



Billing Clinic

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

Provider Training

Introductions & Agenda



- Verifying Eligibility
- Authorization Process
- Establishing Medical Necessity (After an Adverse Determination)
- Claims Submissions
- Electronic Funds Transfer
- Superior HealthPlan Departments
- Secure Provider Portal
- FQHC & RHC Billing Information



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Verifying Eligibility

*Correctly Identify a Member's
Medicaid Plan*

Verify Eligibility



- Texas Medicaid Benefit Card (TMBC)
 - TexMedConnect - http://www.TMHP.com/pages/edi/edi_textmedconnect.aspx.
- Superior Identification Card
- Superior Website: www.SuperiorHealthPlan.com.
- Contact Member Services:
 - STAR, CHIP: 1-800-783-5386
 - CHIP RSA: 1-800-820-5685
 - STAR Health: 1-866-912-6283
 - STAR+PLUS: 1-877-277-9772
 - STAR Kids: 1-844-590-4883
 - MRSA (Medicaid Rural Service Area): 1-877-644-4494
- 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)
 - Prescription information
 - Program eligibility
 - Superior contact information
- Copies of sample member ID cards can be found in the Superior Provider Manual.

This is where your name appears.

This is your Medicaid ID number.

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

Your Texas Benefits
Health and Human Services Commission

Medicaid ID Card

Member name:
Your name goes here

Member ID (Medicaid ID):
999999999

Issuer ID: (80840)
999999999

RxBIN: 001111
RxPCN: ADV
RxGRP: RX1234

Date card sent:
08/01/2011

Your Health Plan goes here:

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

Drug stores use these numbers.

This is the date your card was sent to you.

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

Call this number if you need help using this card.

This card does not guarantee eligibility. La tarjeta no garantiza la elegibilidad.

Need Help? ¿Necesita Ayuda?

1-800-252-8263

Questions about your doctor? Call your health plan. ¿Preguntas sobre su doctor? Llame su plan de salud.

www.YourTexasBenefits.com

TX-CA-0411

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

Go to this website to learn more about this card.



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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.
- Initiate authorizations five (5) working days in advance for non-emergency services.
- Escalate requests to the Medical Management Supervisors or Managers, if needed.
- If additional documentation is requested from Medical Management, submit by fax or through the Superior website.

www.SuperiorHealthPlan.com

Phone: 1-800-218-7508

Fax: 1-800-690-7030

Services Requiring Authorization



- The most current list of services requiring prior authorization are found on the Superior website under Provider Resources.

Superior HealthPlan requires that all services described on this list be authorized prior to the services being rendered. Requests should be submitted no less than 5 business days prior to the start of service. All services are subject to eligibility at the time of service and benefit limitations or exclusions.

