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INTRODUCTION
Welcome to Superior HealthPlan’s (Superior) STAR+PLUS Medicare-Medicaid Plan (MMP). Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals. This Provider Manual is a reference guide for Providers and their staff providing services to Members who participate in STAR+PLUS MMP. In addition to the Provider Manual, Superior provides additional reference materials and policy updates on its website at www.SuperiorHealthPlan.com.

OVERVIEW
STAR+PLUS MMP is the Superior’s product that provides coverage to Members eligible under the Texas Dual Demonstration, effective March 1, 2015. The Texas Dual Demonstration project is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid. Services would include all Medicare benefits, including parts A, B and D; and Medicaid benefits, including wrap-around services and long-term services and support (LTSS).

Superior is designed to achieve six (6) main objectives:
• Ensure the Member’s Medicare and Medicaid Services are provided
• Utilize Care Management Teams for targeted Member outreach and care coordination
• Improve quality and individual experience in accessing care
  o Improving the coordination of care
  o Access to care in underserved areas – no traditional means of care
  o Increase primary care visits
  o Reduce unnecessary Emergency Room visits
  o Reducing the need for in-patient hospital care and institutional care
• Promote independence in the community
• Eliminate cost shifting between Medicare and Medicaid
• Achieve cost savings for the State and Federal Government through improvement in care coordination

All of our programs, policies, and procedures are designed with these objectives in mind. These objectives mirror and support the objective of the Centers for Medicare and Medicaid Services (CMS) and Texas state guidelines to provide covered healthcare services to low-income, elderly and physically disabled Members.

Superior takes the privacy and confidentiality of our Member’s health information seriously. We have established processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and CMS regulations. The services provided by the contracted Superior network Providers are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our Members and their primary care physician (PCP). We want our Members to benefit from their PCP having the opportunity to deliver high quality care through utilizing contracted hospitals and specialists. The Primary Care Physician (PCP) is responsible for coordinating our Member’s health services, maintaining a complete medical record for each Member under their care, and ensuring continuity of care. The PCP advises the Member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.
KEY CONTACTS AND IMPORTANT PHONE NUMBERS

Superior has staff to assist you with your day-to-day operations, questions and/or concerns. Every Provider will have a designated Provider Network Specialist (PNS) that can provide field support. The PNS can coordinate an in-service/training for facility staff, provide face-to-face support in the facility and assist with answering questions on Superior’s policies and procedures. You can also contact Superior's Provider Services Department via our toll-free line for various inquiries such as information or assistance with claims from 8 a.m. to 6 p.m., seven days a week. On weekends and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

For help finding your assigned PNS Office Number go to www.SuperiorHealthPlan.com and click on the “Contact Us” button. From there you can click on a state map of Texas where each county is linked to the office contact.

The following table includes several important telephone and fax numbers available to Providers and their office staff.

<table>
<thead>
<tr>
<th>HEALTH PLAN INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Website</td>
<td><a href="http://www.SuperiorHealthPlan.com">www.SuperiorHealthPlan.com</a></td>
</tr>
<tr>
<td>Health Plan address</td>
<td>2100 S IH-35, Suite 200, Austin, Texas 78704</td>
</tr>
<tr>
<td>Phone Numbers</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>TTY/TDD</td>
</tr>
<tr>
<td>Superior HealthPlan</td>
<td>1-877-391-5921</td>
</tr>
<tr>
<td>Department</td>
<td>Phone</td>
</tr>
<tr>
<td>Provider Services</td>
<td>1-877-391-5921</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-866-896-1844</td>
</tr>
<tr>
<td>Medical Management Inpatient and Outpatient Prior Authorization</td>
<td>1-800-218-7508</td>
</tr>
<tr>
<td>Concurrent Review/Clinical Information</td>
<td>1-800-218-7508</td>
</tr>
<tr>
<td>Admission/Census Reports/Facesheets</td>
<td>1-800-218-7508</td>
</tr>
<tr>
<td>Part C and D Appeals</td>
<td>1-877-398-9461</td>
</tr>
<tr>
<td>Service Coordination</td>
<td>1-855-772-7075</td>
</tr>
<tr>
<td>Behavioral Health Prior Authorization</td>
<td>1-800-466-4089</td>
</tr>
<tr>
<td>24/7 NurseWise (Nurse Advice Line)</td>
<td>1-855-696-2515</td>
</tr>
<tr>
<td>NIA (high tech imaging)</td>
<td>1-800-642-7554</td>
</tr>
<tr>
<td>AECC Total Vision Health Plan (vision)</td>
<td>1-888-756-8768</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>1-877-935-8023</td>
</tr>
<tr>
<td>To report suspected fraud, waste and abuse</td>
<td>1-866-685-8664</td>
</tr>
<tr>
<td>EDI Claims Assistance</td>
<td>1-800-225-2573 ext. 25525</td>
</tr>
</tbody>
</table>
ENROLLMENT

Plan Enrollment
Individuals who meet all of the following criteria will be eligible for STAR+PLUS MMP

• Age 21 or older at time of enrollment
• Entitled to benefits under the Medicare Part A and enrolled under Medicare Parts B and D.
• Required to receive their Medicaid benefits through the Superior STAR+PLUS
• Reside in Bexar, Dallas, or Hidalgo counties.

Certain Superior STAR+PLUS populations excluded from participation in the STAR+PLUS MMP demonstration include those who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions and individuals with developmental disabilities who get services through one of these waivers:

• Community Living Assistance and Support Services (CLASS)
• Deaf Blind with Multiple Disabilities Program (DBMD)
• Home and Community-based Services (HSC)
• Texas Home Living Program (TxHmL)

Initial STAR+PLUS MMP Enrollment
Certain eligible STAR+PLUS MMP Members will receive enrollment notices in January with voluntary option to enroll effective March 1, 2015. Those who do not actively enroll will be passively enrolled effective April 1, 2015. As with all dual eligible demonstrations, Members will be able to opt-out of the program and will not be enrolled in STAR+PLUS MMP. Enrollment requests received through the 12th of the month, the effective date of coverage will be the first calendar day of the next month. Enrollment requests received after the 12th of the month will be effective the first calendar day of the second month following initial receipt of the request. Members are able to disenroll from Superior STAR+PLUS MMP at any time. Members who chose to opt-out or disenroll can re-enroll at any time.

Excluded Individuals:

• Eligible individuals enrolled in a Medicare Advantage plan or PACE (Program of All-Inclusive Care for the Elderly) will not be passively enrolled into the Demonstration but may opt in.
• Individuals enrolled in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS MMP will not be passively enrolled into the Demonstration but may opt-in if they elect to disenroll from their existing plan.

The initial passive enrollment phase-in will occur over a period of at least six months.

Ongoing Plan Enrollment
Enrollment for eligible beneficiaries into a STAR+PLUS MMP may be conducted – when no active choice has otherwise been made – using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the STAR+PLUS MMP at any time. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no fewer than 60 days prior to the effective date of enrollment, and will have the opportunity to opt-out until the last day of the month prior to the effective date of
Disenrollment from STAR+PLUS MMPs and enrollment from one STAR+PLUS MMP to a different STAR+PLUS MMP shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. As mutually agreed upon, CMS and the State will utilize an Enrollment Broker, independent of the STAR+PLUS MMP, to facilitate all enrollment into the STAR+PLUS MMPs. STAR+PLUS MMP enrollments, including enrollment from one STAR+PLUS MMP to a different STAR+PLUS MMP, and opt-outs shall become effective on the same day for both Medicare and Medicaid. For those who lose Medicaid eligibility during the month, coverage and FFP will continue through the end of that month.

Members who do not participate in STAR+PLUS MMP will remain enrolled in Superior STAR+PLUS HealthPlan and will continue to receive their long-term service and supports (LTSS) through Superior HealthPlan.

Accountable Care Organizations (ACOs)

Members enrolled in a Medicare Accountable Care Organization (ACO) are considered to be fee-for-service (FFS) Medicare and may also be eligible for enrollment in STAR+PLUS MMP. To preserve the infrastructure of existing ACOs in the counties in which the demonstration will operate, HHSC will reduce the number of Members who will be passively enrolled from an ACO. Further, HHSC has required participating STAR+PLUS MMPs to contract with ACOs to develop shared savings and/or quality incentives. However, these arrangements will not count as enrollment in a Medicare ACO for purposes of shared savings with Medicare. This will be an ongoing process that only applies to ACOs that were in operation prior to the duals demonstration implementation on March 1, 2015.

HHSC will work with the STAR+PLUS MMPs in an attempt to limit passive enrollment for Members in an ACO with the following attributes:

- Operating in a demonstration county (Bexar, Dallas, El Paso, Harris, Hidalgo or Tarrant)
- Fewer than 9,000 Members
- Established by March 1, 2015

However, Members can elect to participate. Members in an ACO that are excluded from passive enrollment will receive notification about the option to enroll in the STAR+PLUS MMP. If a Member of an ACO elects to participate in the demonstration, they can continue to receive services from their primary care Provider (PCP) aligned with the ACO once enrolled if the PCP is a Superior STAR+PLUS MMP network Provider.

Please note: The Enrollment Broker will not facilitate PCP assignment. Members enrolled in Superior will be assigned through the plans PCP auto-assignment process and not through the state enrollment broker. Members are encouraged to select their own PCP, and are able to call in to Member Services and change their PCP assignment at any time. PCP assignments are effective the first of the month after they are received.
Required Involuntary Disenrollment

Texas and CMS shall terminate a Member’s enrollment in the STAR+PLUS MMP upon the occurrence of any of the conditions listed below:

- Change in residence makes the individual ineligible to remain enrolled in the MMP;
- The Member loses entitlement to either Medicare Part A or Part B;
- The Member loses Medicaid eligibility or additional State-specific eligibility requirements;
- The Member dies;
- The MMP’s contract with CMS is terminated, or the MMP reduces its service area to exclude the Member;
- The individual materially misrepresents information to the MMP regarding reimbursement for third-party coverage;
- When Superior verify Member as having third-party coverage with Superior or with another carrier;
- Upon incarceration in a county jail, Texas Department of Corrections facility, or Federal penal institution; or
- Upon the occurrence of any of the conditions described in this section.

Except for the Contract Management Team (CMT)’s role in reviewing documentation related to a Member’s residence outside the Service Area or alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing Disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering Disenrollment transactions described elsewhere in this Contract.

Superior shall be responsible for ceasing the provision of Covered Services to a Member upon the effective date of Disenrollment. Superior must first provide documentation satisfactory to the CMT that the Member meets one of the disenrollment criteria. Termination of the coverage shall take effect at the 11:59 p.m. on the last day of the month prior to the month in which the CMT determines that the Member is no longer eligible.

Discretionary Involuntary Disenrollment

The STAR+PLUS MMP may submit a written request, accompanied by the required supporting documentation to CMS and HHSC, via the CMT, to disenroll a Member, for cause. CMS and HHSC shall not have independent authority to review requests for discretionary Involuntary Disenrollment under this Section beyond their representation on the CMT. The CMT may approve a STAR+PLUS MMP’s request to disenroll a Member for disruptive behavior only after the STAR+PLUS MMP has met the requirements to disenroll, and the STAR+PLUS MMP must take reasonable measures to correct the Member’s behavior prior to requesting Disenrollment.

Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. If despite efforts by the STAR+PLUS MMP, where appropriate, to resolve and provide an opportunity for the Member to cure the problems, the following exist, the STAR+PLUS MMP may submit a request for disenrollment if:
• A Member engages in conduct or behavior that seriously impairs the STAR+PLUS MMP’s ability to deliver services to either the Member or other Members, provided the Member’s behavior is determined to be unrelated to an adverse change in the Member’s health status, or because of the Member’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs and provided the STAR+PLUS MMP made and documented reasonable efforts to resolve the problems presented by the Member;

• Member misuses or loans Member’s STAR+PLUS MMP membership card to another person to obtain services; or

• Member is disruptive, unruly, threatening or uncooperative to the extent that the Member’s continued enrollment seriously impairs the STAR+PLUS MMP’s or Provider’s ability to provide services to either the Member or other Members, and Member’s behavior is not related to a developmental, intellectual, or physical Disability or behavioral health condition.

A Member will receive an Advance Notice and Notice of Intent as described in the 2013 Medicare – Medicaid Plan Enrollment and Disenrollment Guidance. Termination of a Member’s enrollment shall take effect at 11:59 p.m. on the last day of the month following the month the disenrollment is processed.
MEDICARE REGULATORY REQUIREMENTS

As a Medicare contracted Provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your Provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare Members in any way based on the health status of the Member.
- Providers must ensure that Members have adequate access to covered health services.
- Providers may not impose cost sharing on Members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow Members to directly access screening mammography and influenza vaccinations.
- Providers must provide female Members with direct access to women’s health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Superior will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in you Participation Agreement if greater than 60 days. Providers agree to notify Superior according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the Member and do not discriminate against the Member for any reason. Providers will ensure necessary services are available to Members 24 hours a day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Superior Members without CMS approvals of the materials and forms.
- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- Providers will work with Superior procedures to inform our Members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the Member’s medical record whether the Member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Superior to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit Members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Superior in notifying Members of Provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Superior medical policies, QI programs and medical management procedures.
- Providers will cooperate with Superior in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Superior procedures for handling grievances, appeals, and expedited appeals.
• Providers must fully disclose to all Members before providing a service, if the service may not be covered by Superior. The Member must sign an agreement of this understanding. If the Member does not, the claim may be denied and the Provider will be liable for the cost of the service.

SECURE WEB PORTAL
Superior offers a robust Secure Web Portal with functionality that will be critical to serving Members and to ease administration for the Superior product for Providers. Each participating Provider’s dedicated Provider Network Specialist will be able to assist and provide education regarding Superior’s Web Portal functionality. The Portal can be accessed at www.SuperiorHealthPlan.com.

Functionality
All users of the Secure Web Portal must complete a registration process. If you are already a registered user on the Superior HealthPlan portal, a separate registration is not needed.

