Superior's Secure Provider Portal

Provider Training

Introductions and Agenda

- Secure Provider Portal Highlights
- Secure Provider Portal Registration
- Eligibility
- Patient List
- Authorizations
- Claims
- Secure Messages
- User Management
- Provider/Practitioner Info Management
- Questions and Answers

Secure Provider Portal Highlights

Secure Provider Portal Highlights

- View multiple Tax Identification Numbers (TINs):
  - 1 point of entry allows for quick and easy access to Superior member information for multiple TINs/practices.
- Access daily patient lists from 1 screen:
  - 1 concise view allows Primary Care Providers (PCPs) to scan patient lists for details, such as Superior member eligibility and care gaps.
- Manage batch claims for free:
  - Submit and manage claims, including batch, and view detailed Electronic Funds Transfer (EFT) payment history.

Secure Provider Portal Highlights

- Simplify prior authorization process:
  - Submit prior authorization requests using the “Smart Sheets” feature, with prompts for required clinical information.

Utilize additional features to streamline office operations:

- View patient demographics and history.
- Use the secure messaging feature to communicate with Superior.
- Update provider demographics.

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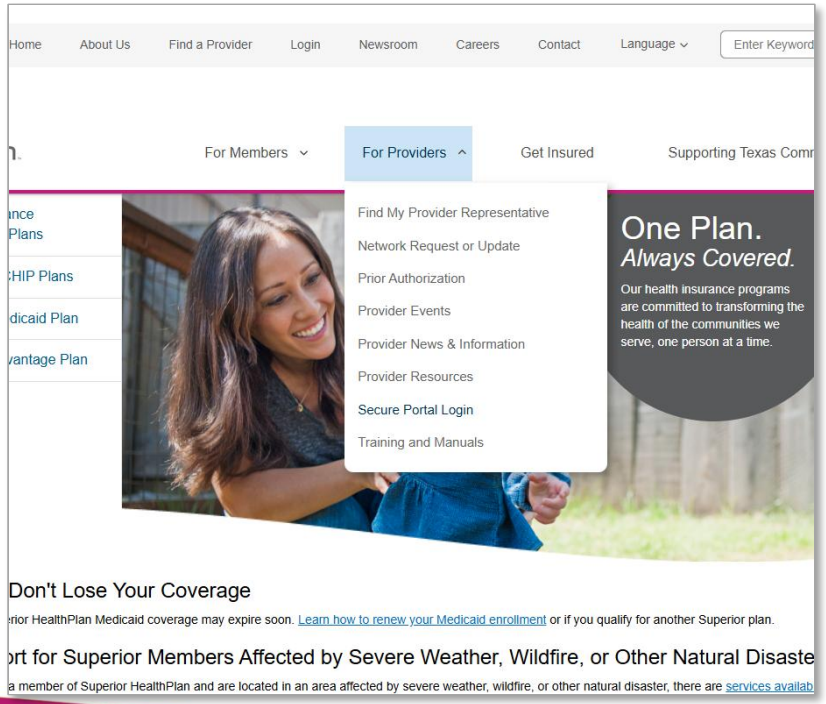
Secure Provider Portal Registration

