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Nursing Facility Provider Training

(includes STAR+PLUS Medicare-Medicaid
Plan)

Nursing Facility Services



Beginning March 1, 2015, Nursing Facilities services will be a statewide covered benefit of the STAR+PLUS program managed by Superior HealthPlan. The following will apply:

DADS will:

- Maintain nursing facility licensing and certification responsibilities
- Maintain the Minimum Data Set (MDS) function
- Continue Trust Fund Monitoring
- Continue its Regulatory Services Division

Nursing Facilities will:

- Complete and submit the MDS forms
- Complete and transmit the 3618s and 3619s

Superior will:

- Contract directly with the Nursing Facility
- Authorize add-on services
- Process claims for reimbursement

Agenda



By the end of this presentation, you will be able to:

- Identify who Superior HealthPlan is and our various departments
- Explain the difference between Unit Rate and Add-on Services
- Understand Service Coordination and how they will work with the Nursing Facility staff
- Obtain authorizations and file claims with Superior HealthPlan

Who is Superior HealthPlan?



- Superior HealthPlan is a subsidiary of Centene Corporation located in St. Louis, MO.
- Superior HealthPlan has held a contract with HHSC since December 1999.
- Superior HealthPlan provides programs in various counties across the State of Texas. These programs include STAR, STAR+PLUS, CHIP, STAR Health (Foster Care), Medicare Advantage, Ambetter by Superior HealthPlan and STAR+PLUS Medicare-Medicaid Plan.
- Superior HealthPlan manages healthcare for over 900,000 Members across Texas.

Contract with Superior HealthPlan



- Nursing Facilities who offer services to our Members should be contracted with Superior HealthPlan.
- To get contracted, you must contact our Network Development department and request a contract.
- Visit www.superiorhealthplan.com, select “For Providers” and then “Network Participation”.
- Follow the instructions to submit a request.
- For help, call 1-877-615-9399 x-22354

Nursing Facility Members



Mandatory Population

Adults age 21 and older who:

- Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income
- Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program)

Excluded Population

- Children and young adults under age 21 receiving SSI or SSI-related services living in a STAR+PLUS service area may choose to enroll in STAR+PLUS or remain in traditional Medicaid
- Residents in the Truman W. Smith Children's Care Center and residents of the State's Veteran's home

Nursing Facility Members



STAR+PLUS Medicare-Medicaid Plan (MMP) Population:

- Individuals who are age 21 and older,
- Receiving Medicare part A, B and D,
- Receive full Medicaid Benefits and are in a STAR+PLUS Program,
- Do not reside in an Intermediate Care Facility or 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), or
 - Texas Home Living Program (TxHmL).
- Members enrolled in the MMP Dual Demonstration,
- Superior's STAR+PLUS MMP program is available in Bexar, Dallas, and Hidalgo County.

Eligibility



STAR+PLUS Members are always enrolled and disenrolled at the beginning of each month. The period begins on the 1st of each month.

Nursing Facilities should verify Member eligibility at the start of each month and **before** providing services.

How can eligibility be verified?

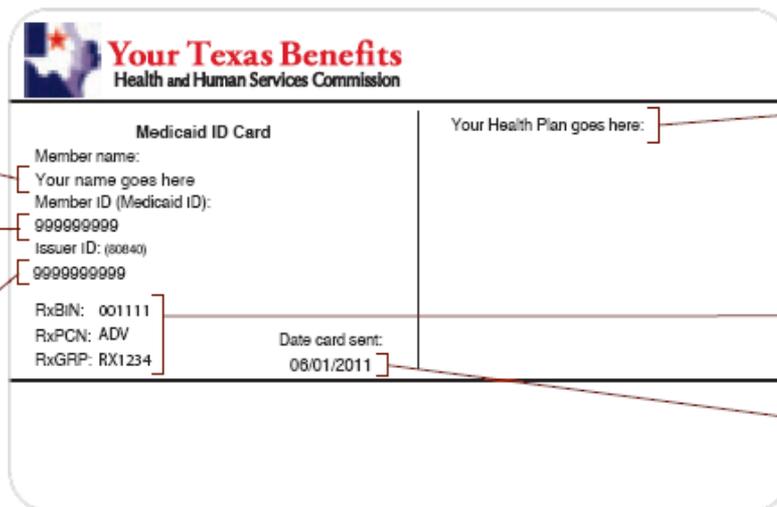
- Texas Medicaid “Your Texas Benefits” Card
- **Preferred**-Superior HealthPlan Identification Card
- **Preferred**-Superior HealthPlan secure provider web portal at:
www.superiorhealthplan.com

Preferred-Call the Member Hotline at 1-877-277-9772

This is where your name appears.

This is your Medicaid ID number.

This is HHSC's agency ID number. Doctors and other providers need this number.



If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.

Drug stores use these numbers.

This is the date your card was sent to you.

This message is for doctors and other providers. This means they need to make sure you are still in the Medicaid program.



This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.

Call this number if you need help using this card.

Go to this website to learn more about this card.

Superior STAR+PLUS ID Card



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MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com

Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-800-466-4089

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

Servicios para Miembros: 1-866-516-4501
Disponible 24 horas al día/7 días de la semana
Coordinadora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-800-466-4089

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que también están elegibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

- Members enrolled in STAR+PLUS only and who receive Medicaid only will show their PCP listed.
- Members enrolled in STAR+PLUS only and who receive Medicare and Medicaid will not list a PCP and will show “LTC benefits only” in the Primary Care Provider field.

Superior STAR+PLUS ID Card Dallas Only



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MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com

Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-888-800-6799

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

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Disponible 24 horas al día/7 días de la semana
Coordinadora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-888-800-6799

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que también están elegibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

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Superior STAR+PLUS MMP ID Card



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Medicare-Medicaid Program

Member Name: <Superior Member>
Medicaid Member ID: <1234567890>
Medicare Member ID: <1234567890>
Health Plan (80840): <ABCD>

PCP Name: <John Smith>
PCP Effective Date: <PCP Effective Date>
PCP Phone: <1-855-555-5555>

<H6870_001>

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Medicare^{Rx}
Prescription Drug Coverage

RxBIN: <012353>
RxPCN: <06244501>
RxGRP: <RxGRP#>
RxID: <RxID#>

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

En caso de emergencia, llame al 911 or vaya a la sala de emergencia mas cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.

Member Services | Servicios al miembro: <1-866-896-1844; TTY: 711>
Behavioral Health | Salud del comportamiento: <1-866-896-1844; TTY: 711>
Service Coordination | Coordinador de servicios: <1-866-896-1844; TTY: 711>

Website | Sitio web: <http://mmp.SuperiorHealthPlan.com>

Pharmacy Help Desk: <1-844-857-4375; TTY: 711>

Send Claims To: <STAR+PLUS MMP Claims Department
PO BOX 3060
Farmington, MO 63640-3822>

Claim Inquiry: <1-877-391-5921; TTY 711>

Available in Bexar, Dallas and Hidalgo counties only

Superior STAR+PLUS ID Card Medicaid Rural Service Area



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Medicaid Rural Service Area

MEMBER ID #:
MEMBER NAME:

**PRIMARY CARE PROVIDER
NAME:**
PHONE:
EFFECTIVE DATE:

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Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com

Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-800-466-4089

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

Servicios para Miembros: 1-866-516-4501
Disponibles 24 horas al día/7 días de la semana
Coordinadora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-800-466-4089

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que también están elegibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

- Members enrolled in STAR+PLUS only and who receive Medicaid only will show their PCP listed.
- Members enrolled in STAR+PLUS only and who receive Medicare and Medicaid will not list a PCP and will show “LTC benefits only” in the Primary Care Provider field.