• Once registered, Providers may:
  o Check eligibility;
  o View the specific benefits for a Member;
  o View benefit details including Member cost share amounts for medical, pharmacy, dental, and vision services
  o View the status of recent claims that have been submitted;
  o View Providers associated with the Tax Identification Number (“TIN”) that was utilized during the registration process;
  o View demographic information for the Providers associated with the registered TIN such as: office location, office hours and associated practitioners;
  o Update demographic information (address, office hours, etc.);
  o View and print patient lists (primary care Providers). This patient list will indicate the Member’s name, Member ID number, date of birth and the product in which they are enrolled;
  o Submit authorizations and view the status of authorizations that have been submitted for Members;
  o View claims and the claim status;
  o Submit individual claims, batch claims or batch claims via an 837 file;
  o View and download Explanations of Payment (EOP);
  o View a Member’s health record including visits (physician, outpatient hospital, therapy, etc.); medications, and immunizations;
  o View gaps in care specific to a Member including preventive care or services needed for chronic conditions; and
  o Send secure messages to Superior staff.
PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Credentialing and Re-credentialing
The credentialing and re-credentialing process exists to verify that participating practitioners and Providers meet the criteria established by Superior, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/Provider already participates with Superior in the Medicaid product, the practitioner/Provider will NOT be separately credentialed for the Superior STAR+PLUS MMP product.

Notice:

In order to maintain a current practitioner/Provider profile, practitioners/Providers are required to notify Superior of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether a state utilizes a standardized credentialing form or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- A valid NPI
- Complete, correct, signed and dated application
- Attestation of history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions;
- Attestation of lack of current substance and/or alcohol abuse;
- Attestation to mental and physical competence to perform the essential duties of the profession;
- Attestation to the correctness/completeness of the application;
- Signed and dated Release of Information form;
- Current unrestricted license in the state where the practice is located. Exception applies for some Long Term Services and Support (LTSS) Provider types;
- Current valid Federal Drug Enforcement Administration (DEA) certificate and State Department of Public Safety (DPS) certificate (as applicable);
- Current liability insurance in compliance with minimum limits set by Superior HealthPlan’s Provider agreement  (Exception applies for some LTSS Provider types);
- Proof of highest level of education. For physicians, proof of graduation from an accredited medical school or school of osteopathy, proof of completion of an accredited residency program, or proof of Board Certification. (Verification of completion of a fellowship does not meet this requirement.);
- Current admitting privileges in good standing at an in-network/inpatient facility or written documentation from a physician/group of physicians, who participate with Superior HealthPlan, stating that they will assume the inpatient care of all of the practitioner’s Plan Members who require admission and that they will do so at a participating facility;
• Education Certificate Foreign Medical Graduate (ECFMG) certification or equivalent, if practitioner is a foreign medical graduate;
• History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner for the past five years or any cases that are pending professional liability actions. When reviewing this history, the CC will consider the frequency of case(s) as well as the outcome of the case(s);
• Written explanation if practitioner has been sanctioned in a Medicare/Medicaid program;
• Disclosure of ownership or financial interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, home health or other business dealing with the provision of ancillary health services, equipment or supplies;
• Work history for the previous five (5) years. Any gap greater than six (6) months must be explained by the practitioner and presented to the credentials committee for approval;
• Is signed and dated within 180 days prior to credentialing decision;
• Contains primary or secondary source verification information that is active upon the credentialing decision; and
• Contains information that the practitioner has been excluded participating in the Medicare/Medicaid program.

Superior will primary source verify the following information submitted for credentialing and re-credentialing:

• License through appropriate licensing agency;
• Board certification, or residency training, or professional education, where applicable;
• Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB);
• Hospital privileges in good standing or alternate admitting arrangements, where applicable; and
• Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General).

For Providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the application is completed, the Credentials Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Practitioners/Providers must be credentialed prior to accepting or treating Members. Primary care practitioners cannot accept Member assignments until they are fully credentialed.

**Credentials Committee**

The Credentials Committee including the Chief Medical Director or his/her physician designee has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are held at least monthly and more often as deemed necessary.
Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site reviews are performed at Provider offices and facilities when the Member complaint threshold is met. A site review evaluates:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space; and
- Adequacy of medical/treatment record keeping.

**Re-credentialing**

Superior conducts practitioner/Provider re-credentialing at least every 36 months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the practitioner’s/Provider’s licensure, sanctions, certification, competence, or health status which may affect the practitioner’s/Provider’s ability to perform services under the contract. This process includes all practitioners, facilities and ancillary Providers previously credentialed and currently participating in the network.

In order to be compliant with re-credentialing expectations, a request for information is sent to the Provider no later than one hundred and fifty (150) days before the Provider is due to be re-credentialed. Superior verifies the information provided by the applicant in support of their application for continued participation through external primary sources.

During the re-credentialing process, the applicant is notified promptly of any problems related to the collection and/or verification of these documents. It is the sole responsibility of the applicant to produce all necessary information and documentation required to conduct a thorough examination. Failure to provide the necessary information within sixty (60) days from the date the application for re-credentialing was received will result in termination/discontinuation of re-credentialing. If the Provider ever seeks to join Superior in the future, he or she must begin the process from inception.

In between credentialing cycles, Superior conducts Provider performance monitoring activities on all network practitioners/Providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/Providers in between credentialing cycles. Additionally, Superior reviews monthly reports released by the Office of Inspector General to identify any network practitioners/Providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A Provider’s agreement may be terminated if at any time it is determined by the Superior Credentials Committee that credentialing requirements or standards are no longer being met.

**Practitioner Right to Review and Correct Information**

All practitioners participating within the network have the right to review information obtained by Superior to evaluate their credentialing and/or re-credentialing application. This includes information obtained
from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a Provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the Provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentialing Committee within thirty (30) days of the initial notification.

The Credentials Committee will then include this information as part of the credentialing or re-credentialing process.

Practitioner Right to Be Informed of Application Status
All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Services Department at 1-877-391-5921.

Practitioner Right to Appeal Adverse Initial and Re-credentialing Determinations
Applicants who are existing Providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within thirty (30) days of the date of the notice.

New applicants who are declined participation may request reconsideration within thirty (30) days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant’s appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than sixty (60) days form the receipt of the additional documentation.

Primary Care Providers
The Primary Care Provider ("PCP") is the cornerstone of Superior’s delivery model. The PCP serves as the “medical home” for the Member. The “medical home” concept should assist in establishing a patient-Provider relationship and ultimately better health outcomes. The PCP is responsible for providing all primary care services for Superior’s Members including but not limited to:

- Supervision, coordination, and provision of care to each assigned Member;
- Initiation of referrals for medically necessary specialty care;
- Maintaining continuity of care for each assigned Member;
• Maintaining the Member’s medical record, including documentation for all services provided to the Member by the PCP, as well as any specialists, behavioral health or other referral services; and
• Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.

Our case managers will partner with the PCP not only to ensure the Member receives any necessary care but to also assist the PCP in providing a “medical home” for the patient.

All PCP’s may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the Member’s choice, Superior does not guarantee a PCP will receive a set number of patients. A PCP must contact their Provider Relations Specialist if they choose to change their panel size or close their panel and only accept established patients. If Superior determines a PCP fails to maintain quality, accessible care, then Superior reserves the right to close the PCP panel if necessary and re-assign Members to a new PCP.

Credentialed Providers in the following specialties can serve as a PCP:

• Certified Nurse Midwife
• Family Practitioner
• General Practitioner
• Internal Practitioner
• Nurse Practitioner
• Advanced Registered Nurse Practitioner
• OB/GYN
• Pediatrician
• Physician Assistant
• Specialist (when appropriate, as described below)

**Specialist as the Primary Care Provider**

Members with disabilities, special health care needs, and Chronic or Complex conditions have the right to designate a specialist as their Primary Care Provider. A specialist may serve as a PCP only under certain circumstances and with approval of Superior. A specialist is eligible to serve as a PCP, the specialist must:

• Meet Superior: requirements for PCP participation, including credentialing; and
• Contract with Superior as a PCP

All requests for a specialist to serve as a PCP must be submitted to Superior on the Request for Specialist PCP Form. The request should contain the following information:

• Certification by the specialist of the medical need for the Member to utilize the specialist as a PCP; and
• A statement signed by the specialist that he or she is willing to accept responsibility for the coordination of all of the Members needs.
Providers may request the form by calling Superior Provider Services at 1-877-391-5921.

Superior will approve or deny the request for a specialist to serve as a PCP and provide notification of the decision to the Member no later than thirty (30) days after receiving the request. The effective date of the designation of a specialist as a Member’s PCP may be applied retroactively.

If the request is denied, Superior will provide a written notification to the Member, which will include the reasons for the denial. The Member may file an appeal as result of the decision to deny the request for their specialist as a PCP. The Member Advocate is available to assist the Member with their appeal.

**Specialty Care Physicians**

The Specialty Care Physician or Specialist agrees to partner with the Member’s PCP and Case Manager to deliver care. A key component of the specialist’s responsibility is to maintain ongoing communication with the Member’s PCP. Most visits to specialists do not require a prior authorization. Most specialists will require a written referral from the Member’s PCP; however, the referral is not required for the claim to be reimbursed by Superior. Specialists can elect to limit their practice to established patients only upon request to their Provider Relations Specialist.

Female Members can self-refer to an OB/GYN for their annual well-woman checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Gynecology and Women’s Services
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

**Long Term Services and Supports Provider**

The Long Term Services and Supports (LTSS) Provider serves certain Members participating in the STAR+PLUS program. A LTSS Provider assists a patient by providing a variety of non-medical services, such as adult day care, adult foster care, home delivered meals, personal attendant services, home modifications, respite services, etc. LTSS services require a prior authorization.
Nursing Facility
Nursing homes are residential facilities that provide care for people whose medical condition regularly requires the skills of licensed nurses. Nursing homes provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies and equipment, rehabilitative services, and personal needs items.

Hospitals
Superior has contracted with several hospitals in the counties we serve; however any facility can be used in the case of an emergency. We also contract with other facilities such as rehabilitation facilities and ambulatory surgery centers to assist our Members. It is important that our contracted Providers have privileges at a contracted facility or have an agreement with a hospital list group to care for their Member when hospitalized. Please see the Provider Directory for a list of contracted hospitals in each county.

Ancillary Providers
Ancillary Providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary Providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (Physical, Occupational, Speech)

Appointment Availability
The following standards are established regarding appointment availability:

- A full-time practice is defined as one where the Provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- Emergency services must be provided upon the Member’s presentation at the service delivery site, including at non-network and out-of-area facilities;
- Urgent care, including urgent specialty care, must be provided within 24 hours;
- Routine primary care must be provided within 14 days;
- Initial outpatient behavioral health visits must be provided within 14 days;
- PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member’s medical condition, but no later than 30 days;
- Prenatal care must be provided within 14 days, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists; and
- Preventive health services for adults must be offered within ninety (90) days of the request.
Note: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare Members.

**Telephone Arrangements**

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the Member telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a Member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special Member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
- **Response time for telephone call-back waiting times:**
  - after hours telephone care for non-emergent, symptomatic issues within 30 minutes;
  - same day for non-symptomatic concerns;
  - crisis situations within 15 minutes;
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a Provider’s absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and transferred to the patient’s medical record.

Note: If after hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.

Superior will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

**Provider Training**

Superior Providers are required to receive training annually which includes, Annual Fraud, Waste, and Abuse Training, Compliance Training and Model of Care Training. Superior provides training on a wide variety of topics ranging from Billing to Cultural Competency and literacy; all of which are accessible online under Provider Resources (Trainings and Manuals) at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com). Superior training includes training modules centered on Nursing Facilities, STAR+PLUS MMP, LTSS Providers and services, in addition to acute care. Training is offered both locally and via webinar. The Training Calendar, also accessible at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com), details the type of training, location and RSVP information for each event. Providers can also contact their local Provider Network Specialist to obtain personalized training on any of the training modules we offer or to help with questions.
SUPERIOR BENEFITS

The list below is not an all-inclusive list of covered services. All services are subject to benefit coverage, limitations and exclusions as described in the applicable Superior coverage guidelines.

The table below lists the covered services for Members. This is not an exhaustive list and is provided herein for quick reference only. Please visit our Secure Web Portal at www.SuperiorHealthPlan.com or contact Provider Services at 1-877-391-5921 with any questions you may have regarding benefits.

