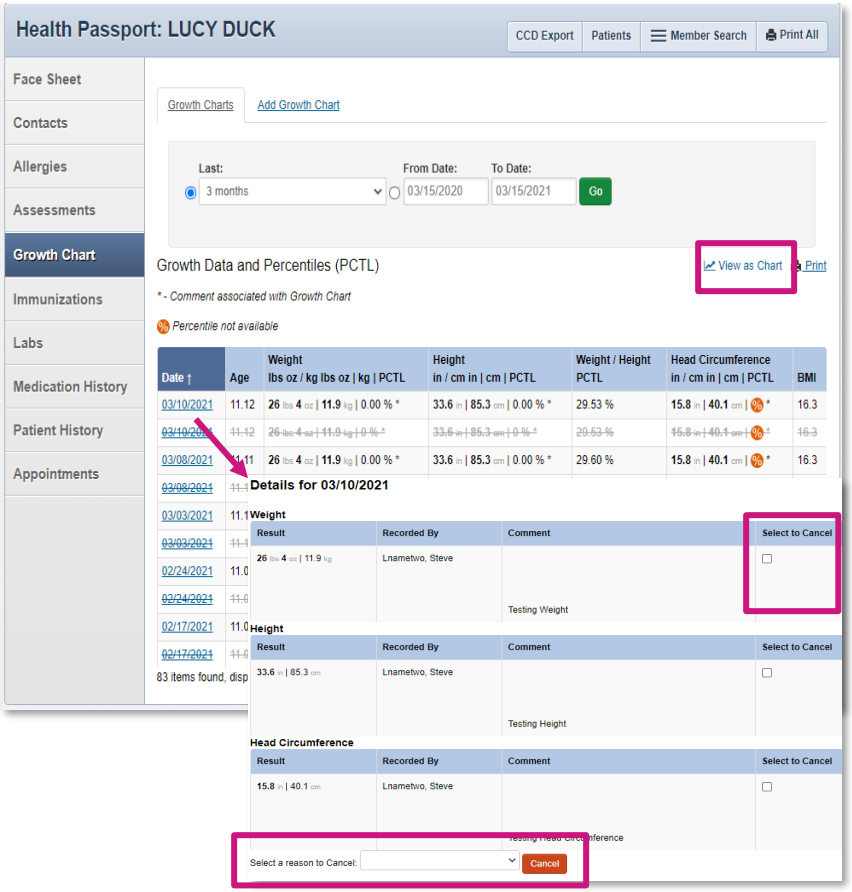
Submit Forms

- 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

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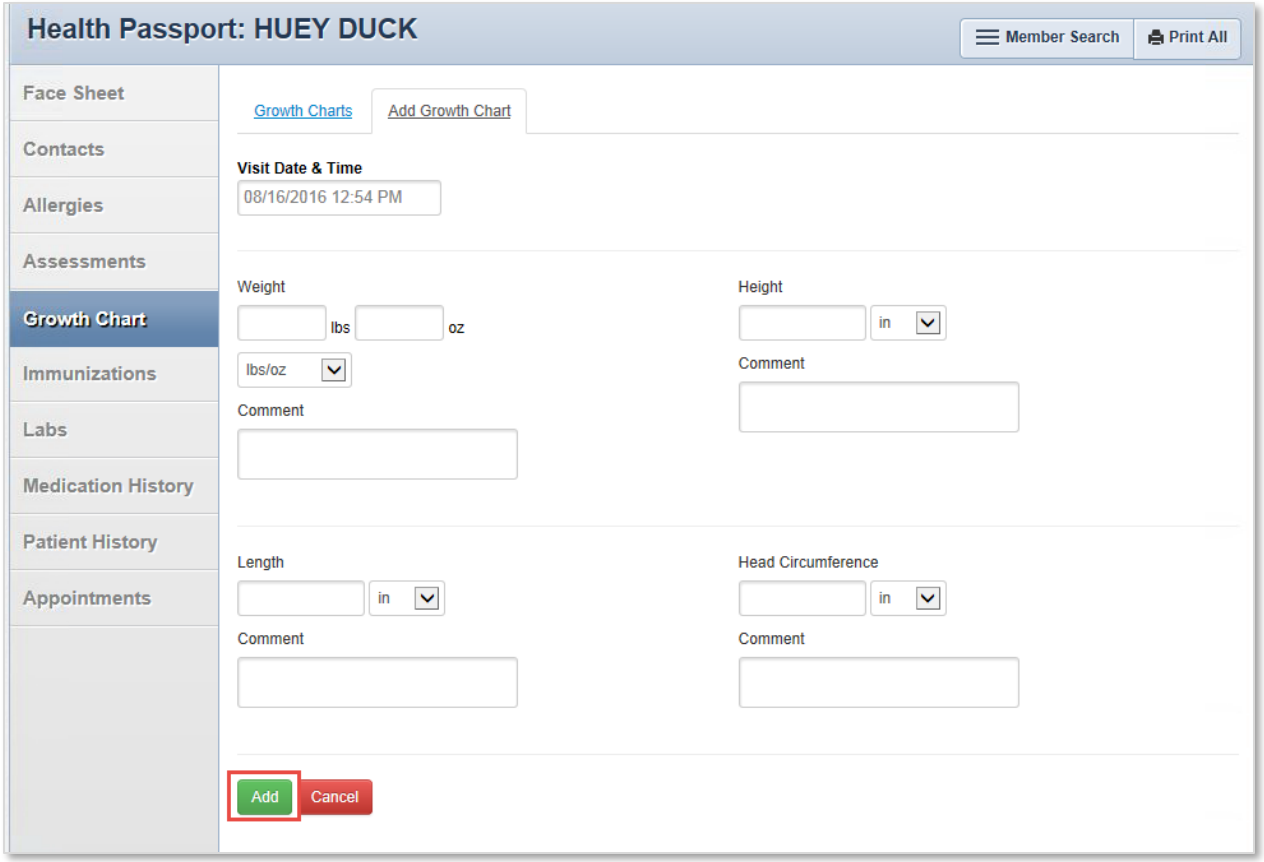
- Click the **Add Growth Chart** tab to add new growth measurements.
  1. Fill in weight, height, length, head circumference, and add comments, if applicable.
  2. Click **Add**.



