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Superior HealthPlan Community First Choice

Provider Training for CFC Services

SHP_20151011

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.

Who is Superior HealthPlan?

- 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
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
- Superior HealthPlan, a subsidiary of Centene Corporation, manages healthcare for over 930,000 members across Texas.

What is STAR+PLUS?

- The program is designed to integrate the delivery of acute care and long-term services and supports (LTSS).
- 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 is a special kind of care management used to coordinate all aspects of care for a member.

What is STAR Health?

- A statewide managed care program that provides comprehensive and coordinated health services to children and young adults in state conservatorship.
  - Provides greater access and coordination to all health care services.
  - Establishes a Medical Home for medical and behavioral care.
  - Provides emergency support and services.

How do you know if a member is eligible and enrolled with Superior?

- Texas Medicaid “Your Texas Benefits” Card
- ***Preferred*** - Superior HealthPlan Identification Card
- ***Preferred*** - Superior HealthPlan secure provider web portal at: www.superiorhealthplan.com
- ***Preferred*** - Call Member Services. You can navigate the Interactive Voice Response System 24/7 or reach a live agent during normal business hours, Monday through Friday 8:00 a.m. to 5:00 p.m. local time.
- For STAR Health members, use the DFPS 2085B Form

Community First Choice: Background

- S.B. 7, 83rd Session, requires the most cost-effective approach to basic attendant and habilitation service delivery.
- HHSC is meeting this requirement by implementing Community First Choice (CFC) services.
- CFC benefits are state plan benefits and available to all Medicaid enrolled individuals who meet criteria.

CFC: Eligibility

- Be enrolled in managed care through STAR+PLUS or STAR Health and not enrolled in a 1915(c) waiver.
- Meet the institutional level of care for a hospital, an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), nursing facility (NF), or Institution for Mental Disease (IMD).
- Due to a federal limitation, STAR+PLUS HCBS waiver members whose financial eligibility is established as Medical Assistance Only are excluded from CFC.

CFC

- Starts June 1, 2015
- Services include:
  - Personal assistance services (PAS/PCS)
  - Emergency Response Services (ERS)
  - Habilitation (HAB)
  - Support Management

Personal Assistance Services

- Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision or cueing.
- CFC personal assistance services provide assistance to a member in performing the ADLs and IADLs based on the person-centered service plan.

Personal Assistance Services

- Non-skilled assistance with ADLs and IADLs
- Household chores
- Daily living assistance (dressing, bathing, eating)
- Assistance with health-related tasks, including:
  - Delegated nursing
  - Heath maintenance activities
  - Extension of therapy

Habilitation

- Helps members acquire, maintain, and enhance skills to accomplish ADLs, IADLs and health-related tasks.
- May also include components of personal assistance services.

Habilitation

- Self-care
- Personal hygiene
- Household tasks
- Mobility
- Money management
- Community integration
- Use of adaptive equipment
- Restoring or compensating for reduced cognitive skills
- Personal decision-making
- Interpersonal communication
- Socialization
- Leisure activity participation
- Self-administration of medication
- Use of natural supports/community services

Emergency Response Service

- A service for members who would otherwise require extensive routine supervision and who:
  - Live alone
  - Are alone for significant parts of the day
  - Do not have regular caregivers for extended periods of time

Support Management

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- Provides voluntary training on selecting, managing and dismissing attendants.
- Offered to all members regardless of service delivery model.
- Not a billable service.

CFC: Assessments

- A functional, person-centered assessment will be performed to determine the level of need for CFC services.
  - For STAR+PLUS members with IDD, the Local Intellectual and Developmental Disability Authority (LIDDA) will complete the assessment.
  - For STAR+PLUS members with physical disabilities, the MCO will complete the assessment.
  - For STAR Health members with IDD or physical disabilities, the MCO will complete the assessment.
- Assessments will result in a plan of care reflect the member's needs and goals.
- Assessments will be done annually, at minimum.

CFC: LIDDA

- Collaborate with Superior in agreeing to and jointly presenting a service plan to adult members.
- Conduct a Determination of Intellectual Disability (DID), if needed.
- Conduct the ID/RC assessment for ICF/IID LOC.
- Develop recommended service plans for adult members who receive a DID and approved LOC.
- Transmit DID and ID/RC information to DADS.

CFC: DADS/TMHP

- DADs will determine whether members meet ICF/IID LOC criteria based on ID/RC submitted by LIDDA and coordinating with the Superior HealthPlan and LIDDA as needed for LOC determinations.
- DADs will facilitate the fair hearing process when DADS staff denies LOC.
- TMHP will continue to determine Nursing Facility LOC based upon the MN/LOC assessment submitted by Superior.