<table>
<thead>
<tr>
<th>Monthly Premium, Deductible and Limits on How Much Members Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Services</strong></td>
</tr>
<tr>
<td><strong>How much is the Members deductible?</strong></td>
</tr>
<tr>
<td><strong>Is there any limit on how much Member will pay for covered services?</strong></td>
</tr>
<tr>
<td><strong>Is there a limit on how much the plan will pay?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care Services</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tobacco Cessation Counseling for Pregnant Women</td>
</tr>
<tr>
<td>- Freestanding Birth Center Services</td>
</tr>
<tr>
<td>- Family Planning Services</td>
</tr>
<tr>
<td>- Nursing Home Services</td>
</tr>
<tr>
<td>- Home and Community Based Services</td>
</tr>
<tr>
<td>- Self-Directed Personal Assistance Services</td>
</tr>
<tr>
<td>- Institution for Mental Disease Services for Individuals 65 and older</td>
</tr>
<tr>
<td>- Personal Assistance Services (30 visits per year, requires prior authorization)</td>
</tr>
<tr>
<td><strong>Member Pays Nothing</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acupuncture and Other Alternative Therapies</th>
<th><strong>Not Covered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td><strong>Member Pays Nothing</strong></td>
</tr>
<tr>
<td>Service Description</td>
<td>Member Pays Nothing</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation Services</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care (Manipulation of the spine to correct a subluxation when 1 or more bones of your spine move out of position) up to 12 visits a year</td>
<td></td>
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<tr>
<td>Dental Services (Limited Dental Services: This doesn’t include services in connection with care, treatment, filling, removal, or replacement of teeth)</td>
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</tr>
<tr>
<td>Diabetic Supplies and Services (Includes Diabetes Monitoring Supplies, Diabetes Self-Management Training, Therapeutic shoes or Inserts)</td>
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</tr>
<tr>
<td>Diagnostic Tests, Lab and Radiology Services, and X-Rays (Includes Diagnostic Radiology Services (Such as MRI’s, CT scans), Diagnostic Test &amp; Procedures, Lab Services, Outpatient X-Rays, Therapeutic Radiology Services (Such as Radiation treatment for cancer))</td>
<td></td>
</tr>
<tr>
<td>Doctor’s Office Visits (Includes Primary Care Physician Visit &amp; Specialist Visit)</td>
<td></td>
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<tr>
<td>Durable Medical Equipment (Includes Wheelchairs, Oxygen, etc. &amp; Durable Medical Equipment for use outside the home)</td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
</tr>
<tr>
<td>Enhanced Benefits (Value Added Services) – See Member Handbook or SuperiorHealthPlan.com</td>
<td></td>
</tr>
<tr>
<td>Foot Care Includes Podiatry Services, Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions, Routine Foot Care)</td>
<td></td>
</tr>
<tr>
<td>Hearing Services (Includes Exam to diagnose &amp; treat hearing &amp; balance issues, Routine Hearing Exam, Hearing Aid Fitting/Evaluations (For up to 1) &amp; Hearing Aid)</td>
<td></td>
</tr>
<tr>
<td>Home Health Care (Includes Additional Hours of Care)</td>
<td></td>
</tr>
<tr>
<td>Long Term Services &amp; Supports (LTSS) – Waiver Program, Requires Prior Authorizations</td>
<td></td>
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<tr>
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<td></td>
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<tr>
<td>• Nursing Services</td>
<td></td>
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<tr>
<td>• Minor Home Modifications*</td>
<td></td>
</tr>
<tr>
<td>• Emergency Response Services</td>
<td></td>
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<tr>
<td>• Assisted Living</td>
<td></td>
</tr>
<tr>
<td>• Adult Foster Care</td>
<td></td>
</tr>
<tr>
<td>• Transitional Assistance Services^^</td>
<td></td>
</tr>
<tr>
<td>• Respite Care**</td>
<td></td>
</tr>
<tr>
<td>• Employment Assistance</td>
<td></td>
</tr>
<tr>
<td>• Supported Employment</td>
<td></td>
</tr>
<tr>
<td>• Cognitive Rehabilitations Therapy</td>
<td></td>
</tr>
<tr>
<td>• Adaptive Aids and Medical Supplies^^^</td>
<td></td>
</tr>
<tr>
<td>• Home Delivered Meals</td>
<td></td>
</tr>
<tr>
<td>• Speech, Physical, Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>• Dental Services^</td>
<td></td>
</tr>
<tr>
<td>• Support Consultations</td>
<td></td>
</tr>
<tr>
<td>Member Pays Nothing</td>
<td></td>
</tr>
</tbody>
</table>

* $7,500 maximum benefit lifetime limit, $300 per year for repairs
** Up to 30 visits per year
^ $5,000 maximum benefit per year
^^ $2,500 maximum benefit lifetime limit
^^^ $10,000 maximum benefit per year

<table>
<thead>
<tr>
<th>Mental Health (Outpatient Group Therapy Visit, Outpatient Individual Therapy Visit) Authorizations must be obtained from designated behavioral health vendor, Cenpatico.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Pays Nothing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Visit (Benefits and limits as described in the Texas Medicaid Provider and Procedures Manual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Pays Nothing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Rehabilitation (Respiratory Care Services, Occupational Therapy Visits, Occupational Therapy, Physical Therapy &amp; Speech &amp; Language Therapy Visit, Physical Therapy, Additional Speech, Hearing &amp; Language Therapy) (Must receive a prior authorization and submit to Medical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Pays Nothing</td>
</tr>
<tr>
<td>Service Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Director/Utilization Management Review</td>
</tr>
<tr>
<td>Outpatient Substance Abuse (Includes Group Therapy Visits and Individual Therapy Visits) Authorizations must be obtained from designated behavioral health vendor, Cenpatico.</td>
</tr>
<tr>
<td>Outpatient Surgery (Includes Ambulatory Surgical Center, Outpatient Hospital, Freestanding Birth Center Services)</td>
</tr>
<tr>
<td>Physician Specialist Services</td>
</tr>
<tr>
<td>Podiatry Services (Routine Foot care)</td>
</tr>
<tr>
<td>Prosthetic Devices (Includes Braces, Artificial Limbs, etc., Prosthetic Devices, Related Medical Supplies, Additional Medical Supplies)</td>
</tr>
<tr>
<td>Psychiatric Services</td>
</tr>
<tr>
<td>Renal Dialysis</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Urgent Care</td>
</tr>
<tr>
<td>Vision Services (Includes Exam to diagnose &amp; treat diseases &amp; conditions of the eye (including yearly glaucoma screening), Routine Eye Exam (for up to 1 every two years), Contact Lenses, Eyeglasses (Frames and Lenses for up to 1 every two years), Eyeglasses or Contact Lenses after cataract surgery)</td>
</tr>
<tr>
<td>Preventive Care</td>
</tr>
<tr>
<td>Preventive Care (Our Plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol Misuse Counseling, Bone Mass Measurement, Breast Cancer Screening (Mammogram), Cardiovascular Disease (Behavioral Therapy), Cardiovascular Screenings, Cervical &amp; Vaginal Cancer Screening, Colonoscopy, Colorectal Cancer Screenings, Depression Screening, Diabetes Screening, Fecal Occult Blood Test, Flexible</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sigmoidoscopy, HIV Screening, Medical Nutrition Therapy Services, Obesity Screening &amp; Counseling, Prostate Cancer Screenings (PSA), Sexually Transmitted Infections Screening &amp; Counseling, Tobacco Use Cessation Counseling (Counseling for people with no sign of tobacco-related disease), Vaccines, including Flu, Hepatitis B, Pneumococcal, &quot;Welcome to Medicare&quot; Preventive Visit (One time), Yearly &quot;Wellness&quot; Visit, Family Planning Services, Tobacco Cessation Counseling for Pregnant Women)</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
</tr>
<tr>
<td>Hospice Care from Medicare-Certified Hospice</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
</tr>
<tr>
<td>Inpatient Hospital Care (Our Plan covers all medically necessary days for an inpatient hospital stay)</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
</tr>
<tr>
<td>Institutional Care (Institution for mental disease services for individuals 65 or older)</td>
</tr>
<tr>
<td>Institutional Care (Institution for mental disease services for individuals 65 or older) Non-skilled Nursing Facility</td>
</tr>
<tr>
<td>Nursing Home Services</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) – can be submitted without having required 3 day hospital stay. Secure prior authorization.</td>
</tr>
<tr>
<td><strong>Prescription Drug Benefits</strong></td>
</tr>
<tr>
<td>Part B Drugs (Chemotherapy Drugs)</td>
</tr>
<tr>
<td>Other Part B Drugs</td>
</tr>
</tbody>
</table>
## Pre-Catastrophic Coverage

Member may get drugs at Network Retail Pharmacies & Mail Order Pharmacies

<table>
<thead>
<tr>
<th>Cost Sharing Tier</th>
<th>Generic Drugs</th>
<th>Brand Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic Drugs)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Brand Drugs)</td>
<td>$0 Copay; or $1.20 Copay; or $2.65 Copay</td>
<td>$0 Copay; or $1.20 Copay; or $2.65 Copay</td>
</tr>
<tr>
<td>Tier 3 (Non-Medicare Rx/OTC Drugs)</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Member Pays the Following*

### Standard Retail Cost Sharing

- Tier (Generic Drugs): $0
- Tier 2 (Brand Drugs): For Generic Drugs (including brand drugs treated as generic), either $0 Copay; or $1.20 Copay; or $2.65 Copay
- Tier 3 (Non-Medicare Rx/OTC Drugs): $0

- Tier (Generic Drugs): $0
- Tier 2 (Brand Drugs): For Generic Drugs (including brand drugs treated as generic), either $0 Copay; or $1.20 Copay; or $2.65 Copay
- Tier 3 (Non-Medicare Rx/OTC Drugs): $0

### Standard Mail Order Cost-Sharing

- Tier (Generic Drugs): $0
- Tier 2 (Brand Drugs): For Generic Drugs (including brand drugs treated as generic), either $0 Copay; or $1.20 Copay; or $2.65 Copay
- Tier 3 (Non-Medicare Rx/OTC Drugs): $0

If Member resides in a long-term care facility, you pay the same as at a retail pharmacy. Member may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

## Catastrophic Coverage

Member may pay the following:

- Tier 1 (Generic Drugs): $0
- Tier 2 (Brand Drugs): $0
- Tier 3 (Non-Medicare Rx/OTC Drugs): $0
VERIFYING MEMBER BENEFITS, ELIGIBILITY AND COST SHARES

It is imperative that Providers verify benefits, eligibility, and cost shares each time a Superior Member is scheduled to receive services.

Member Identification Card

All Members will receive a Superior Member identification card. Below is a sample Member identification card.

Note: Presentation of a Member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Benefits, Eligibility and Cost Shares

To verify Member benefits, eligibility, and cost share information, the preferred method is the Superior secure web portal found at www.SuperiorHealthPlan. Using the Portal, any registered Provider can quickly check Member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, Member name and date of birth or the Member ID number and date of birth.

Other Methods to Verify Benefits, Eligibility and Cost Shares

<table>
<thead>
<tr>
<th>24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-877-391-5921</th>
<th>The automated system will prompt you to enter the Member ID number and the month of service to check eligibility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services at 1-877-391-5921</td>
<td>If you cannot confirm a Member’s eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the Member name or Member ID number and date of birth to verify eligibility. Monday through Friday 8 a.m. – 6 p.m. CST</td>
</tr>
</tbody>
</table>
UTILIZATION MANAGEMENT

The Superior Utilization Management initiatives are focused on optimizing each Member’s health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program’s goals are to provide covered services that are medically necessary, appropriate to the Member’s condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Prior authorization is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Authorization/Concurrent Hospital</td>
<td>One (1) business day after receipt of the request</td>
</tr>
<tr>
<td>Standard Authorization</td>
<td>Three (3) business days of receipt of the request</td>
</tr>
<tr>
<td>Post Stabilization/life-Threatening</td>
<td>One (1) hour, except that for Emergency Medical Conditions as they do not require prior authorization.</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

Services Requiring Prior Authorization

A list of the services requiring prior authorization can be found at www.SuperiorHealthPlan.com. You can also visit the Superior website at and use the Pre-Screen Tool or call the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. Note: All out of network services require prior authorization excluding emergency room services.

Procedure for Requesting Prior Authorizations

Prior Authorizations for Emergent Medical or Behavioral Health Admissions is not required.

Medical

The preferred method for submitting authorizations is through the Secure Web Portal at www.SuperiorHealthPlan.com. The Provider must be a registered user on the Secure Web Portal. (If a Provider is already registered for the Secure Web Portal for one of our other products, that registration will grant the Provider access to Superior). If the Provider is not already a registered user on the Secure Web Portal and needs assistance or training on submitting prior authorizations, the Provider should contact his or her dedicated Provider Relations Specialist.

Other methods of submitting the prior authorization requests are as follows:

- Fax prior authorization request utilizing the Prior Authorization fax forms posted on the Superior website at www.SuperiorHealthPlan.com. Please note: faxes will not be monitored after hours and will be responded to on the next business day.
- Submit the request via the Provider portal at www.SuperiorHealthPlan.com.
• Phone the Medical Management Department at 1-800-218-7508.

Behavioral
The required method for prior authorization of inpatient admissions is to contact the health plan telephonically using the phone number provided within this manual.

Medical and Behavioral
The requesting or rendering Provider must provide the following information to request authorization (regardless of the method utilized):

• Member’s name, date of birth and ID number;
• Provider’s NPI number, taxonomy code, name and telephone number;
• Facility name, if the request is for an inpatient admission or outpatient facility services;
• Provider location if the request is for an ambulatory or office procedure;
• The procedure code(s). Note: If the procedure codes submitted at the time of authorization differ from the services actually performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-800-218-7508 to update the authorization otherwise, this may result in claim denials;
• Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
• Admission date or proposed surgery date, if the request is for a surgical procedure;
• Discharge plans; and
• For obstetrical admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate.

Behavioral Health Services
Superior has delegated the management of covered mental health and substance abuse disorder services to Cenpatico. Please refer to your contract with Cenpatico for specific information related to covered services and authorization requirement. Additional information regarding Behavioral Health Services can be found in other sections of this manual as applicable.

Pharmacy
The pharmacy benefits for Superior Members vary based on the plan benefits. Information regarding the Member’s pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the Superior Preferred Drug List, the Argus (Pharmacy Benefit Manager) Provider Manual and Medication Request/Exception Request forms.

The Superior Preferred Drug List (PDL) is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The PDL provides instruction on the following:

• Which drugs are covered, including restrictions and limitations;
• The Pharmacy Management Program requirements and procedures;
• An explanation of limits and quotas;
• How prescribing Providers can make an exception request; and
• How Superior conducts generic substitution, therapeutic interchange and step-therapy.

The Superior PDL does not:
• Require or prohibit the prescribing or dispensing of any medication;
• Substitute for the professional judgment of the physician or pharmacist; and
• Relieve the physician or pharmacist of any obligation to the Member.