Registration

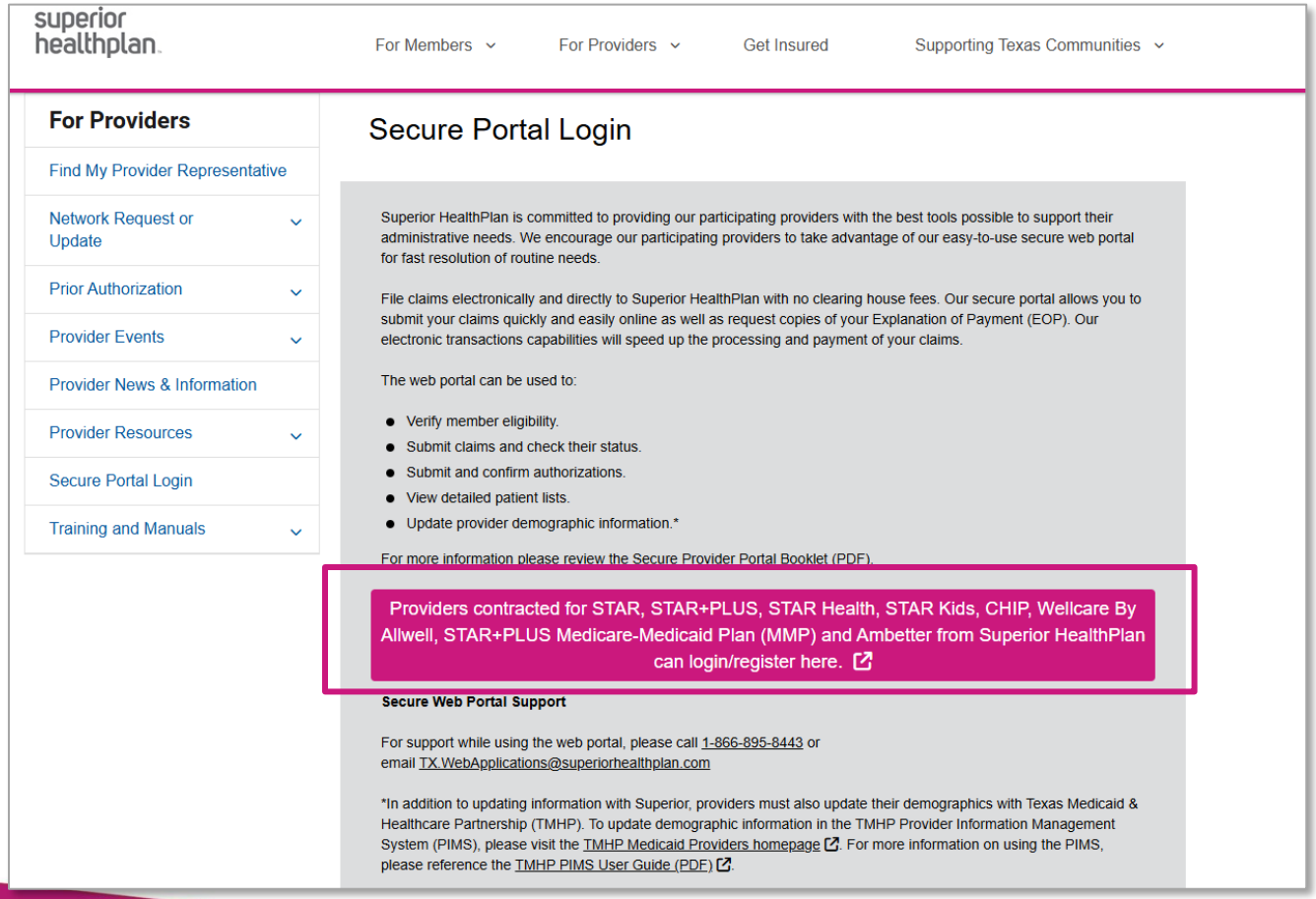
- Navigate to SuperiorHealthPlan.com and hover over **For Providers**. Click on **Secure Portal Login** to register.

Please note: A user account is required to access Superior's Secure Provider Portal.



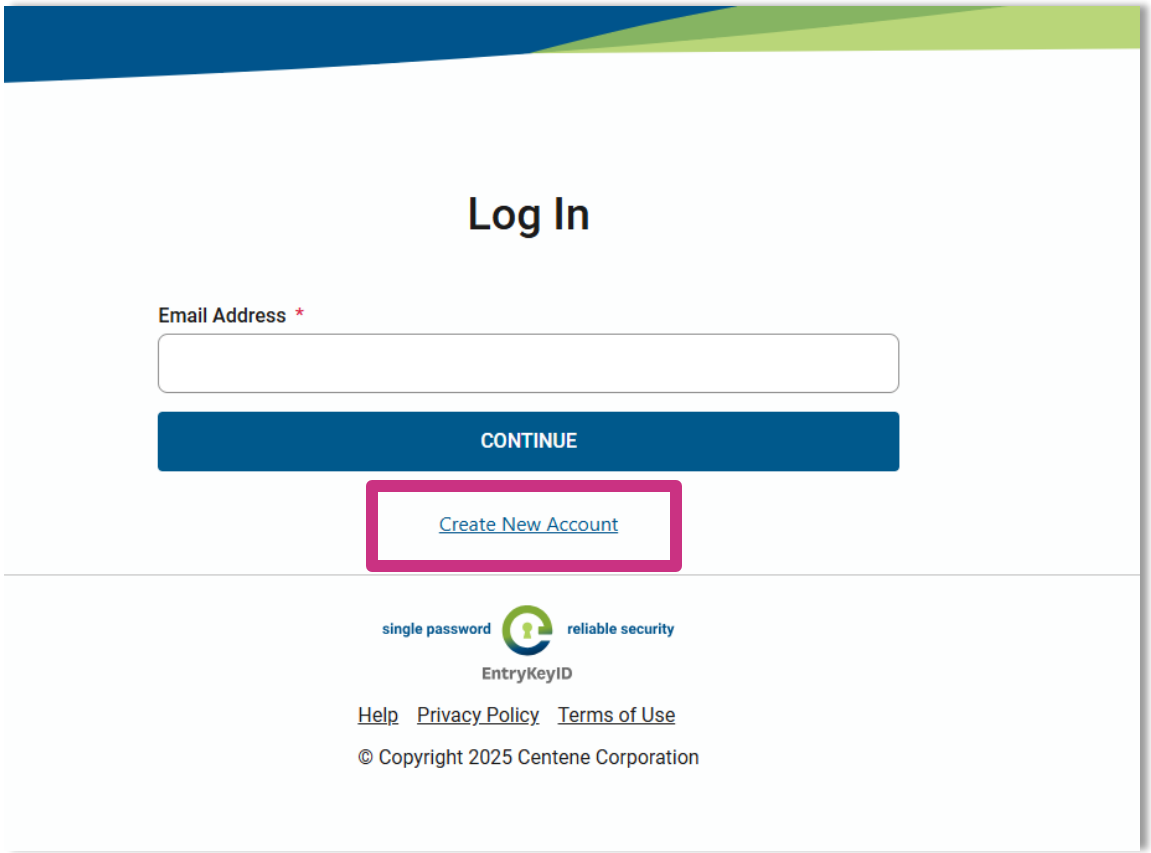
Registration

Click on the pink button that reads **Providers contracted for STAR...** to proceed to the Log In screen.