What is managed care?



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HHSC contracts with managed care organizations (MCO)/companies who are licensed by the Texas Department of Insurance to provide the services specified.

HHSC pays the MCO a monthly amount to coordinate health services for Medicaid clients enrolled in their health plan.

HHSC designs the benefit package and describes what services will be covered in the program. MCOs can offer additional benefits, referred to as value added services, but has to offer the full scope of services outlined in their contract with HHSC.

The health plans contract directly with doctors, hospitals and many other health care and service providers to create comprehensive provider networks.

What is STAR+PLUS?



The program is designed to integrate the delivery of acute care and long-term services and supports (LTSS) through a managed care system, combining traditional health care (doctors visits) with long-term services and support, such as providing help in the home with daily living activities, home modifications and personal assistance.

Members, their families and Providers work together to coordinate Member's health care, long-term care and community support services.

The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a Member.

What is STAR+PLUS MMP?



- STAR+PLUS MMP is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid.
- Services will include all Medicare benefits, including parts A, B, and D; and Medicaid benefits, including long term supports & services and flexible benefits/value added benefits. STAR+PLUS MMP is an opt-in/opt-out program.
- STAR+PLUS MMP will begin on March 1, 2015. NF residents will begin passive enrollment in August 2015.
- Superior will offer STAR+PLUS MMP in Bexar, Dallas and Hidalgo County.

Service Coordination-

The cornerstone of STAR+PLUS



- Is a special kind of care management used to coordinate all aspects of care for a Member.
- Utilizes a multidisciplinary approach in meeting Members' needs.
- Is available to all STAR+PLUS and STAR+PLUS MMP Members.
- Nursing Facilities and their Superior residents will be assigned the same Superior Service Coordinator.
- Service Coordinators participate with the Member, their family or representative, the Nursing Facility staff, and other members of the interdisciplinary team to provide input for the development of the Nursing Facility plan of care.

Service Coordinator & Nursing Facility Staff



The Service Coordinator (SC) will partners with the Nursing Facility staff to ensure members' care is holistically integrated and coordinated.

Service Coordinators will:

- Quarterly Member visits (may be less for Hospice residents)
- Participate in Nursing Facility care planning meetings
- Assist with the collection of applied income, when necessary
- Perform initial Member assessments within 30 days of notification, then at 90 days and quarterly thereafter to develop a plan of care for the Member to transition back into the community.
- Comprehensively reviewing the member's service plan, including the NF plan of care, at least annually, or when there is a significant change in condition.

This is not an all inclusive list.

For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.

Service Coordinator & Nursing Facility Staff



Nursing Facility staff will:

- Invite the SC to provide input for the development of the NF care plan
- Provide SC access to the facility, staff, and Member's medical information and records.
- Notify the SC within one business day of admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, non-contracted bed, or another nursing or long-term care facility.
- Notify the SC within one business day of an adverse change in a member's physical or mental condition or environment that potentially leads to hospitalization.
- Notify the SC within one business day of an emergency room visit by a Member.
- Notifying the SC within 72 hours of a member's death.

This is not an all inclusive list.

For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.

Service Coordinator & Nursing Facility Staff



- To notify Superior's Service Coordinator, Nursing Facility staff must fill out the applicable areas of the Service Coordination Notification Form and fax it to the attention of your Service Coordinator at:
1-888-209-4584.
- You can find a copy of this form on our website or contact your Service Coordinator or Provider Relations Specialist.
- Questions about Service Coordination, call them at:
1-877-277-9772.

How were Members enrolled?



- In November 2014, Nursing Facility residents received both introduction letters and enrollment packets from the State's enrollment broker, Maximus.
- The packets included a welcome letter informing them of the change to STAR+PLUS, a yellow comparison chart that provided information of any value added services offered by each plan, an enrollment form, Provider Directory and an FAQ document to help answer their questions.
- Candidates were asked to make a selection by either mailing the form back, calling Maximus or visiting the website by February 11, 2015.
- If a candidate does not make their selection, they will be automatically enrolled into a health plan by Maximus and follow the HHSC default methodology.

How were NF residents enrolled into STAR+PLUS MMP?



Intro letter	60 day reminder	30 day reminder	Enrollment Start Date	Population
May 2015	June 1, 2015	July 1, 2015	August 1, 2015	Nursing Facility residents in Bexar & El Paso Counties
June 2015	July 1, 2015	August 1, 2015	September 1, 2015	Nursing Facility residents in Harris County
July 2015	August 1, 2015	September 1, 2015	October 1, 2015	Nursing Facility residents in Hidalgo, Dallas, and Tarrant counties

- Passive Enrollment begins March 1. This is open to any eligible client who opts-in.
- Nursing Facility residents in Bexar County will begin phasing in starting August 1 and all residents that are eligible for STAR+PLUS MMP to be in the program by October 1, 2015.
- **Note:** 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. The enrollment broker will not be selecting PCPs for STAR+PLUS MMP Members.
- Reminder: Superior will offer STAR+PLUS MMP in Bexar, Dallas and Hidalgo County.

After a plan is selected...



Once a plan is selected, the state enrollment broker will send an enrollment file to the selected plan at the end of February for March's enrollment. The file will list all of the Members that are enrolled on March 1, 2015.

At the end of each month, the state enrollment broker, Maximus, sends an enrollment file to each plan of all of the members enrolled with the plan the first of the following month.

Members can switch plans anytime. The change takes 15-45 days and are made through Maximus.



Services, Benefits and Prior Authorizations

Nursing Facility Unit Rate



The Nursing Facility Unit Rate means the types of services included in the DADS daily rate for nursing facility providers, such as:

- room and board
- medical supplies and equipment
- personal needs items
- social services
- over –the-counter drugs

The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. The Nursing Facility Unit Rate excludes Nursing Facility add-on services.

Note: HHSC will authorize the daily rate. DADS will authorize and make the medical necessity determinations. Superior will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Questions call THMP at 1-800-626-4117 Option 2.

Applied Income



- Applied Income (AI) means the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and their spouse, that is paid under the Medicaid program to a Nursing Facility.
- It is the **responsibility** of the Nursing Facility to make reasonable efforts to collect AI, document those efforts and notify Superior's Service Coordinator when two unsuccessful attempts in one month have been made to collect AI.
- Superior's Service Coordinator will assist with the collection of AI from the Member.

Additional Benefits



- **Prescriptions**

- All STAR+PLUS (non-duals) Members receive unlimited prescriptions.

Note: Members who receive Medicare as their primary insurance will continue to receive their prescriptions through their Medicare Part D.

- **Value Added Services/Flexible Benefits**

- Superior offers added benefits beyond the traditional Medicaid benefits. For a complete listing, refer to the STAR+PLUS Nursing Facility Member Handbook or visit www.superiorhealthplan.com.