The Superior PDL will be approved initially by the Superior Pharmacy and Therapeutics Committee (P & T), led by the Pharmacist and Medical Director, with support from community based primary care Providers and specialists. Once established, the Preferred Drug List will be maintained by the P & T Committee, using quarterly meetings, to ensure that Superior Members receive the most appropriate medications. The Superior PDL contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the PDL Change Request policy can be used as a method to address the request. The Superior P & T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the PDL are available on the following websites: www.txvendrodrug.com/formulary/PDLSearch.asp or www.txvendordrug.com or www.epocrates.com. Providers may also call Provider Services for hard copies of the PDL.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, Superior will assist with the following:
• Transitions of prescription drugs
• Out Of Network coverage
• Quality assurance
• Utilization Management (Prior Authorization requirements)
• Exceptions and appeals
• Locate a pharmacy near you
• Information about any formulary changes

72-Hour Emergency Supply of Medicaid Prescription Drugs:
If a prescription for Medicaid-only covered drugs cannot be filled when presented to the pharmacist due to a prior authorization requirement and the prescriber's office cannot be reached, then the STAR+PLUS MMP must instruct the pharmacy to dispense a 72-hour emergency supply of the prescription. The pharmacy is not required to dispense a 72-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber. The pharmacy may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The STAR+PLUS MMP must reimburse the pharmacy for dispensing the temporary supply of medication.
Transition Policy
Under certain circumstances Superior can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, Members must meet the requirements below:

1. The drug the Member has been taking is no longer on the Superior formulary or the drug is now restricted in some way
2. The Member must be in one of the situations described below:
   - For those Members who were enrolled with Superior last year and are not in a long-term care facility: We will cover a temporary supply of the drug one time only during the first 90 days enrolled in Superior of the calendar year. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
   - For those Members who are new to Superior and are not in a long-term care facility: Superior will cover a temporary supply of the drug one time only during the first 90 days of the membership in Superior. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
   - For those who are new Superior Members, and are residents in a long-term care facility: We will cover a temporary supply of the drug during the first 90 days of membership in Superior. The first supply will be for a maximum of a 31-day supply, or less if the prescription is written for fewer days. If needed, we will cover additional refills during the first 90 days in Superior up to a maximum of 91 – 98 day supply.
   - For those who have been a Member of Superior for more than 90 days, are a resident of a long-term care facility and need a supply right away; Superior will cover one 31-day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.

Prior Authorization Requirements
Superior has a team of doctors and pharmacists to create tools to help provide quality coverage to Superior Members. The tools include, but are not limited to: prior authorization criteria, clinical edits and quantity limits. Some examples include:

- **Age Limits**: Some drugs require a prior authorization if the Member’s age does not meet the manufacturer, FDA, or clinical recommendations.
- **Quantity Limits**: For certain drugs, Superior limits the amount of the drug we will cover per prescription or for a defined period of time.
- **Prior Authorization**: Superior requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process.) This means that approval will be required before prescription can be filled. If approval is not obtained, Superior may not cover the drug.
• Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand-name drug was requested. If the brand-name drug is approved, the Member may be responsible for a higher co-pay and/or the difference in cost between the brand and generic medications.

Superior can make an exception to our coverage rules, please refer to the Comprehensive Formulary. When requesting a utilization restriction exception, submit a supporting statement along with a completed Request for Medicare Prescription Drug Coverage Determination form. Generally, Superior must make a decision within 72 hours of getting the supporting statement. Providers can request an expedited (fast) exception if the Member’s health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, Superior must provide a decision no later than 24 hours after receiving the prescriber’s or prescribing doctor’s supporting statement.

Second Opinions
Members or a healthcare professional with the Member’s consent may request and receive a second opinion from a qualified professional within the Superior network. If there is not an appropriate Provider to render the second opinion within the network, the Member may obtain the second opinion from an out of network Provider only upon receiving a prior authorization from the Superior Utilization Management Department.

Women’s Health Care
Female Members may see a network Provider, who is contracted with Superior to provide women’s health care services directly, without prior authorization for:

• medically necessary maternity care;
• covered reproductive health services;
• preventive care (well care) and general examinations particular to women;
• gynecological care; and
• follow-up visits for the above services.

If the Member’s women’s health care Provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Superior’s prior authorization requirements.

Utilization Determination Timeframes – Concurrent Review
Utilization Management decision making is based on appropriateness of care and service and the covered benefits of the plan. Superior does not reward Providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. In some cases it may be necessary for an extension to extend the timeframe above. You will be notified in writing if an extension is necessary. Superior must make a determination by the close of the next business day following the date of request for
authorization. In order to meet the state requirements, Superior requires receipt of the clinical by 2:00 p.m. on the day following the request for authorization. The Superior utilization management nurse will review the clinical to determine medical necessity and appropriateness of services, including setting of care, are met according to InterQual criteria. If medical necessity is not met through InterQual criteria, a secondary review is completed by a physician (medical director) to make a final determination. If approved, a letter will be faxed to the hospital, with approved days and the date of the next review. If a denial is issued, a denial letter is sent and a call is made by the utilization management. Please contact Superior if you would like a copy of the policy for UM timeframes.

Retrospective Review
Retrospective review is an initial review of services after services have been provided to a Member. This may occur when authorization or timely notification to Superior was not obtained due to extenuating circumstances (i.e. Member was unconscious at presentation, Member did not have their Superior ID card or otherwise indicated other coverage, services authorized by another payor who subsequently determined Member was not eligible at the time of service). Requests for retrospective review must be submitted promptly.

Medically Necessary
Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These services include:

- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member’s medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms; and
- Not provided solely for the convenience of the Member or the convenience of the healthcare Provider or hospital

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a Member or Provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Superior clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

In the event that a Member may not agree with the medical necessity determination, a Member has the opportunity to appeal the decision. Please refer to the “Grievance Process” section of the contract.

Emergency Medical Condition
An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the
health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Utilization Review Criteria
Superior has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- InterQual®
- Health Plan Clinical Policy

Superior’s Medical Director reviews, or other health care professionals that have appropriate clinical expertise in treating the Member’s condition or disease review, all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from InterQual® or other criteria as mentioned above. Superior’s Clinical Policies are posted at www.SuperiorHealthPlan.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-877-391-5921. Providers have the opportunity to discuss any adverse decisions with a Superior physician or other appropriate reviewer at the time of the notification to the requesting Provider of an adverse determination. The Medical Director may be contacted by calling Superior at 1-800-218-7453 and asking for the Medical Director. A Superior Care Manager may also coordinate communication between the Medical Director and the requesting Provider.

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Superior does not reward Providers or other individuals for issuing denials of authorizations.
SERVICE COORDINATION

Service Coordination is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs, using communication and available resources to promote quality, cost effective outcomes. Service Coordination is Member-centered, goal-oriented, and culturally relevant and logically managed processes to help ensure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Superior’s Service Coordination teams support physicians by tracking compliance with the Service Coordination plan, and facilitating communication between the PCP, Member, managing physician, and the Service Coordination. The Service Coordinator also facilitates referrals and links to community Providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the Member’s ongoing care needs. The Superior Service Coordinator will contact the PCP, and/or, managing physician if the Member is not following the plan of care or requires additional services.

Members with needs may be identified via clinical rounds, referrals from other Superior staff Members, via hospital census, via direct referral from Providers, via self-referral or referral from other Providers.

The Role of the Service Coordinator

The Superior Service Coordinator provides a specialized level of care management service that includes but is not limited to:

- Identification of needs, including physical health, mental health services and Long Term Support Services (LTSS) for MMP Members.
- Development of a Service Plan of Care to address those identified needs.
- Assistance to ensure timely and a coordinated access to an array of Providers and covered services;
- Attention to addressing unique needs of Members.
- Coordination of covered services with social and other services delivered outside the benefit plan as necessary and appropriate and.
- Conduct mandatory telephonic or face to face contacts.

Service Coordination services provided to Members are:

- Review Assessments and develop plan of care utilizing input from Member, family and Providers.
- Coordinate with the Member’s PCP, Specialist and LTSS Providers to ensure the Member’s health and safety needs are met in the least restrictive setting.
- Refer Members to support services such as disease management and community resource.
- Authorize LTSS services.
- Service Coordination utilizes a multidisciplinary approach in meeting the Member’s needs including behavioral health.

For details on Service Coordination for Nursing Facility Members, please see Nursing Facility Provider Manual.
Levels of Service Coordination

To provide Service Coordination, we collaborate with the Member, caregiver/family and informal supports desired by the Member, all treating Providers regardless of network status, and community resources.

For each identified Member, the Service Coordination team identifies the appropriate Level assignment using the following criteria:

- **Level 1**
  - Members, including Dual Eligible, receiving Home and Community Based Services STAR+PLUS Waiver (SPW) services and/or with complex medical needs.
  - Members under age 21.
  - Members who move from nursing facility/institution to community.
  - Members who require Complex Service Coordination for high risk, complex or catastrophic conditions

- **Level 2**
  - Dual Eligible Members who do not meet Level 1 criteria.
  - Non-Waiver Members receiving Personal Assistance Services (PAS) or Day Activity and Health Services (DAHS).
  - Members not receiving LTSS with a history of BH and/or substance use issues during the previous year.
  - All Members who do not meet criteria for Level 1

- **Companion Cases**
  - Both Members will be assigned the same Service Coordinator at the highest Level of complexity.
Discharge Planning
The SC collaborates with our nurses who follow Members while they are in hospital in order to schedule needed assessments and work with the Member, family, attending physician, discharge planner, PCP and other relevant Providers to coordinate services and equipment required at discharge. If a Member was receiving any LTSS prior to admission to a hospital, once a Member is discharged, SC staff notifies LTSS Providers to resume services. If an LTSS Provider becomes aware of a Member that is admitted to a hospital, the Provider should alert the Service Coordinator when services cease after the admission and resume once Member returns home from the hospital.

When a dual Member is hospitalized, Superior is not notified of the admission by the hospital since Superior is not financially responsible for the hospital stay. So, it is very important that the LTSS Provider notify the Service Coordinator right away once they become aware of a Member’s hospital admission. The Service Coordinator will partner with the LTSS Provider to restart services once the Member is discharged. The Service Coordinator will also authorize any additional needs the Member may have.

Model of Care
The Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to Superior Members.

Purpose
To improve quality, reduce costs, and improve the Member experience:

- Ensure Members have full access to the services they are entitled
- Improve the coordination between the federal government and state requirements
- Develop innovative care coordination and integration models
- Eliminate financial misalignments that lead to poor quality and cost shifting

Model of Care Elements include:

- Description of the MMP Population
- Care Coordination
- SNP Provider Network
- Quality Measurements and Performance Improvement

Model of Care Process:
Every Member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and annually or more frequently if significant changes in the Member’s condition or transition of care. The HRA is designed to collect information about the Member’s medical, psychosocial, cognitive, and functional needs in coordination of medical and behavioral health history. Once triaged, Members are then assigned to the appropriate case management program.

- Individualized Care Plan (ICP): Service Coordination will develop an Individualized Care Plan based on input from all parties involved in the Member’s care. The ICP includes:
  - Goals and objectives
Members will then receive monitoring, service referrals, and condition specific education from service coordinators who will work closely with PCPs, Members, and their family to prepare, implement, and evaluate the ICP.

**Interdisciplinary Care Team (ICT)**
The Superior Service Coordinators will coordinate the Member’s care with the ICT. The ICT includes the Superior health plan, Member and caregiver, external practitioners, and vendors involved in the plan, the Member’s care which all are dependent on who the Members chooses to attend.

- **Inpatient Care:** Service Coordinators will coordinate with facilities to assist Members with the appropriate level of care and develop an appropriate discharge plan. Superior will then notify the PCP of the transition of care and anticipated discharge date to ensure Members receive the appropriate follow-up care.
- **Transition of Care:** Managing transition of care for discharged Members may include but is not limited to face to face or telephonic contact with the Member or their representative in the hospital prior to discharge to discuss the discharge plan.
- **Provider ICT Responsibilities:** Provider responsibilities include accepting ICT meeting invitations on Members when possible, maintain copies of the ICP, ICT worksheets and transition of care notifications in the Member’s medical record, and collaborating with Superior case managers, ICT, and Members or caregivers.
- **ICT Training:** All internal and external ICT Members will be trained annually on the current Model of Care.

**ENCOUNTERS AND CLAIMS**

**Encounter Reporting**

What is an Encounter versus a Claim?

An *encounter* is a claim which is paid at zero dollars as a result of the Provider being pre-paid or capitated for the services he/she provided our Members. For example; if you are the PCP for Superior Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as an “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Superior utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by CMS. Encounters do not generate an EOP.
A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the Provider who submitted the original claim. Claims will generate an EOP. Providers are required to submit either an encounter or a claim for each service that you render to a Superior STAR+PLUS MMP Member.

 CLAIMS
Nursing Facilities: Please refer to the Superior Nursing Facility Provider Manual, Section 13 Claims, for claim filing guidelines and billing instructions.

Clean Claim Definition
A clean claim is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in the health plan’s systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.

A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate Claim type encounter guides as follows:

1.20.1 837 Professional Combined Implementation Guide;
1.20.2 837 Institutional Combined Implementation Guide;
1.20.3 837 Professional Companion Guide;
1.20.4 837 Institutional Companion Guide; or
1.20.5 National Council for Prescription Drug Programs (NCPDP) Companion Guide.

Non-Clean Claim Definition
Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Timely Filing
Participating Providers must submit first time claims within 95 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration or claim disputes from participating Providers must be received within 120 days from the date of explanation of payment or denial is issued.
Who Can File Claims?

All Providers who have rendered services for Superior Members can file claims. It is important that Providers ensure Superior has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Specialist that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code (This is a REQUIRED field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that Providers notify Superior as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information with a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Billing for Acute Care Services

- Providers will use the same codes and modifiers as used for original Medicare.
- Hospitals must include, when appropriate, the Present on Admission, and Hospital Acquired Conditions indicators on claims.

Billing for LTSS Services

- Providers will bill and report LTSS in compliance with the STAR+PLUS MMP LTSS Health Care Common Procedure Codes (HCPC) and STAR+PLUS Modifiers Matrix (Matrix).
- The uniform billing requirements and billing Matrix can be found in the HHSC Uniform Managed Care Manual (UMCM), Chapter 2. at http://www.hhsc.state.tx.us/medicaid/managed-care/umcm.
- Some LTSS Providers are considered “Atypical Providers” because they render non-health or non-medical services to STAR+PLUS Members. These Providers bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form
  - Examples include pest control services and building and supply services. Atypical Providers will submit appropriate documentation to Superior to accurately populate an 837 Professional Encounter

How to File a Paper Claim

Providers must file claims using standard claims forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).

Tips that Providers should remember:

- Enter the Provider’s NPI number in the “Rendering Provider ID#” section of the CMS 1500 form (see box 24J).
- Providers must include their taxonomy code (ex. 207Q00000X for Family Practice) in this section for correct processing of claims.
• Black and white UB-04 or CMS-1500 forms copied/downloaded or handwritten red forms will be rejected.

• Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form. For EDI claims, the CLIA number must appear in X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4 when a single claim is submitted for laboratory services or in X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4 when there are laboratory and non-laboratory services on the claim. If the CLIA number is not present on the claim the claims will be rejected.