CFC: Superior

- Assess or refer members who request services or have been identified as benefiting from CFC Services.
- Authorize all CFC services for eligible members.
- Conduct the MN/LOC assessment and submit it to TMHP for a LOC decision.
- Consider, develop, collaborate and agree upon recommended service plans.
- Meet regularly with the LIDDA.
- Provide ongoing service coordination and annually assessments to qualified members.

CFC: Authorizations

- Once assessments are completed a plan of care will be created for the Member.
- The approved plan of care will be discussed and accepted by the member and/or their medical consenter/LAR.
- Members will select Superior providers/provider agencies for their CFC services.
- Authorizations will be created by Superior and be valid for one year.

CFC: Authorizations

- PAS Only:
  - Members with no identified Habilitation service need will select a Superior contracted PAS provider.
  - Authorization will utilize the CFC PAS-only codes/modifiers and rate
- PAS with HAB
  - Members with any identified Habilitation service need will select a Superior contracted HAB/PAS provider
  - Must use a single provider for HAB and PAS services
  - Single authorization will utilize the CFC blended HAB codes/ modifiers and rate
- HAB Only:
  - Members with a Habilitation service need but no PAS need will select a Superior contracted HAB provider.
  - Authorization will utilized the CFC blended HAB codes/modifiers and rate
- Non-CFC PAS and ERS:
  - Continue to use existing LTSS codes/modifiers and rates

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Claims Submission and Payment Options

What does Superior Pay for?

DUALs

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

- Medicare is the primary payor for **all acute care** services (e.g. PCP, hospital, outpatient services)
- Medicaid Acute Care (TMHP) - Covers **co-insurance, deductible, and some Long Term Care Services** (ex: incontinence supplies).
- STAR+PLUS (Superior) – **ONLY** Covers **Long Term Support Services** (ex: PAS, HAB, CFC Services etc.).

What does Superior pay for?

NON-DUALS – STAR+PLUS

- Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.
- STAR+PLUS (Superior) covers **BOTH** Acute Care Services and Long Term Support Services.

  Exception: For IDD members, DADS will pay for CFC Services for IDD members. Superior only pays acute care services.

STAR Health

Superior is responsible for payment of all CFC services.

Claims Submission

There are four ways claims can be submitted:

- Direct Connect (must submit 300 or more claims per month)
- Provider Portal
- Clearinghouse/Trading Partner
- Paper

Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS).
- Filed electronically through clearinghouse or Superior's Provider Portal.
- If filing by paper claim, mail to:

  Superior HealthPlan
  P.O. Box 3003
  Farmington, MO 63640-3803
- Claims must be completed in accordance with TMHP billing guidelines.
- Use appropriate modifiers and procedure codes for CFC services.
- All member and provider information completed.
- Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved.

Electronic Claim Filing Tips

- If your clearinghouse does not have our **Payor ID 68069**, they may drop the claim to paper.
- If a provider uses electronic data interchange (EDI) software but it is not setup with a clearinghouse, they must bill Superior via paper claims or through our Provider Portal until the provider has established a relationship with a clearinghouse listed on our website.
- To send claim adjustments via EDI, the CLM05 -3 "Claim Frequency Type Code" must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
- Claims can also be submitted through the Superior HealthPlan website via the Provider Portal. Claims submitted through our portal are considered Electronic Claims.

EDI: Current Trading Partners List

- Allscripts/ Payerpath
- IGI
- Availity
- MD On-Line
- Capario
- Physicians CC
- Claim Remedi
- Practice Insight
- Claimsource
- Relay/ McKesson
- CPSI
- Smarta Data
- DeKalb
- SSI
- Emdeon
- Trizetto Provider Solutions, LLC.
- First Health Care
- Viatrack
- GHNonline

Telephone: 1-800-225-2573 x.25525
Email: ediba@centene.com
Web Info:
http://www.superiorhealthplan.com/for-providers/electronic-transactions/

Paper Claim Filing Tips

To assist our mail center in improving the speed and accuracy to complete scanning please take the following steps:

- Remove all staples from pages
- Do not fold the forms
- Claim must be typed using a 12pt font or larger and submitted on original CMS 1500 or UB04 red form (not a copy).
- Handwritten claim forms are no longer accepted.