Immunizations

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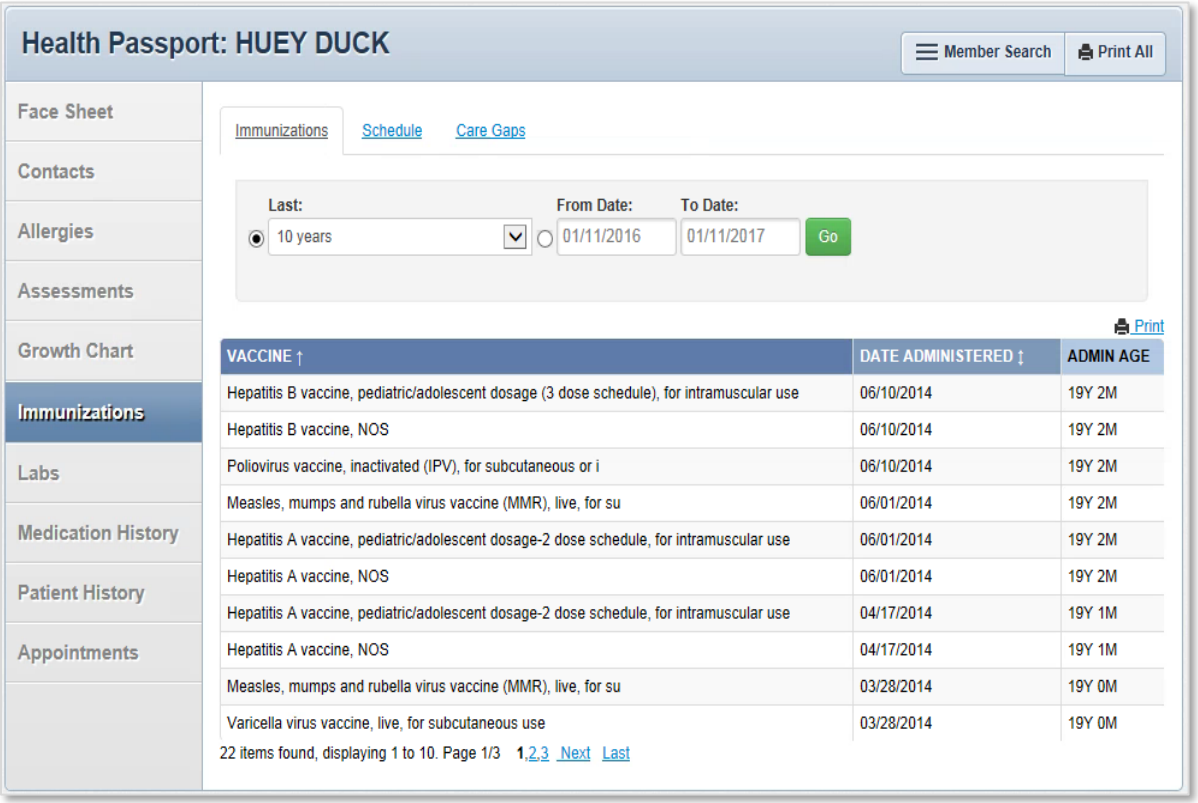
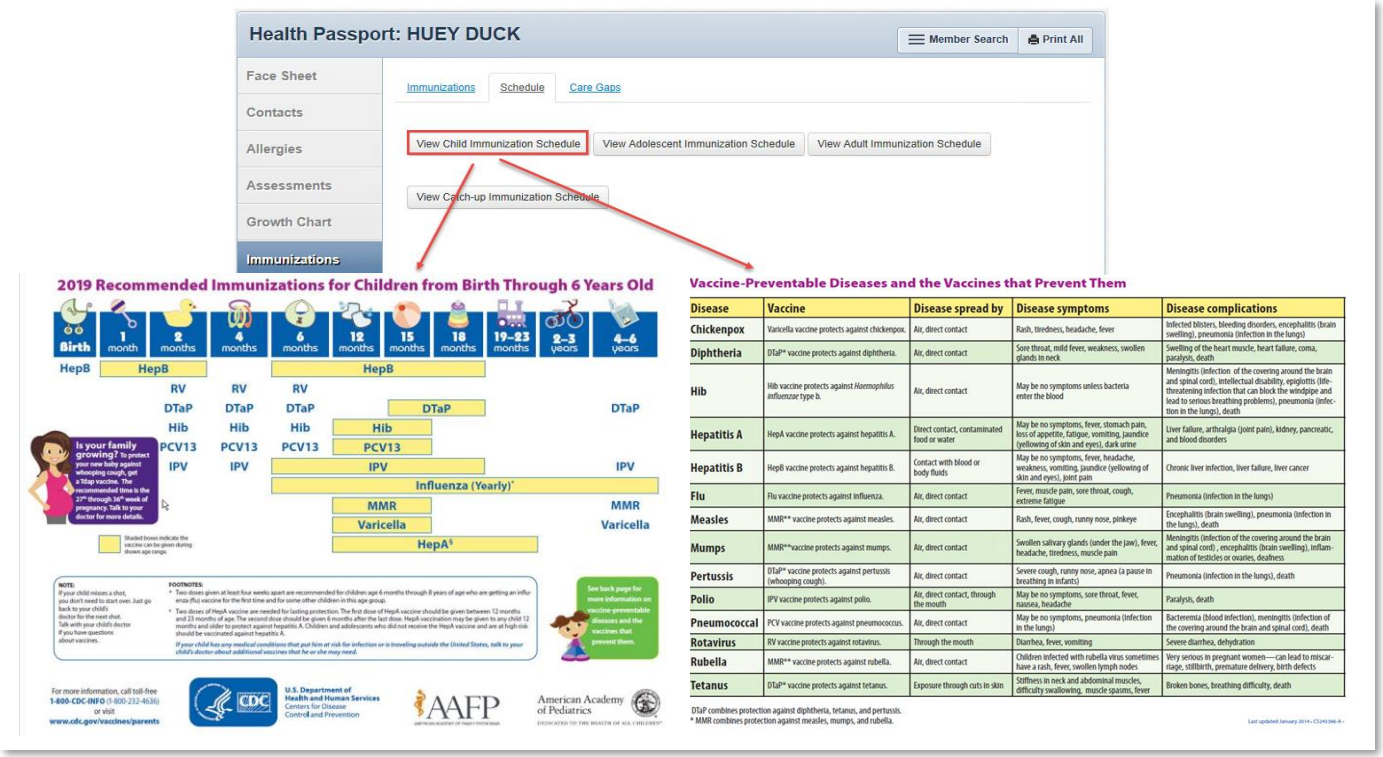
- This module presents a comprehensive list of a member's immunizations that have been reported to ImmTrac, the Texas Immunization Registry.
- Additionally, there is a tab that displays immunization schedules for the Centers for Disease Control and Prevention (CDC). The "Care Gaps" tab shows any gaps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