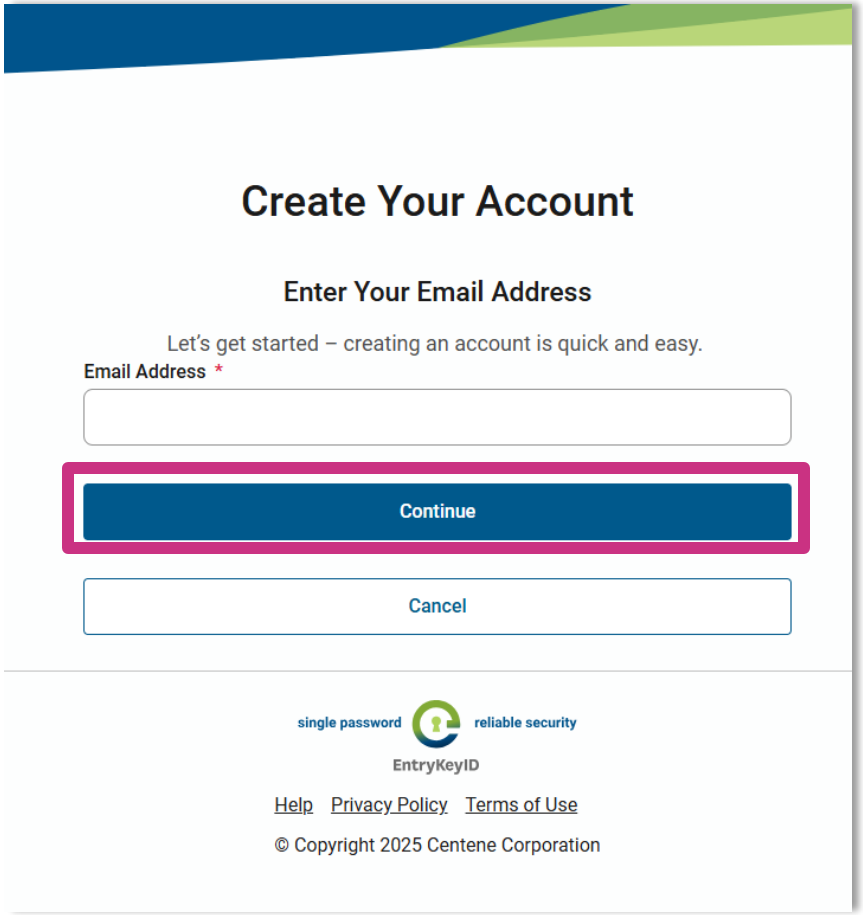
Registration

Select **Create New Account** to begin registering.



