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Billing Clinic

(STAR, STAR+PLUS [non-nursing facility],
STAR Kids, STAR Health and CHIP)

Provider Training

Introductions and Agenda



- Verifying Eligibility
- Authorization Process
- Establishing Medical Necessity (After an Adverse Determination)
- Claims Submissions
- FQHC and RHC Billing Information
- Electronic Payments and Remittance
- Superior HealthPlan Departments
- Secure Provider Portal
- Questions and Answers



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Verifying Eligibility

Verify Eligibility



- Texas Medicaid Benefit Card (TMBC) (STAR Only)
 - TexMedConnect - www.TMHP.com/pages/edi/edi_textmedconnect.aspx.
- Superior Identification Card
- Secure Provider Portal: www.Provider.SuperiorHealthPlan.com.
- Contact Member Services:
 - STAR, CHIP: 1-800-783-5386
 - STAR Health: 1-866-912-6283
 - STAR+PLUS: 1-877-277-9772
 - STAR Kids: 1-844-590-4883
- Verify eligibility the first of each month using our website or by contacting Member Services.

Superior Member ID Cards



- The member ID cards contain the following information:
 - Member name
 - Primary Care Provider (except CHIP Perinate mother and STAR+PLUS dual members)
 - Prescription information
 - Program eligibility
 - Superior contact information
- Copies of sample member ID cards can be found in the Superior Provider Manual.



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Authorization Process

*Ensure Proper Authorizations
are in Place*

Medical Management Authorizations



- Prescheduled elective admissions must have authorization prior to admission.
- All out of network services require an authorization.
 - Emergent and urgent services provided by an out-of-network provider do not require prior authorization.
- Initiate authorizations 5 business days in advance for non-emergency services.
- If clinical information is requested by Medical Management, submit by fax or through the Superior's Secure Provider Portal.
www.Provider.SuperiorHealthPlan.com
Fax: 1-800-690-7030

Authorization TAT Requirements



Program	Authorization Type	TAT
STAR (Medicaid), STAR Health, STAR Kids and STAR+PLUS	Outpatient	3 business days
CHIP	Outpatient	2 business days
Medicaid and CHIP	Urgent, outpatient	1 business day
Medicaid and CHIP	Inpatient	1 business day

Authorization TAT Requirements



Authorization Type	TAT
<p>Concurrent Review – The process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission.</p>	<ul style="list-style-type: none">• For Medicaid and CHIP, all urgent requests must be reviewed the same day, or within 1 business day of notification of admission, or within 1 business day of next review date.• Timeframe should not exceed 72 hours or 3 calendar days.
<p>Retrospective Review – A form of utilization review for health-care services that have been provided to a member.</p>	<p>If discharge can be confirmed at the time of the initial request/notification of the admission, post-service review timeframes may be applied. A medical necessity determination and written notification is made within 30 calendar days from the date of the request.</p>

Services Requiring Authorization



- Services requiring authorization include, but are not limited to:
 - Specialty procedures, including Chiropractic, Podiatry, Oral Surgery and Plastic and Reconstructive Surgery
 - In-Home and Outpatient Therapy/Rehabilitation
 - Durable Medical Equipment (Over \$500, Incontinence Supplies, Enteral Nutrition, etc.)
 - Transportation
 - Pharmaceuticals
 - Surgical/Other Procedures
 - Transplants
 - Long-Term Services and Support (LTSS)
 - Radiology
 - Vision

Medicaid Pre-Authorization Tool



Providers can determine if a prior authorization is required by using the Pre-Auth tool on the Superior website, answering a series of questions and searching by procedure codes: www.SuperiorHealthPlan.com/providers/preauth-check.html

Secure Portal Login

Prior Authorization -

- Medicaid Prior Authorization
- Medicare Prior Authorization
- STAR+PLUS MMP Prior Authorization
- Ambetter Prior Authorization

Network Request or Update +

Training and Manuals +

Provider Resources +

Provider News & Information

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [provider manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision Services](#)
Dental services need to be verified by [DentaQuest](#)
Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)
Non-participating providers must submit prior authorization for all services*
For non-participating providers, [Join Our Network](#)

**Please note, Incontinence Supplies ordered through the preferred DME provider do not require prior authorization.*

Would this be for Family Planning services billed with a contraceptive management diagnosis?

Yes No

Types of Services	YES	NO
Are services being provided by a non-participating provider?	<input type="radio"/>	<input type="radio"/>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for dental procedures?	<input type="radio"/>	<input type="radio"/>
Is the member receiving oral surgery services?	<input type="radio"/>	<input type="radio"/>
Is the member receiving plastic and reconstructive surgeon services?	<input type="radio"/>	<input type="radio"/>
Is the member having chiropractic services?	<input type="radio"/>	<input type="radio"/>
Is the member receiving podiatry services?	<input type="radio"/>	<input type="radio"/>

Prior Authorization Form



- The 2020 Outpatient Medicaid Authorization Form is located at www.SuperiorHealthPlan.com/providers/resources/forms.html
- Providers may also utilize the Texas Standard Prior Authorization Request Form at:
www.SuperiorHealthPlan.com/providers/resources/forms.html
- Prior authorizations can also be submitted through the Secure Provider Portal.