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 • CS249366-A •

Immunizations: Care Gaps Tab

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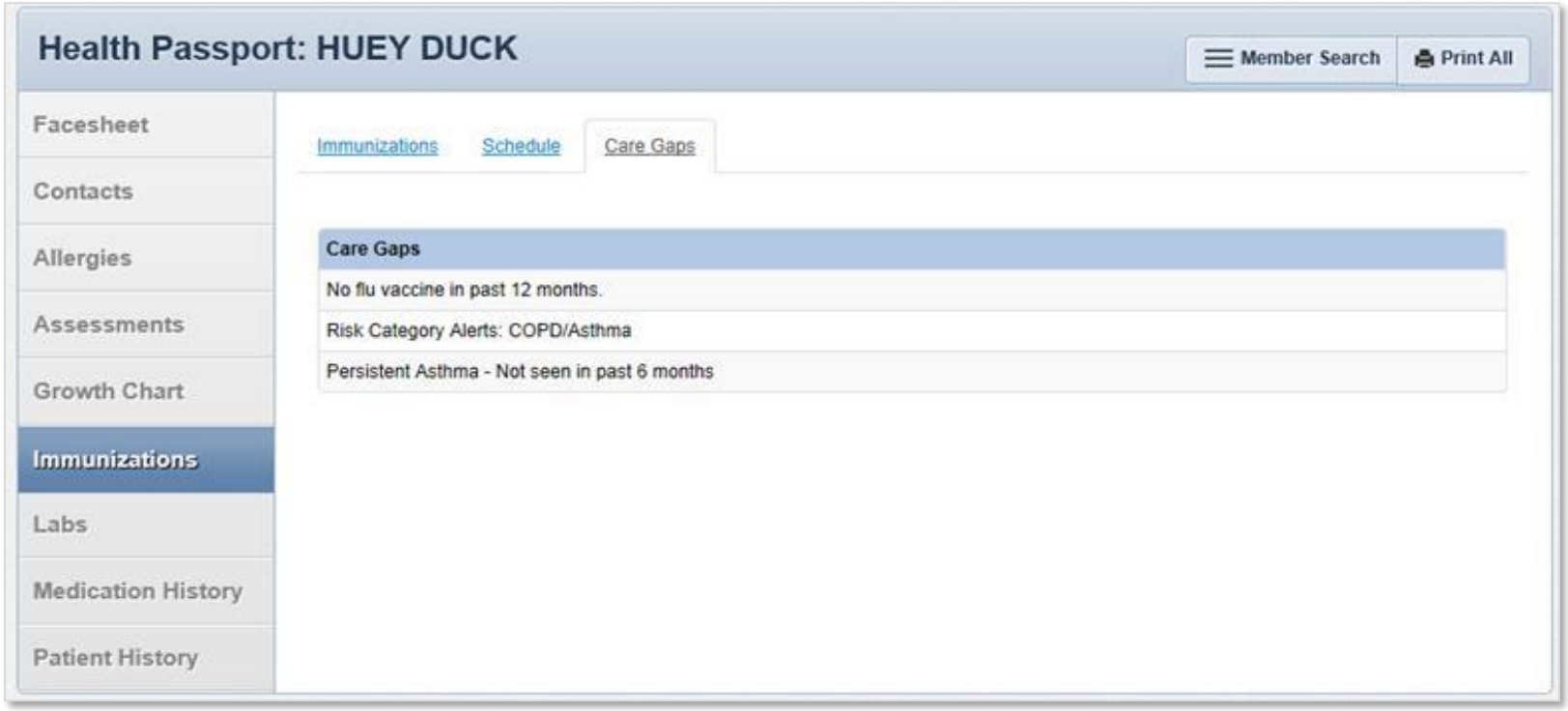
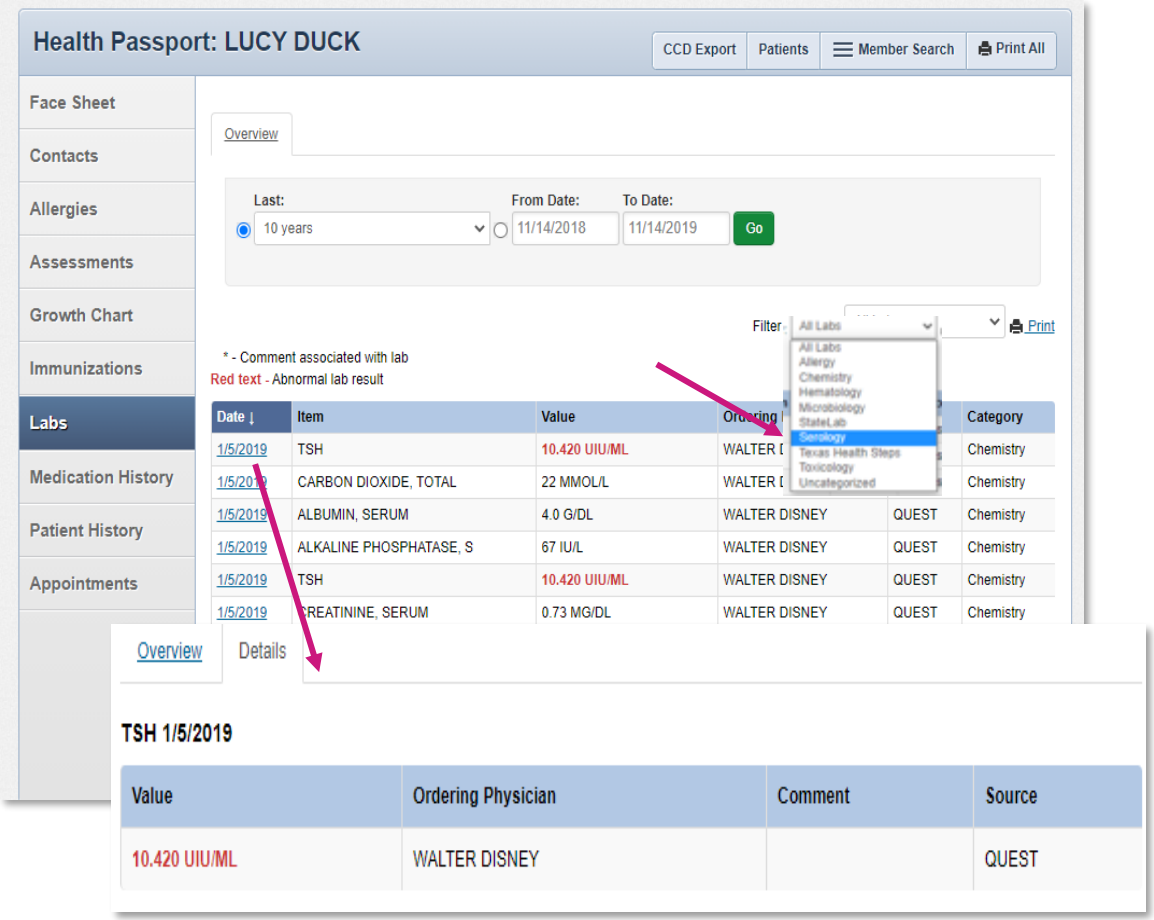
- This tab allows you to identify gaps in care, including missing immunizations.