Inpatient Hospitalization: Pre-scheduled, elective admissions must have authorization prior to admission. Fax the request along with clinical to 1-800-690-7030. Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, and all other inpatient facility type require notification by the close of the next business day. Phone notifications may be completed by contacting phone 1-855-594-6103 for all regions, except Medicaid RSA and CHIP RSA phone 877-804-7109. Fax notifications: Austin Region fax 877-650-6939; Corpus Christi Region fax 877-650-6940; Dallas Region fax 855-707-5480; El Paso Region fax 877-650-6941; Lubbock/Amarillo Region fax 866-865-4385; McAllen (Hidalgo) Region fax 877-212-6661; San Antonio Region fax 877-650-6942; Medicaid RSA and CHIP RSA Regions: fax 877-505-0823. Web notifications: www.superiorhealthplan.com .			
Non-Participating/Out of Network Providers: Request for services from a non-participating, out of network facility, provider, or vendor in any location requires authorization. Except in the case of emergent admissions. The notification process above should be followed.			
Services Requiring Authorization:			
Specialists Chiropractor Oral Surgeon* Plastic and Reconstructive Surgery* Podiatry* <i>*NOTE: Office visits do not require authorization; only procedures performed in any location require an authorization.</i> In Home/Outpatient Therapy/Rehabilitation Initial and re-evaluations require an authorization, and must be submitted by PCP or pertinent physician. Physician signature on treatment plan required. <u>Speech*, Occupational*, Physical*</u> <u>Pulmonary & Cardiac Rehab</u> <u>Cognitive Rehabilitation Therapy</u> <i>*NOTE: Therapy provided by an ECI provider as part of an ECI IFSP are excluded from authorization requirement</i> Other Services and Tests <u>DME over \$500 purchase price each item (enter link)</u> <u>Standardized DME List:</u> http://www.superiorhealthplan.com/files/2013/11/StandardizedDMEList_20131121.pdf Exception: Miscellaneous codes & over the limit items require an authorization. Incontinence Supplies ordered through the preferred DME provider do not require authorization. <u>Enteral Nutrition</u> <u>Genetic Testing</u> <u>Quantitative Testing for Drugs of Abuse</u> <u>Home Health/Skilled Nursing/Private-Duty Nursing</u> <u>Hearing Aids</u> <u>Nutritional Counseling</u> (authorization not required when performed as part of a THSteps exam or for ECI assessment) <u>OB ultrasounds</u> -limited to 3 ultrasounds for non-high risk pregnancy without authorization; no authorization required for high-risk pregnancy ultrasounds <u>Orthotics/Prosthetics</u> over \$500 purchase price each item <u>Allergen Immunotherapy Services</u> , unless services provided by an allergist or immunologist. Pain Management Services - All providers, regardless of specialty, require an authorization to perform pain management procedures except for the CPT codes listed below. These codes do not require prior authorization. <ul style="list-style-type: none"> • 62355 Remov Prev Implt Intrathecal/Epidural Cath • 62365 Remov Prev Implt Subq Reservoir/Pump • 62367 Elec Analys Spine Intus Pump • 62369 Elec Analys Anal Sp Inf Pmp W/Reprg&Fil • 63661 Remove Spine Eltrd Perq Aray • 63662 Remove Spine Eltrd Plate • 63688 Revis/Remov Implt Spinal Neurostim Pulse Gen • 62368 Elec Analys Programable Implt Pump; W/Reprogram • 62370 Elec Analys Anal Sp Inf Pmp W/MDreprg&Fil • 64585 Revise/Remove Neuroelectrode • 64595 Revis/Remov Peripheral Neurostim Pulse Gen All other pain management procedures not listed still require a prior authorization.	Transportation Air transport Non-emergent ambulance-including facility to facility transport Pharmaceuticals (Fax request to 1-866-683-5631) Botox, Viscosupplementation Injectable medications with miscellaneous billing codes Synagis All off-label chemotherapy requires preauthorization. Excludes: epogen/aranesp for ESRD members on dialysis Excludes: epogen/neupogen for oncology members. Excludes: chemotherapy J9000-J9999 prescribed by oncologist Surgical or Other Procedures <table> <tr> <td> Abortion Bariatric Surgery Blepharoplasty Dental Anesthesia Circumcision 1 year and older Hysterectomy Infertility Implantable devices including </td><td> Cochlear Implant Mammoplasty Otoplasty Rhinoplasty/Septoplasty Scar Revision Excision/scraping/having of lesions Treatment of Varicose Veins Vagus Nerve Stimulation </td></tr> </table> Transplant: All services for Transplant Evaluation and Transplant Procedures. Long Term Services & Support (LTSS) Personal Attendant Services (PAS) Day Activity & Health Services (DAHS) STAR+PLUS Waiver Services: Personal Attendant Services (PAS) Day Activity & Health Services (DAHS) Nursing Services (In home) Emergency Response Services (ERS) Home Delivered Meals (HDM) Minor Home Modifications (MHM) Assisted Living (AL) Transition Assistance Services (TAS) Adult Foster Care (AFC) Radiology (Contact NIA at 1-800-218-7508 opt 3 or visit www.radmd.com) Precertification through NIA, Inc. is required for outpatient diagnostic procedures: CT, CTA, MRI, MRA, PET <u>Cardiac imaging modalities (all products effective 2/1/14):</u> CCTA Stress Echo, Echocardiography (only for STAR+PLUS), and Nuclear Cardiology Vision (Contact TVHP at 1-877- 865-1977) Effective September 1, 2013, TVHP will assume the administration for ophthalmology medical and surgical services.	Abortion Bariatric Surgery Blepharoplasty Dental Anesthesia Circumcision 1 year and older Hysterectomy Infertility Implantable devices including	Cochlear Implant Mammoplasty Otoplasty Rhinoplasty/Septoplasty Scar Revision Excision/scraping/having of lesions Treatment of Varicose Veins Vagus Nerve Stimulation
Abortion Bariatric Surgery Blepharoplasty Dental Anesthesia Circumcision 1 year and older Hysterectomy Infertility Implantable devices including	Cochlear Implant Mammoplasty Otoplasty Rhinoplasty/Septoplasty Scar Revision Excision/scraping/having of lesions Treatment of Varicose Veins Vagus Nerve Stimulation		