Billing Reminders

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- The Prior Authorization Number starts with “OP” followed by 7 digits (Ex: OP2279410) and is found on the authorization summary.
- If a provider bills less than the contracted amount, the claim will pay the lesser of.
- In the Diagnosis Codes section, enter Diagnosis Code 1 (required).
- In the Service Line #1 section, enter required information.
  - From Date, To Date, Place of Service, Procedure Code, Charges, Days/Units. Use the Diagnosis Pointer checkboxes to associate the previously entered Diagnosis Code 1, 2, 3 & 4 with the Service Line as needed.

Billing Reminders

- Include National Provider Identifier (NPI) of Rendering Provider (or Atypical ID).
- Appropriate 2 digit location code must be listed.
- ZZ qualifier to indicate taxonomy (24 J shaded/ 33b) when you are billing with your NPI/Atypical ID number.
- Ensure appropriate modifiers have been entered.
- Taxonomy codes are required on encounter submissions effective for the Rendering and Billing Providers.
- Ensure the EVV data matches the units/hours on the claim.

Authorization & Billing Tips

- Avoid Denials - remember to use the same Tax ID/ LTSS Number on authorizations requests and your claim.
- If your authorization denies because you billed with a different combination than was authorized, you can
  - Rebill with the correct combo.
  - Request that the authorization number you obtained be updated to the Tax ID being used on your claim.
- Authorizations for PAS/PCS and HAB will only reflect the authorization for the HAB procedure code and with the units combined.
- Whenever both PAS/PCS and HAB are billed for the same member, it is required that all hours be billed using the HAB procedure code T2021 for STAR+PLUS or T1019 for STAR Health.

Recurring Bills Reminder

- Superior may issue authorizations that extend to multiple dates of service.
- In order for the claim to process correctly, Dates of Services billed on a claim must be covered under a single authorization.
- Claim must reflect the services under the authorization - including billing period.
- One claim per authorization period.

Recurring Bills Reminder

- Superior frequently issues authorizations that span over multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under one single authorization.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Adjustments, Reconsiderations and Disputes

- All claim adjustments (corrected claims), or requests for reconsideration, or disputes 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.

Corrected Claim Filing

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

Corrected Claims Filing

- Must reference original claim number 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
Attn: Claims
P.O. Box 3003
Farmington, MO 63640-3803

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
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800
  - 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.

Clean Claim

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- Clean claims will be paid within thirty (30) days.
- Once a clean claim is received, Superior will either pay the total amount of the claim or part of the claim in accordance with the contract, or deny the entire claim or part of the claim, and notify the provider why the claim will not be paid within the 30-day claim payment period.
- Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Superior, or the date of electronic transmission, if payment is made electronically.

Explanation of Payment

- Paper EOP (via Emdeon)
- ERA/835- Electronic Remittance Advice
  - PaySpan (EFT and ERA).
  - Providers may be set up to receive via their Clearinghouse/Trading Partners (and still receive a paper check).

EFT or Paper Check

- Providers will receive a paper check unless they are signed up for EFT via PaySpan.
- A provider can submit claims via paper and still enroll for EFT/ERA. A provider that likes their EDI Vendor can still go through their vendor.
- We simply divert the return file – aka the ERA (835) through PaySpan.

PaySpan Health

- Superior has partnered with PaySpan Health to offer expanded claim payment services:
  - Electronic Claim Payments (EFT)
  - Online remittance advices (ERA's/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant
  - Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com
- For further information:
- Call PaySpan at 1-877-331-7154
- E-mail: providerssupport@PaySpanHealth.com

For additional questions, call Superior's Provider Services.

Billing Codes: PAS

For members over age 21 enrolled in STAR+PLUS

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
S5125	U7	U5	U7		1 hour = 1 unit	PAS Agency Model Non-SPW
S5125	U3	U3	U3		1 hour = 1 unit	PAS Agency Model SPW
S5125	99	99	U7	UC	1 hour = 1 unit	PAS Consumer Directed Services (CDS) Non-SPW
S5125	U3	99	U3	UC	1 hour = 1 unit	PAS Consumer Directed Services (CDS) SPW
S5125	99	99	U7	US	1 hour = 1 unit	PAS Service Responsibility Option (SO) Non-SPW
S5125	U3	99	U3	US	1 hour = 1 unit	PAS Service Responsibility Option (SO) SPW
S5125	U5					CDS admin fee

Billing Codes: PCS

For children under age 21 enrolled in STAR+PLUS or STAR Health (Foster Care)

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
T1019	UD				15 minutes = 1 unit	Attendant Only
T1019	U3				15 minutes = 1 unit	PCS Consumer Directed Services (CDS) Attendant Care
T1019	U1				15 minutes = 1 unit	Service Responsibility Option Model