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

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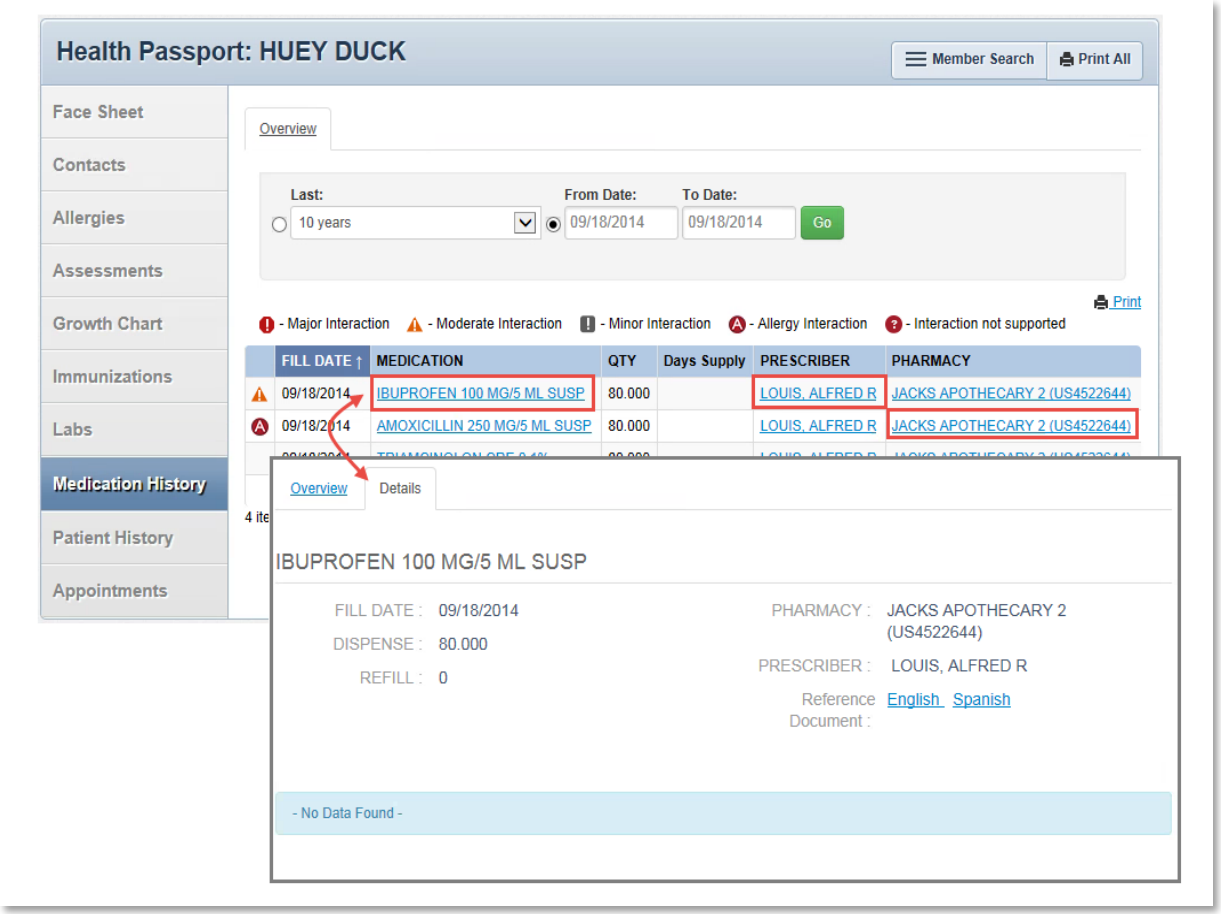
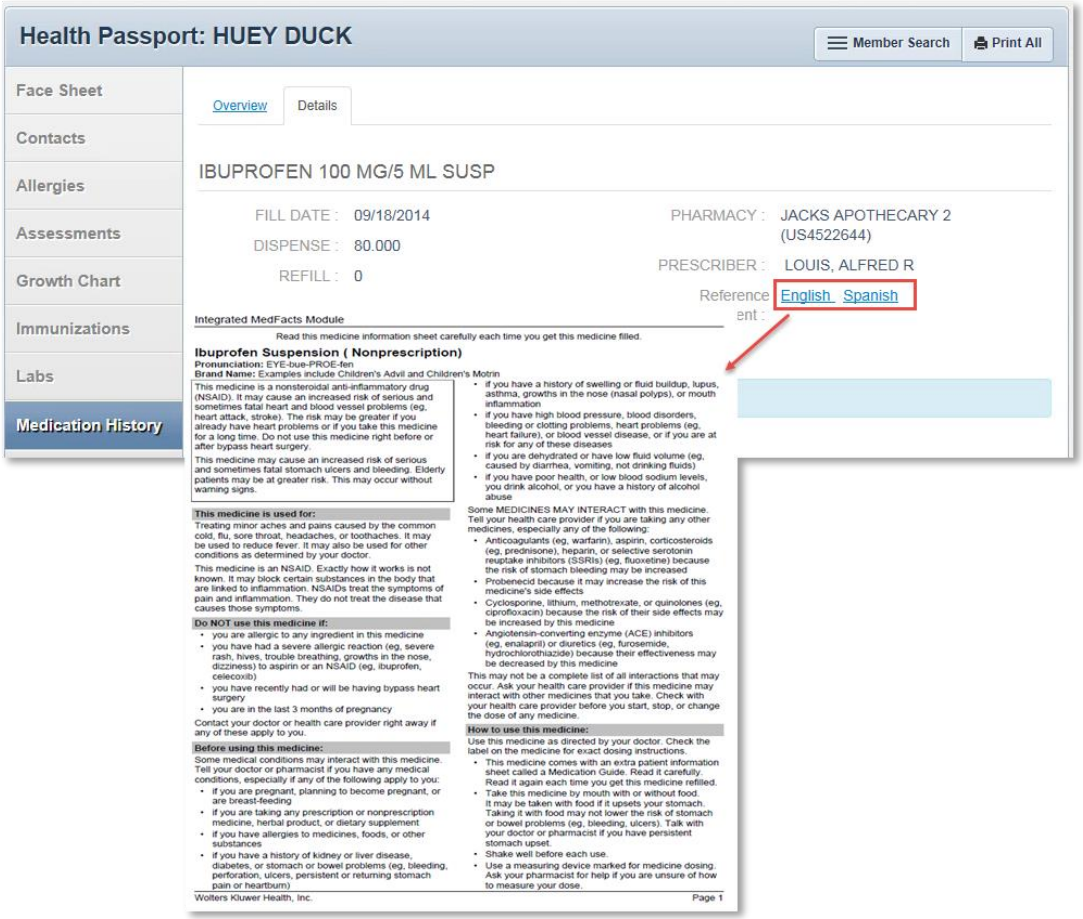
- This module contains a detailed list of medications.
  - Click **medication name** to view more details.
  - Scroll over **Prescriber** and **Pharmacy** to view contact information.
  - The legend of icons ( ) denote different medication interactions. Major interactions are potentially life threatening.