High-Tech Imaging: NIA



- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for high-tech imaging services, including:
 - CT/CTA
 - MRI/MRA
 - PET Scan
 - CCTA
 - Nuclear Cardiology/MPI
 - Stress Echo
- Echocardiography (STAR+PLUS).
- Inpatient and ER procedures do not require authorization.
- All claims should be submitted to Superior through paper claims submission, or electronic submission on Provider.SuperiorHealthPlan.com.

High-Tech Imaging: NIA



- The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures.
- Servicing providers may request authorization and check status of an authorization by:
 - Accessing www.RadMD.com
 - Utilizing the toll-free number: 1-800-642-7554

TurningPoint Healthcare Solutions



- Effective November 15, 2019, Superior will be working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint will be responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures.
- This new process applies to: Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS), CHIP, Allwell from Superior HealthPlan and Ambetter from Superior HealthPlan.
- Physicians will begin submitting requests to TurningPoint for prior authorization beginning on November 1, 2019 for dates of service on or after November 15, 2019.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under billing resources at the following link:
www.SuperiorHealthPlan.com/providers/resources.html.

TurningPoint Healthcare Solutions



- Prior authorization will be required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

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

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

TurningPoint Healthcare Solutions



- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
 - Web Portal Intake: www.myturningpoint-healthcare.com
 - Telephonic Intake: 469-310-3104 | 855-336-4391
 - Facsimile Intake: 214-306-9323



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Establishing Medical Necessity

Medical Management Denials



- Type of Denial
 - Adverse Determination (Medical Necessity) Denial - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
 - Medical necessity is defined as health services that are reasonably necessary to:
 - Prevent illness or medical conditions.
 - Provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, or limitations in function.
 - Contractual (Administrative) Denials (non-clinical reasons)
 - Late notification.
 - Failure to obtain prior authorization.
 - Alberto N. missing information denial.
 - Non-Covered Benefit Denial
 - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by the State.
 - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by the State (Non-covered Benefit).

Appealing Medical Management Denials



- Peer-to-Peer Review
 - When medical necessity cannot be established, a peer-to-peer review is offered. A peer-to-peer discussion is available to the ordering physician, nurse practitioner, physician assistant during the prior authorization, denial or appeal process with regard to medical necessity.
- Communication of Denials
 - Denial letters will be sent to member, requesting provider and servicing provider to include:
 - The clinical basis for the denial.
 - Criteria used to make the medical necessity decision.
 - Member appeal/complaint, external review (CHIP) or fair hearing rights (Medicaid) fully explained.
- Provider may request an appeal in writing on behalf of the member.
 - Mail: Superior HealthPlan
Attn: Appeal Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
 - Fax: 1-866-918-2266

Appealing of Adverse Determination



- Types of Medical Necessity Appeals:
 - Level 1: Internal/standard appeal (appeal to Superior HealthPlan)
 - Level 2: External appeal (appealing to a third party)
 - CHIP (External Review must be requested directly through Maximus)
 - STAR/STAR Health/STAR Kids/STAR+PLUS = FH (Fair Hearing – HHSC)
- Medical necessity appeals (*Note: Contractual denials only have complaint rights*).
 - Appeals must be submitted to Superior within 60 days from the date of the last denial.

Appeal Timeframe by Product



Medicaid

- Provider or member has:
 - 60 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal for STAR, STAR Health, STAR Kids and STAR+PLUS.
 - 30 calendar days for an expedited appeal.
 - 90 days for CHIP.
 - 120 calendar days from the date of notification of adverse determination to file a Fair Hearing for STAR products.
 - Non-covered benefit denial also has Fair Hearing rights.
 - Complaint rights.
- Superior will review and respond to the appeal within 30 calendar days.

Appeal Timeframe by Product



CHIP/CHIP RSA

- Provider or member has:
 - 90 calendar days from the date of the notification of adverse determination to file an appeal
 - IRO rights
 - Complaint rights
- Provider or member does not have Fair Hearing rights.
- Appeal is to be completed within 30 calendar days.

Expedited Appeals



- Expedited Appeals
 - IP expedited appeals are processed within 1 working day of appeal request.
 - All other expedited appeals are completed within 3 days.
- Expedited Appeals Criteria
 - Will it cause severe pain if not processed within a 30 day time frame?
 - Is it life/limb threatening if not processed within a 30 day time frame?
 - Has it been reviewed by a medical director?

Provider Complaints



- Provider complaints can be submitted in writing, verbally or online.
 - Mail:
Superior HealthPlan
Attn: Complaint Department
5900 E. Ben White Blvd.
Austin, Texas 78741
 - Verbally:
During a face-to-face interaction/visit or telephone call into any Superior department.
 - Fax:
Attn: Complaint Department
1-866-683-5369
 - Online:
www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html
- Complaint form can be printed, completed and faxed or mailed to Superior for resolution response. Form can be found under Contact – Complaint Form: www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.

Compliance



Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines, found at: www.HHS.gov/ocr/privacy.
- Fraud, Waste and Abuse (Claims/Eligibility):
 - Providers and contractors are all required to comply with state and federal provisions.
 - 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: 1-800-252-8011
 - Superior HealthPlan Fraud Hotline: 1-866-685-8664



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Claim Submissions

Clean Claims



- Clean claims will be processed within 30 days.
- For electronic pharmacy claim submissions, claims will be paid in 18 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.
- Each claim payment check will be accompanied by an Explanation of Payment (EOP), which itemizes your charges for that reimbursement and the amount of your check from Superior.
- 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.