• All paper claim forms should be typed or printed with either 10 or 12 Times New Roman font. Do not use highlights, italics, bold text or staples for multiple page submissions.

Claims missing the necessary requirements are not considered “clean claims” and will be returned to Providers with a written notice describing the reason for return.

Initial Paper Claims may be submitted to:

Superior HealthPlan STAR+PLUS MMP
PO BOX 3060
Farmington, MO 63640-3822

Superior will accept claims from Providers in multiple, HIPAA compliant methods. We support all HIPAA EDI (Electronic Data Interchange) transaction formats, including HIPAA 837 Institutional and Professional transactions and HIPAA compliant NCPDP format for pharmacies. Providers may submit EDI using our preferred claims clearinghouses or submit HIPAA 837 claims to us directly via our secure web based Provider Portal. Providers may enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature – another secure component of our Provider Portal. Finally, Providers may also mail CMS 1500 or UB-04 standard paper claims to us.

Electronic Claims Submission

We encourage all Providers to submit clean claims and encounter data electronically. Superior can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to Providers electronically or in paper format, dependent on Provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Superior has partnered with, contact:

Superior HealthPlan STAR+PLUS MMP
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same timely filing requirements as Providers filing paper claims. Providers that bill electronically must monitor their error reports and
evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounter information.

The Superior Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at www.SuperiorHealthPlan.com.

**Corrected Claims, Requests for Reconsideration or Claim Disputes**

All requests for corrected claims, reconsiderations or claim disputes must be received within 120 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or Provider claim requests for reconsideration or disputes received outside of the [insert timeframe] unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the Provider, or damage or destruction of the Provider’s business office or records by a natural disaster, mechanical, administrative delays or errors by Superior or the Federal and/or State regulatory body.

2. The Member was eligible; however the Provider was unaware that the Member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
   - The Provider’s records document that the Member refused or was physically unable to provide his or her ID Card or information;
   - The Provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered; and
   - The Provider has not filed a claim for this Member prior to the filing of the claim under review.

Below are relevant definitions.

1. Adjusted or corrected claim – A Provider is CHANGING the original claim
2. Request for Reconsideration – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
3. Claim Dispute – Provider disagrees with the outcome of the Request for Reconsideration

**Corrected Claims**

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
2. Submit a corrected claim electronically via a Clearinghouse
   - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
   - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
3. Submit a corrected paper claim to:
• Include the original Explanation of Payment (EOP). Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing or denial for exceeding the timely filing limit.

Reconsiderations
1. A request for reconsideration is a written communication (i.e. a letter) from the Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
2. The documentation must also include a description of the reason for the request.
   • Indicate “Reconsideration of (original claim number)”
   • Include a copy of the original Explanation of Payment
   • Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.
3. The “Request for Reconsideration” should be sent to:
   Superior HealthPlan STAR+PLUS MMP
   Attn: Claims - Reconsiderations
   PO BOX 4000
   Farmington, MO 63640-4000

Claim Dispute
1. A claim dispute should be used only when a Provider has received an unsatisfactory response to a request for reconsideration.
2. Providers wishing to dispute a claim must complete the Claim Dispute Form located at www.SuperiorHealthPlan.com.
3. To expedite processing of the dispute, please include the original request for reconsideration letter and the response.
4. The Claim Dispute form and supporting documentation should be sent to:
   Superior HealthPlan STAR+PLUS MMP
   Attn: Claims Appeals
   PO BOX 4000
   Farmington, MO 63640-4000

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the Provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the Provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.
Superior shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status in accordance with state law and regulation.

**Risk Adjustment and Correct Coding**

Risk adjustment is a critical and a requirement defined in CFR42 and the Medicare Modernization Act that will help ensure the long-term success of the Health Insurance Marketplace and Medicare Superior programs. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM, CPT, DSM-IV, and HCPCs code sets. Services rendered after October 1, 2015 are required, per CMS, to be billed using ICD-10 and DSM-V coding guidelines. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity using the 4th and 5th digits, when applicable and defensible through chart audits and medical assessments;
- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management;
- Ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone);
- Submit claims and encounter information according to contract requirements specified in your contract or this Provider manual
- Alert Superior of any erroneous data submitted and follow Superior’s policies to correct errors according to contract requirements specified in your contract or this Provider manual
- Provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

**Failure to Obtain Authorization**

Providers may NOT bill Members for services when the Provider fails to obtain an authorization and the claim is denied by Superior.
Attendant Care Enhanced Payment Methodology

LTSS Providers contracted with Superior may participate in the attendant care enhanced payment program if they currently participate in the attendant compensation rate enhancement program with the Department of Aging and Disability Services (DADS). The following LTSS services are eligible for enhanced payments:

- Personal assistant services (PAS) both waiver and non-waiver.
- Day activity and health Services (DAHS).
- Assisted living and residential care (ALRC) services.

Superior will reimburse Providers at the same participation level as they are assigned by DADS. Superior will increase the fee schedules for the codes included in the enhancement program for our contracted Providers who are contracted to participate in Superior’s attendant care enhanced payment program. Providers who are enrolled and subsequently do not continue participation in DADS, the level will remain the same throughout the duration of their participation in the Superior program. For assisted living facilities that do not hold a DADS contract, Superior will establish an additional amount to be added on to the unit rates by type of service. If based upon Superior’s review of quality measures and determines a change to the Providers level, Superior will supply appropriate advance notice to such Providers.

Superior will have an enrollment period to allow Providers to participate in the Superior MMP attendant care enhanced payment program. Once a Provider elects to participate in the Superior attendant care enhanced Payment program, they will be required to complete and submit an annual affidavit stating they applied the enhancement funds to the compensation for direct care attendant staff. Compensation may include increased hourly rates, bonuses, paid holidays, or additional benefits such as employer paid insurance.

For Providers that are assigned a new participation level by DADS for PAS or DAHS services, these Providers must submit the updated level in writing to Superior requesting a change in participation level. Superior will verify new participation level using the list as published on the HHSC website under the Attendant Compensation Rate Enhancement webpage. All rate enhancement level changes are effective month following the month the notice was provided to Superior and rate level was verified on website. Rate enhancement level changes are made prospectively, and will not be made retrospectively.

The enhanced rate payment will be paid at the time of claims payment as an added amount to the hourly attendant care rate. Rates are established by Superior based on type of service. Failure to comply with the attendant compensation spending requirement for the annual reporting period may be subject to audit and/or recoupment of enhanced funds.
Each Provider’s compliance with the attendant compensation spending requirements will continue to be monitored on an annual basis by Superior. Compensation may include increased hourly rates, bonuses, paid holidays or additional benefits such as employer paid insurance. In addition, Providers may be audited on an as-needed basis to ensure financial records support the pass through of the enhanced funds. Enhanced payments could potentially be recouped for those Providers who fail to pass the funds to their direct care staff, or failure to return required affidavit to Superior upon request.

**Minimum Wage Requirements for STAR+PLUS MMP**

**Attendants in Community Settings**
Superior must ensure that facilities and agencies that provide attendant services in community settings pay attendants at or above the minimum rates. This requirement applies to the following types of services, whether or not the Member chooses to self-direct these services:

- Day activity health care services (DAHS).
- Personal assistance services (PAS).
- Texas Health Steps personal care services (PCS).

This requirement does not apply to attendant services provided by non-institutional facilities, such as assisted living, adult foster care, residential care and nursing facilities.

**Billing the Member**
It is imperative that Providers verify benefits, eligibility, and cost shares each time a Superior Member is scheduled to receive services. Providers may not seek payment from Superior Members for the difference between the billed charges and the contracted rate allowed by Superior. Superior reimburses only those services that are medically necessary and a covered benefit; an Explanation of Payment is provided that will detail reimbursement for each claim submitted.

Providers may bill Members for services NOT covered by Superior STAR+PLUS MMP or for applicable copayments, deductibles or coinsurance as defined by the Explanation of Payment. In order for a Provider to bill a Member for services not covered under the Superior or to bill the Member if the service limitations have been exceeded, the Provider must obtain a written acknowledgement following this language, PRIOR to rendering services:

“I understand that, in the opinion of (Provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Superior program as being reasonable and medically necessary for my care. I understand that Superior HealthPlan determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”
MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights
Providers must comply with the rights of Members as set forth below.

1. To participate with Providers in making decisions about his/her health care. This includes working on any treatment plans and making care decisions. The Member should know any possible risks, problems related to recovery, and the likelihood of success. The Member shall not have any treatment without consent freely given by the Member or the Member’s legally authorized surrogate decision-maker/representative. The Member must be informed of their care options.

2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.

3. To receive the benefits for which the Member has coverage.

4. To be treated with respect and dignity.

5. To privacy of their personal health information, consistent with state and federal laws, and Superior policies.

6. To receive information or make recommendations, including changes, about Superior’s organization and services, the Superior network of Providers, and Member rights and responsibilities.

7. To candidly discuss with their Providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the Member’s primary care physician about what might be wrong (to the level known), treatment and any known likely results. The Provider must tell the Member about treatments that may or may not be covered by the plan, regardless of the cost. The Member has a right to know about any costs they will need to pay. This should be told to the Member in a way that the Member can understand. When it is not appropriate to give the Member information for medical reasons, the information can be given to a legally authorized person/representative. The Provider will ask for the Member’s approval for treatment unless there is an emergency and the Member’s life and health are in serious danger.

8. To voice complaints or appeals about: Superior, any benefit or coverage decisions Superior makes, Superior coverage, or the care provided.

9. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the Provider(s) of the medical consequences.

10. To see their medical records.

11. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, Providers, advance directive information, referrals and authorizations, benefit denials, Member rights and responsibilities, and other Superior rules and guidelines. Superior will notify Members at least 30 days before the effective date of the modifications. Such notices shall include the following:
   - Any changes in clinical review criteria.
   - A statement of the effect of such changes on the personal liability of the Member for the cost of any such changes.
12. To have access to a current list of network Providers. Additionally, a Member may access information on network Providers’ education, training, and practice.

13. To select a health plan or Provider or switch health plans or Providers, within the guidelines, without any threats or harassment.

14. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion

15. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

16. To receive information in a different format in compliance with the Americans with Disabilities Act, if the Member has a disability.

17. To refuse treatment to the extent the law allows. The Member is responsible for their actions if treatment is refused or if the Provider’s instructions are not followed. The Member should discuss all concerns about treatment with their primary care physician or other Provider. The primary care physician or other Provider must discuss different treatment plans with the Member. The Member must make the final decision.

18. To select a primary care physician within the network. The Member has the right to change their primary care physician or request information on network Providers close to their home or work and have that choice be effective the first calendar day of the following month.

19. To know the name and job title of people providing care to the Member. The Member also has the right to know which physician is their primary care physician.

20. To have access to an interpreter when the Member does not speak or understand the language of the area.

21. To a second opinion by a network physician, at no cost to the Member, if the Member believes that the network Provider is not authorizing the requested care, or if the Member wants more information about their treatment.

22. To execute an advance directive for health care decisions. An advance directive will assist the primary care Provider and other Providers to understand the Member’s wishes about the Member’s health care. The advance directive will not take away the Member’s right to make their own decisions. Examples of advance directives include:
   - Living Will
   - Health Care Power of Attorney
   - “Do Not Resuscitate” Orders

Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

23. Receive a Comprehensive Health Risk Assessment upon Enrollment in a plan and to participate in the development and implementation of a Plan of Care. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Member’s strengths and weaknesses, and a plan for managing and coordination Member’s care. Members, or their LAR, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
24. Receive complete and accurate information on his or her health and functional status by the Service Coordination Team and have the right to involve caregivers or family Members in these discussions.

25. Provided information on all program services and health care options before enrollment, at enrollment, and at a time as Member’s needs necessitate the disclosure and delivery of such information in order to allow the Member or their legally authorized representative to make an informed choice.

26. Receive reasonable advance notice, in writing, of any Transfer to another treatment setting and the justification for the Transfer.

27. To be protected from liability for payments of any fees that are the obligation of Superior STAR+PLUS MMP.

28. To not be charged any cost sharing for Medicare Parts A and B services.

Member Responsibilities

1. To read their STAR+PLUS MMP contract in its entirety.

2. To treat all health care professionals and staff with courtesy and respect.

3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The Member should make it known whether they clearly understand their care and what is expected of them. The Member needs to ask questions of their Provider so they understand the care they are receiving.

4. To review and understand the information they receive about STAR+PLUS MMP. The Member needs to know the proper use of covered services.

5. To show their ID card and keep scheduled appointments with their Provider, and call the Provider’s office during office hours whenever possible if the Member has a delay or cancellation.

6. To know the name of their assigned primary care physician. The Member should establish a relationship with their primary care physician. The Member may change their primary care physician verbally or in writing by contacting the Superior STAR+PLUS MMP Member Services Department.

7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.

8. To understand their health problems and participate, along with their health care Providers in developing mutually agreed upon treatment goals to the degree possible.

9. To supply, to the extent possible, information that STAR+PLUS MMP and/or their Providers need in order to provide care.

10. To follow the treatment plans and instructions for care that they have agreed on with their health care Providers.

11. To understand their health problems and tell their health care Providers if they do not understand their treatment plan or what is expected of them. The Member should work with their primary care physician to develop mutually agreed upon treatment goals. If the Member does not follow the treatment plan, the Member has the right to be advised of the likely results of their decision.

12. To follow all health benefit plan guidelines, provisions, policies and procedures.
13. To use any emergency room only when they think they have a medical emergency. For all other care, the Member should call their primary care physician.

14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the Member gains other medical coverage besides STAR+PLUS MMP coverage, the Member must provide this information to STAR+PLUS MMP.