Nursing Facility Add-on Services



Nursing Facility Add-on Services mean the types of services that are provided in the Facility setting by the Provider or another network provider and are outside of the Nursing Facility Unit Rate.

Add-on Services include but are not limited to:

- Emergency dental services
- Physician-ordered rehabilitative services (PT, OT, ST)
- Customized power wheel chairs (CPWC)
- Augmentative communication device (ACD)
- Ventilator care*
- Tracheostomy care*

Note: All add-on services require a prior authorization with the exception of Ventilator and Tracheostomy care unless authorization request is for supplemental payment for Members 21 years of age and older only.

Acute Care Services (non-duals only)



Some common acute care services that require authorization are:

- Hearing Aids
- Orthotics/Prosthetics
- Non-emergent ambulance transportation

For a full list of acute care services that require authorization, you can:

1. You can also call the Prior Authorization Department at 1-800-218-7508, Monday through Friday, 8:00am-5:00pm local time and speak to a live agent.

Non-emergent Ambulance Transport



Superior is required to cover medically necessary non-emergency ambulance services when medically necessary and when ordered by a physician.

Non-emergency transport by ambulance can be provided:

- to or from a scheduled medical appointment.
- to or from a licensed facility for treatment.
- to a member's home after discharge when there is a medical condition such that the use of an ambulance is the only appropriate means of transportation.

Non-emergent Ambulance Transport



All non-emergency ambulance transports require prior authorization.

How can you find a participating ambulance provider?

- In-network ambulance providers can be found at <http://apps.superiorhealthplan.com/findadoc/legacy/selectProduct?busLine=TX> and by using the Specialty search field.

How can you get a prior authorization?

- Calling the Medical Management Department at 1-800-218-7508.
- Faxing a request for prior authorization to 1-800-690-7030.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through our secure web portal at www.SuperiorHealthPlan.com.

Non-emergent Ambulance Transport



Authorization Tips

Nursing facility providers must follow the steps below:

- A physician or physician extender writes an order for non-emergency transport.
- NF staff should contact Superior HealthPlan's member services line, utilization management department, or the assigned Service Coordinator to find an ambulance company that is in-network.
- The NF staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI, and other business information.
- The ambulance provider will document the request was initiated by the NF staff and include name, time, and date.
- The NF must sign and submit the form to Superior for review along with documentation to support medical necessity.
- The ambulance company and NF will coordinate the scheduling of the appointment.

Non-emergent Ambulance Transport



Approvals

- Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider.
- The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied.

Non-emergent Ambulance Transport



Denials

- Any service denied will have standard appeal rights for denials of medical necessity.
- Providers may follow the standard provider appeal process.
- Members may also file an appeal.

Add-on and Acute Care Services Authorization Process



- STAR+PLUS Medicaid Only:
 - Call the Prior Authorization Hotline at 1-800-218-7508,
 - Submit via the secure web portal at www.superiorhealthplan.com, or
 - Fax the Prior Authorization Form to 1-800-690-7030
- Dual-Eligible Members (non-STAR+PLUS MMP):
 - Contact the Member's Medicare carrier
- STAR+PLUS MMP
 - Call the Prior Authorization Hotline at 1-800-218-7508,
 - Submit via the secure web portal at www.superiorhealthplan.com, or
 - Fax the Prior Authorization Form to
 - Inpatient: 1-877-259-6960
 - Outpatient: 1-877-808-9368

Physician-ordered Rehabilitative Services (PT, OT, ST) Authorization Process



- Select 'Medical Outpatient' then 'Therapy' as the Service Type.
- Do not select 'Rehab Inpatient' as the Service Type.
- Authorization requests must be submitted for each type of therapy (i.e. physical, speech, or occupational).

A screenshot of a web-based authorization form. At the top, it says "Authorizations for" followed by a redacted name and "Your Progress" with a progress bar. Below that, it says "THIS SECTION: Service Type Please select a service type." The main form area has a "Service Type" dropdown menu. The dropdown is open, showing a list of options: "Medical Outpatient", "Biopharmacy", "Cardiac / Pulmonary Rehabilitation", "DME", "Home Health", "Inpatient Services (S&P)", "Office Visit", "Outpatient Services", "Therapy - Evaluation", "Therapy - Treatment", "Transport", "Medical Inpatient", "Boarder Baby", "Medical", "Neonate", "Rehab Inpatient", "Sub Acute", "Surgical", and "Transplant". An arrow points from the text "Select one of these appropriate options." to the "Therapy - Evaluation" option. Another arrow points from the text "Do not select this option." to the "Rehab Inpatient" option. Below the dropdown, there are fields for "Contact Information" including "Name", "Phone", and "Fax". A "Next" button is at the bottom right.



Claims Submissions

What does Superior Pay for?



DUALS

These are members who receive both Medicare and Medicaid. Members may select a managed care Medicare plan and have Superior as their STAR+PLUS Medicaid plan.

- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services), skilled nursing facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the RUG.
- STAR+PLUS (Superior) covers Vent and Trach add-on services, is the primary payor for the *co-insurance* for the SNF Unit Rate for days 21 – 100 (if the stay meets qualifying hospital stay criteria and skilable needs) and add-on services, and is the primary payor for the NF Unit Rate starting day 101.

NON-DUALS

Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.

- Covers acute care, add-on services and the NF Unit Rate.

Nursing Facility Unit Rate



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- **Preferred** Way to Submit Claims – Superior’s Web Portal, as claims will be received immediately by Superior.
- Nursing Facilities can also submit claims through TMHP’s portal, which will redirect to Superior.
- HHSC will set the prevailing rate for the date of service as found on their website.
- Nursing Facilities have within **365** days to submit the claims from the date of service.
- Superior will follow the clean claim criteria used by DADS.
- Superior HealthPlan has **10** days to pay clean claims from the date of submission.
- All rate adjustments will be processed no later than 30 days after the receipt of the HHSC rate notification.

Add-on Services



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- **Preferred** Way to Submit Claims – Superior’s Web Portal, as claims will be received immediately by Superior.
- Nursing Facilities can also submit claims through TMHP’s portal, which will redirect to Superior.
- Nursing Facilities have to submit the claims within **95** days from the date of service.
- Superior will follow the clean claim criteria used by DADS.
- Superior HealthPlan has **30** days to pay clean claims from the date of submission.
- Nursing Facilities may submit claims for NF add-on physician-ordered therapies on behalf of employed or contracted therapy providers.
- Add-on Therapy claims must be submitted separately from the NF Unit Rate Claims.
- DME add-on providers must submit claims directly to Superior. Emergency Dental claims must be submitted to dental carrier.