Billing Codes: Habilitation

For members over age 21 enrolled in STAR+PLUS

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
T2021	U7	U7	U7		1 hour = 1 unit	Habilitation Agency Model Non-SPW
T2021	U3	U3	U3		1 hour = 1 unit	Habilitation Agency Model SPW
T2021	U7	U7	U7	UC	1 hour = 1 unit	Habilitation Consumer Directed Services Non-SPW
T2021	U3	U3	U3	UC	1 hour = 1 unit	Habilitation Consumer Directed Services SPW
T2021	U7	U7	U7	US	1 hour = 1 unit	Habilitation Service Responsibility Option (SRO) Non-SPW
T2021	U3	U3	U3	US	1 hour = 1 unit	Habilitation Service Responsibility Option (SRO) SPW

Billing Codes: Habilitation

For children under age 21 enrolled in STAR+PLUS or STAR Health (Foster Care)

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
T1019	U9				15 minutes = 1 unit	Habilitation
T1019	U4				15 minutes = 1 unit	Habilitation – Consumer Directed Option
T1019	U2				15 minutes = 1 unit	Habilitation - Service Responsibility Option Model

Billing Codes: Emergency Response Services

For members enrolled in STAR+PLUS or STAR Health (Foster Care)

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
S5160					1 hour = 1 unit	Emergency Response Services Installation and Testing
S5161	U3	U3	U3		1 month = 1 unit	Emergency Response Services (Monthly) SPW
S5161	U7	U7	U7		1 month = 1 unit	Emergency Response Services (Monthly) Non-SPW

Billing Codes: Nurse Delegation

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For members enrolled in STAR+PLUS or STAR Health (Foster Care)

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Service Description
G0162					15 minutes = 1 unit	RN assessment of delegable tasks
G0162	U1				15 minutes = 1 unit	RN supervision and training of delegate

Billing Requirements: Rates

- If a provider bills less than the contracted amount, the claim will pay the lesser of.
- For a copy of the CFC rate packet, visit:

http://www.hhsc.state.tx.us/rad/long-term-svcs/downloads/2015-09-cfc-rates.pdf

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Electronic Visit Verification (EVV)

Provider Training

Electronic Visit Verification

- Anyone providing covered services to a member must use their selected Electronic Visit Verification (EVV) system to record visit arrival and departure times.
- The provider agency will use the time recorded in the EVV system to determine billable units/hours before requesting payment.
- CFC (including basic attendant and habilitation) require EVV usage.

Provider Responsibilities

- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.
- All providers must select an EVV vendor.
- Providers are not allowed to request a vendor change before the first date of full compliance. Providers are required to submit the Medicaid EVV Provider System Selection Form 120 days before they begin receiving services from a different EVV vendor.
- To change your EVV vendor, fill out a Vendor Selection Form. Using the contact information on the form, submit the completed form to:
  - Your selected vendor
  - Superior HealthPlan
  - TMHP

Provider Responsibilities

- The Grace Period for provider on-boarding, training, overall readiness and full compliance with the EVV system functionality will expire 30 days following HHSC notification of the compliance date.
- Providers should learn new and revised reason codes.
- Each provider is responsible for ensuring their attendants are trained on the use of EVV and that accurate data is being submitted to Superior.

Provider Responsibilities

- EVV related claims are subject to denials when grace period ends.
- For partially or full claim denials, due to inaccurate\incomplete\invalid EVV transaction data, contact your vendor directly to review data submission.
  - Reason for denial will be listed on the Explanation of Payment (EOP)
- Providers must inform the member about the use of their telephonic landline in order to use EVV.
- If a member refuses the use of the landline, then the provider must educate on the use of a small alternative device (SAD) and how that device must remain affixed to a designated location within the member’s home.
- Providers must inform the member’s Superior Service Coordinator in any instances where a member refuses to allow the use of their landline and the installation of an alternative device.

EVV Vendors

MEDsys Software Solutions, LLC
Phone: 1-877-698-9392
Fax: 1-866-437-9066
www.medsyshcs.com

DataLogic (Vesta) Software, Inc.
Phone: 1-844-880-2400
Fax: 1-956-412-1464
www.vestaevv.com

Vendor Responsibilities

- Each Vendor is responsible for training providers on the use of their system.
- Each vendor is responsible for providing technical support for their system. Contact your vendor directly for training or support.
- Vendors must submit a monthly training list of Superior contracted providers to Superior.
- Vendors cannot pass on transaction fees to providers nor Members.
- Vendors will provide EVV data reports to providers for review.