Claims Filing: Initial Submission



- Claims must be filed within 95 days from the Date of Service (DOS):
 - Filed on CMS-1450/UB-04 or CMS 1500
 - Filed electronically through clearinghouse
 - Filed directly through Superior's Provider Portal
- Claims must be completed in accordance with Medicaid billing guidelines.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.
- Mailing Address (paper claims):
 - Superior HealthPlan
 - Attn: Claims
 - P.O. Box 3003
 - Farmington, MO 63640-3803
- Effective January 1, 2020, medical eye services, provided by an ophthalmologist, will be submitted to Superior for processing.

Paper Claims Filing



- To help process paper claims quickly and accurately, 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-1450/UB-04 or CMS 1500 red form (not a copy).
 - Handwritten claim forms are no longer accepted.
 - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

CMS 1500 Form



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Referring
Provider: [C]

17 Name of
the referring
provider

17b NPI

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 00/02

1. MEDICARE **2. MEDICAID** **3. TRICARE** **4. CHAMPVA** **5. GROUP HEALTH PLAN** **6. FICA (Self)** **7. OTHER** **8. INSURED'S POLICY NUMBER** (For Program in Item 1)

9. PATIENT'S NAME (Last Name, First Name, Middle Initial) **10. PATIENT'S BIRTH DATE** MM / DD / YY **11. PATIENT'S SEX** M F

12. PATIENT'S ADDRESS (No. Street) **13. PATIENT RELATIONSHIP TO INSURED** Spouse Spouse Child Other

14. CITY **15. STATE** **16. RESERVED FOR NUCC USE** **17. CITY** **18. STATE**

19. ZIP CODE **20. TELEPHONE** (Include Area Code) **21. ZIP CODE** **22. TELEPHONE** (Include Area Code)

23. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **24. IS PATIENT'S CONDITION RELATED TO:** **25. INSURED'S POLICY OR FICA NUMBER**

26. EMPLOYMENT (Current or Pre-out) YES NO **27. INSURED'S DATE OF BIRTH** MM / DD / YY **28. INSURED'S SEX** M F

29. RESERVED FOR NUCC USE **30. AUTO ACCEPTANCE?** YES NO **31. OTHER CLAIM ID** (Designated by NUCC)

32. RESERVED FOR NUCC USE **33. OTHER ACCEPTANCE?** YES NO **34. INSURANCE PLAN NAME OR PROGRAM NAME**

35. INSURANCE PLAN NAME OR PROGRAM NAME **36. CLAIM CODES** (Designated by NUCC) **37. IS THERE ANOTHER HEALTH BENEFIT PLAN?** YES NO (If yes, complete items 3, 9a, and 14)

38. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized for release of any medical or other information necessary to process this claim. I/We request payment of goods or services, either in-kind or to the party who accepts assignment.) **39. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

40. DATE OF CURRENT ILLNESS OR INJURY (If none, leave blank) MM / DD / YY **41. OTHER DATE** MM / DD / YY **42. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** FROM MM / DD / YY TO MM / DD / YY

43. NAME OF REFERRING PROVIDER OR OTHER SOURCE **44. IDENTIFICATION DATES RELATED TO CURRENT SERVICES** FROM MM / DD / YY TO MM / DD / YY

45. ADDRESS OF CLAIM INFORMATION (Designated by NUCC) **46. OUTSIDE LAST** \$ CHANGES YES NO

47. SIGNATURE ON NATURE OF ILLNESS OR INJURY (Reference to service line # in 44) **48. ASSIGNMENT CODE** ORIGINAL REF. NO.

49. SIGNATURE **50. PHYSICIAN AUTHORIZATION NUMBER**

1	A. DATE(S) OF SERVICE		B. PROCEDURES, SERVICES, OR SUPPLIES	C. DIAGNOSIS	D. CHARGES	E. ICD-9-CM	F. ICD-9-PCS	G. PROVIDER ID	
	MM / DD / YY	MM / DD / YY							EMG
1									
2									
3									
4									
5									
6									

51. FEDERAL TAX ID NUMBER **52. PATIENT'S ACCOUNT NO.** **53. ACCEPT ASSIGNMENT?** YES NO **54. TOTAL CHARGE** \$ **55. AMOUNT PAID** \$ **56. NEED FOR NUCC USE**

57. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address on credit/invoice. I certify that the statements on the reverse apply to this claim and are made a part thereof.) **58. SERVICE FACILITY LOCATION INFORMATION** **59. BILLING PROVIDER INFO & PAYEE**

60. NPI **61. NPI** **62. NPI**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1107 FORM 1500 (REV. 10)

Rendering Provider: [R]

Place your NPI (National Provider Identifier #) in box 24J (unshaded) and Taxonomy Code in box 24J (shaded).

These are required fields when billing Superior claims.

If you do not have an NPI, place your API (Atypical Provider Identifier #/LTSS #) in Box 33b.

Billing Provider: [R]

Billing NPI # in box 33a and Billing Taxonomy # (or API # if no NPI) in 33b.