Medication History: Details Tab

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



Patient History

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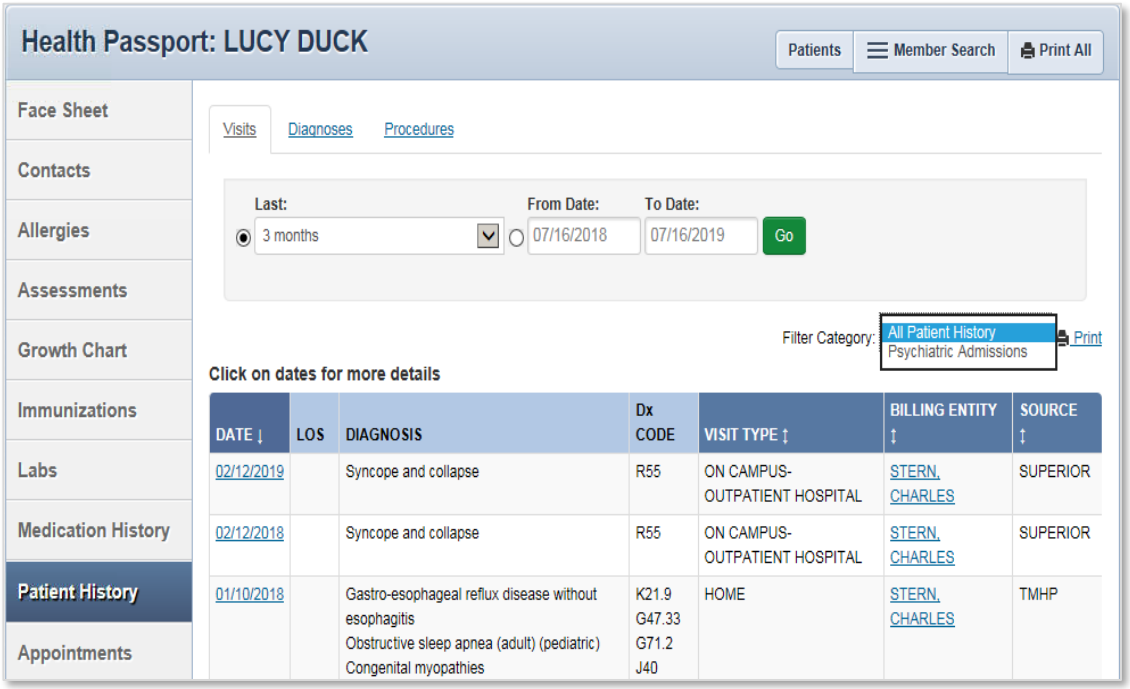
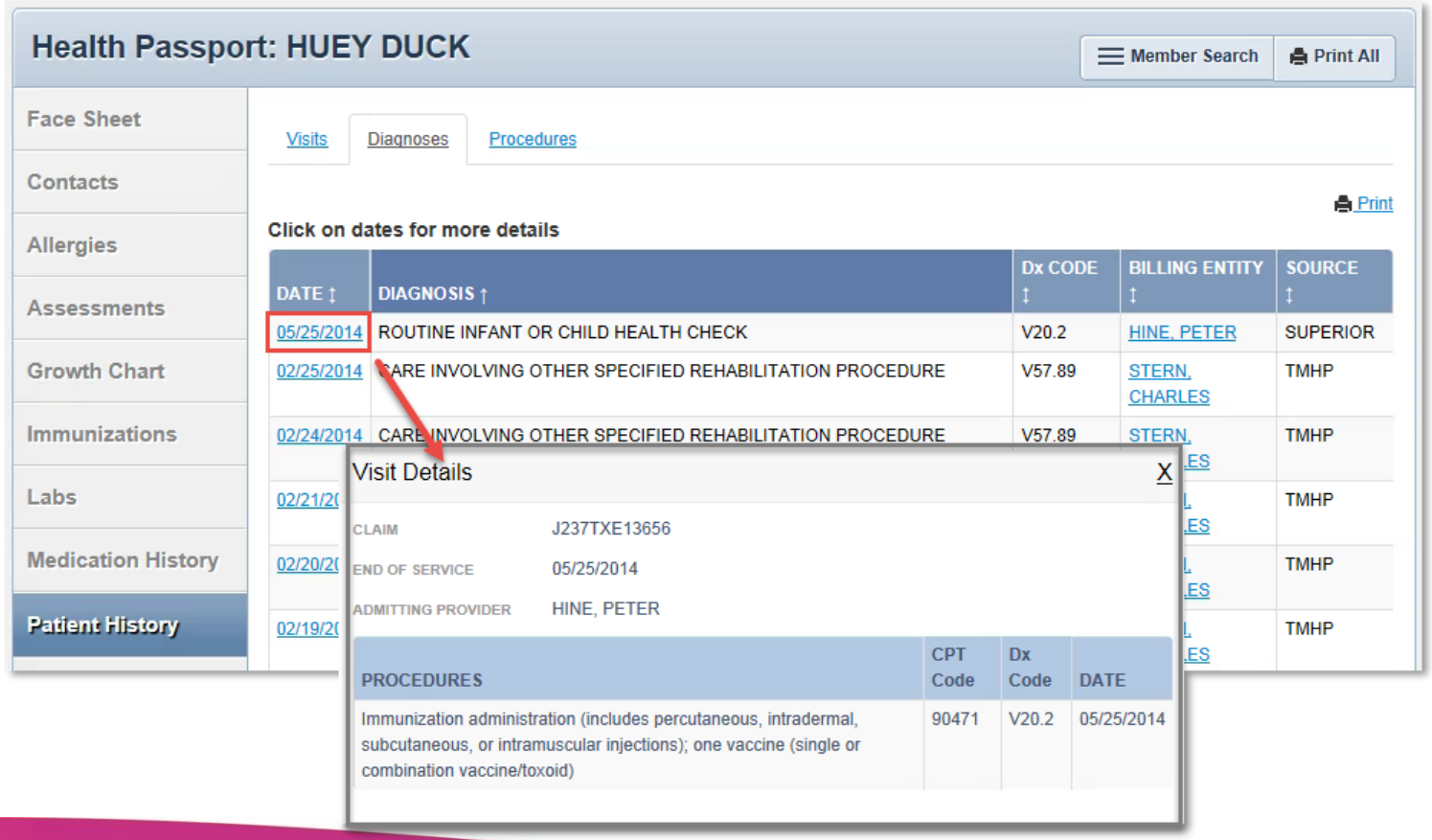
- This module contains visit information from claims data on all services rendered, whether paid or denied. Claims come from all provider types and providers do not need to do anything extra for this data to load.
  - Click the **date** to view more visit details.