Vendor Fees

- Providers nor members pay EVV transaction fees. Superior HealthPlan will pay approved transaction fees for Superior members directly to the vendor.
- EVV vendors will not bill providers for the use of equipment that is needed.
- The transaction fee includes but is not limited to:
  - Vendor provision of provider training
  - Visit verification
  - Customer assistance and support,
  - Interfacing
  - Reporting
  - Hardware
  - Software
  - Any other additional costs the Vendor will incur to perform all of the required services and deliverables
- For Superior HealthPlan, the transaction fee does not include upfront costs for Alternative Devices. Superior HealthPlan will not be paying for any costs associated with alternative devices.

Vendor Reports

- EVV Reporting is done primarily through your selected vendor.
- Any requests for EVV reports should be directed to your vendor.
- Each vendor is required to provide you reports of transaction activity.
- Each provider is responsible for ensuring that their vendor is submitting accurate data to Superior on their behalf prior to submitting claims.

EVV Process and Claims

Process

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- Providers will verify times of service using the vendor's specified process.
- Each vendor will submit daily reports directly to Superior for all completed EVV transactions.
- Provider claims are compared to EVV data prior to adjudication.
- Superior will only pay for verified units of service based on EVV data.

EVV Service Claims

- Ensure that authorization for services is in place prior to providing services to the member.
- To avoid denials and/or delay in payment, claims for multiple DOS should be billed on a separate line for each day with the number of units per day.
- Superior will compare EVV data to claims prior to adjudication.
- Only authorized and verified units of service will be paid. Any unauthorized and/or unverified units will be denied.
- Superior will adjudicate claim data starting with the first date of service billed.

EVV Service Claims

- If a claim fully denies:
  - Review submitted data with your EVV Vendor.
  - Any changes to your data will need to be made by the provider agency into your vendor system.
  - Per HHSC, providers must complete any and all required visit maintenance in EVV within 60 days of the date of service. No visit maintenance will be allowed more than 60 days after the date of service.

EVV Service Claims

- If a claim fully denies (continued):
  - Any data updates made outside the defined visit maintenance window will continue to deny regardless if EVV Vendor system allows such changes.
  - Once corrected data has been received by Superior, your claim will be automatically reprocessed.
  - DO NOT resubmit your claim. Resubmissions will result in a rejection or denial for duplicate claim.

EVV Service Claims

- If a claim partially denies:
  - Review data with your EVV Vendor.
  - Any changes to your data will need to be made by the provider agency into your vendor system.
  - Per HHSC, providers must complete any and all required visit maintenance in EVV within 60 days of the date of service. No visit maintenance will be allowed more than 60 days after the date of service.

EVV Service Claims

- If a claim partially denies (continued):
  - Any data updates made outside the defined visit maintenance window will continue to deny regardless if Vendor system allows such changes.
  - Once corrected data has been received by Superior, resubmit a NEW claim for the portion of your claim that was previously denied.

Reason Codes

- Reason Codes are standardized HHSC approved numbers of up to three digits and description that is used during visit maintenance to explain the specific reason a change was made to an EVV visit record.
- Providers must associate the most appropriate reason code(s) with each change made in the visit maintenance and enter any required free text in the required field.
- Superior will analyze utilization of reason codes on a monthly basis. If patterns of regular Visit Maintenance activity (usage of both/either preferred and non-preferred reason codes) are present, provider may be subject to:
  - Additional education and Vendor training
  - A corrective action plan
  - Potential termination from the network (if continued non-compliance occurs)

Preferred vs Non-Preferred Reason Code Definitions

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- **Preferred Reason Code** – A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider staff IS documenting services in accordance with program and policy requirements.
- **Non-preferred Reason Code** – A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider staff is NOT documenting services in accordance with program and policy requirements.

Reason Codes

- Providers must use a state approved reason code on visit maintenance EVV Transactions.
- For an up-to-date list and definitions, visit: https://www.dads.state.tx.us/evv/reasoncodes.html

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Secure Provider Web Portal
Submitting Claims

Provider Portal & Website

Provider Portal:

- Up-to-date member eligibility and Service Coordinator assignment.
- Secure claim submission portal you can submit claims at no cost!
- Claim wizard tool that walks you through filling in a claim to submit online.
- Claim status and payment information.

Public Site:

- View our Provider Directory and on-line lookup.
- Easily identify the office of the field Provider Relations Specialist assigned to you via a map on the Contact Us page.
- View Provider Manuals, newsletters, bulletins, forms and other resources.
- Lists links 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.

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ambetter from Superior HealthPlan

Features CREATE ACCOUNT

The Tools You Need Now!

Our site has been designed to help you get your job done.Manage all products with ease in one location

Check Eligibility

Find out if a member is eligible for service.