Identifying a Claim Number



- Superior assigns claim numbers for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.
- When calling Provider Services, please have the following ready to expedite handling:
 - Claim Number (can be found on the Secure Provider Portal)
 - EDI Rejection/Acceptance reports
 - Rejection letters
 - EOP

Note: Remember that rejected claims have never made it through Superior's claims system for processing. The claim number that is provided on the rejection letter is a claim image number that helps us retrieve a scanned image of the rejected claim.

Identifying a Claim Number



- **Electronic:** Secure Provider Portal or EDI through a clearinghouse.
 - Your response to your submission is viewable through an EDI rejection/acceptance report, rejection letters, Superior Provider Portal and EOPs.
- **Paper:** Mailed to our processing center.
 - Your response to your submission is viewable through rejection letters, Superior's Provider Portal and EOPs.

Note: On all correspondence, please reference either the claim number or control number.

Where Do I Find a Claim Number?



You can find claim numbers on:

- EDI reports
- Explanation of Payment Details on the Provider Portal

EDI Reports

DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44812		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	

Explanation of Payment Details on Provider Portal

Explanation of Payment Details Back to Payments List Download (Excel Format) Print

Check/Trace Number: 0000000000 Check Date: 05/16/2014

Insured Name: [REDACTED] Group: [REDACTED]

Patient Name: [REDACTED] ID: [REDACTED]

Control Number: N12STXP02973 Account: AYEU9245

Service Provider: [REDACTED] NPI: [REDACTED]

[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

Electronic Claims Filing



- Claims can be submitted through Superior's Secure Provider Portal.
- Claims can also be submitted by using a Superior preferred trading partner/clearinghouse.
- If provider uses Electronic Data Interchange (EDI) software but is not set up with a trading partner/clearinghouse, they must bill Superior by submitting paper claims or through the Secure Provider Portal until the provider has established a relationship with a trading partner/clearinghouse listed at:
www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
 - For Superior medical electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **68069**.
 - For Superior behavioral health claim submissions, the correct payor ID is: **68068**
 - For MMP, Allwell and Ambetter, behavioral health claims are still submitted to 68069
 - Contact EDI: EDIBA@Centene.com

Electronic Claims Filing



Superior will not pay any claim submitted by a provider, if the provider:

- Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- Is on payment hold under the authority of HHSC or its authorized agent(s).
- Has provided neonatal services provided on or after September 1, 2013, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2013, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

**In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.*

Claim Adjustments, Reconsiderations and Disputes



- Submit appeal within 120 days from the date of adjudication or denial.
 - Adjusted or Corrected Claim: The provider is changing the original claim.
 - Correction to a Prior Claim: 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.
- Claim Adjustments/Corrections and Submissions can be processed through the Provider Portal or a paper claim.
 - Paper claims require a Superior Corrected Claim or Claim Appeal form.
 - Claim forms can be found at [SuperiorHealthPlan.com/providers/resources/forms.html](https://www.SuperiorHealthPlan.com/providers/resources/forms.html).

Corrected Claims 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 to, 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)
 - Quantity Billed
 - Prior Authorization Number (PAN)
 - Beginning DOS
 - Ending DOS or Discharge Date

Corrected Claims Filing



- Must reference original claim number on EOP within 120 days of adjudication date.
- Can be submitted electronically, through your clearinghouse/EDI software or through Superior's Provider Portal.
- Corrected or adjusted paper claims can also be submitted with a corrected claim form attached and sent to:

Superior HealthPlan

Attn: Claims

P.O. Box 3003

Farmington, MO 63640-3803

Claims Appeal Form



- A claims appeal is a request for reconsideration of a claim for anything other than medical necessity and/or any request that would require review of medical records to make a determination.
- Submit appeal within 120 days from the date of adjudication or denial.
 - Can be submitted electronically through Superior's Provider Portal or be submitted in writing.
- Claims appeals must be in writing and submitted to:
Superior HealthPlan
Attn: Claims Appeals
P.O. Box 3000
Farmington, MO 63640-3800

Appeals Documentation



- Examples of supporting documentation may include, but are not limited to:
 - A copy of Superior's 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, Texas Medicaid and Healthcare Partnership (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.

Billing Reminders



- All institutional claims must contain Present on Admission (POA) indicators and Superior will utilize the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
 - For per diem hospital payments, Superior utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.
- If a provider bills for procedure codes not identified as valid encounter services (identified specifically in the TMHP manual available at www.tmhp.com), the service will not pay as the services are considered to be informational only.

Billing Reminders - Authorizations



- When calling in to request an authorization, or to notify of a patient admission, please have available the Tax Identification Number (TIN) and NPI or LTSS ID number that will be used to bill your claim. If these numbers are not presented, your request will not be processed.
- The TIN/NPI used to request the authorization must match what is used to bill the claim, or the claim will deny.
- If the claim denies because it was billed with a different TIN/NPI combination than was authorized:
 - Verify that the TIN/NPI combination on the requested authorization matches what was billed.
 - If authorization and claim match, contact Provider Services.
 - If the claim was billed incorrectly, a corrected submission is required.

Billing Reminders - Authorizations



- Superior may issue authorizations that extend to multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under a single authorization.
- Bill must reflect the services under the authorization, including billing period.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Billing Reminders - Elective Delivery Policy



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- Superior will review all Neonatal Intensive Care Unit (NICU) admissions delivered prior to 39 weeks to determine whether the delivery was elective or medically necessary.
- If elective, Superior will deny the delivering physician and the facility (for both the delivery and the NICU).
- Superior will not deny other physicians (Anesthesia, Neonatology) or other facilities, if the infant is transferred due to medical necessity.
- If you have any questions regarding this policy, please contact Provider Services at 1-877-391-5921.