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

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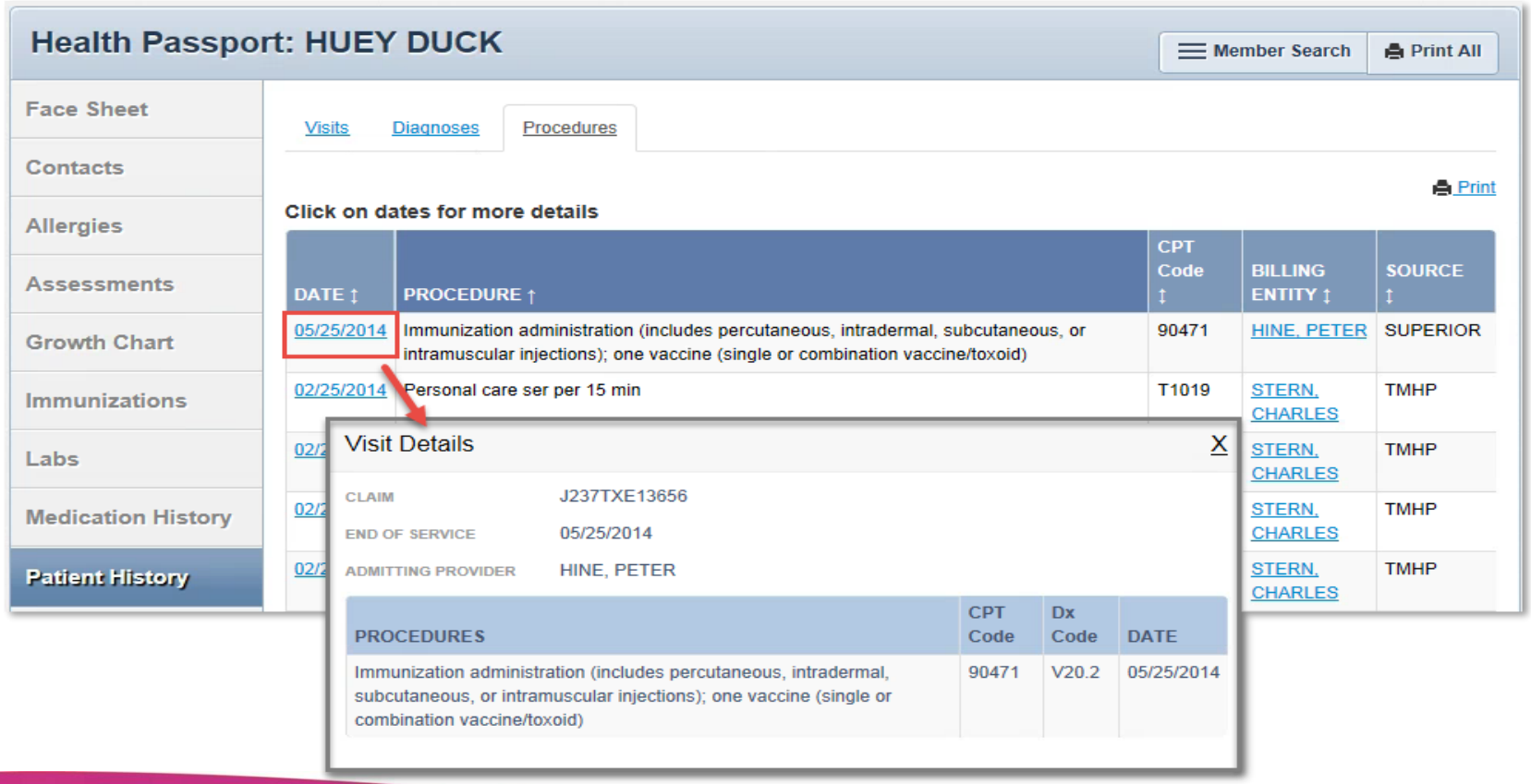
- Click the **Procedures tab** to view visits by procedures.