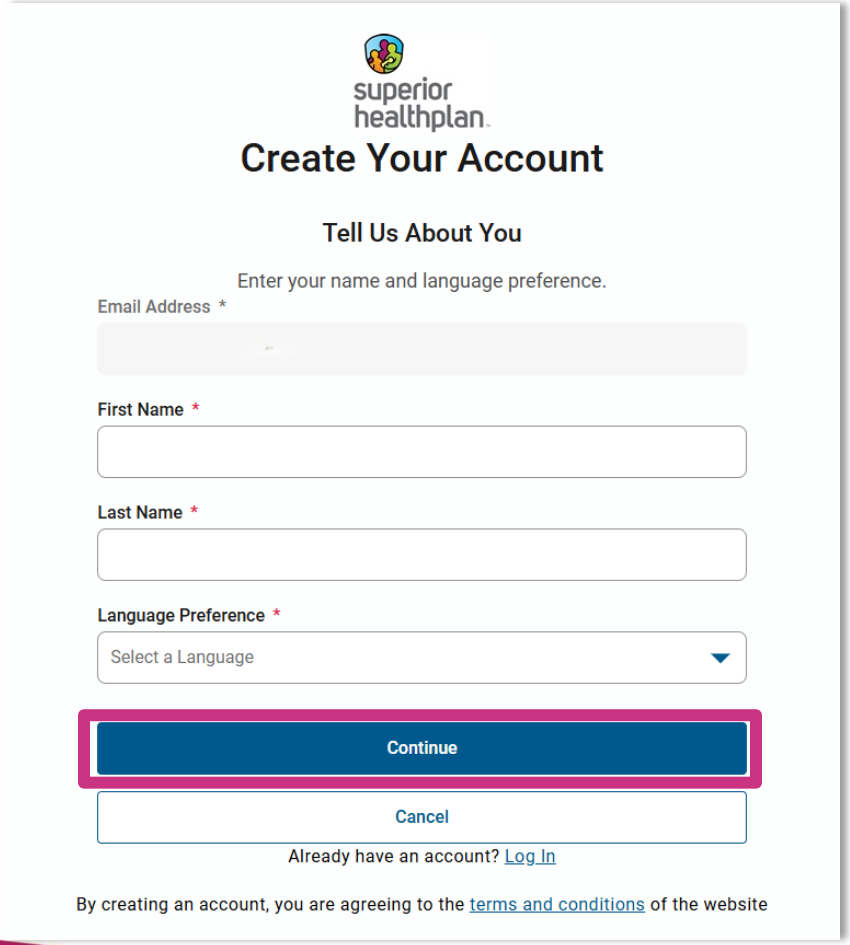
Registration

Enter your Email Address and click **Continue** to begin registering.



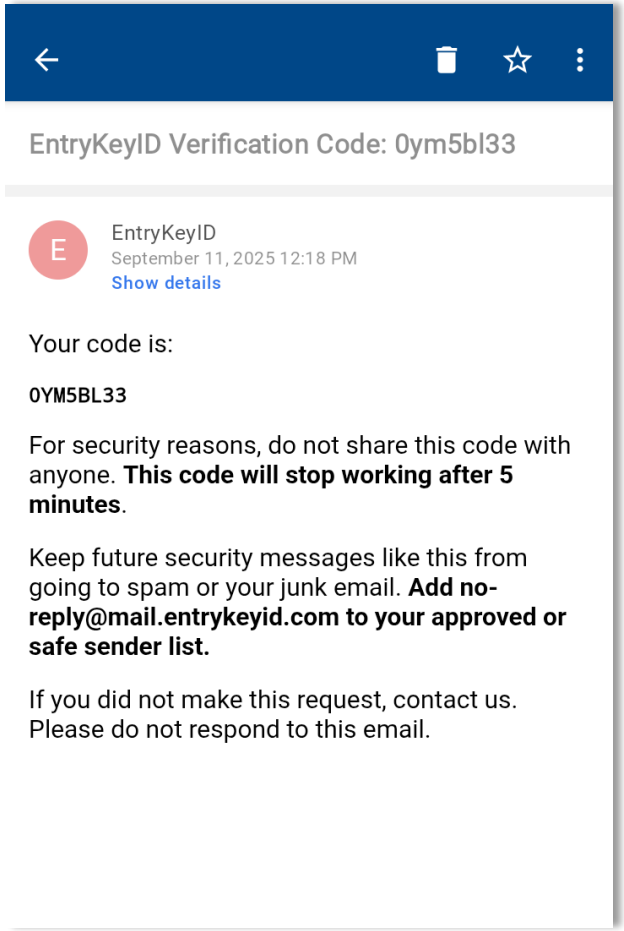
Registration

Complete the registration form and click **Continue**.



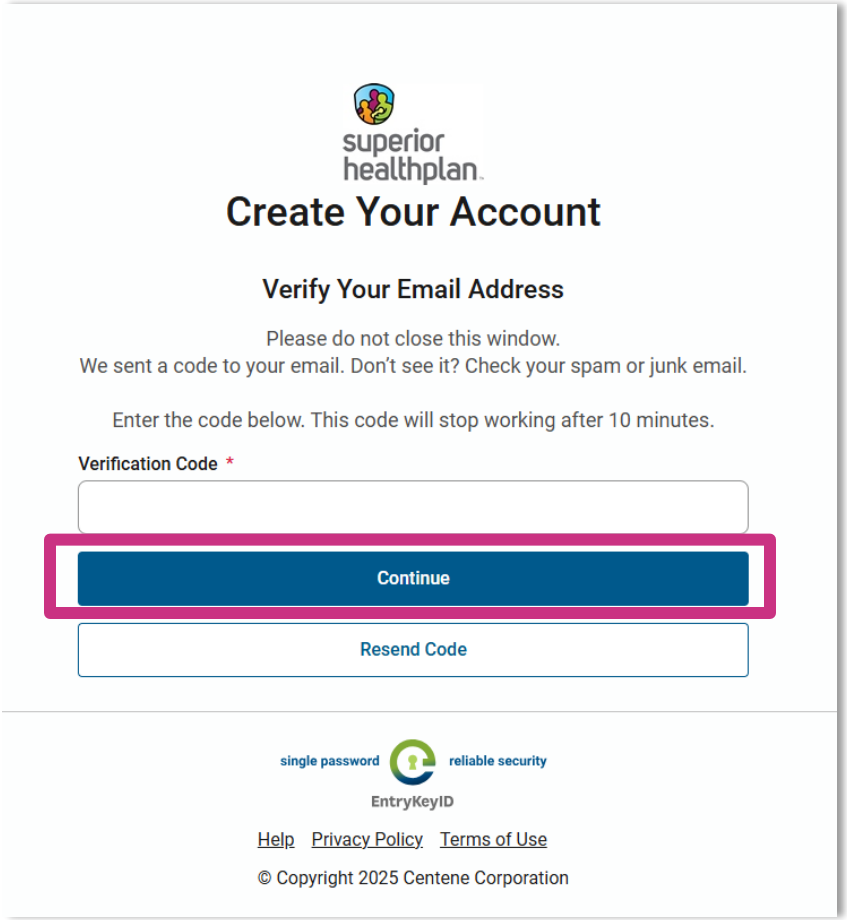
Registration

A Verification Code email will automatically be sent to the email address provided during registration.