Billing Reminders - Obstetrics: Delivery Claim Requirements



- Delivery and Postpartum services must be billed separately for all products.
 - Improves our ability to report HEDIS quality outcomes for Postpartum Care.
- Corrected claims can be submitted within 120 days from the Explanation of Payment date for payment with the separate procedures codes.
- Superior will reimburse for 2 postpartum visits.

Reimbursable Codes	
Procedure Code	Code Description
59409	Vaginal Delivery Only
59612	
59514	C-Section Delivery Only
59620	
59430	Postpartum Outpatient Visit

Non-Reimbursable Codes	
59400	Vaginal Delivery including Postpartum Care
59410	
59510	C-Section Delivery & Postpartum Care
59615	
59610	Delivery after C-Section including Postpartum Care
59614	
59618	
59622	

Billing Reminders - Sterilization Form



- Providers must complete all sections of the Sterilization Consent Form as applicable.
 - All of the fields must be completed legibly in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form.
- Providers must resubmit denied consent forms with all required fields on the consent form completed legibly.
 - Resubmission with information indicated on a cover page or letter will not be accepted.
- Copies of the Sterilization Consent Form and Instructions can be found at Claim forms can be found at [SuperiorHealthPlan.com/providers/resources/forms.html](https://www.superiorhealthplan.com/providers/resources/forms.html).

Billing Reminders - Sports Physicals



- Superior will reimburse sports physicals for eligible members:
 - STAR, STAR Health and CHIP
 - 4-17 years of age (STAR and CHIP) and 4-18 years of age (STAR Health)
 - 1 per calendar year
- For prompt claim payment please follow these guidelines:
 - Diagnosis Code: Z02.5
 - CPT Codes: 99382-99385 or 99392-99395
- Reimbursement will be \$35.00 (there is no co-pay).

Clean Claim Requirements



- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS-1450/UB-04 or CMS 1500 forms.
 - NPI of a referring or ordering physician on a claim.
 - Appropriate two-digit location code must be listed.
 - Appropriate modifiers must be billed when applicable.
 - Taxonomy codes are required on encounter submissions for the referring or ordering physician.
 - ZZ qualifier for CMS 1500 or B3 qualifier for UB04 to indicate taxonomy.
- For additional information on the clean claim requirements, review the Superior HealthPlan STAR, STAR+PLUS, CHIP & STAR Health and STAR Kids Provider Manual at: www.SuperiorHealthPlan.com/providers/training-manuals.html.

Provider Training



- Depending on the type of services provided and billed for, Superior offers targeted billing presentations located on www.SuperiorHealthPlan.com/providers/training-manuals.html
 - Example: LTSS Billing Clinics
- There are also product-specific trainings available on STAR, STAR Health, STAR Kids and STAR+PLUS.
 - Access the schedule for face-to-face trainings or webinars at: www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html



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FQHC and RHC Billing Information

FQHC: Medicaid and CHIP Billing Procedures



- In order to receive the full PPS encounter rate, Federally Qualified Health Centers (FQHCs) must bill a T1015 procedure code and all applicable modifiers on the first service line, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge).
- CMS 1500 claim form.
- Bill using location 50.
- Bill with the billing provider's NPI in box 33a and billing provider's taxonomy in box 33b.
 - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission.
- Rendering Provider NPI/taxonomy is required for all services in box 24J.

FQHC: Medicaid and CHIP Billing Procedures



- Providers must bill with modifier “TH” for antepartum or postpartum care.
- Claims must be billed with the appropriate family planning diagnosis code for family planning services.
- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to the Prospective Payment System [PPS] encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
 - Please note: After-hours care and Long Acting Reversible Contraception (LARC) services will be paid in addition to the provider’s PPS encounter rate.

RHC: Medicaid and CHIP Billing Procedures



- The Rural Health Clinic (RHC) must bill a T1015 procedure code for general medical services.
- Exceptions claims (“other” health visits, e.g. Texas Health Steps and Family Planning) must be billed with appropriate or applicable CPT codes.
- A RHC is paid their full encounter rate directly from Superior.
- All services provided at an RHC and billed on a CMS 1500 form must be submitted using location POS code 72. This includes Texas Health Steps/Well visits and Family Planning Services.
- Services rendered at an RHC facility and billed with a location code other than 72 may be denied.
- Providers must use the appropriate modifiers in order to receive payment for services.



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Electronic Payments and Remittance

*Signing up for Electronic Funds
Transfer (EFT) and Retrieving
your Explanation of Payment
(EOP)*

EFT vs. Paper Check



- Providers will receive a paper check and EOP, unless they are signed up for EFT through PaySpan.
- Did you know?
 - A provider can submit claims by paper and still enroll for EFT/ERA.
 - A provider that prefers their EDI vendor can still go through their vendor to submit their claims.
 - We simply divert the return file (the ERA [835]) through PaySpan along with EFT.

PaySpan



- Superior has partnered with PaySpan to offer expanded claim payment services.
 - EFT
 - Online remittance advices (ERA's/EOPs)
 - Health Insurance Portability Accountability Act (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, contact PaySpan at 1-877-331-7154, or email ProviderSupport@PayspanHealth.com, or contact your local Account Manager or Provider Services at 1-877-391-5921.