Authorize Services

See if the service you provide is reimbursable.

Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (*Email*)

name@domain.com

Password

Login

Forgot Password / Unlock Account

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF

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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Create Recurring UB-04 Claims

Viewing Claims For : 440605373 Testing Nickname

Upload EDI | Create Claim

Claims | Individual | Saved | Submitted | Batch | Reoccurring | Payment History | My Downloads | Claims Audit Tool

Get Started Used only by LTC and ADC Providers.

Your Progress

Claim Type: 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

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Select Your Service Location

Create Recurring UB-04 Claims

Click to View Your Member List

Enter Member ID or Last name and Member Birthdate

- 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

Viewing Claims For: 440605373 Testing Nickname | Upload EDI | Create Claim

Claims | Individual | Saved | Submitted | Batch | Reoccurring | Payment History | My Downloads | Claims Audit Tool

Member List

Your Progress

Claim Type

Location:

123 ADC Lane, Tampa, FL 33607

Member ID or Last Name: 123456789 or Smith | Birthdate: mm/dd/yyyy | Add Member

Member Added.

Select All	Member Name	Member ID	Bill Type*	DOS Start*	DOS End*	Rev Code*	Serv Units*	Total Charges*	Action
☐	JANE PATIENT	00123456789	XXX	MM/DD/YYYY	MM/DD/YYYY	XXXXX	XX.XX	XXXX	✖
☐	DAVID PATIENT	00123456789	XXX	MM/DD/YYYY	MM/DD/YYYY	XXXXX	XX.XX	XXXX	✖
				MM/DD/YYYY	MM/DD/YYYY	Update All DOS		Create Claim(s)	

- Once members are added, you'll be alerted with a members Added remark at the top of the list.
- Members are listed in alphabetic order by last name.
- If you can't find a member, check that the ID and birthdate were entered correctly.

Create Recurring UB-04 Claims

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

Claims to Submit (2)

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

Claims to Submit (2)

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	132456789	

Service Lines

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

Diagnosis Codes

Admiting 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 | Reoccurring | Payment History | My Downloads | Claims Audit Tool

Claims to Submit (2)

Your Progress

Claim Type

Location:

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

Viewing Claims For : 440605373 Testing Nickname

Upload EDI | Create Claim

Claims | Individual | Saved | Submitted | Batch | Reoccurring | Payment History | My Downloads | Claims Audit Tool

Claims to Submit (2)

Your Progress

Claim Type: Nursing Facility Residential
Location: Nurses Clinic
NPI: 132456789| Medicaid#: 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 | Reoccurring | Payment History | My Downloads | Claims Audit Tool

Claims Submitted (2)

Your Progress

Claim Type: Nursing Facility Residential
Location: Nurses Clinic
NPI: 123456789| Medicaid#: 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

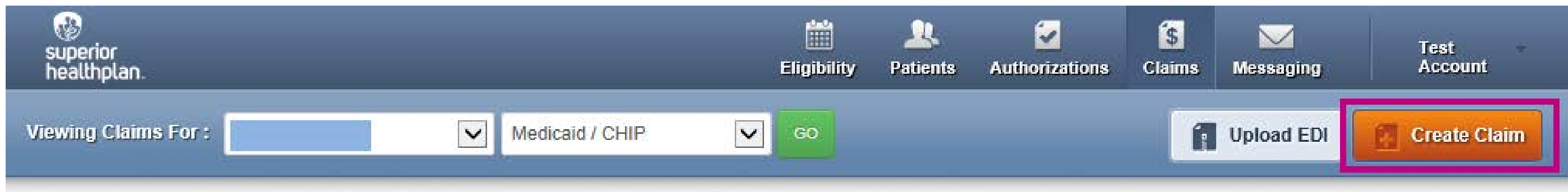
- Click Print to print a copy of the claims submitted including the Web Reference#.
- Click Submit More Claims to request a new template or move on to other functions.

Create Professional Claims

From the navigation menu select:

Claims at the top of the landing page

Then select Create Claim



Create Professional Claims

superior healthplan
Eligibility Patients Authorizations Claims Messaging Test Account
Viewing Claims For : Medicaid / CHIP GO
Member ID or Last Name Birthdate mm/dd/yyyy Find

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

Create Professional Claims

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

Choose a Claim Type

CMS 1500

Professional Claim →

CMS UB-04

Institutional Claim →

General Information

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Professional Claim for
Your Progress

THIS SECTION
General Info
Information about the dates of the claim.