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.

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 Prior Authorization form is located on the Superior website, under Provider Resources and then clicking the Forms page.
- Prior Authorizations can be submitted through the Secure Provider Portal.

REQUEST FOR PRIOR AUTHORIZATION		superior healthplan	
Date of Request* <input type="text"/> / <input type="text"/> / <input type="text"/>			
<small>*Required Items. Please write only in designated areas.</small>			
Member Information			
<input type="text"/> Member ID*		<input type="text"/> First Name	
<input type="text"/> / <input type="text"/> / <input type="text"/> Date of Birth*		<input type="text"/> Last Name	
Provider to Perform the Service			
<input type="text"/> NPI*		<input type="text"/> Contact Number*	
<input type="text"/> TPI*		<input type="text"/> Fax Number*	
<input type="text"/> Tax ID*			
<input type="text"/> Last Name, First Initial or Facility Name		<input type="text"/> Contact Name / Requestor	
Submitting / Referring / Performing Provider			
<input type="checkbox"/> *K in box if same as above.			
<input type="text"/> NPI*		<input type="text"/> Contact Number*	
<input type="text"/> Tax ID*		<input type="text"/> Fax Number*	
<input type="text"/> Last Name, First Initial or Facility Name		<input type="text"/> Contact Name / Requestor	
Requested Service			
Type of Service		Place of Service*	
<input type="checkbox"/> DME Rental <input type="checkbox"/> DME Purchase* <input type="checkbox"/> DME Incontinence Supply* <input type="checkbox"/> Home Health <input type="checkbox"/> SNV <input type="checkbox"/> PDN <input type="checkbox"/> Therapy <input type="checkbox"/> Genetic Testing Type: <input type="text"/> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Outpatient Services <input type="checkbox"/> Office Visit <input type="checkbox"/> Rehab <input type="checkbox"/> Evaluations <input type="checkbox"/> Re-Evaluations <input type="checkbox"/> Non-Emergent Transportation <input type="checkbox"/> Inpatient <input type="checkbox"/> Other <input type="text"/>		<input type="checkbox"/> PAS <input type="checkbox"/> DAHS <input type="checkbox"/> ERS <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Med Box Refills <input type="checkbox"/> Other <input type="text"/>	
		<input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital / ASC Gen <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Outpatient Rehab <input type="checkbox"/> Inpatient <input type="checkbox"/> Other <input type="text"/>	
<small>*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.</small>			
Clinical Review			
Procedure Codes		Service Description	
<input type="text"/> Procedure code / CPT, HCPCS* modifier		<input type="text"/>	
<input type="text"/> Procedure code / CPT, HCPCS* modifier			
<input type="text"/> Procedure code / CPT, HCPCS* modifier			
Diagnosis		Start date*	
<input type="text"/> Referring Diagnosis Code*		<input type="text"/> End date*	
<input type="text"/> Referring Diagnosis Code		<input type="text"/> Units / Visits* X	
<input type="checkbox"/> *K indicates clinicals or plan of care		<input type="text"/> Day	
		<input type="text"/> Week	
		<input type="text"/> Month	
Contact Information			
Fax Numbers:		<input type="checkbox"/> Urgent Request - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.	
LTSS Bear: 1-866-224-8254		<small>Please Note: Urgent is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to require medical treatment evaluation or treatment within 24 hours to prevent serious deterioration of the member's condition or health.</small>	
LTSS Nurses: 1-866-703-0903			
Admissions: 1-888-886-0170			
Referrals: 1-800-690-7030			
Hotline: 1-800-218-7508			
Outpatient CHIP Requests Only: 1-844-310-5517		Signature of Requesting Physician (required)	
Discharge Planning: 1-844-495-2361		<input type="text"/>	
<small>Superior requires services be approved before the service is rendered. Please refer to www.SuperiorHealthPlan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.</small>			
For Office Use Only			
		Authorization Number: <input type="text"/>	
		Units: <input type="text"/>	
		Dates Authorized: <input type="text"/>	