Admit Discharge and Transfer Notifications

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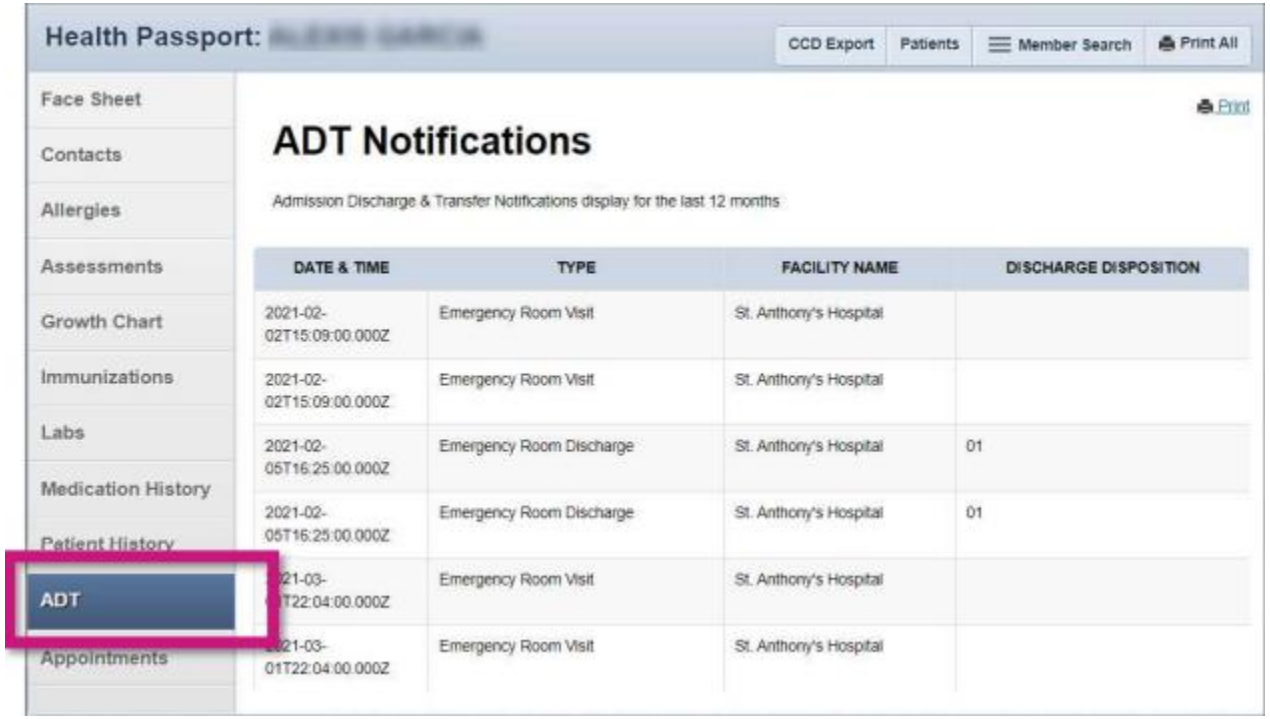
The Admit Discharge and Transfer (ADT) Module provides:

- Date admitted in to the Emergency Room
- Facility name
- Date and time of discharge
- Discharge disposition code



DATE & TIME	TYPE	FACILITY NAME	DISCHARGE DISPOSITION
2021-02-02T15:09:00.000Z	Emergency Room Visit	St. Anthony's Hospital	
2021-02-02T15:09:00.000Z	Emergency Room Visit	St. Anthony's Hospital	
2021-02-05T16:25:00.000Z	Emergency Room Discharge	St. Anthony's Hospital	01
2021-02-05T16:25:00.000Z	Emergency Room Discharge	St. Anthony's Hospital	01
2021-03-01T22:04:00.000Z	Emergency Room Visit	St. Anthony's Hospital	
2021-03-01T22:04:00.000Z	Emergency Room Visit	St. Anthony's Hospital	

The ADT data is transferred in real time from the following Health Information Exchanges (HIEs) services: HASA, Greater Houston Health Connect (GHHC), Integrated Care Collaboration (ICC) and Rio Grande Valley Health Information Exchange (RGV)

Appointments

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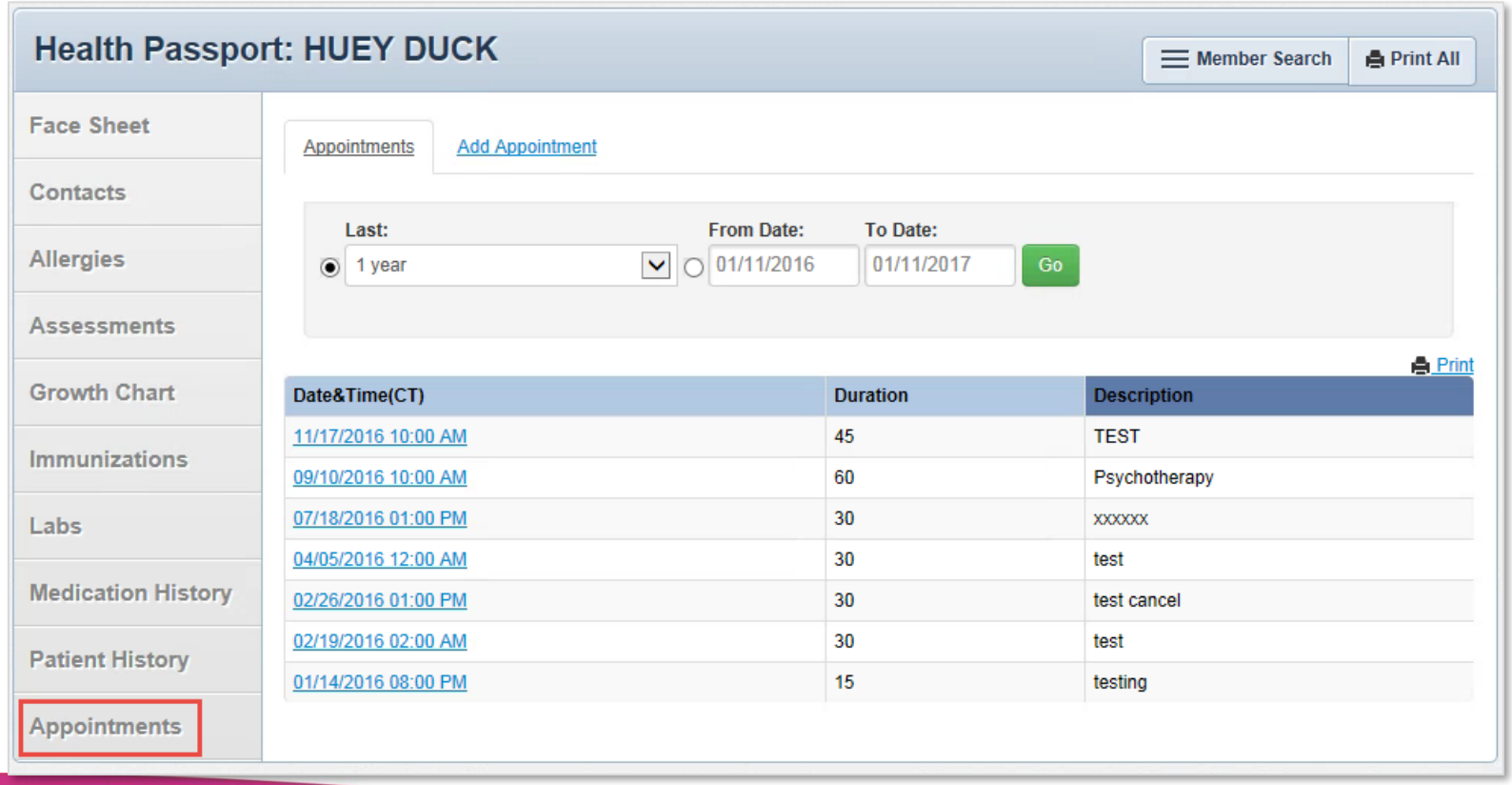
- On this module, users can create, modify and cancel their own appointment entries.