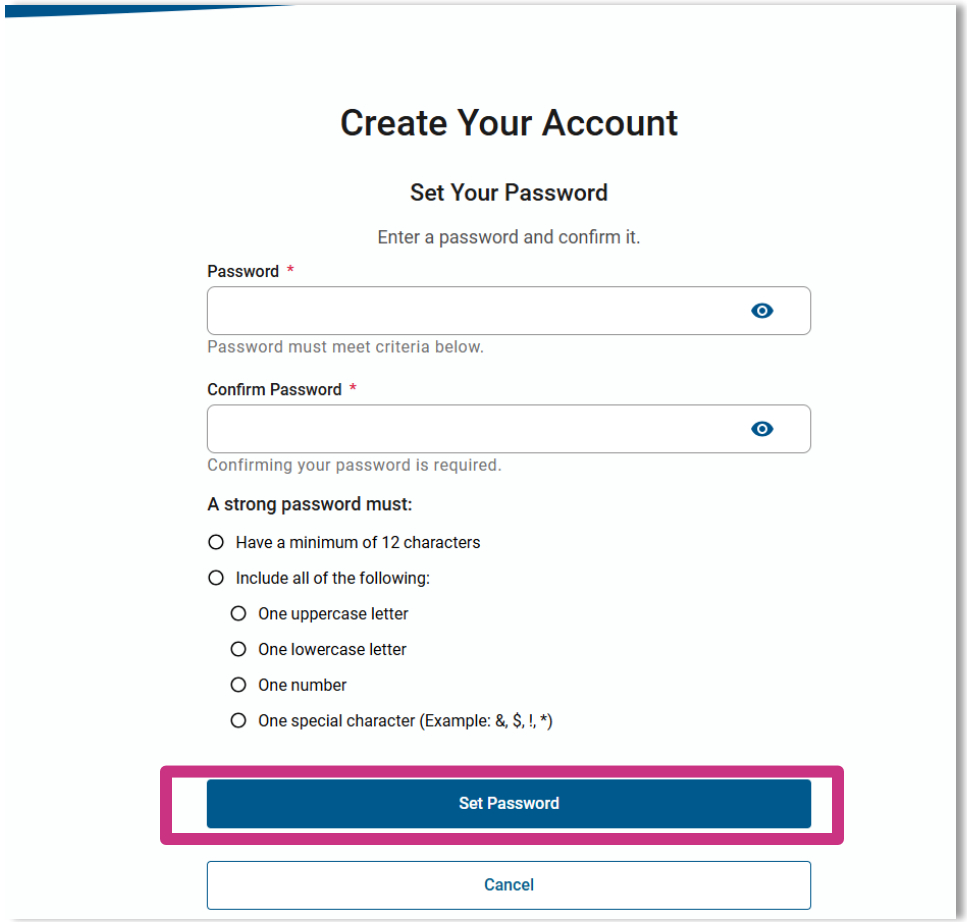
Registration

Enter the Verification Code you received in your email and click **Continue**.