SHP_2013218

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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.



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Establishing Medical Necessity

After an Adverse Determination

Medical Management Denials



- Adverse Determination (Denial) - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
- Type of Denial
 - Administrative Denials (non-clinical reasons)
 - Member ineligibility; and/or
 - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by the State; and/or
 - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by the State (Non-covered Benefit).
 - No prior authorization
 - Late notification
 - Alberto N. missing information denial
 - Medical Necessity
 - Medical director or appropriate practitioner reviewer may make an adverse determination (organization determination) to deny, terminate or reduce services when insufficient clinical information is received to determine medical necessity for requested service(s).

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 or fair hearing rights fully explained.
- Provider may request an appeal in writing an appeal on behalf of member, if authorized to do so.
 - Mail: Superior HealthPlan
Attn: Appeal Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
 - Fax: 1-866-918-2266
- For questions, providers may call 1-877-398-9461 / TTY: 1-800-735-2989.

Appealing Medical Management Denials



- Authorized representatives of members acting on their behalf, may appeal adverse determinations regarding their care and service (designation of a member's authorized representative must be submitted in writing).
- Types of Medical Necessity Appeals:
 - Level 1: Internal/standard appeal (appeal to Superior HealthPlan)
 - Level 2: External appeal (appealing to a third party)
 - CHIP = IRO (independent review organization)
 - STAR/STAR+PLUS/STAR Health/STAR Kids = FH (Fair Hearing – HHSC)
 - Claims: Medical necessity appeals only (*Note: Administrative denials only have complaint rights*).
 - Appeals must be submitted to Superior within 120 days from the date of the last denial.

Appeal Timeframe by Product



Medicaid

- Provider or member has:
 - 30 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal for STAR, STAR+PLUS, STAR Health and STAR Kids.
 - 60 days for MMP
 - 90 days for CHIP
 - 180 days for Ambetter
 - 90 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 one (1) working day of appeal request.
 - All other expedited appeals are completed within three (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: Compliant 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: Compliant Department
1-866-683-5369
 - Online:
<https://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 **Filing Provider Complaints:**
<https://www.SuperiorHealthPlan.com/providers/resources/complaint-procedures.html>

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, 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

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



**Referring
Provider: [C]**

17 Name of
the referring
provider and

17b NPI

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

1. MEDICARE ☐ **2. MEDICAID** ☐ **3. TRICARE** ☐ **4. CHAMPVA** ☐ **5. GROUP HEALTH PLAN** ☐ **6. FED. EMP. BENEFIT PLAN** ☐ **7. OTHER** ☐