15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

16. You must abide by the health plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan’s rules and Medicaid rules.
   b. Choose your health plan and a primary care Provider quickly.
   c. Make any changes in your health plan and primary care Provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care Provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care Provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Superior Members, and other healthcare workers with dignity and respect.
2. To receive accurate and complete information and medical histories for Members’ care.
3. To have their patients, who are Superior Members, act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly.
4. To expect other network Providers to act as partners in Members’ treatment plans.
5. To expect Members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Superior and/or a Member.
7. To file a grievance on behalf of a Member, with the Member’s consent.
8. To have access to information about Superior quality improvement programs, including program goals, processes, and outcomes that relate to Member care and services.
9. To contact Provider Services with any questions, comments, or problems.
10. To collaborate with other health care professionals who are involved in the care of Members.
11. To not be excluded, penalized, or terminated from participating with Superior for having developed or accumulated a substantial number of patients in Superior with high cost medical conditions.
12. To collect Member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for Members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
   - Recommend new or experimental treatments.
   - Provide information regarding the nature of treatment options.
   - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered.
   - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
2. To treat Members with fairness, dignity, and respect.
3. To not discriminate against Members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.
4. To maintain the confidentiality of Members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
5. To give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider’s practice and scope of service.

6. To provide Members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

7. To allow Members to request restriction on the use and disclosure of their personal health information.

8. To provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

9. To provide clear and complete information to Members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow Member participation in the decision-making process.

10. To tell a Member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment.

11. To allow a Member who refuses or requests to stop treatment the right to do so, as long as the Member understands that by refusing or stopping treatment the condition may worsen or be fatal.

12. To respect Members’ advance directives and include these documents in the their medical record.

13. To allow Members to appoint a parent/guardian, family Member, or other representative if they can’t fully participate in their treatment decisions.

14. To allow Members to obtain a second opinion, and answer Members’ questions about how to access health care services appropriately.

15. To follow all state and federal laws and regulations related to patient care and rights.

16. To participate in Superior data collection initiatives, such as HEDIS and other contractual or regulatory programs.

17. To review clinical practice guidelines distributed by Superior.

18. To comply with the Superior Medical Management program as outlined herein.

19. To disclose overpayments or improper payments to Superior.

20. To provide Members, upon request, with information regarding the Provider’s professional qualifications, such as specialty, education, residency, and board certification status.

21. To obtain and report to Superior information regarding other insurance coverage the Member has or may have.

22. To give Superior timely, written notice if Provider is leaving/closing a practice.

23. To contact Superior to verify Member eligibility and benefits, if appropriate.

24. To invite Member participation in understanding any medical or behavioral health problems that the Member may have and to develop mutually agreed upon treatment goals, to the extent possible.

25. To provide Members with information regarding office location, hours of operation, accessibility, and translation services.

26. To object to providing relevant or medically necessary services on the basis of the Provider’s moral or religious beliefs or other similar grounds.

27. To provide hours of operation to Superior Members which are no less than those offered to other commercial Members.
Long Term Services and Supports

LTSS Providers deliver a continuum of care and assistance ranging from in-home and community-based services for elderly people and persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals while providing the support required. LTSS Providers have certain responsibilities for the STAR+PLUS MMP program and the Members they serve. This includes, but is not limited to:

- Contacting Superior to verify Member eligibility and/or authorizations for service.
- Providing continuity of care.
- Notifying Superior of any change in Member’s physical condition or eligibility.

LTSS Providers are required to provide covered health services to Members within the scope of their Superior agreement and specialty license.

Superior requires that LTSS Providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code §355.403 (Vendor Hold). If an LTSS Provider fails to comply with these requirements, HHSC will notify the Superior to hold payments to the LTSS Provider until HHSC instructs the Superior to release the payments. HHSC will forward notices directly to LTSS Providers about such costs reports and information that is required to be submitted.

LTSS must be previously authorized and all requests should be faxed to the Superior STAR+PLUS MMP Service Coordination Department at 1-855-277-5700.

Nursing Facility

The Nursing Facility staff will partner with Superior’s Service Coordinators (SC) to ensure the Members’ plan of care meets the Members’ needs in the least restrictive setting. The NF is responsible for:

- Inviting the MCO SC to provide input for the development of the NF care plan, subject to the Member’s right to refuse, by notifying the MCO SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on MCO SC participation;
- Notifying the MCO SC within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home;
- Notifying the MCO SC if a Member moves into hospice care;
- Notifying the MCO SC within one business day of an adverse change in a Member’s physical or mental condition or environment that could potentially lead to hospitalization;
- Coordinating with the MCO SC to plan discharge and transition from a NF;
- Notifying the MCO SC within one business day of an emergency room visit;
- Notifying the MCO SC within 72 hours of a Member’s death;
• Notifying the MCO SC of any other important circumstances such as the relocation of Members due to a natural disaster; and providing the MCO SC access to the facility, NF staff, and Members’ medical information and records; and
• Responsibilities as outlined in Superior’s Nursing Facilities Provider Manual, Section 8 – Provider Responsibilities.

CULTURAL COMPETENCY
Superior views Cultural Competency as the measure of a person or organization’s willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are Members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient’s culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among Providers and staff to ensure that services are delivered in a culturally competent manner.

Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, Members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Superior is committed to the development, strengthening and sustaining of healthy Provider/Member relationships. As part of Superior’s Cultural Competency Program, Superior offers training and resources to Providers and their staff that they can use to develop their skills and office culture.

Providers must ensure that:

• Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
• Medical care is provided with consideration of the Members’ primary language, race and/or ethnicity as it relates to the Members’ health or illness;
• Office staff routinely interacting with Members has been given the opportunity to participate in, and have participated in, cultural competency training;
• Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each Member. Staff will also explain race categories to a Member in order assist the Member in accurately identifying their race or ethnicity;
- Treatment plans are developed with consideration of the Member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the Member’s perspective on health care;
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and
- Members with disabilities are provided with reasonable accommodations to ensure effective communication including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:
  - Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;
  - Ensuring that all written materials are available in formats compatible with optical recognition software;
  - Reading notices and other written materials to individuals upon request;
  - Assisting individuals in filling out forms over the telephone; and
  - An appropriate mechanism is established to fulfill the Provider’s obligations under the Americans with Disabilities Act including that all facilities providing services to Members must be accessible to persons with disabilities. Additionally, no Member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Superior considers mainstreaming of Members an important component of the delivery of care and expects Providers to treat Members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a Member a covered service or availability of a facility; and
- providing a Superior Member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay Members (examples: separate waiting rooms, delayed appointment times).

Providers can contact Member Services at 1-866-896-1844, for assistance in locating Providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.

There are other numerous resources available to physicians, nurses and those working in the medical field.

The following are some of the resources available:

- On the Office of Minority Health’s website, you can find “A Physician’s Practical Guide to Culturally Competent Care.” By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp.
- Think Cultural Health’s website includes classes, guides and tools to assist you in providing culturally competent care. The website is: https://www.thinkculturalhealth.hhs.gov.
The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html.

Interpreter Services
Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.

To arrange interpreter/translation services, contact Member Services as soon as possible or at least two business days before the appointment. All Providers (Medical, Behavioral, LTSS, Pharmacy, etc.) can call Member Services at 1-866-896-1844 or TTY 1-800-735-2989 or 7-1-1 to help arrange translation services.
MEMBER GRIEVANCES AND APPEALS

Grievances/Complaints
Members must follow the complaint or dispute (grievance) process as listed below when a Member is dissatisfied with the manner in which Superior or a delegated entity provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services
- Setting of health services
- Procedures
- Items
- Standards for delivery of care

Members or their legally authorized representative may submit a grievance verbally or in writing via phone, mail, facsimile, electronic mail or in person within 90 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the Member as expeditiously as the Member’s case requires, based on health status, but no later than 24 hours for expedited grievances and 30 calendar days for standard grievances. Extensions of up to 14 calendar days can be granted for standard grievances if the Member requests the extension or if Superior justifies the need for additional information and the delay is in the best interest of the Member. For grievances that are received in person or by telephone, if the grievance cannot be resolved within 1 business day of receipt, Superior will provide the Member or their legally authorized representative with written notice of resolution.

A grievance can be filed one of the following ways:

- Calling Superior HealthPlan STAR+PLUS MMP Member Services Department at 1-866-894-1844 / TTY 711
- Writing Superior a letter that includes Member’s name, Member ID number, address and telephone and an explanation of why you are not happy. Mail it to:
  
  Superior HealthPlan STAR+PLUS MMP
  Attn: Grievances
  2100 South IH-35, Suite 200
  Austin, TX 78704

- Calling Medicare 1-800-Medicare / TTY 1-877-486-2048
- Online by visiting Medicare.gov

If a Member files a grievance with Medicare via the phone or through their website, Superior must respond to each Member grievance according to the earlier time from outline or 14 days from the date the Member files the grievance.
Appeals

Members or their legally authorized representative may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Superior. Appeals must be submitted within 60 days of the decision. Expedited determinations will be made on medical care or drug coverage not yet received if standard deadlines can cause serious harm to the Member’s health. Written appeals must be mailed to:

Superior HealthPlan STAR+PLUS MMP
Attn: Appeals and Grievances
2100 S. IH 35, Suite 200
Austin, TX 78704

For process or status questions, Members or their legally authorized representative can contact Member Services at 1-866-896-1844.

Initial appeals maybe filed with Superior at the address above. Subsequent appeals for Traditional Medicare A and B services that are not fully in favor of the Member will be forward to the Medicare Independent Review Entity (IRE) by Superior.

Appeals for services covered by HHSC only may also be appealed to the HHSC Appeals Division for a Fair Hearing at any time.

For services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D), decisions made by Superior that are not fully in favor of the Member will be auto-forwarded to the IRE by Superior. A Member may also file a request for a fair hearing with the HHSC Appeals Division. If an Appeal is both auto-forwarded to the IRE and filed with the HHSC Appeals Division, any determination in favor of the Member will bind the Superior and will require payment by Superior for the service or item in question granted in the Member’s favor which is closest to the Member’s relief requested on appeal. Part D appeals may not be filed with the HHSC Appeals Division.

Superior shall respond in writing to standard appeals as expeditiously as the Member’s health condition requires and shall not exceed 30 calendar days. Superior may extend this timeframe by up to an additional 14 calendar days if the Member requests the extension or if Superior provides evidence satisfactory to HHSC that a delay in rendering the decision is in the Member’s best interest. If a decision cannot be made within the timeframe, Superior will notify the Member in writing of the reason for the delay.

If a Member is not satisfied with the outcome of the appeal, they can file a complaint with the Health and Human Services Commission (HHSC) at 1-866-566-8989 or by mail at the address below:

Texas Health and Human Services Commission
Health Plan Management – H-320
Attn: Resolution Services
P.O. Box 85200
Austin, TX 78708-520
**Adverse Action**

Superior must give the Member written notice of any Adverse Action. Notice shall be provided at least 10 days in advance of the date of the action.

A Member or a Provider acting on behalf of a Member and with the Member’s written consent may appeal the Superior’s decision to deny, terminate, suspend, or reduce services. A Member or Provider on behalf of a Member may also appeal Superior’s delay in providing or arranging for a covered service.

Appeals may be submitted orally or in writing. Any appeals received orally must be confirmed by a written, signed appeal by the Member or their legally authorized representative, unless the Member or representative requests an Expedited Appeal.

**Expedited Appeals**

Members, a legally authorized representative, or their Provider may request an expedited appeal of an adverse determination if waiting thirty (30) days for a standard resolution could seriously jeopardize the Member’s life or health. Expedited appeal requests may be submitted verbally or in writing.

Superior shall inform the Member about the decision within 72 hours from the initial request for the appeal. Superior may extend the timeframe for an additional fourteen (14) days, if they feel an extension would be in the best interest of the Member. Superior will notify the Member about a decision orally as soon as one is made that is not in favor of the Member and follow up with a written letter within 2 calendar days.

**CMS Independent Review Entity (IRE)**

All appeals sent to IRE will be reviewed and a letter will be sent to the Member and Superior with its decision within 30 calendar days, after it received the case from Superior or at the end of the up to 14 calendar day extension and a payment decision within 60 calendar days.

If Superior or the Member disagrees with the CMS IRE’s decision, further levels of appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. Superior will comply with any requests for information or participation from such further Appeal entities.

**Fair Hearing**

If a Member disagrees with the health plan’s decision, the Member has the right to ask for a fair hearing any time during or after the Managed Care Organization’s (MCO’s) appeal process. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A Provider may be the Member’s representative. The Member or the Member’s representative must ask for the fair hearing within ninety (90) days of the date on the health plan’s letter that tells of the decision being challenged. If the Member does not ask for the fair
hearing within ninety (90) days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member’s representative should contact the health plan at:

Superior HealthPlan
ATTN: Fair Hearings Coordinator
2100 S. IH 35, Ste. 200
Austin, TX, 78704
Phone: 1-866-896-1844

If the Member asks for a fair hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or the Member’s representative can tell why the Member needs the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

**Medicaid Expedited Fair Hearings**
Medicaid Members or their authorized representatives may request an expedited fair hearing if they believe that waiting for a standard fair hearing could seriously jeopardize the Member’s life or health. In order to qualify for an expedited fair hearing, the Member must first complete Superior’s expedited appeal process.

An expedited fair hearing may be requested verbally by calling Superior or by completing the Fair Hearing Form, and attaching the denial letter or the appeal resolution Letter, and sending to Superior. Verbally expedited fair hearing requests must be confirmed in writing and signed by the Member or the Member’s authorized representative.

Expedited Fair Hearings shall be resolved within seventy-two (72) hours or as expeditiously as the Member’s condition requires. Superior may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if Superior provides evidence satisfactory to HHSC that a delay in rendering the decision is in the Member’s interest. For any extension not requested by the Member, Superior shall provide written notice to the Member of the reason for the delay.

**Continuation Of Benefits**
Superior must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending Superior appeals, time frames and conditions. Appeals filed with the HHSC Appeals Division, a Member may request Continuing Services. HHSC will make a determination on continuation of services in accordance with the State’s existing appeals policy.
If Superior or HHSC Appeals Division reverses a decision to deny authorization of Covered Services, and the Member received the disputed services while the appeal was pending, then Superior must pay for those services in accordance with State rules and policy.

An appeal requesting continuation of benefits must be filed within 10 days from the notice of action or the intended effective date to reduce or deny previously authorized services, whichever is later.

**PROVIDER COMPLAINT PROCESS**

**Provider Complaint/Grievance and Appeal Process**

Claim Complaints must follow the Dispute Process and then Complaint Process below. Medical necessity and authorization denial complaints are handled in the Appeals Process below. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint Process.