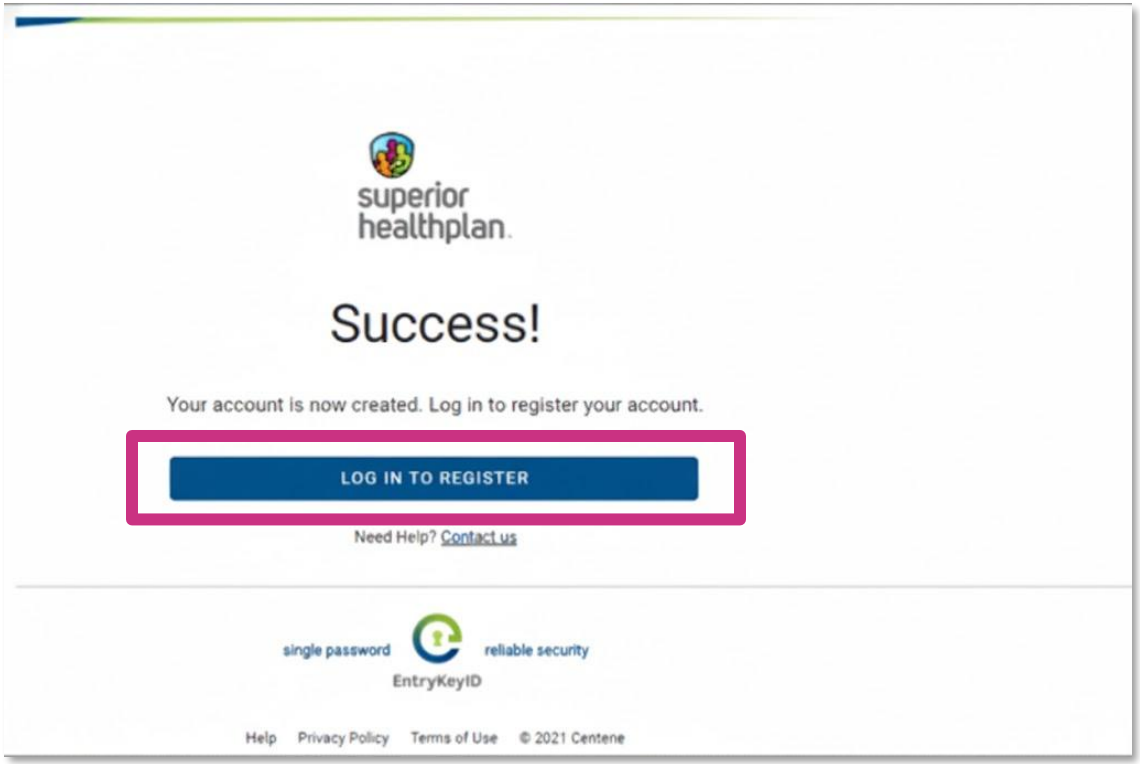
Registration

Enter a Password and confirm it and click **Set Password**.



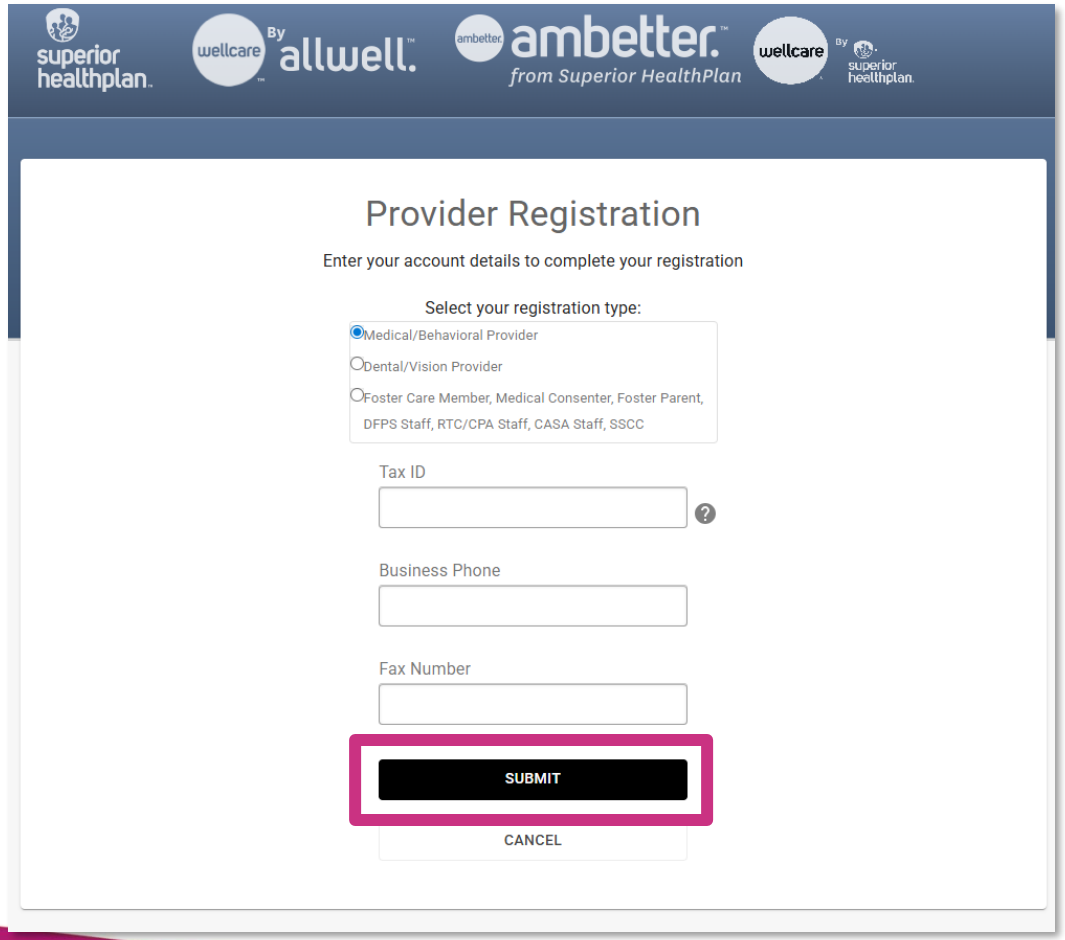
Registration

Log In To Register to complete registration.