8. PATIENT'S NAME (Last Name, First Name, Middle Initial) _____

9. PATIENT'S ADDRESS (No. Street) _____

10. CITY _____ **11. STATE** _____ **12. ZIP CODE** _____

13. PATIENT'S BIRTH DATE MM/DD/YY _____ **14. SEX** ☐ M ☐ F ☐ U

15. PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other _____

16. INSURED'S NAME (Last Name, First Name, Middle Initial) _____

17. INSURED'S ADDRESS (No. Street) _____

18. CITY _____ **19. STATE** _____ **20. ZIP CODE** _____

21. INSURED'S POLICY OR GROUP NUMBER _____

22. INSURED'S DATE OF BIRTH MM/DD/YY _____ **23. SEX** ☐ M ☐ F ☐ U

24. OTHER CLAIM ID (Designated by NUCC) _____

25. INSURANCE PLAN NAME OR PROGRAM NAME _____

26. CLAIM CODES (Designated by NUCC) _____

27. THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO (If yes, complete items 8, 9a, and 10a)

28. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE _____ **29. AUTHORIZED PERSON'S SIGNATURE** _____

30. DATE OF CURRENT ILLNESS/INJURY - WHEN DID IT BEGIN? MM/DD/YY _____ **31. OTHER DATE** MM/DD/YY _____

32. NAME OF REFERRING PROVIDER OR OTHER SOURCE _____ **33. NPI** _____

34. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) _____

35. DESCRIPTION OF NATURE OF ILLNESS OR INJURY (Reference to service line #s) (40) _____

36. DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY **37. PLACE OF SERVICE** (EMG) _____ **38. PROCEDURE, SERVICE, OR SUPPLY** (CPT/HCPCS) _____ **39. DIAGNOSIS** (ICD-9-CM) _____

40. FEDERAL TAX ID NUMBER SSN EIN _____ **41. PATIENT'S ACCOUNT NO.** _____ **42. ACCEPT ASSIGNMENT?** ☐ YES ☐ NO **43. TOTAL CHARGE** \$ _____ **44. AMOUNT PAID** \$ _____ **45. REMIT FOR NUCC USE** _____

46. SIGNATURE OF PHYSICIAN OR SUPPLIER _____ **47. SERVICE FACILITY LOCATION INFORMATION** _____ **48. BILLING PROVIDER INFO & PH #** _____

49. NPI _____ **50. NPI** _____

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-09/08-1107 FORM (Rev. 12)

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/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	NUMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
M317TXE44842			000209200	INVALID			76	20130710	
M317TXE44820			000164200	ACCEPT				20131109	
M317TXE44819			000193510	INVALID			76	20130704	
M317TXE44858			001141694	ACCEPT				20131108	
M317TXE44868			000759989	ACCEPT				20131108	
M317TXE44826			000310600	ACCEPT				20131108	
M317TXE44814			000116222	ACCEPT				20131108	
M317TXE44828			000405752	ACCEPT				20131103	
M317TXE44835			000112728	ACCEPT				20131108	
M317TXE44824			000113004	ACCEPT				20131109	
M317TXE44829			000984375	ACCEPT				20131024	
M317TXE44816			000103600	INVALID			09	20131105	
M317TXE44821			000999375	ACCEPT				20131106	
M317TXE44843			001183267	ACCEPT				20131101	
M317TXE44815			000103600	ACCEPT				20131107	
M317TXE44817			000011500	INVALID			76	20121003	
M317TXE44825			000207700	ACCEPT				20131107	

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]

Patient Name: [REDACTED]

Control Number: N12STXP02973

Service Provider: [REDACTED]

Group: [REDACTED]

ID: [REDACTED]

Account: AYE09245

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 on our website.
 - For Superior electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **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, 2017, 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, 2019, 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 & 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.
 - Find claims forms under Provider Resources>Forms at www.SuperiorHealthPlan.com.

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 DOS
 - Ending DOS or Discharge Date

Corrected Claims Filing



- Must reference original claim number on EOP within 120 days of adjudication paid 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, an appeal can be made:
 - 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.
- One claim per authorization period.