Acute Care & Add-on Services



- **Preferred** Way to Submit Claims – Superior’s Web Portal, as claims will be received immediately by Superior.
- Acute Care-Providers have **95** days from the date of service to submit their claims.
- Superior will follow the clean claim criteria as set by TMHP billing guidelines.
- Superior HealthPlan has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing acute care claims include: Through a clearinghouse or on the red and white paper claim.
 - For a list of preferred clearing houses, visit our website.
 - For 1st time paper claims, mail them to:
 - Superior HealthPlan
Attn: Claims
P.O. Box 3003
Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Bill Code Crosswalk



- Details on required coding for claims submission can be found on the LTC Bill Code Crosswalk.
- This document updates periodically. For the most current LTC Bill Code Crosswalk visit:

<https://hhs.texas.gov/sites/hhs/files/documents/services/health/medicaid-chip/programs/carved-in-carved-out-services.pdf>

Nursing Facility Billing Reminders



- Nursing Facility identification requirements remain in effect
 - Nursing Facilities must be contracted, certified, and licensed by DADS to submit claims.
 - You must use your valid DADS contract number, vendor number and NPI for both contracting with Superior and on the claims when billing Superior.
 - If they differ from what is on record at DADS, your claims may result in denials as Superior cannot pay your claim until this information is corrected.
- Valid Attending Provider NPI, TIN and Principle Diagnosis Code are required when submitting claims
 - Entry of invalid format for the National Provider Identifier (NPI), Tax Identification Number (TIN), or Principle Diagnosis Code on a claim may result in rejection or denial from Superior.
- Questions for TexMedConnect Portal Contact:
 - 1-800-626-4117, Option 1

Auto Adjusted Claims



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- There may be occasions in which a claim which is in a paid status may require a payment adjustment of the **daily unit rate**. Superior will be informed of the need to re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are **automatic** and Nursing Facilities are not required to take any action.
- Some of the reasons a claim may require an adjustment are due to changes in:
 - Nursing Facility Daily Rates
 - Provider Contracts
 - Service Authorizations
 - Applied Income
 - Level of Service (RUG)
- In each of these instances, Superior will automatically re-adjudicate claims affected by the change. Payment on adjusted claims will be made within **30** days from receipt of the adjustment reason.

Claim Adjustments, Disputes & Reconsiderations



If a provider wants to adjust/correct a claim or submit a claim appeal, these must be received within **120** days from the date of notification or denial.

- **Adjusted or Corrected Claim** – The Provider is changing the original claim. Correction to a prior- finalized claim that was in need of correction as a result of a denied or paid claim.
- **Claim Appeals** – Often require additional information from the Provider.
 - **Request for Reconsideration:** Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
 - **Claim Dispute:** Provider disagrees with the outcome of the Request for Reconsideration.

Both can be submitted via the web portal or through paper. Paper claims require a Superior Corrected Claim or Claim Appeal form. Find them under Resources at www.SuperiorHealthPlan.com.

Corrected Claims Filing



- Must reference original claim # from EOP
- Must be submitted within 120 days of adjudication paid date
- Resubmission of claims can be done via your clearinghouse or through Superior's web portal.
 - To send both individual and batch claim adjustments via a clearinghouse, you must provide the following information to your billing company: the CLM05-3 must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject)
 - For batch adjustments, upload this file to your clearinghouse or through Superior's web portal
 - To send individual claim adjustments through the web portal, log-in to your account, select claim and then the Correct Claim button
- Corrected or adjusted paper claims can also be submitted to:

Superior HealthPlan	Superior HealthPlan STAR+PLUS MMP
Attn: Claims	Attn: Claims:
P.O. Box 3003	P.O. Box 4000
Farmington, MO 63640-3803	Farmington, MO 63640-4000

Corrected Claims Filing



- There may be occasions in which a Nursing Facility will need to resubmit/submit a corrected claim, if they billed incorrectly. These claims will not auto adjust. Nursing Facilities should submit a corrected claim, if:
 - Billed across multiple months i.e. 2/15-3/15
 - Billed for days spans that include unauthorized days, i.e. SAS approves 3/5-3/31 provider bills 3/1-3/31
 - Billed for days when the member is in an acute care facility
 - Billed for days that span across multiple years i.e. 12/31/2015 - 1/5/2016
 - Billed for Medicare coinsurance days when non-Medicare days are authorized
 - Billed for non-Medicare days when only Medicare coinsurance days are authorized

Appealing Denied Claims



- Submit appeal within 120 days from the date of adjudication or denial.
- Claims appeals may be submitted one of two ways:
 - In writing:

Superior HealthPlan	Superior HealthPlan STAR+PLUS MMP
Attn: Claims Appeals	Attn: Claims Appeals
P.O. Box 3000	P.O. Box 4000
Farmington, MO 63640-3800	Farmington, MO 63640-4000
 - Or through the secure web portal.
 - At this time, batch adjustments are not an option via the SHP secure portal
- Attach & complete the claim appeal form from the website.
- Include sufficient documentation to support appeal.
- Include copy of UB04 or CMS1500 (corrected or original) or EOP copy with claim # identified.

Appeals Documentation



Examples of supporting documentation may include but are not limited to:

- A copy of the SHP EOP (required)
- A letter from the provider stating why they feel the claim payment is incorrect (required)
- A copy of the original claim
- An EOP from another insurance company
- Documentation of eligibility verification such as copy of ID card, TMBC, TMHP documentation, call log, etc.
- Overnight or certified mail receipt as proof of timely filing
- Centene EDI acceptance reports showing the claim was accepted by Superior
- Prior authorization number and/or form or fax

Coordination of Benefits



- Any other insurance, including Medicare, is always primary to Medicaid coverage.
- If a Member has other insurance, you must submit your claim to the primary insurance for consideration first.
- For duals, if the Member is admitted under the 3-day hospital stay criteria and has a skillable need then days 0-20 are billed directly to Medicare (or to Superior if the member is enrolled in STAR+PLUS MMP), use Revenue Code 100. Then, bill with Revenue Code 101 for days 21 – 100. Starting day 101, the claim should be billed with Revenue Code 100.
- For Superior payment consideration, file the claim with a copy of the EOB, EOP or rejection letter from the other insurance.

Coordination of Benefits



- If this information is not sent with an initial claim filed for a Member with other insurance, the claim will pend and/or deny until this information is received.
- Preferred way to submit is through Superior's web portal. You cannot send through TMHP's web portal. It does not allow for attachments. You may also submit via a paper claim to Superior.

Note: If a Member has more than one primary insurance, then Medicaid would be the third payor. These claims must be submitted on paper.



Secure Provider Web Portal

- Submitting Claims

Superior Web Portal & Website



Superior HealthPlan is committed to providing you with all of the tools, resources and support you need to be make your business transactions with Superior as smooth as possible. One of the most valuable tools is our web portal. Once you are registered you get access to the full site.

Secure site:

- It is secure.
- It provides up-to-date member eligibility and Service Coordinator assignment.
- It has a secure claim submission portal you can submit claims for FREE!
- It provides a claim wizard tool that walks you through filling in a claim to submit on-line.
- It provides claim status and payment information.
- It allows you to check the status of an authorization.

Public Site:

- It contains our Provider Directory and on-line lookup.
- It has a map where you could easily identify the office of the field Provider Network Specialist assigned to you.
- It contains an archive of newsletters, bulletins, the Provider Manual, and link to important sites to keep you up to date on any new changes that may affect you.

Registration



<https://provider.Superiorhealthplan.com/sso/login>

- A user account is required to access the Provider Secure area.
- If you do not have a user account, click **Register** to complete the 4-step registration process.