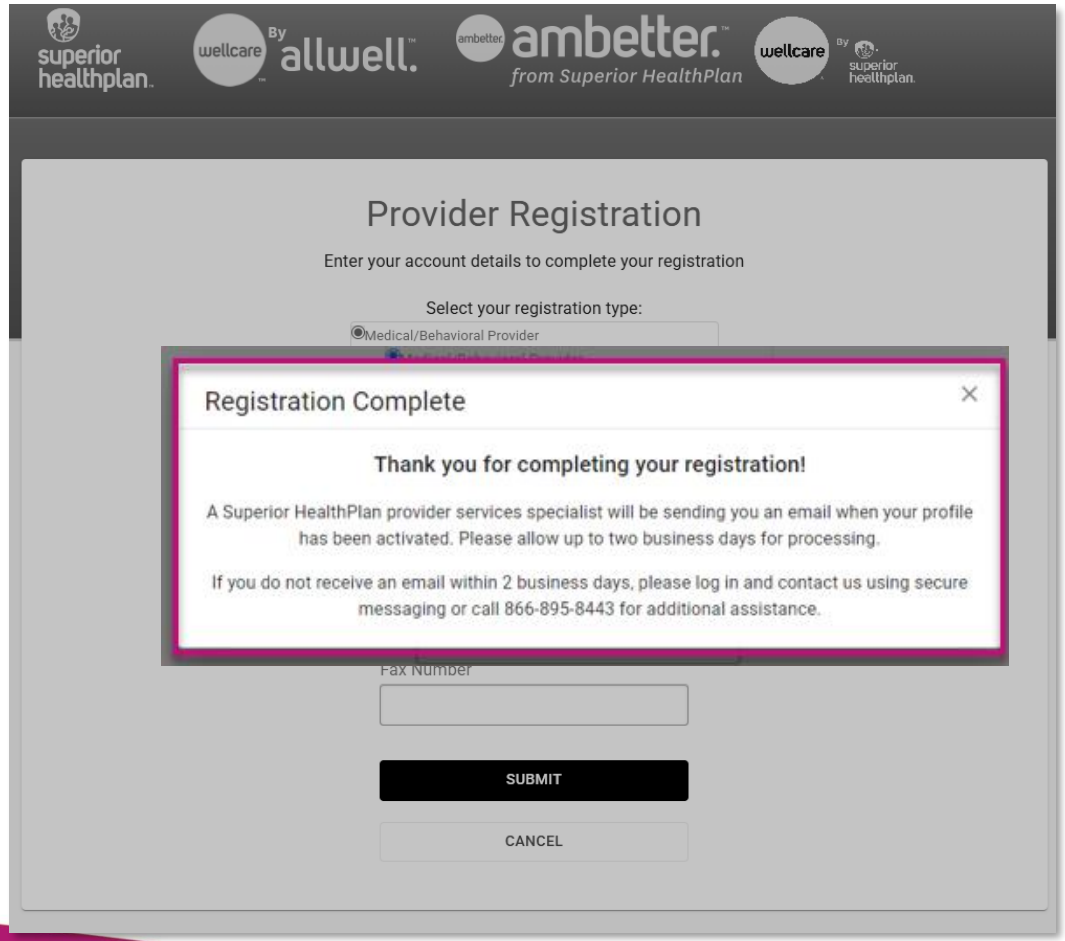
Registration

Enter information and click **Submit**.