Billing Reminders - Elective Delivery Policy



- 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 two (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 itself completed legibly.
 - Resubmission with information indicated on a cover page or letter will not be accepted.
- Copies of the Sterilization Consent Form and instructions (English/Spanish) can be found at www.SuperiorHealthPlan.com.
 - Provider Resources > Forms > Member Management.

Billing Reminders - Sports Physicals



- Superior will reimburse sports physicals for eligible members:
 - STAR, STAR Health and CHIP members only
 - Ages 4-17 (STAR and CHIP) and ages 4-18 (STAR Health)
 - One (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).

Billing Reminders - STAR+PLUS



- STAR+PLUS Service Coordination team prior authorization phone number: 1-877-277-9772
- The prior authorization number starts with “OP” followed by 10 digits (Ex: OP2279143510).
- If a provider bills less than the contracted amount, the claim will pay the lesser of the amounts.
- In the Diagnosis Codes section, enter **Diagnosis Code 1** (required).
- In the Service Line Number 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.
- Providers will receive a Notification of Authorization letter that will indicate if the member is Waiver or Non-Waiver.
 - Review the LTSS Billing Matrix found in the STAR+PLUS Handbook on the DADS website for additional information.
- Include rendering provider information.

Billing Reminders



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

Provider Training



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



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FQHC & RHC Billing Information

FQHC: Medicaid & CHIP Billing Procedures



- The Federally Qualified Health Center (FQHC) must bill a T1015 procedure code and applicable modifier for general medical services.
- Exception claims (“other” health visits, e.g. well-child, vision care and mental health) must be billed with appropriate or applicable CPT codes.
- An FQHC is paid their full encounter rate for medical services directly from Superior.
- An FQHC is paid a contracted rate by the CHIP Dental MCO for dental services.
- All Optometry provider claims should be billed directly to Envolve Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatico.

RHC: Medicaid 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.
- An 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 a 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.
- All Optometry provider claims should be billed directly to Envolve Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatico.

RHC: CHIP Billing Procedures



- The RHC must bill a T1015 procedure code for general medical services.
- Well Child visits must be billed with appropriate or applicable CPT codes.
- An 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 a location, POS code 72. This includes Texas Health Steps/Well visits, and Family Planning Services.
- Services provided at an RHC 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.

RHC: CHIP Billing Procedures



- An RHC is paid a contracted rate by the CHIP Dental MCO for dental services.
- All Optometry provider claims should be billed directly to Envision Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatenco.

Note: CHIP coverage is secondary when coordinating benefits with all other insurance coverage. Coverage provided under CHIP will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been applied.



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Electronic Funds Transfer (EFT)

*Signing up for EFT and
Retrieving your EOPs*

Outgoing



- Providers receive the information back from Superior in two (2) ways:
 - On Paper: EOP (Emdeon)
 - Electronically: ERA/835- Electronic Remittance Advice
 - PaySpan (EFT and ERA)
 - Providers may be set up to receive through their Clearinghouse/Trading Partners (and still receive a paper check).

EFT vs. Paper Check



- Providers will receive a paper check 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 1-877-331-7154, or email ProvidersSupport@PayspanHealth.com or contact your local Account Manager or Provider Services at 1-877-391-5921.



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Superior HealthPlan Departments

Member Services



- The Member Services staff can help you with:
 - Verifying eligibility
 - Reviewing member benefits
 - Assisting with non-compliant members
 - Helping to find additional local community resources
 - Answering questions
 - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:

– STAR/CHIP/Perinate:	1-800-783-5386
– MRSA:	1-877-644-4494
– STAR+PLUS:	1-866-516-4501
– STAR Kids:	1-844-590-4883
– STAR Health:	1-866-912-6283
– CHIP RSA:	1-800-820-5685

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 your Service Coordinator and 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:

– STAR/CHIP/STAR+PLUS/STAR Kids:	1-877-391-5921
– MRSA:	1-877-644-4494
– CHIP RSA:	1-800-522-8923

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 also find a map that can assist you with identifying the field office you can call to get in touch with your Account Manager on our website.
 - <https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html>

Network Development



- Providers who offer services to our members should be contracted with Superior.
- To get contracted, providers must contact our Network Development department and request a contract.
 - By Phone: 1-877-391-5921.
 - By Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com
 - By Website: www.SuperiorHealthPlan.com



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Secure Provider Portal

Submitting Claims

Secure Provider Portal & Website



Superior is committed to providing you with all of the tools, resources and support you need to be make your business transactions with Superior as smooth as possible. One of the most valuable tools is our 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, new 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 the Provider Secure website interface. The header includes logos for superior healthplan, superior healthplan Advantage, and ambetter from Superior HealthPlan, along with a "Features" link and a "CREATE ACCOUNT" button. The main content area is titled "The Tools You Need Now!" and lists three services: "Check Eligibility" (with a thumbs up icon), "Authorize Services" (with a checkmark icon), and "Manage Claims" (with a dollar sign icon). A "Login" form is overlaid on the right, containing fields for "User Name (Email)" and "Password", a "Login" button, and a link for "Forgot Password / Unlock Account". Below the login form, there is a section titled "Need To Create An Account?" with a "Create An Account" button and a "How to Register" section explaining the registration process.

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 several menu items: Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, there is a section for "Viewing Claims For:" with a dropdown menu set to "Medicaid / CHIP" and a green "GO" button. To the right of this, there is a search area with two input fields: "Member ID or Last Name" and "Birthdate". The "Member ID or Last Name" field has a red 'X' icon to its left. The "Birthdate" field has a placeholder "mm/dd/yyyy". An orange "Find" button is located to the right of the "Birthdate" field. This entire search area is highlighted with a red rectangular border. Below the search area, there is a row of buttons: "Claims", "Individual" (with a hamburger menu icon), "Saved", "Submitted", "Batch", "Recurring", "Payment History", "My Downloads", "Claims Audit Tool", and a "Filter" button with a hamburger menu icon.

Create Professional Claims



- Choose a Claim Type.
- Select Professional Claim.

The screenshot shows the Superior Healthplan Claims Management System interface. At the top is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a header section with a "Viewing Claims For:" dropdown menu, a "Medicaid / CHIP" dropdown menu, and a "GO" button. To the right of these are "Upload EDI" and "Create Claim" buttons. The main content area is titled "Choose Claim for" and "Choose a Claim Type". It features two large green buttons: "CMS 1500 Professional Claim →" and "CMS UB-04 Institutional Claim →". At the bottom, there is an "UPDATE:" notice regarding ICD-10 regulations effective October 1, 2015.

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Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : Medicaid / CHIP

Choose Claim for

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

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

Your Progress

THIS SECTION:

General Info

Information about the dates of the claim.

Next →

* Required field

Patient's Account Number*

26

Statement Dates*

From

06/02/2016

To

06/02/2016

Date of current illness,
Injury, Pregnancy (LMP)

Select Type...

▼

MM/DD/YYYY

14.

Other Date

Select Type...

▼

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*

XXXX e.g. V871

Add

(Enter diagnosis code and click on Add button)

21.

R1310 -- DYSPHAGIA UNSPECIFIED

Remove X

A170 -- TUBERCULOUS MENINGITIS

Remove X

Z931 -- GASTROSTOMY STATUS

Remove X

Add Coordination of Benefits

← 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 To 24.a

Place of Service* 24.b

Procedure Code* 24.d

Modifiers Add 24.e

Please enter the modifier and click the Add button.

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

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="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="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

Find Provider

Last Name or Organizational Name

Find Provider

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
XXXXXXXXXX

Tax ID
[redacted] 66

Find Provider

Taxonomy #
XXXXXXXXXX

Last Name or Organizational Name
Last Name

First Name
First Name

Clear X

24.j

Billing Provider Section



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

Billing Provider

Tax ID

Name*

NPI

Taxonomy

Address*

City*

State*

Texas

▼

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

Last Name

NPI

XXXXXXXXXX

Address

XXXXXXXXXX

City

XXXXXXXXXX

State

Select...