The screenshot shows the provider portal interface. At the top, there are logos for superior healthplan, superior healthplan Advantage, and ambetter from Superior HealthPlan. A 'CREATE ACCOUNT' button is located in the top right corner. The main heading is 'The Tools You Need Now!' with a subtext: 'Our site has been designed to help you get your job done. Manage all products with ease in one location'. Below this, there are three service cards: 'Check Eligibility' (with a thumbs up icon), 'Authorize Services' (with a checkmark icon), and 'Manage Claims' (with a dollar sign icon). To the right of these cards is a 'Login' form with fields for 'User Name (Email)' and 'Password', and a 'Login' button. Below the login form is a link for 'Forgot Password / Unlock Account'. Further down, there is a 'Need To Create An Account?' section with a subtext: 'Registration is fast and simple, give it a try.' This section contains a prominent orange 'Create An Account' button, a blue 'Provider Registration Video' button, and a blue 'Provider Registration PDF' button. A red arrow points from the 'Manage Claims' card to the 'Create An Account' button.

Create Recurring UB-04 Claims



Claims Individual Saved Submitted Batch **Recurring** Payment History My Downloads Claims Audit Tool

Get Started Used only by LTC and ADC Providers. [Service Package II Coding Guide](#) **Your Progress**

Claim Type: **Select a Template to Start Your Claim**
Our preset templates help speed up the claims process.

- Emergency Response
- Primary Home Care/PAS Type Services
- Adult Day Care
- Nursing Services: RN
- Nursing Assessment Evaluation
- Nursing Services: LVN
- UB-04
- Adult Foster Care
- Respite Care
- Nursing Daily Rate

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Select Nursing Daily Rate

Create Recurring UB-04 Claims



Viewing Claims For: 440605373 Testing Nickname Upload EDI Create Claim

Claims Individual Saved Submitted Batch **Recurring** Payment History My Downloads Claims Audit Tool

Get Started Used only by LTC and ADC Providers. **Your Progress**

Claim Type: **Nursing Facility Residential** Change

Location: **Select a Service Location**
Choose which location you would like to use with this template.

- Nurses On Call, Inc.
NPI: 123456789 | Medicaid #: 654321
123 ADC Lane, Tampa, FL 33607
- Nurses, Inc.
NPI: 123456789 | Medicaid #: 654321
123 ADC Lane, Tampa, FL 33607
- Nurses Clinic**
NPI: 123456789 | Medicaid #: 654321
123 ADC Lane, Tampa, FL 33607

[Conditions](#) [Privacy Policy](#) [Copyright © 2013, Centene Corporation](#)

Select Your Service Location

Create Recurring UB-04 Claims



This screenshot shows the 'Get Started' page of the claims system. At the top, it says 'Viewing Claims For: 44065373 Testing Nickname' with 'Upload EDI' and 'Create Claim' buttons. Below is a navigation bar with tabs: 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. The 'Recurring' tab is active. The main content area has a 'Get Started' section with a progress indicator. Below that, there are two main sections: 'Claim Type: Residential Nursing Facility' and 'Location: Nurses Clinic'. The location section includes NPI: 123456789, Medicaid #: 654321, and address: 123 ADC Lane, Tampa, FL 33607. At the bottom, there is a 'Click to View Your Member List' link with a 'View Member List' button.

This screenshot shows the 'Member List' page. It has the same navigation bar as the previous page. The main content area shows 'Member List' with a progress indicator. Below that, it displays 'Claim Type: Nursing Facility Residential' and 'Location: Nurses Clinic'. There is a search box with the prompt 'Enter Member ID or Last name and Member Birthdate'. Below the search box, there are input fields for 'Member ID or Last Name' (containing '00123456789') and 'Birthdate' (containing '02/02/2000'), with an 'Add Member' button. Below this is a table with columns: 'Select All', 'Member Name', 'Member ID', 'Bill Type*', 'DOS Start*', 'DOS End*', 'Rev Code*', 'Serv Units*', 'Total Charges*', and 'Action'. The table contains one row for 'JANE PATIENT' with Member ID '00123456789'. The 'Action' column has a delete icon (an 'x' in a square). Below the table, there are 'Update All DOS' and 'Create Claim(s)' buttons. An orange arrow points from the 'Delete' label below to the delete icon in the table.

- Click on View Your Member List. Member Lists only need to be created once during your first time using the Multiple Claims Wizard.
- Enter Member ID or Last Name and Birthdate. Member ID is the Medicaid ID on the Member ID card.

Delete

Create Recurring UB-04 Claims

The screenshot shows the "Create Claim" interface. At the top, it says "Viewing Claims For: 440605373 Testing Nickname" and has buttons for "Upload EDI" and "Create Claim". Below is a navigation bar with "Claims" selected, and sub-tabs for "Individual", "Saved", "Submitted", "Batch", "Recurring", "Payment History", "My Downloads", and "Claims Audit Tool". The "Member List" section shows "Claim Type: Nursing Facility Residential" and "Location: Nurses Clinic" with NPI and Medicaid numbers. A "Member ID or Last Name" and "Birthdate" field are present with an "Add Member" button. A table below has columns: "Select All", "Member Name", "Member ID", "Bill Type*", "DOS Start*", "DOS End*", "Rev Code*", "Serv Units*", "Total Charges*", and "Action". The "Bill Type*", "DOS Start*", "DOS End*", "Rev Code*", "Serv Units*", and "Total Charges*" columns are circled in red. Below the table are "Update All DOS" and "Create Claim(s)" buttons, with a red arrow pointing to the latter. Footer text includes "Instruction Manual (PDF)", "Terms & Conditions", "Privacy Policy", and "Copyright © 2013, Centene Corporation".

Create claim(s) by selecting the appropriate member(s) from Member List.

For each member selected enter the:

- Bill Type
- First date of service (DOS Start)
- Last date of service (DOS End)
- Rev Code (Revenue Code)
- Serv Units (days or service units)
 - Note: Serv Units must match the total number of days
- Total Charges

After entering all the required information, click Create Claim(s). Click on X under Action to delete the claim.

Create Recurring UB-04 Claims



Viewing Claims For : 440605373 Testing Nickname Upload EDI Create Claim

Claims Individual Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool

Claims to Submit (2) Your Progress

Claim Type: **Nursing Facility Residential**
Location: **Nurses Clinic**
NPI: 132456789 | Medical#: 654321
123 ADC Lane, Tampa, FL 33607

Claim(S) created successfully.

Member Name	Member ID	Bill Type	DOS Start	DOS End	Rev Code	Serv Units	Total Charges	Action
JANE PATIENT	00123456789	123	04/01/2013	04/30/2013	191	500	30.0	
DAVID PATIENT	00123456789	123	04/01/2013	04/30/2013	191	500	30.0	

I certify that these claims are accurate.

Back Submit Claim(s)

- You can review claims prior to submitting.
- To review click on the eye. You can review the claim or change some of the fields pre-coded for you. Some fields may not allow you to edit. If those fields need to be changed you will need to delete the claim and start over.
- You can click on the X to delete claim.