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Superior HealthPlan Departments

Provider Services



- The Provider Services staff can help you with:
 - Answering questions on claim status and payments.
 - Assisting with claims appeals and corrections.
 - Finding Superior network providers.
 - Locating a member's Service Coordinator.
 - Locating your Account Manager.
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available, as HIPAA validation will occur.
- Available Monday - Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
 - Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS) and CHIP:
1-877-391-5921

Account Management



- Account Managers are here to assist you with:
 - Face-to-face orientations and Provider Portal training.
 - Office visits to review ongoing claim trends and quality performance reports.
- You can locate your Account Manager by using the field office map located at:
www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html



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Secure Provider Portal

Submitting Claims

Secure Provider Portal and Website



Superior is committed to providing you with all of the tools, resources and support you need to make your business transactions with Superior as smooth as possible. One of the most valuable tools is Superior's Secure Provider Portal. Once you are registered you get access to the full site.

- Secure Provider Portal Features:
 - View multiple TINs
 - Access daily patient lists from one screen
 - Manage Batch Claims for free
 - Simplify prior authorization process
 - Check patient care gaps
 - Streamline office operations
- Public Site:
 - Provider Directory with online lookup tool
 - Map of Account Managers by region
 - Newsletters, news posts, provider manuals, forms and helpful links

Registration



To register, visit: Provider.SuperiorHealthPlan.com

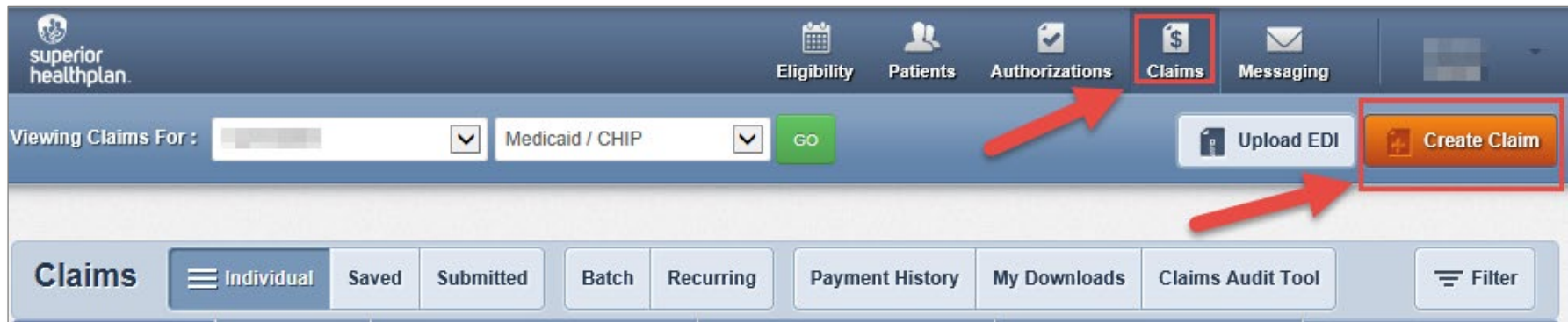
- A user account is required to access the **Provider Secure** area. If you do not have a user account, click **Create An Account** to complete the 4-step registration process.

A screenshot of a web browser showing the "Register Provider" form on the Superior HealthPlan website. The browser's address bar shows the URL "https://provider.superiorhealthplan.com/care". The page header includes the Superior HealthPlan logo and logos for "allwell™ from Superior HealthPlan" and "ambetter™ from Superior HealthPlan". A "CREATE ACCOUNT" button is visible in the top right. The main form is titled "Register Provider" and has a progress indicator showing the first step is active. The form is titled "Your Details" and includes a "Registration Type" section with three options: "Medical Provider Behavioral Provider" (selected), "Dental Provider Vision Provider", and "Foster Care Member, Medical Centerler, Foster Parent, DFPS Staff, RTC/CPA Staff, CASA Staff, SSCC". Below this are input fields for "Tax ID" (masked with "XXXXXXXXXX"), "First Name" (with a "First" placeholder), "Last Name" (with a "Last" placeholder), "Email" (with a "name@domain.com" placeholder), "Re-enter Email" (with a "name@domain.com" placeholder), "Password" (with a "Password" placeholder), and "Retype Password" (with a "Password" placeholder). A green "Next" button is at the bottom right of the form. At the bottom of the page, there are links for "Terms and Conditions", "Privacy Policy", and "Copyright © 2018, Centene Corporation".

Create Professional Claims



- From the **navigation menu**:
 - Select **Claims** at the top of the landing page.
 - Then select **Create Claim**.



Create Professional Claims



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

A screenshot of the Superior Healthplan web application interface. The top navigation bar includes the Superior Healthplan logo and icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar with a dropdown menu set to "Medicaid / CHIP" and a green "GO" button. To the right of the search bar is a search form with two input fields: "Member ID or Last Name" and "Birthdate" (with a placeholder "mm/dd/yyyy"). A red box highlights this search form. Below the search bar is a "Claims" section with a menu for "Individual" and buttons for "Saved", "Submitted", "Batch", "Recurring", "Payment History", "My Downloads", "Claims Audit Tool", and a "Filter" button.