Next →

* Required field

Patient's Account Number* XXXXXXXXXX 26
Date of current Illness, Injury, Pregnancy (LMP) Select Type... MM/DD/YYYY 14
Other Date Select Type... MM/DD/YYYY 15
Hospitalization From MM/DD/YYYY To MM/DD/YYYY 18
Outside Lab? Yes No 20
Prior Authorization Number XXXXXXXXXXXX 23a
CLIA Number XXXXXXXXXXXX 23b
Amount Paid XXXX.XX 29
ICD Version Indicator* ICD 9 ICD 10 Please note that we are currently accepting valid ICD-9 codes only
Diagnosis Codes* XXXX e.g. 1409 Add (Enter diagnosis code and click on Add button) 21
Add Coordination of Benefits

CMS 1500 Question #23
Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization.

Next →

Required Fields:

- ✓ **Patient Account Number**
- ✓ **Diagnosis Codes**

Enter other pertinent information for the claim as necessary.

Use any of the field tabs to get details for what information should be entered.

Coordination of Benefits

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Diagnosis Codes* XXXX e.g. 1409 Add (Enter diagnosis code and click on Add button)

2598 -- OTHER SPECIFIED ENDOCRINE DISORDERS Remove X

Add Coordination of Benefits

Next →

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

Primary Insurance x Remove

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* Select... / C50M -- Commercial / M5ED -- Medicare

Policy Number* XXXXXXXX

Next →

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

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*	XXXX.XX
Deductible	XXXX.XX
Copay	XXXX.XX
Co-Insurance	XXXX.XX
Amount Paid	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	Select...
Denied Amount	XXXX.XX

Add Denied Reason

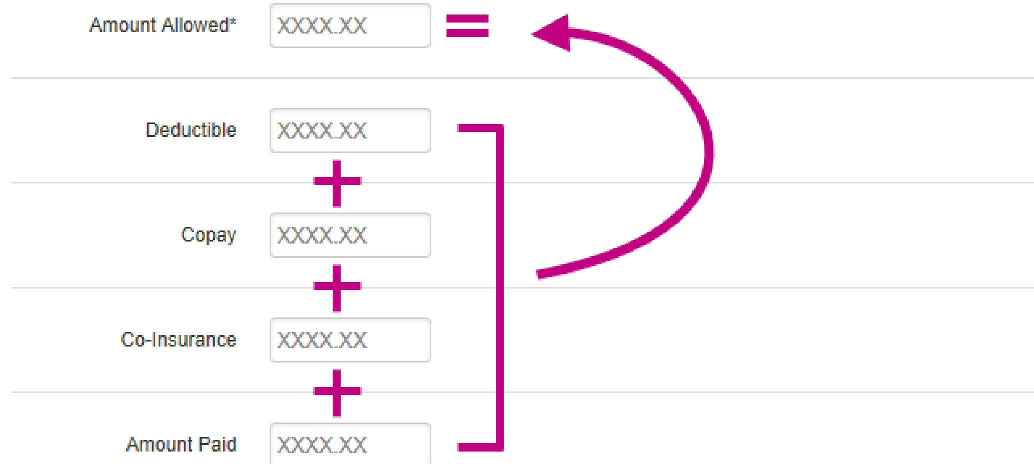
Save / Update

Back

Provider Details

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.

Coordination of Benefits



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

Deductible + Copay + Co-Insurance + Amount Paid = 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: Select...

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

Denied Amount: 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: Select...

Denied Amount: XXXX.XX

Add Denied Reason

$ 20.00 Adjustment   Remove X

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.

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* XX.XX =

24.f

Primary Insurance

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

Amount Allowed* 50 +

Deductible XXXX.XX

Copay XXXX.XX

Co-Insurance XXXX.XX

Amount Paid 50

Service Line Denial Reasons

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

Denied Category Select...

Denied Amount XXXX.XX

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

superior healthplan

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

XXXXXXXXX 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

XXXXXXXXX

Tax ID

Find Provider

24.j

Taxonomy #

XXXXXXXXX

Last Name or Organizational Name

Last Name

First Name

First Name

Clear X

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

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

Billing Provider Section

Billing Provider

Tax ID

Name* | NPI | Taxonomy #*
Last Name | XXXXXXXXX | XXXXXXXXX

Address* | City* | State* | Zip*
XXXXXXXXXX | XXXXXXXXXX | Select... | XXXXX

33.

Service Facility Location

Name | NPI
Last Name | XXXXXXXXX

Address | City | State | Zip
XXXXXXXXXX | XXXXXXXXXX | Select... | XXXXX

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 Clain for

Your Progress

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

Attach

Attachment Name	Type	
TX_TX_2148131_Claim Attachment example.pdf	Primary Carrier EOB	Remove X

← Back   If there are no attachments, click Next.   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

Your Progress

THIS SECTION:

Review Please review your claim and submit.