Create Recurring UB-04 Claims



Claims to Submit (2) Your Profile

Review Claim:

Member Name: JANE PATIENT

General Info
 Patient Control #: 123456789
 Medical Record #:
 Type Of Bill: 123
 Statement From Date: 04/01/2013
 Statement To Date: 04/30/2013
 Prior Payments:
 Prior Authorization Number:
 Admission Date:
 Admission Type:1
 Admission Source:1
 Discharge Status:01
 Discharge Hour:01

Provider Details

Provider Type	NPI
Billing Provider	123456789

Claims to Submit (2) Your Profile

Review Claim:

Provider Details

Provider Type	NPI	Taxonomy	Name	Tax ID	Address
Billing Provider	123456789		Nurses Clinic	123456789	123 ADC Lane, Tampa, FL, 33607
Pay to Provider	123456789		Nurses Clinic	123456789	123 ADC Lane, Tampa, FL, 33607
Attending Provider	123456789		Nurses Clinic	123456789	

Service Lines

Line	Revenue Code	HCPCS/Rate/MIPPS	NDC	Date
1	123			04/01/2013

Diagnosis Codes
 Admitting Diagnosis Code :123
 Principal Diagnosis Code :123
 Principal POA Indicator :
 Value Code(0) :01
 Value Amount(0) :

Create Recurring UB-04 Claims



Viewing Claims For: 440605373 Testing Nickname Upload EDI Create Claim

Claims Individual Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool

Claims to Submit (2) Your Progress

Claim Type: **Nursing Facility Residential**
Location: **Nurses Clinic**
NPI: 132456789 | Medical#: 654321
123 ADC Lane, Tampa, FL 33607

Claim(S) created successfully.

Member Name	Member ID	Bill Type	DOS Start	DOS End	Rev Code	Serv Units	Total Charges	Action
JANE PATIENT	00123456789	123	04/01/2013	04/30/2013	191	500	30.0	
DAVID PATIENT	00123456789	123	04/01/2013	04/30/2013	191	500	30.0	

I certify that these claims are accurate.

← Back Submit Claim(s)

Viewing Claims For: 440605373 Testing Nickname Upload EDI Create Claim

Claims Individual Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool

Claims Submitted (2) Your Progress

Claim Type: **Nursing Facility Residential**
Location: **Nurses Clinic**
NPI: 132456789 | Medical#: 654321
123 ADC Lane, Tampa, FL 33607

Success! Your claims have been submitted.

Date: 07/15/2013
Web Reference#: 123456789

Member Name	Member ID	Bill Type	DOS Start	DOS End	Rev Code	Serv Units	Total Charges
JANE PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0
DAVID PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0

Submit More Claims Print

After all the claims have been reviewed for accuracy, select “I certify that these claims are accurate” and click Submit Claims.

Create Recurring UB-04 Claims



7/15/13

Date: 07/15/2013

Web Reference#: 123456789

Member Name	Member ID	Bill Type	DOS Start	DOS End	Rev Code	Serv Units	Total Charges
JANE PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0
DAVID PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0

- Click Print to print a copy of the claims submitted including the Web Reference#.
- Click Submit More Claims to request a new template or move on to other functions.

Create Professional Claims



From the navigation menu select:

Claims at the top of the landing page

Then select Create Claim



Create Professional Claims

A screenshot of the Superior Healthplan web interface. The top navigation bar includes the Superior Healthplan logo and several menu items: Eligibility, Patients, Authorizations, Claims (highlighted with a red box), Messaging, and Test Account. Below the navigation bar, there is a search area for claims. It includes a dropdown menu for "Viewing Claims For:" with "Medicaid / CHIP" selected, a "GO" button, and a search form with two input fields: "Member ID or Last Name" and "Birthdate" (with a placeholder "mm/dd/yyyy"). A "Find" button is located to the right of the search form. The search form and the "Claims" menu item are highlighted with red boxes.

- Enter the **Member's Medicaid ID** or **Last Name** and **Birthdate**
- Click the **Find** button

Create Professional Claims



- Choose a Claim Type
- Select **Professional Claim**

Choose a Claim Type

CMS 1500 Professional Claim →	CMS UB-04 Institutional Claim →
---	---

A red arrow points from the top right towards the "Professional Claim" button, which is highlighted with a red border.

Coordination of Benefits



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Use the **Add Coordination of Benefits** button to include primary insurance information when applicable.

New fields will appear to enter the **Carrier Type** and the **Primary Insurance Policy Number**.

Diagnosis Codes* (Enter diagnosis code and click on Add button)

21.

2598 -- OTHER SPECIFIED ENDOCRINE DISORDERS

←

Primary Insurance

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type*
C50M -- Commercial
M5ED -- Medicare

Policy Number*

If the member has more than one primary insurance (Medicaid would be the 3rd payer) the claim cannot be submitted via the Web

Coordination of Benefits



The **Primary Insurance** and **Service Line Denial Reasons** fields will be present when Coordination of Benefits is selected at step one. Complete based on the primary insurance EOP.

Primary Insurance
Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Amount Allowed*	<input type="text" value="XXXX.XX"/>
Deductible	<input type="text" value="XXXX.XX"/>
Copay	<input type="text" value="XXXX.XX"/>
Co-Insurance	<input type="text" value="XXXX.XX"/>
Amount Paid	<input type="text" value="XXXX.XX"/>

Service Line Denial Reasons
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

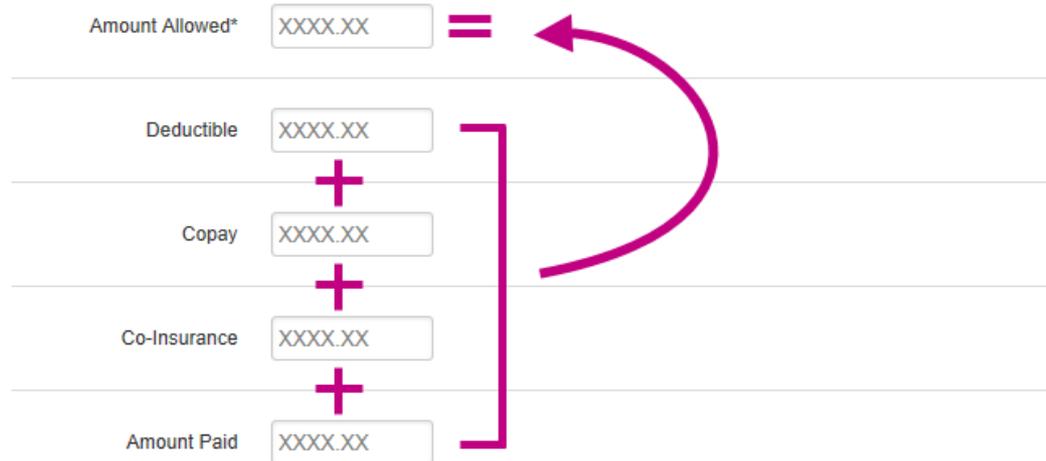
Denied Category	<input type="text" value="Select..."/>
Denied Amount	<input type="text" value="XXXX.XX"/>

Coordination of Benefits



Primary Insurance

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.