**Complaint/Grievance**

A Complaint/Grievance is a verbal or written expression by a Provider which indicates dissatisfaction or dispute with Superior’s policies, procedure, or any aspect of Superior’s functions. Superior logs and tracks all complaints/grievances whether received verbally or in writing. A Provider has thirty (30) calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint/grievance. After a complete review of the complaint/grievance, Superior shall provide a written notice to the Provider within thirty (30) calendar days from the received date of Superior’s decision. If the complaint/grievance is related to claims payment, the Provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Grievances may be submitted at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com). You can also submit via mail or fax to:

Superior HealthPlan  
Attn: Provider Complaints  
2100 South IH 35, Suite 200, Austin, TX 78704  
Fax: 1-866-683-5369

**Authorization and Coverage Complaints**

Authorization and Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows Providers the right to appeal actions of Superior such as a prior authorization denial, or if the Provider is aggrieved by any rule, policy or procedure or decision made by Superior. A Provider has thirty (30) calendar days from Superior’s notice of action to file the appeal. Superior shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Superior shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the Member’s health condition requires, but shall not exceed thirty (30) calendar days from the date Superior receives the appeal. Superior may extend the timeframe for resolution of the appeal up to
fourteen (14) calendar days if the Member requests the extension or Superior demonstrates that there is need for additional information and how the delay is in the Member’s best interest. For any extension not requested by the Member, Superior shall provide written notice to the Member for the delay.

Expedited appeals may be filed with Superior if the Member’s Provider determines that the time expended in a standard resolution could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a Provider that requests an expedited resolution or supports a Member’s appeal. In instances where the Member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the Member’s health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal. Superior may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if Superior provides evidence satisfactory evidence that a delay in rendering the decision is in the Member’s best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

**Utilization Review Appeals**

(1) A utilization review appeal is a request for review of, not a hearing on, a determination made by the HHSC Utilization Review department to the Medical Appeals area within HHSC.

(2) A utilization review appeal must be:

- submitted in writing by the Provider delivering the service or claiming reimbursement for the service, and
- received by HHSC Medicaid Administrative Claim and Medical Appeals within 120 days from the date of the decision letter from HHSC Medicaid Fraud and Abuse Utilization Review,
- a complete request and contain all the information required by HHSC Medicaid/CHIP Administrative Claim and Medical Appeals including a written explanation of the request for appeal, and any necessary medical information.

(3) Additional information requested by HHSC Medicaid Administrative Claim and Medical Appeals must be returned to HHSC Medicaid Administrative Claim and Medical Appeals within 21 calendar days of the request. If the information is not received within 21 calendar days, the case will be closed.

(4) A utilization review appeal will be reviewed and a determination made by HHSC within 60 days of the date a complete appeal is received at HHSC. A determination made by HHSC Medicaid Administrative Claim and Medical Appeals is the final decision in a utilization review appeal.
Additional Provider and Member Resources:

Contact Information

Denial letters are sent to Members and Providers which include the clinical basis for the denial and a full explanation of the Member appeal rights. To request an appeal, Medicaid fair hearing, the Member or Member’s legally authorized representative may call or write Superior at:

Superior HealthPlan  
Attn: Appeals/Denials Coordinator  
2100 South IH-35, Ste. 200  
Austin, Texas 78704  
Phone: 1-877-398-9461

Consumer Rights and Services

Consumer Rights and Services (CRS) is an area at the Department of Aging and Disability Services (DADS) that receives complaints regarding long-term care services provided to individuals in any type of facility or setting. Complaints come from a variety of sources and in several formats.

- A complaint *allegation* (an assertion that a requirement of licensure or certification has been violated) can come directly from individuals or residents, family Members, health care Providers, advocates, law enforcement, or other state agencies. Report sources may be oral or written.
- A self-reported *incident* is an official notification to the state survey and licensing agency from a DADS-regulated Provider that the physical or mental health or welfare of an individual or resident has been, or may be, adversely affected by mistreatment, neglect, or abuse. These reports also include injuries of unknown source and exploitation or misappropriation of individual or resident property.

Contact information:

- CRS Website: http://www.dads.state.tx.us/services/crs/about.html
- Telephone Number: 1-800-458-9858

Long-Term Care Ombudsman

The State Long-Term Care Ombudsman program operated through DADS, advocates for the rights of people who live in nursing homes and assisted living facilities so they receive optimal quality of care and achieve high quality of life. The LTC Ombudsman identifies, investigates and resolves complaints that may adversely affect the health, safety, welfare or rights of people who live in nursing facilities or assisted living facilities.

Across Texas, through 28 Area Agencies on Aging, certified ombudsmen serve residents, their families and friends. Professional staff supervises the volunteers.
Contact information:

- LTC Ombudsman website: 
  http://www.dads.state.tx.us/news_info/ombudsman/index.html
- A list of the 28 Area Agencies on Aging and their contact information can be found at: 
  http://www.dads.state.tx.us/contact/aaa.cfm

**Health Plan Management**

Health Plan Management (HPM) at the Texas Health and Human Services Commission in the managed care division receives complaints, inquiries or disenrollment requests either directly from Providers and Members or via secondary sources, such as the Office of the Ombudsman, Legislative offices (External Relations Division), Member advocates (family), Vendor Drug Program, DADS, Department of Family and Protective Services or other stakeholders.

HPM uses a mailbox designated to receive MCO-related inquiries, which is HPM_complaints@hhsc.state.tx.us to submit a complaint or inquiry to HPM.

**Ombudsman Services**

The Mission of the Ombudsman is to serve as an impartial and confidential resource, assisting our clients with health and human services-related complaints and issues. The Health and Human Services Commission's Office of the Ombudsman helps people when the agency's normal complaint process cannot or does not satisfactorily resolve the issue.

The Office of the Ombudsman's services include:

- Conducts independent reviews of complaints concerning agency policies or practices
- Ensures policies and practices are consistent with the goals of the Texas Health and Human Services Commission
- Ensures individuals are treated fairly, respectfully and with dignity
- Makes referrals to other agencies as appropriate

Providers or Members can contact the Office of the Ombudsman-877-787-8999/ TTY 711 or 1-800-735-2989 for assistance. For additional information on Ombudsman Complaint Process, visit http://www.hhsc.state.tx.us/ombudsman/complaint-process.shtml.
QUALITY IMPROVEMENT PLAN

Overview
Superior’s culture, systems and processes are structured around its mission to improve the health of all enrolled Members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all Members, including those with special needs. This system provides a continuous cycle for assessing the level of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to selected the interventions. Superior requires all practitioners and Providers to cooperate with all quality improvements (QI) activities, as well as allow Superior to use practitioner and/or Provider performance data to ensure success of the QAPI Program.

Superior intends to arrange for the delivery of appropriate care with the primary goal being to improve the health status of its Members. Where the Member’s condition is not amenable to improvement, Superior will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. This will include the strategic identification of Members at risk of developing conditions, implementation of appropriate interventions and designation of adequate resources to support selected interventions. Whenever possible, the Superior QAPI Program supports these processes and QI activities (both clinical and non-clinical) that are designed to achieve demonstrable and sustainable improvement in the health status of its Members.

QAPI Program Structure
The Superior Board of Directors (BOD) has the ultimate oversight for the healthcare and service provided to Members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and provide support for QI activities designated within the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is:

- enhance and improve quality of care;
- provide oversight and direction regarding policies, procedures, and protocols for Member care and services; and
- offer guidelines based on evidence-based “based practice” and national guideline recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process issue; the identification of opportunities to improve Member outcomes; and the education of Members, Providers and staff regarding the QI, UM, and Credentialing Programs.
The following sub-committees report directly to the Quality Improvement Committee (QIC):

- Credentials Committee
- Utilization Management Committee
- Think Culture Committee (CLAS- Task Force)
- Performance Improvement Team
- Member, Provider Advisory Groups
- Joint Operations Committees
- Peer Review Committee (Ad Hoc Committee)

**Practitioner Involvement**
Superior recognizes the integral role that practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through Provider representation. Superior encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentials Committee, Peer Review Committee and select ad-hoc committees.

**Quality Assessment and Performance Improvement Program Scope and Goals**
The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Superior Members. The Superior QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, Providers, and services in QI activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

Superior’s primary QAPI Program goal is to improve Members’ health status through a variety of meaningful QI activities implemented across all care settings and aimed at improving the care and services delivered.

To that end, the Superior QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health, continuity and coordination of care
- Compliance with Member confidentiality laws and regulation
- Compliance with preventive health and Practice Guidelines
- Delegated entity oversight
- Plan performance and service
- Employee and Provider cultural competency
- Fraud and abuse detection and prevention
- Member enrollment and disenrollment
- Member complaint system
- Member satisfaction
- Patient safety
- Pharmacy
- Provider After-Hours telephone Accessibility & Linguistic Standards
- Provider Appointment Availability compliance
- Provider complaint system
- Provider Network adequacy and capacity
- Provider satisfaction
- Selection and retention of Providers (credentialing and re-credentialing)
- Utilization Management, including over- and under-utilization

**Practice Guidelines**

Superior approves, adopts, and promotes Practice Guidelines to Providers in an effort to improve health care quality and reduce unnecessary variation in care for its enrolled membership. These evidence-based guidelines are known to be effective in improving health outcomes and are adopted from recognized sources. The following are Superior’s QIC approved Practice Guidelines:

- Guidelines for Diagnosis and Management of Asthma
- Guidelines for Antepartum Care
- Practice Guidelines for Preventive Health Maintenance of Sickle Cell Disease Patients
- Practice Guidelines for Lead Toxicity Screening
- Practice Guidelines for General Diabetes Care
- Guidelines for the Prevention for Childhood Obesity
- Practice Guidelines for Diagnosing and Treating with Child for Attention Deficit/Hyperactivity Disorder
- Practice Guidelines for Treatment of Patients with Major Depressive Disorder
- Practice Guidelines for Treatment of Bipolar Disorder
- Adult Preventive Services Guidelines
- Practice Guidelines for the Diagnosis and Management of Pharyngitis
- Disease Management Practice Guidelines for Coronary Artery Disease
- Disease Management Practice Guidelines for Chronic Respiratory Disease (CRD), including Asthma and COPD
- Disease Management Practice Guidelines for Heart Failure

Copies of these guidelines are available on our website at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com).

All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published.
Superior’s QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are evidence-based and include preventive health services
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than bi-annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
  - Provider orientations and other group sessions
  - Provider e-newsletters
  - Online via the HEDIS Resource Page
  - Online via the Provider Portal
  - Targeted mailings

Guidelines are posted on Superior’s website or paper copies are available upon request by contacting Superior’s QI Department.

Other QAPI Program Activities

The Quality Improvement (QI) Department performs ongoing monitoring of quality metrics, credentialing reviews, medical record audits, barrier/root cause analysis, data warehouse retrieval and analysis, etc.; to identify areas of concern, health delivery system issues or issues in regards to Member and Provider services.

Superior utilizes a ten-step methodology recommended by Health Care System for Managed Care: *A Guide for States to implement its quality improvement initiatives*. However, there may be opportunities for improvement identified in which a modified version (“Plan, Do, Study, Act” (PDSA), an approach to continuous improvement where changes are tested in small cycles. All QI initiatives (clinical and non-clinical performance improvement projects (PIPs), focus studies, medical record audits, etc.) may be selected upon the following:

- Based on health care initiatives having the greatest potential for improving health outcomes or the quality of service delivered to Superior’s Members and network Providers.
- To test an innovative performance improvement strategy or as required by State/contract targeted at specific populations, age groups, disease categories or risk status.
- To detect distinctive regional emphasis on populations and cultures, in efforts to eliminate healthcare disparities.
- Include behavioral health care issues and/or improvement strategies.
- Conduction of medical record reviews and Practitioner audits (which may include review of specifications and appropriateness of care consistent with utilization, such as; compliance with practice guidelines, access to care, and appointment wait time).
All PIPs, focus studies and other QI initiatives are designed and implemented in accordance with national quality improvement standards/benchmarks (i.e., NCQA, HEDIS®, CAHPS®, as applicable). These focus studies are developed utilizing sound research design and appropriate statistical analysis.

**Patient Safety and Level of Care**

Patient Safety is a key focus of the Superior QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a Member. Superior employees (including medical management staff, Member services staff, Provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary Providers, Members or Member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential level of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential level of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential level of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

**Performance Improvement Process**

The Superior QIC reviews and adopts an annual QAPI Program Description and Work Plan based on regulatory requirements and managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Superior to monitor improvement over time.

Annually, Superior develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QAPI activities, reporting and scheduled activities from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the various QI Committees as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.
Superior communicates activities and outcomes of its QAPI Program to both Members and Providers through avenues such as the Member newsletter, Provider newsletter and the Superior website at www.SuperiorHealthPlan.com.

At any time, Superior Providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Superior’s progress in meeting the QAPI Program’s goals by contacting the QI Department.

Office Site Surveys
Superior conducts site visits to the Provider/practitioner’s office to investigate Member complaints related to physical accessibility, physical appearance, and adequacy of exam room and waiting room space. Site Visits can also be conducted as part of the credentialing process, or as part of standard audits to ensure standards are being met. Standards are determined based on NCQA guidelines, State and Federal regulations.

Site visits conducted by Superior Representatives include at a minimum:

- Staff information
- Access for the Disabled
- Licensure
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained
- Cultural competence
- Physical accessibility (Access, Office Hours, Wait Time, Preventive Health Appointment)
- Physical appearance
- Adequacy of waiting and examining room space
- Scheduling/appointment availability, including office protocols/policies
- Availability of emergency equipment
- Clinical lab (CLIA) standards
- Medication administration/dispensing/storage of drug samples
- Adequacy of medical records keeping practices
Medicare Star Ratings
The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Star Ratings in order to provide information to consumers about Medicare Superior Health Plans and to reward top-performing health plans. CMS developed a set of Quality Performance Ratings for Health Plans that includes specific Clinical, Member Perceptions and Operational measures. The Star Ratings are drawn from various data sources including but not limited to: Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS®); Healthcare Outcomes Survey (HOS).