Almost done!

You can go back to review your claim or submit now.

Submit →

Claim Id:

Member Record Number:
Member Claim Amount Paid:
Patient's 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 (U2)	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!

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Eligibility | Patients | Authorizations | Claims | Messaging

Viewing Claims For : Medicaid / CHIP GO

Upload EDI | Create Claim

THIS SECTION:

Success Congratulations!

Your claim has been submitted

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 GO Upload EDI Create Claim

Claims | Individual | Saved | Submitted | Batch | Multiple | Payment History | My Downloads | Claims Audit Tool | Filter

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED / PAID	STATUS
[illegible]	Institutional	[illegible]	04/02/2014 - 04/02/2014	$ 175.00 / 121.63	
[illegible]	Institutional	[illegible]	04/01/2014 - 04/01/2014	$ 175.00 / 121.63	
[illegible]	Institutional	[illegible]	04/01/2014 - 04/01/2014	$ 200.00 / 111.13	
[illegible]	Institutional	[illegible]	04/01/2014 - 04/01/2014	$ 175.00 / 121.63	
[illegible]	Institutional	[illegible]	04/01/2014 - 04/01/2014	$ 175.00 / 121.63	
[illegible]	Institutional	[illegible]	04/01/2014 - 04/01/2014	$ 175.00 / 121.63	
[illegible]	Institutional	[illegible]	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 GO

Upload EDI | Create Claim

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

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

Reject | Submit

Select the **Claims Audit Tool**.

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

Claims Audit Tool

superior healthplan

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						-- select --	
2						-- select --	
3						-- select --	
4						-- select --	
5						-- select --	

Add More Procedures >>

Review Claim Audit Results | Clear

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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. Any

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

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Superior HealthPlan Departments

- We Can Help You!

Contracting and Implementation

- A centralized team that handles all contracting for new and existing providers to include:
  - New provider contracts
  - Adding providers to existing Superior contracts
  - Adding additional products (i.e. STAR+PLUS or STAR Health) to existing Superior contracts
  - Amendments to existing contracts
- Contract packets can be requested online:
  - http://www.superiorhealthplan.com/for-providers/join-our-network/
  - For questions, contact your local Provider Relations Representative.

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.

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 Specialist.
- 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.

Identifying a 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?

Examples:

EDI Reports

DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842		000209200	INVALD			76	20130710	
	M317TXE44820		000164200	ACCEPT				20131109	
	M317TXE44819		000193510	INVALD			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	INVALD			09	20131105	
	M317TXE44821		000999375	ACCEPT				20131106	
	M317TXE44843		001183267	ACCEPT				20131101	
	M317TXE44815		000103600	ACCEPT				20131107	
	M317TXE44817		000011500	INVALD			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:0000000000 Check Date:05/16/2014

Insured
Patient Name:
Control Number: N125TXP02973
Service Provider:

Group:
ID:
Account: AYEU9245
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 and provider trainings.
  - Face-to-face web portal training.
  - Office visits to review ongoing claim trends.
  - Office visits to review quality performance reports.
- Identify the field office and contact information for your Provider Relations Specialist on our website.

Provider Training

- Superior offers targeted billing and product specific training.
- Current training schedule can be found on our website 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 (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

Contact Information

STAR+PLUS

Service Coordination (Authorizations/Assessments)

Phone: 1-877-277-9772

Fax (determined by member's Service Delivery Area):

Bexar 1-866-224-8254
Dallas 1-855-707-5475
Hidalgo 1-866-895-7856
Lubbock 1-866-896-8210
Nueces 1-866-703-0903
MRSA Central 1-844-501-8250
MRSA West 1-866-896-8210

Member Services (Eligibility)

Phone: 1-877-277-9772

Provider Services (Billing, Training, Visits)

Phone: 1-877-391-5921

LTSS Billing Matrix (Procedure Codes & Modifiers):
http://www.dads.state.tx.us/handbooks/sph/appendix

Contact Information

STAR Health

Service Management (authorizations/assessments)

Phone: 1-800-218-7508

Fax: 1-800-690-7030

Member Services (eligibility, benefits)

Phone: 1-866-912-6283

Provider Services (billing, claim status and questions)

Phone: 1-866-439-2042

Procedure Codes and Modifiers:

http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx

Questions?

Need More Information:

http://www.hhsc.state.tx.us/medicaid/managed-care/community-first-choice/