The **Primary Insurance** fields perform a calculation to help ensure accuracy when billing.

$$\text{Deductible} + \text{Copay} + \text{Co-Insurance} + \text{Amount Paid} = \text{Amount Allowable}$$

Coordination of Benefits



Service Line Denial Reasons

Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Denied Amount

- Select...
- Duplicate
- Eligibility
- Capitation
- Over Allowable
- Authorization
- Timely Filing
- Billing Error
- Third Party
- Adjustment
- Non-Covered Service
- Other
- Waiting for Information

Service Line Denial Reasons are used to indicate instances where the **Amount Allowed** is less than the **Charges**. These can be indicated using the drop down menu and entering the denied amount.

Service Line Denial Reasons

Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Denied Amount

←

Add Denied Reason must be clicked to include the **Denied Category** and **Denied Amount**.

A new line will be created when the **Denied Category** has been successfully added to the service line.

Coordination of Benefits



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Charges* =

Primary Insurance
Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim c...mitted through the Web.

Amount Allowed* +

Deductible

Copay

Co-Insurance

Amount Paid

Service Line Denial Reasons
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Denied Amount

Final Calculations: Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

*****Denied Category** and **Denied Amount** are not required and can be left blank when appropriate***

Referring and Rendering Provider



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Enter pertinent provider information for **Referring and Rendering Provider**.

Professional Claim for [] Your Progress [] [] [] [] []

THIS SECTION:
Providers Providers on this claim.

← Back Next →

Please note: a taxonomy code is required for all claim submissions

* Required field

Referring Provider

NPI [XXXXXXXX] Find Provider 17.

Last Name or Organizational Name [Last Name] Find Provider First Name [First Name]

Rendering Provider Only enter rendering provider information if not the same as Billing Provider information.

NPI [XXXXXXXX] Tax ID [] Find Provider 24.j

Taxonomy # [XXXXXXXX] Last Name or Organizational Name [Last Name] First Name [First Name] Clear X

Only enter **Rendering Provider** information if it is not the same as **Billing Provider** information

Billing Provider Section



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Billing Provider

Tax ID

33.

Name*

NPI

Taxonomy #*

Address*

City*

State*

Zip*

Service Facility Location

Same As Billing Provider

Name

NPI

Address

City

State

Zip

32.

← Back



Next →

- In the **Billing Provider** section, enter the required information. Under Service Facility Location, enter the necessary information or click **Same as Billing Provider** to automatically copy the billing provider information into the service facility fields.

Attachments



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Professional Claim for [redacted] Your Progress [progress bar]

THIS SECTION:
Attachments Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

Attachments

File* Browse... Attachment Type*
Select Type...
Primary Carrier EOB
Medical Records
Consent Form
DME or Rx Invoice

Attachment Name	Type	
TX_TX_2148131_Claim Attachment example.pdf	Primary Carrier EOB	<input type="button" value="Remove X"/>

If there are no attachments, click Next.

Add attachments, if applicable. **Browse** for the document, select an **Attachment Type**, and then **Attach**. If there are no attachments, click **Next**.

There is an attachment upload limit of 5MB

Review & Submit



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Professional Claim for **XXXXXXXXXX** Your Progress

THIS SECTION:
Review Please review your claim and submit.

Almost done! [Submit →](#)
You can go back to review your claim or submit now.

Claim Id:

Member Record Number: **XXXXXXXXXX**
Member Claim Amount Paid:
Patients Account Number: **12345**

General Info
Hospitalized From:
Hospitalized To:
Outside Lab?: **No**
Outside Lab Amount:
Prior Authorization Number:

Diagnosis Codes
1234 -- DIPHYLLOBOTHRIASIS, INTESTINAL

Service Lines

Line	From	To	Place	Proc	Diagnosis	Amount	Days/Units	Family Plan	EPSDT	NDC	Supplemental Info
1	01/01/2014	01/01/2014	23	123 (UZ)	1234	\$5.00	2.00	No			

Providers

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
ReferringProvider					
RenderingProvider					
BillingProvider					
Service Facility Location					

[← Back](#) [Submit →](#)

Review to ensure that all information is correct.

- If information is incorrect, click **Previous Step** to move to the section that needs changes and change the information within the section
- If all information is correct, click **Submit Claim** and the claim will be transmitted. A “Claim Submitted” confirmation will be displayed

Claim Submitted Successfully!



A screenshot of the Superior Healthplan web portal. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are dropdown menus for "Viewing Claims For:" and "Medicaid / CHIP", followed by a green "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. The main content area displays a success message: "THIS SECTION: Success Congratulations!" followed by a box containing the text: "Your claim has been submitted" and "Your Web/Ref# is 500006538".

Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Provider Services Representative.

Checking Claim Status



Viewing Claims For : Medicaid / CHIP

Claims

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED / PAID	STATUS
111111111111	Institutional	JOHN BARTONER WARD	04/02/2014 - 04/02/2014	\$ 175.00 / 121.63	Ⓛ
111111111111	Institutional	JOHN BARTONER WARD	04/01/2014 - 04/01/2014	\$ 175.00 / 121.63	Ⓛ
111111111111	Institutional	JOHN BARTONER WARD	04/01/2014 - 04/01/2014	\$ 200.00 / 111.13	Ⓛ
111111111111	Institutional	JOHN BARTONER WARD	04/01/2014 - 04/01/2014	\$ 175.00 / 121.63	Ⓛ
111111111111	Institutional	JAMES WILSON	04/01/2014 - 04/01/2014	\$ 175.00 / 121.63	Ⓛ
111111111111	Institutional	JOHN BARTONER WARD	04/01/2014 - 04/01/2014	\$ 175.00 / 121.63	Ⓛ
111111111111	Institutional	WILLIAM BARTONER WARD	04/01/2014 - 04/01/2014	\$ 375.00 / 283.63	Ⓛ

Claims status could be viewed on claims that have been sent EDI, Paper or Web portal

Claims Audit Tool



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Eligibility Patients Authorizations Claims Messaging Test Account

Viewing Claims For : Medicaid / CHIP

Claims

PASS-THROUGH TERMS AND CONDITIONS

1. Superior Health Plan, licenses a code auditing reference tool on the Web (the "Software") that enables Superior Health Plan to disclose its code auditing rules and associated clinical rationale to Providers. Superior Health Plan provides access to such Software to its Providers subject to the terms and conditions contained in this agreement ("Agreement"), which may be updated from time to time at Superior Health Plan or its licensors' sole discretion without notice.
2. Provider's right to access and use the Software is non-transferable, nonexclusive, and for the sole purpose of internal use within the United States.
3. Provider will limit access to the Software to (i) only employees and agents of Provider and (ii) only to the extent necessary to request the outcome of specific code combinations that Provider proposes to submit to Superior Health Plan regarding billing activity; and/or (iii) request information about submitted code combinations to evaluate the results of claims activity from Superior Health Plan only as related to Provider's practice management.
4. Provider shall protect the confidentiality of the information contained in and provided by the Software and that it has access to in this web site, by using at least the degree of care and security it uses to protect its own confidential information. Provider acknowledges and agrees that any unauthorized disclosure or distribution of the confidential information may result in irreparable injury to Superior Health Plan or licensor(s), entitling the injured entity to obtain immediate injunctive relief in addition to any other legal remedies available.
5. Provider shall not modify, translate, decompile, disclose, create nor attempt to create any derivative work of the Software.
6. Provider acknowledges that the Software is in no way intended to prescribe, designate or limit medical care to be provided or procedures to be performed

Select the **Claims Audit Tool**.