How can Providers help to improve Star Ratings?
• Continue to encourage patients to obtain preventive screenings annually or when recommended
• Continue to talk to your patients and document interventions regarding topics such as: fall prevention; bladder control; and the importance of physical activity
• Create office practices to identify noncompliant patients at the time of their appointment
• Submit complete and correct encounters/claims with appropriate codes & properly document medical chart for all Members
• Review the gap in care files listing Members with open gaps
• Identify opportunities for you or your office to have an impact

Healthcare Effectiveness Data and Information Set (HEDIS)
HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual Provider. CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan’s ability to demonstrate an improvement in preventive health outreach to its Members.

HEDIS Rate Calculations
HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-9 (ICD-10 effective October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews. HEDIS measures typically requiring medical record review include: diabetic HbA1c, diabetic retinopathy eye exam and nephropathy screening, controlling high-blood pressure, and cervical cancer screening.
Who conducts Medical Record Reviews (MRR) for HEDIS?

Superior may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your patient’s medical records are selected for review, you will receive a call from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, sharing of Protected Health Information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Superior which allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

- **Understand the specifications** established for each HEDIS measure.
- **Submit claims and encounter data for each and every service rendered.** All Providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Superior. Claims and encounter data is the most clean and efficient way to report HEDIS.
- **Submit claims and encounter data correctly, accurately, and on time.** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- **Ensure chart documentation reflects all services provided.** Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- **Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.**

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department at SHPHEDIS@centene.com.

**Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey**

The CAHPS survey is a Member care experience survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to Members by an NCQA certified survey vendor. The survey provides information on the experiences of Members with health plan and practitioner services and gives a general indication of how well the plan is meeting the Members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

**Medicare Health Outcomes Survey (HOS)**

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping Medicare beneficiaries make informed health care choices. Superior must participate in the Medicare Health Outcomes Survey.
REGULATORY MATTERS

Medical Records
Superior Providers must keep accurate and complete patient medical records which are consistent with 45 CFR §164.316 and National Committee for Quality Assurance (NCQA) standards, and financial and other records pertinent to Superior Members. Such records will enable Providers to render the most appropriate level of health care service to Members. They will also enable Superior to review the level and appropriateness of the services rendered. To ensure the Member’s privacy, medical records should be kept in a secure location. Superior requires Providers to maintain all records for Members for at least ten (10) years after the final date of service, unless a longer period is required by applicable state law.

Required Information
To be considered a complete and comprehensive medical record, the Member’s medical record (file) should include, at a minimum: Provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the Member’s participating primary care physician or Provider. All medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for Members in accordance with the standards set forth below.

- Written policy regarding confidentiality and safeguarding of Member information; records are protected through secure storage with limited access.
- Records are organized, consistent and easily retrieved at the time of each visit. Written procedure for release of information and obtaining consent for treatment.
- Each page in the record contains the patient's name or ID number.
- Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.
- All entries in the medical record contain author identification, are legible (to someone other than the writer), in ink and dated.
- The history and physical exam records appropriate subjective and objective information for presenting complaints.
- Problem List documenting significant illnesses, behavioral health and/or medical conditions; unresolved problems from previous office visits are addressed in subsequent visits.
- Medication List includes instructions to Member regarding dosage, initial date of prescription, and number of refills.
- Medical allergies and adverse reactions are prominently documented in a uniformed location in the medical record; if no known allergies, NKA or NKDA is documented.
• An immunization record is established for pediatric Members or an appropriate history is made in chart for adults.
• Evidence that preventive services/risk screening are offered in accordance with Plan’s established practice guidelines.
• Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
• Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.
• Consultation lab/imaging reports and other studies are ordered, as appropriate. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries are initialed by the ordering practitioner (or other documentation of review) to signify review.
• All working diagnoses and treatment plans are consistent with findings. Ancillary tests and/or services (diagnostic and therapeutic) ordered by practitioner are documented; encounter forms or notes include follow-up care, calls, or visits., with specific time of return noted in weeks, months, or PRN, and include follow up of outcomes and summaries of treatment rendered elsewhere.
• No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).
• Health teaching and/or counseling is documented. If a consultation is requested, there is a note from the consultant in the record.
• For Members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for Members seen three or more times substance abuse history should be queried).
• Documentation of failure to keep an appointment.
• Evidence that an Advance Directive has been discussed with adults 18 years of age and older.

Additional Behavioral Health Documentation Standards:
• For Members receiving behavioral health treatment, documentation is to include “at risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
• For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
• For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.

Medical Records Release
All Member medical records are confidential and must not be released without the written authorization of the Member or their parent/legal guardian, in accordance with state and federal law and regulation. When
the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR part 2 and any applicable State Laws.

**Medical Records Transfer for New Members**

All PCPs are required to document in the Member’s medical record attempts to obtain historical medical records for all newly assigned Superior Members. If the Member or Member’s parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous Providers, then this should also be noted in the medical record.

**Medical Records Audits**

Superior may conduct random medical record audits in conjunction with ongoing Quality Improvement program activities. The coordination of care and services provided to Members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Superior will provide written notice prior to conducting a medical record review.

**Health Insurance Portability and Accountability Act**

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic health care transactions and code sets, unique health identifiers, and security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards.
- Employer identifier standard.
- National Provider identifier standard.

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at [http://www.hhs.gov/ocr/privacy/hipaa/administrative/](http://www.hhs.gov/ocr/privacy/hipaa/administrative/)

**Privacy Regulations**

The Privacy rules regulate who has access to a Member’s/patient’s personally identifiable health information (PHI), whether in written, verbal or electronic form. In addition, this regulation affords individuals the right to keep their PHI confidential, and in some instances, from being disclosed.
In compliance with the privacy regulations, Superior has provided each Superior Member with a privacy notice, which describes how Superior can use or share a Member’s health records and how the Member can get access to the information. In addition, the Member privacy notice informs the Member of their health care privacy rights and explains how these rights can be exercised.

Copies of Superior’s Member privacy notices can be found at www.SuperiorHealthPlan.com.

As a Provider, if you have any questions about Superior’s privacy practices, contact Superior’s compliance officer at 1-800-218-7453.

Members should be directed to Superior’s Member Services Department with any questions about the privacy regulations. Member Services can be reached at 1-866-896-1844.

The Security Rule
The HIPAA Security Rule establishes national standards to protect individuals’ electronic personal health information that is created, received, used, or maintained by Superior. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.


Breach Notification Rule
On January 25, 2013, the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) published in the Federal Register a final omnibus rule (Final Rule) that revises certain rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These revised rules were issued pursuant to changes enacted by Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination (GINA) Act of 2008. Effective March 23, 2013, the Final Rule implements section 13402 of the HITECH Act by requiring various notifications following a breach of unsecured protected health information.

The Final Rule eliminates the significant risk of harm standard from the Interim Rule for determining whether a breach has occurred. Covered entities and business associates must ensure compliance with regulatory definitions relating to breach notifications.

Transactions and Code Sets Regulations
Transactions are activities involving the transfer of health care information for specific purposes. Under HIPAA, if Superior or a health care Provider engages in one of the identified transactions, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The Standards for Electronic Transactions and Code Sets, published August 17, 2000 and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any health care Provider that conducts a standard transaction also must comply with the Privacy Rule.
Version 5010 refers to the revised set of HIPAA electronic transaction standards adopted to replace the current standards. Every standard has been updated, including claims, eligibility and referral authorizations.

All HIPAA covered entities must be using version 5010 as of January 1, 2012. Any electronic transaction for which a standard has been adopted must have been submitted using version 5010 on or after January 1, 2012.

**HIPAA Required Code Sets**
The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding. Only national standard codes can be used for electronic claims and/or authorization of services.

Nationally recognized code sets include:

1. **Health Care Common Procedure Coding System (HCPCS)** - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.
2. **Current Procedure Terminology (CPT) codes** - The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the AMA.
3. **International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 and 2 (diagnosis codes)** - These are maintained by the National Center for Health Statistics and Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
4. **International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures)** - Those are maintained by CMS.
5. **International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM-** This is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 and 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3, and two parts:
   - **Part 1:** ICD-10-CM for diagnosis coding. ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.
   - **Part 2:** ICD-10-PCS for inpatient procedure coding. ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims.
Everyone covered by HIPAA who transmits electronic claims must also switch to Version 5010 transaction standards. The change to ICD-10 does not affect CPT coding for outpatient procedures.

6. National Drug Code (NDC) - The NDC is a code that identifies the vendor (manufacturer), product and package size of all medications recognized by the Federal Drug Administration (FDA). To access the complete NDC code set, see www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

**HIPAA Regulated Transactions**

Below are the eight electronic standardized transactions that are mandated by the HIPAA legislation.

<table>
<thead>
<tr>
<th>Transaction Name</th>
<th>HIPAA Transaction Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims and encounters</td>
<td>837</td>
</tr>
<tr>
<td>Enrollment and disenrollment</td>
<td>834</td>
</tr>
<tr>
<td>Health plan eligibility solicitations and response</td>
<td>270/271</td>
</tr>
<tr>
<td>Payment and remittance advice</td>
<td>835</td>
</tr>
<tr>
<td>Premium payment</td>
<td>820</td>
</tr>
<tr>
<td>Claim status solicitation and response</td>
<td>C276/277</td>
</tr>
<tr>
<td>Coordination of benefits</td>
<td>837</td>
</tr>
<tr>
<td>Referral and authorization</td>
<td>278</td>
</tr>
</tbody>
</table>

Though it is standard operating process, Superior does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets is made available to Superior’s Members and Providers via various alternative capabilities, such as online tools. Superior currently offers an alternative through the online web tool, Superior’s secure Provider Portal, for the following transactions:

- ASC X12 270 Eligibility Status Inquiry.
- ASC X12 271 Eligibility Status Response.
- ASC X12 276 Claim Status Inquiry.
- ASC X12 277 Claim Status Response.
- ASC X12 278 Referral Certification and Response.

For more information on conducting these transactions electronically, contact the EDI Department at 1-800-225-2573 ext. 25525 or by email at EDIBA@centene.com.

**National Provider Identifier**

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care Providers. Covered health care Providers and all health plans and health care clearing houses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care Providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy Provider identifiers in all
electronic HIPAA standards transactions. However, some LTSS Providers are considered “Atypical Providers” because they render non-health or non-medical services to STAR+PLUS Members. These Providers bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form.

As outlined in the federal regulation, covered Providers must also share their NPI with other Providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol/substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and Providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or “Part 2”). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the CMS website at: www.cms.hhs.gov and then select “Regulations and Guidance” and “HIPAA – General Information”;
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov.
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted Providers within the Superior network are independently obligated to know, understand and comply with these laws.

Superior takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Superior Compliance Officer by phone at 1-877-391-5921 or in writing (refer to address below) with any questions about our privacy practices.

Superior HealthPlan
Attn: Compliance Officer
2100 South IH-35, Suite 200
Austin, TX 78704
WASTE, ABUSE AND FRAUD

Superior takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with the federal and state laws. Superior, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Superior routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against Providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- remedial education and training to prevent the billing irregularity;
- more stringent utilization review;
- recoupment of previously paid monies;
- termination of Provider agreement or other contractual arrangement;
- civil and/or criminal prosecution; and
- any other remedies available to rectify

Some of the most common WAF practices include:

- unbundling of codes;
- up-coding services;
- add-on codes billed without primary CPT;
- diagnosis and/or procedure code not consistent with the Member’s age/gender;
- use of exclusion codes;
- excessive use of units;
- misuse of benefits; and
- claims for services not rendered.

Let us know if you suspect or witness a Provider inappropriately billing or a Member receiving inappropriate services, a pharmacist or other health care Provider or person getting benefits doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that were not given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their MMP ID.
- Using someone else’s MMP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184.
• Visit https://oig.hhsc.state.tx.us and select “Click Here to Report Waste, Abuse, and Fraud” to complete the online form; or
• Contact Superior’s Corporate Special Investigative Unit directly at:

Centene Corporation
Superior HealthPlan Fraud and Abuse Unit
7700 Forsyth Boulevard
Clayton, MO 63105
1-866-685-8664

Information Needed to Report Waste, Abuse or Fraud
To report waste, abuse or fraud, gather as much information as possible. When reporting about a Provider (doctor, dentist, therapist, pharmacist, etc.) include:

• Name, address, and phone number of Provider.
• Name and address of the facility (hospital, nursing home, home health agency, etc.).
• Medicaid number of the Provider and facility, if you have it.
• Type of Provider (physician, therapist, pharmacist, etc.).
• Names and phone numbers of other witnesses who can aid in the investigation.
• Dates of events.
• Summary of what happened.

When reporting a Member (a person who receives benefits), include:

• The person’s name.
• The person’s date of birth, social security number, or case number if available.
• The city where the person resides.
• Specific details about the waste, abuse or fraud.

WAF Program Compliance Authority and Responsibility
The Superior Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Superior is committed to identifying, investigating, sanctioning and prosecuting suspected waste, abuse and fraud.

The Superior Provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.
False Claims Act
The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. Knowingly presenting, or causing to be presented a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying Government property from an unauthorized officer of the Government; and
7. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government

For more information regarding the False Claims Act, please visit [www.cms.hhs.gov](http://www.cms.hhs.gov).

Physician Incentive Programs
On an annual basis and in accordance with Federal Regulations, Superior must disclose to CMS, any Physician Incentive Programs that could potentially influence a physician’s care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program;
- Type of Incentive Arrangement;
- Amount and type of stop-loss protection;
- Patient panel size;
- Description of the pooling method, if applicable;
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services;
- The calculation of substantial financial risk (SFR);
- Whether Superior does or does not have a Physician Incentive Program; and
- The name, address and other contact information of the person at Superior who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to Providers/Provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place Providers/Provider groups at SFR may not operate unless there is adequate stoploss protection, Member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.
Substantial financial risk occurs when the incentive arrangement places the Provider/Provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a Provider/Provider group’s referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Specialist.

**First-Tier and Downstream Providers**

Through written agreement, Superior may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and Provider training. Superior oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities’ performance is inadequate. Superior will ensure written agreements which specify these responsibilities by Superior and the delegated entity are clear and concise. Agreements will be kept on file by Superior for reference.