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Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : Medicaid / CHIP

Member ID or Last Name Birthdate

X

Claims

Create Professional Claims



- Choose a Claim Type.
- Select Professional Claim.

The screenshot shows the Superior Healthplan Claims Management System interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, there is a search bar for "Viewing Claims For:" with a dropdown menu set to "Medicaid / CHIP" and a "GO" button. To the right of the search bar are buttons for "Upload EDI" and "Create Claim".

The main content area is titled "Choose Claim for" and contains a section "Choose a Claim Type". This section has two options:

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

Below the options, there is an update notice: "UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date."

General Information



- Enter **Patient Account Number**.
 - * = required

Note: This is the internal patient account number assigned by servicing provider.

Professional Claim for [REDACTED] Your Progress

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

[Next →](#)

* Required field

Patient's Account Number*	<input type="text"/>	26
Statement Dates*	From <input type="text" value="06/02/2016"/> To <input type="text" value="06/02/2016"/>	
Date of current Illness, Injury, Pregnancy (LMP)	Select Type... <input type="text"/> <input type="text" value="MM/DD/YYYY"/>	14.
Other Date	Select Type... <input type="text"/> <input type="text" value="MM/DD/YYYY"/>	15.

General Information



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.

Next →

Diagnosis Codes



THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance information.

← Back Next →

* Required field

ICD Version Indicator* ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* (Enter diagnosis code and click on Add button) 21.

R1310 -- DYSPHAGIA UNSPECIFIED	<input type="button" value="Remove X"/>
A170 -- TUBERCULOUS MENINGITIS	<input type="button" value="Remove X"/>
Z931 -- GASTROSTOMY STATUS	<input type="button" value="Remove X"/>

← Back Next →

Coordination of Benefits



- If applicable, select **Coordination of Benefits**.

* Required field

ICD Version Indicator* ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* (Enter diagnosis code and click on Add button) 21.

R1310 -- DYSPHAGIA UNSPECIFIED	<input type="button" value="Remove X"/>
A170 -- TUBERCULOUS MENINGITIS	<input type="button" value="Remove X"/>
Z931 -- GASTROSTOMY STATUS	<input type="button" value="Remove X"/>

Service Lines



- Enter maximum of 50 services lines.

THIS SECTION:
Service Lines
Enter maximum of 50 service lines.

← Back Next →

Total: \$1,048.15 * Required field Delete Save / Update

+ New Service Line

PROCEDURE / CHARGES

1: B4160 / \$408.00
2: B4035 / \$457.65
3: E0776 / \$37.50
4: B9002 / \$145.00

Now Viewing Line 1: B4160 / \$408.00

Dates of Service* From 04/20/2016 To 05/16/2016 24.a

Place of Service* 12 -- HOME 24.b

Procedure Code* B4160 24.d

Modifiers XX 24.e

Diagnosis Code(s)*
 R1310 - DYSPHAGIA UNSPECIFIED
 A170 - TUBERCULOUS MENINGITIS
 Z931 - GASTROSTOMY STATUS

Please enter the modifier and click the Add button.

Service Lines



Charges*	<input type="text" value="408.00"/>		<input type="button" value="24.f"/>
Units / Minutes / Days*	<input type="text" value="336.0"/>	Type * <input type="text" value="UN - Units"/> <input type="button" value="v"/>	<input type="button" value="24.g"/>
Family Planning	<input type="button" value="Yes"/> <input checked="" type="button" value="No"/>	EPSDT <input type="text" value="Select..."/> <input type="button" value="v"/>	<input type="button" value="24.h"/>
NDC	<input type="text" value="NDC"/>		<input type="button" value="NDC"/>
Supplemental Information	<input type="text" value="Supplemental Information"/>		

Referring Provider



- In the **Referring Provider** section, enter information as needed.

Referring Provider

NPI

Last Name or Organizational Name First Name

17.



Rendering Provider Section



- In the **Rendering Provider** section:
 - Enter your **NPI** number.
 - Select the provider info from the drop-down list associated with your location and taxonomy code.

Note: Only enter Rendering Provider information if not the same as billing provider information.

Rendering Provider

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

NPI	Tax ID	
<input type="text" value="XXXXXXXXXX"/>	<input type="text" value="XXXXXX66"/>	<input type="button" value="Find Provider"/>
Taxonomy #	Last Name or Organizational Name	First Name
<input type="text" value="XXXXXXXXXX"/>	<input type="text" value="Last Name"/>	<input type="text" value="First Name"/>
		<input type="button" value="Clear X"/>

Billing Provider Section



- In the **Billing Provider** section, enter the required information.

Billing Provider

Tax ID

Name* NPI Taxonomy

Address* City* State* Zip*

33.



Service Facility Location Section



- In the **Service Facility Location** section, enter information as needed. Click **Same as Billing Provider** to automatically copy the Billing Provider information into the service facility fields.
- Click the **Next** button.

Service Facility Location

[Same As Billing Provider](#)

Name	NPI		
<input type="text" value="Last Name"/>	<input type="text" value="XXXXXXXX"/>		
Address	City	State	Zip
<input type="text" value="XXXXXXXXXX"/>	<input type="text" value="XXXXXXXXXX"/>	<input type="text" value="Select..."/>	<input type="text" value="XXXXX"/>

32.