Click **Submit** to enter the **Clear Claim Connection** page.

Claims Audit Tool



 **Clear Claim Connection™**

McKesson Edit Development Glossary About Help Logoff

Claim Entry

Gender: Male Female

Date of Birth: (mm/dd/yyyy)

Click grid to enter information.
* For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

Line	Procedure	Quantity	Mod 1	Mod 2	Date of Service	Place of Service	Diagnosis
1	<input type="text"/>	-- select --	<input type="text"/>				
2	<input type="text"/>	-- select --	<input type="text"/>				
3	<input type="text"/>	-- select --	<input type="text"/>				
4	<input type="text"/>	-- select --	<input type="text"/>				
5	<input type="text"/>	-- select --	<input type="text"/>				

Add More Procedures >>

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CPT only © 2005 American Medical Association. All Rights Reserved.
The information provided herein is confidential and solely for the use of the authorized provider practice, and is not intended to describe, designate or limit medical care to be provided or procedures to be performed. The user accepts responsibility for and acknowledges that it will exercise its own independent judgment and shall be solely responsible for such use.

Test claim coding by entering core information to be audited before submitting the live claim.



***Superior HealthPlan Departments
- We Can Help You!***

Member Services



The Member Services staff can help you with:

- Verifying eligibility
- Reviewing Member benefits
- Assist with non-compliant Members
- Help find additional local community resources

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time at 1-877-277-9772.

Provider Services



The Provider Services staff can help you with:

- Questions on claim status and payments
- Assisting with claims appeals and corrections
- Finding Superior Network Providers
- Locating your Service Coordinator and Provider Relations Representative

For claims related questions, be sure to have your claim number, TIN, and other pertinent information available as HIPAA validation will occur.

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

1-877-391-5921

Identifying a Superior Claim Number



Superior HealthPlan assigns claim numbers (aka Claim Control Number or Submission ID) for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.

When calling into Provider Services, please have your claim number ready for expedited handling.

- EDI Rejection/Acceptance reports
- Rejection Letters*
- Web portal
- Explanation of Payments (EOP)

*Remember that rejected claims have never made it through Superior's claims system for processing. The submission ID that is provided on the Rejection Letter is a claim image number that helps us retrieve a scanned image of the rejected claim.

Where do I find a Claim Number?



There are two ways of submitting your claims to Superior:

- Electronic – Web Portal or EDI via a clearing house
- Paper – Mailed to our processing center

If your submission is electronic your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior Web Portal and EOPs.

If your submission is paper your response to your submission is viewable via rejection letters, Superior Web Portal and EOPs.

Note: On all correspondence, please reference either the ‘Claim Number’, ‘Control Number’, or ‘Submission ID’.

Where do I find a Claim Number?



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Examples:

EDI
Reports

DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842		000209200	INVALID			76	20130710	
	M317TXE44820		000164200	ACCEPT				20131109	
	M317TXE44819		000193510	INVALID			76	20130704	
	M317TXE44858		001141694	ACCEPT				20131108	
	M317TXE44868		000759989	ACCEPT				20131108	
	M317TXE44826		000310600	ACCEPT				20131108	
	M317TXE44814		000116222	ACCEPT				20131108	
	M317TXE44828		000405752	ACCEPT				20131103	
	M317TXE44835		000112728	ACCEPT				20131108	
	M317TXE44824		000113004	ACCEPT				20131109	
	M317TXE44829		000984375	ACCEPT				20131024	
	M317TXE44816		000103600	INVALID			09	20131105	
	M317TXE44821		000999375	ACCEPT				20131106	
	M317TXE44843		001183267	ACCEPT				20131101	
	M317TXE44815		000103600	ACCEPT				20131107	
	M317TXE44817		000011500	INVALID			76	20121003	
	M317TXE44825		000207700	ACCEPT				20131107	
	M317TXE44882		000414130	ACCEPT				20131109	
	M317TXE44827		001399000	ACCEPT				20131109	
	M317TXE44910		005690360	ACCEPT				20131030	
	M317TXE44837		000109830	ACCEPT				20131004	
	M317TXE44853		000310700	ACCEPT				20131109	
	M317TXE44839		000338276	ACCEPT				20130906	
	M317TXE44878		000472927	ACCEPT				20131109	
	M317TXE44823		000086211	ACCEPT				20131109	

Explanation of Payment Details

[Back to Payments List](#) [Download \(Excel Format\)](#) [Print](#)

Check/Trace Number:000000000 Check Date:05/16/2014

Insured: [REDACTED]
 Patient Name: [REDACTED]
 Control Number: N125XP02973
 Service Provider: [REDACTED]

Group: [REDACTED]
 Account: AYE09245
 NPI: 1003885641

[View Service Line Details](#)

Serv	Date	Diag#/ Drug#	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	09/16/2013	2920	270		0/1	51.71	10.34	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00
20	09/16/2013	2920	272		0/1	9.17	1.83	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00

Payment History
via Web Portal
(EOP)

Field Provider Relations



Field staff are here to assist you with:

- Face-to-face orientations
- Face-to-face web portal training
- Office visits to review ongoing claim trends
- Office visits to review quality performance reports
- Provider trainings

You can also find a map that can assist you with identifying the field office you can call to get in touch with your Provider Relations Specialist on our website.

Provider Training



Superior HealthPlan offers targeted billing presentations depending on the type of services you provide and bill for. For example, LTSS Billing, Electronic Visit Verification (EVV), and General Billing Clinics. We also offer product specific training on STAR+PLUS, MMP and STAR/CHIP.

You can find the schedule for all of the training presentations on our website at www.superiorhealthplan.com in the Provider Resources section.

We encourage you to come join us!

Complaints



Superior requires complaints to be submitted in writing. The website contains a complaint form that can be completed and submitted online or printed, completed and faxed or mailed to Superior for resolution response:

- **Address:**
Superior HealthPlan
5900 E. Ben White Blvd.
Austin, Texas 78741
ATTN: Complaint Department
- **Fax number:** 1-866-683-5369
- **Website Links:**
 - <http://www.SuperiorHealthPlan.com/contact-us/complaint-hotline/complaint-form/>
(submit online)
 - [http://www.superiorhealthplan.com/files/2014/10/Provider Complaint Form 10282014.pdf](http://www.superiorhealthplan.com/files/2014/10/Provider_Complaint_Form_10282014.pdf)(form)

Compliance



Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines <http://www.hhs.gov/ocr/privacy>.

Fraud, Abuse and Waste (Claims/Eligibility)

- Providers and Contractors are all required to comply with State and Federal provisions that are set forth.
- To report Fraud, Waste and Abuse, call the numbers listed below:
 - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
 - Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
 - Superior HealthPlan Fraud Hotline: 1-866-685-8664



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Questions And Answers

In conclusion...



We are committed to assisting all of our network providers & Nursing Facilities in making the transition as easy as possible.

By now you are able to:

- Identify who Superior HealthPlan is and our various departments
- Explain the difference between Unit Rate and Add-on Services
- Understand Service Coordination and how the Service Coordinator will work with the Nursing Facility staff
- Obtain authorizations and file claims with Superior HealthPlan

Let us know what we can do to help.

Thank you for attending!