Zip

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 & 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 [progress bar]

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]
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	04/20/2016	05/16/2016	IC	99000	R1310	100.00	1.00				

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	[redacted]	[redacted]	[redacted]		
Rendering Provider	[redacted]	[redacted]	[redacted]		
Billing Provider	[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 Mulliner". Below the navigation bar, there is a section for "Viewing Claims For:" with a dropdown menu and a "Create Claim" button. The main content area displays a "Success" message with the text "Congratulations!" and "Your claim has been submitted". Below this, it states "Your confirmation ID is 500000635".

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.

superior healthplan.					
Eligibility Patients Authorizations Claims Messaging					
Viewing Claims For:		Medicaid / CHIP	GO	Upload EDI	Create Claim
Claims					
Individual Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool Filter					
CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
C010467402	Institutional	ABRIANA PEREZ	06/12/2016 - 06/12/2016	\$1,099.75 / \$450.00	(L)
C010467403	Institutional	DAVID HAMILTON	06/12/2016 - 06/12/2016	\$2,217.82 / \$75.00	(L)
C010467402	Institutional	VERONICA CASTILLO	06/12/2016 - 06/12/2016	\$448.94 / \$450.00	(L)
C010467402	Institutional	CATALITA MUNIZ	06/12/2016 - 06/12/2016	\$198.43 / \$15.00	(L)
C010467404	Institutional	ELVIS CERVANTES	06/12/2016 - 06/12/2016	\$450.00 / \$75.00	(L)
C010467409	Institutional	ROSE BRISSET	06/12/2016 - 06/12/2016	\$228.00 / \$45.14	(L)
C010467402	Institutional	ALEX TIPPON	06/12/2016 - 06/12/2016	\$198.43 / \$25.15	(L)

Checking Claims Status

The screenshot shows the "Viewing Claims For" section of the Superior Healthplan portal. It includes a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, there are dropdown menus for "Viewing Claims For:" (set to "All Claims") and "Medicaid / CHIP" (set to "Medicaid / CHIP"), followed by a green "GO" button. To the right are buttons for "Upload EDI" and "Create Claim". A secondary navigation bar contains tabs for "Claims", "Individual", "Saved", "Submitted", "Batch", "Recurring", "Payment History", "My Downloads", "Claims Audit Tool", and a "Filter" button. The "Claims Audit Tool" tab is currently selected.

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 **Clear Claim Connection Page**

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 >>

Review Claim Audit Results

Clear

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.

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Viewing Patients For :			Medicaid / CHIP	GO	Find Patient			
Patient List as of 06/19/2016					Download	Filter		
Eligible	HPR	Member Name ↑	Member ID / CHIP ID ↑	Member # ↑	Date of Birth ↑	Phone Number ↑	ALERTS	Texas Health Steps Last Visit Date ↑
✓		AGUILAR, JOEL	628271647	00104477161	01/16/2008	(432) 448-8500		07/29/2015
✓		AGUILAR, JOSELINE J	628271648	00104477162	06/25/2001	(432) 448-8500		07/29/2015
✓		AGUILAR, JESUS	628271649	00104477163	04/02/1988	(432) 448-8500		07/29/2015
✓		AGUILAR, DAVID W	600384550	00347602801	11/12/2010	(325) 574-8300		02/22/2016
✓		AGUILAR, JOSEPH	628271650	00104477164	02/03/2014	(325) 574-8300		02/15/2016
✓		BENTLEY, ALAN W	628271640	00104477160	01/11/2008	(325) 438-6247		None On File
✓	⊕	BORRERO, ELISE	757080740	00347602802	08/13/2015	(325) 762-7888		03/07/2016



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Questions & Answers

Thank you for attending!