Other Tools

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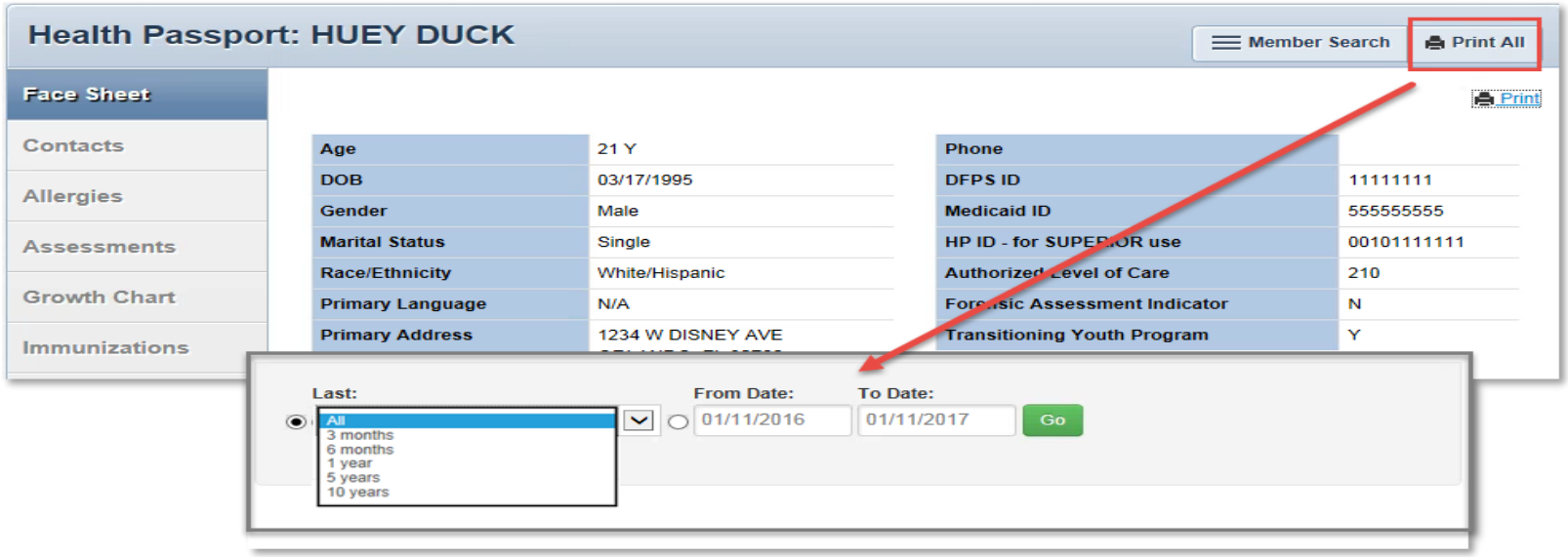
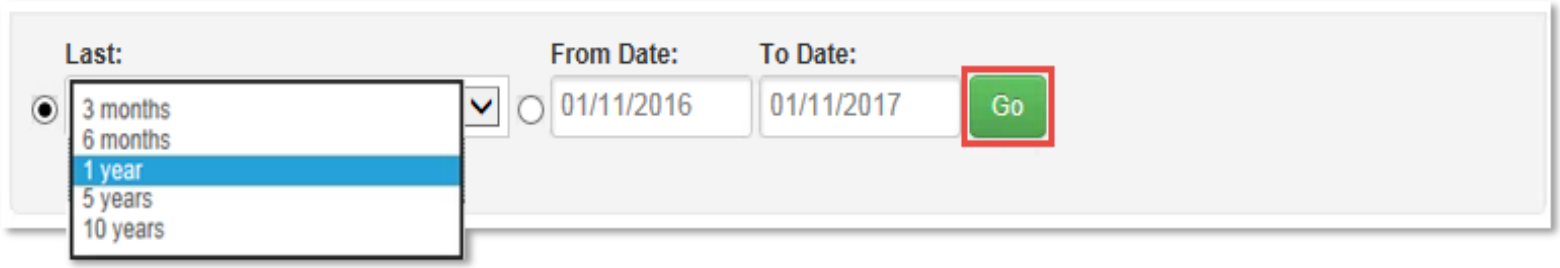
- **Member Search**: Return to search screen.
- **Print All**: Print complete health record by either (1) selecting a time frame or (2) selecting a date range and clicking **Go**.
- **Print**: Print single module.
- **Demo Info**: Hover over member name to view core demographic information.

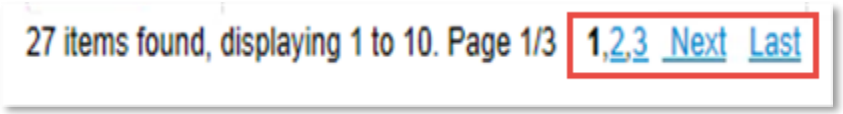


Other Tools

- 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.



Other Tools

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- 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**.

DATE ↕	PROCEDURE ↕	CPT Code ↕	BILLING ENTITY ↕	SOURCE ↕
		90471	STERN, CHARLES	
		T1019	STERN, CHARLES	
		T1019	STERN, CHARLES	TMHP
		T1019	STERN, CHARLES	TMHP
		T1019	STERN, CHARLES	TMHP
		T1019	STERN, CHARLES	TMHP
		T1019	STERN,	TMHP

STERN, CHARLES

7700 FISH POND RD
WACO, TX 76710
Business: (713) 555-1234

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: Tx.PassportAdministration@SuperiorHealthPlan.com

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 claims trends
- 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: To find out how to contact your local Account Manager, please visit SuperiorHealthPlan.com/FindMyAM.

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 SuperiorHealthPlan.com/JoinOurNetwork.

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 SHP.NetworkDevelopment@SuperiorHealthPlan.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 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:

    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 www.SuperiorHealthPlan.com/for-members/programs/star-health/.
- For questions, please contact your local Account Manager or click on “Contact Us” at www.SuperiorHealthPlan.com.

Let us know what we can do to help.