Attachment Section



THIS SECTION:
Attachments
Add attachments to the claim (5MB limit).

Supported types are .jpg, .tif, .pdf and .tiff

← Back If there are no attachments, click Next. Next →

Attachments

**Do NOT send password protected files. You must click ATTACH for each file being submitted.*

File* Browse... Attachment Type* ▼ Attach

There are no attached files.

← Back If there are no attachments, click Next. Next →

Review and 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.

Professional Claim for [redacted] Your Progress

THIS SECTION:
Review
Please review your claim and submit.

[← Back](#) [Submit →](#)

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

Claim Id: [redacted]0
Member Record Number: [redacted]
Member Claim Amount Paid: [redacted]
Patient's Account Number: [redacted]

General Info [Edit](#)
Statement From Date: 04/20/2016
Statement To Date: 05/16/2016
Date of current illness, injury, pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)

Diagnosis Codes
R1310 -- DYSPHAGIA UNSPECIFIED
A170 -- TUBERCULOUS MENINGITIS
Z931 -- GASTROSTOMY STATUS

Service Lines [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPSDT	NDC	Supplemental Info
1											

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Rendering Provider	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Billing Provider	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Service Facility Location

Attachments

[← Back](#) [Submit →](#)

Claim Submitted Successfully



- 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 Account Manager.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging, along with the user name Jerome Mullner. Below the navigation bar, there is a "Viewing Claims For:" field with a dropdown menu and a search box. To the right of the search box are buttons for "Upload EDI" and "Create Claim". The main content area displays a success message: "THIS SECTION. Success Congratulations! Your claim has been submitted Your confirmation ID is 500000635".

Eligibility Patients Authorizations Claims Messaging Jerome Mullner

Viewing Claims For : [Dropdown] [Search Box]

Upload EDI Create Claim

THIS SECTION.
Success Congratulations!

Your claim has been submitted
Your confirmation ID is 500000635

Checking Claims Status



- Claims status can be viewed on claims that have been sent EDI, Paper or Secure Provider Portal.

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/PAID ↓	CLAIM STATUS ↓
E000000001	Institutional	ABRYANA PEREZ	06/12/2016 - 06/12/2016	\$1,399.76 / \$450.00	(L)
E000000002	Institutional	DAVID HAMILTON	06/12/2016 - 06/12/2016	\$2,217.62 / \$75.00	(L)
E000000003	Institutional	VERONICA CASTELLO	06/12/2016 - 06/12/2016	\$480.04 / \$450.00	(L)
E000000004	Institutional	CATALIYA MUNZ	06/12/2016 - 06/12/2016	\$100.43 / \$18.00	(L)
E000000005	Institutional	ELISE CERVAJANTEZ	06/12/2016 - 06/12/2016	\$480.00 / \$75.00	(L)
E000000006	Institutional	ROSE BRASSHART	06/12/2016 - 06/12/2016	\$225.68 / \$48.14	(L)
E000000007	Institutional	ALEX TIPTON	06/12/2016 - 06/12/2016	\$100.42 / \$25.15	(L)

Checking Claims Status



A screenshot of the Superior Healthplan claims management interface. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search area with "Viewing Claims For:" followed by two dropdown menus (one showing "Medicaid / CHIP") and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. A secondary navigation bar below contains "Claims" and several tabs: "Individual", "Saved", "Submitted", "Batch", "Recurring", "Payment History", "My Downloads", "Claims Audit Tool", and "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, non-exclusive, 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 **Clear Claim Connection Page**

Claim Audit Tool



Clear Claim Connection™ - CENTENE - Windows Internet Explorer

https://centene.claimsxten.com/C3/Main.asp

File Edit View Favorites Tools Help

Clear Claim Connection™ - CENTENE

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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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. Any unauthorized use, disclosure or distribution is prohibited.

Internet 100%

Additional Features



- Eligibility and Service Coordinator information
- Primary Care Physicians Patient List
 - Pull list of patients and save as an Excel document or PDF.
 - See and sort by alerts including care gaps (missing Texas Health Steps checkups, well child checkups, etc.), Case Management, Disease Management or Special Needs.
 - See Emergency Room alerts. Providers can see when one of their patients has been to the ER within 90 days.

Eligible	HPR	Member Name ↑	Member ID / CHIP ID ↓	Member # ↓	Date of Birth ↑	Phone Number ↑	ALERTS	Texas Health Steps Last Visit Date ↑
👍		AGUIAR, JESSIE	528271647	68714477181	07/29/2008	(432) 448-8388		07/29/2015
👍		AGUIAR, JACQUELINE J	528271648	68714477182	06/25/2001	(432) 448-8388		07/29/2015
👍		AGUIAR, JESSIE	528284874	68714477183	04/02/1988	(432) 448-8388		07/29/2015
👍		AGUIAR, DALE W	686284890	68714477184	11/12/2010	(325) 574-8388		02/22/2016
👍		AGUIAR, JR, ROBERTO	627812224	68714477185	02/03/2014	(325) 574-8388		02/15/2016
👍		BENTLEY, ALEXANDER W	528238840	68714477186	01/11/2008	(325) 438-8247		None On File
👍	🌐	BORRERO, ELISE	707888746	68714477187	08/13/2015	(325) 762-7888		03/07/2016



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Questions and Answers

Thank you for attending!