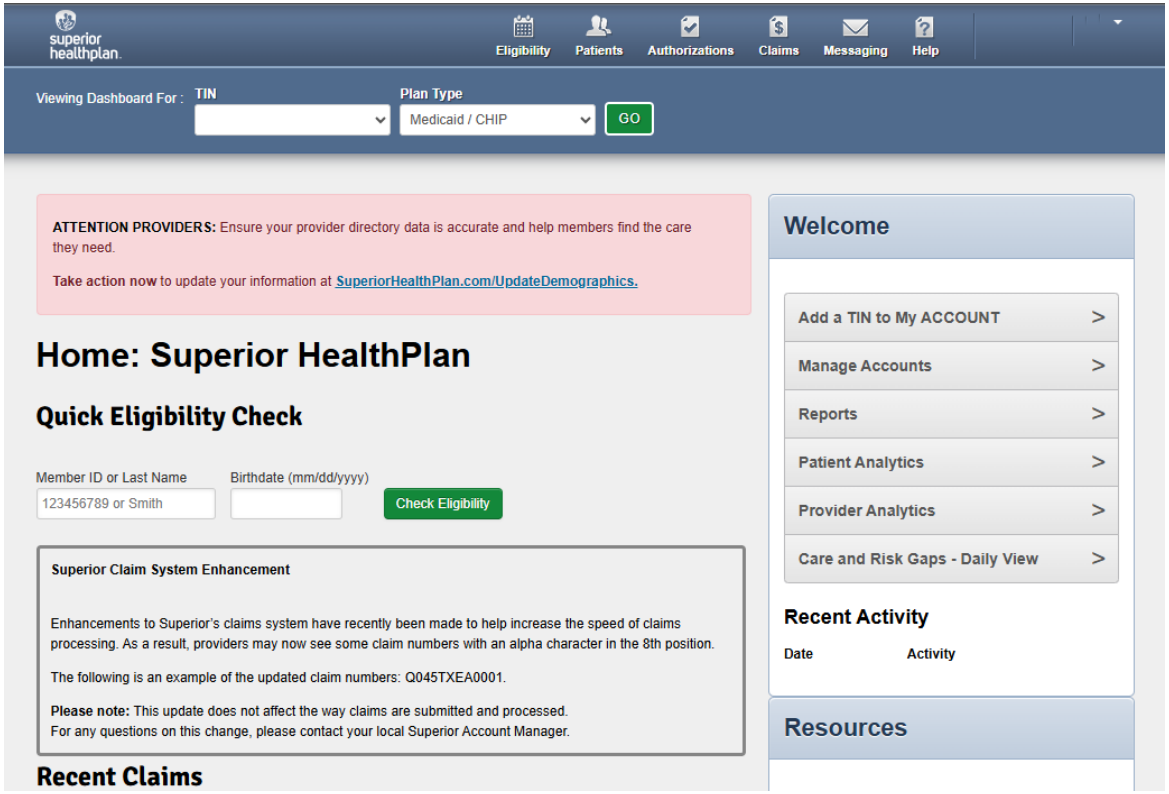
Registration

Registration is Complete!



Provider Portal Dashboard

- Once logged into the web portal account, you will see the Welcome Screen



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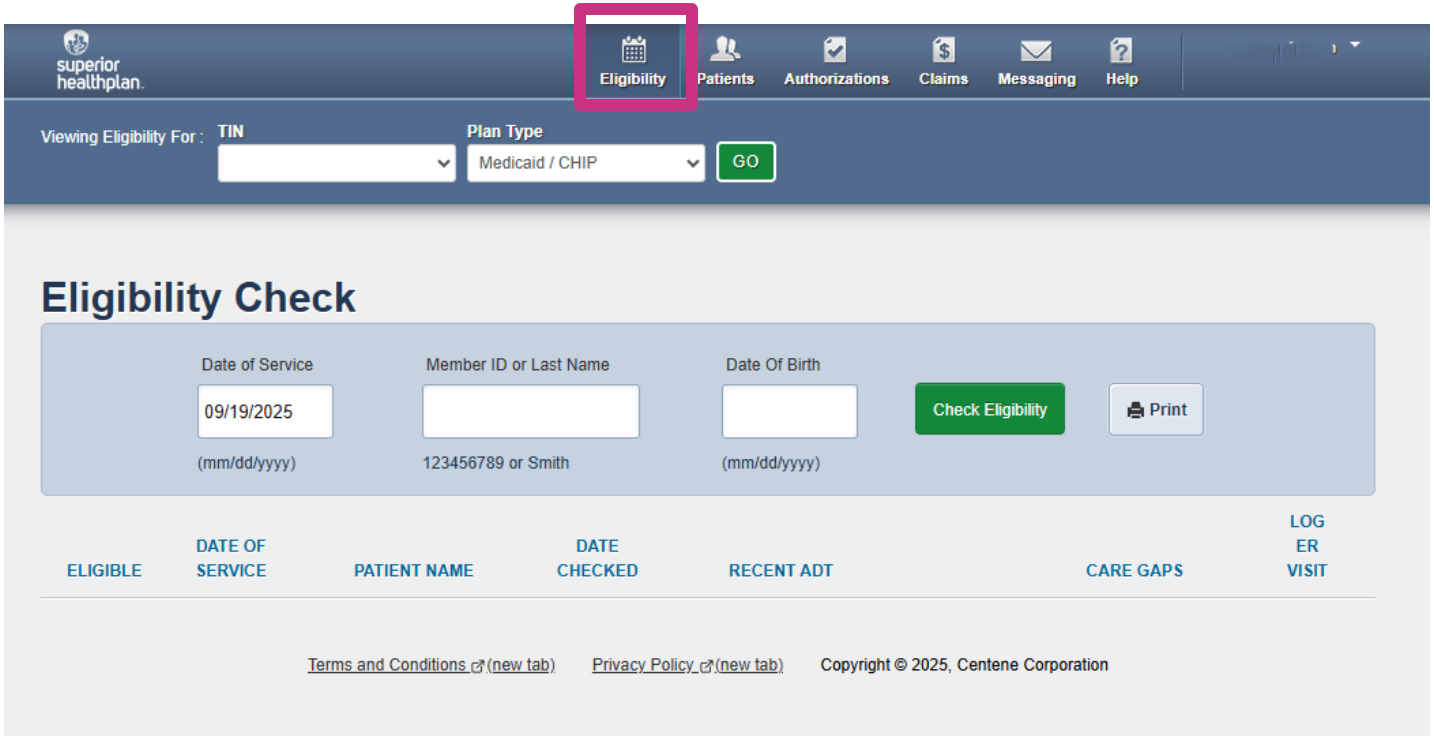
Eligibility

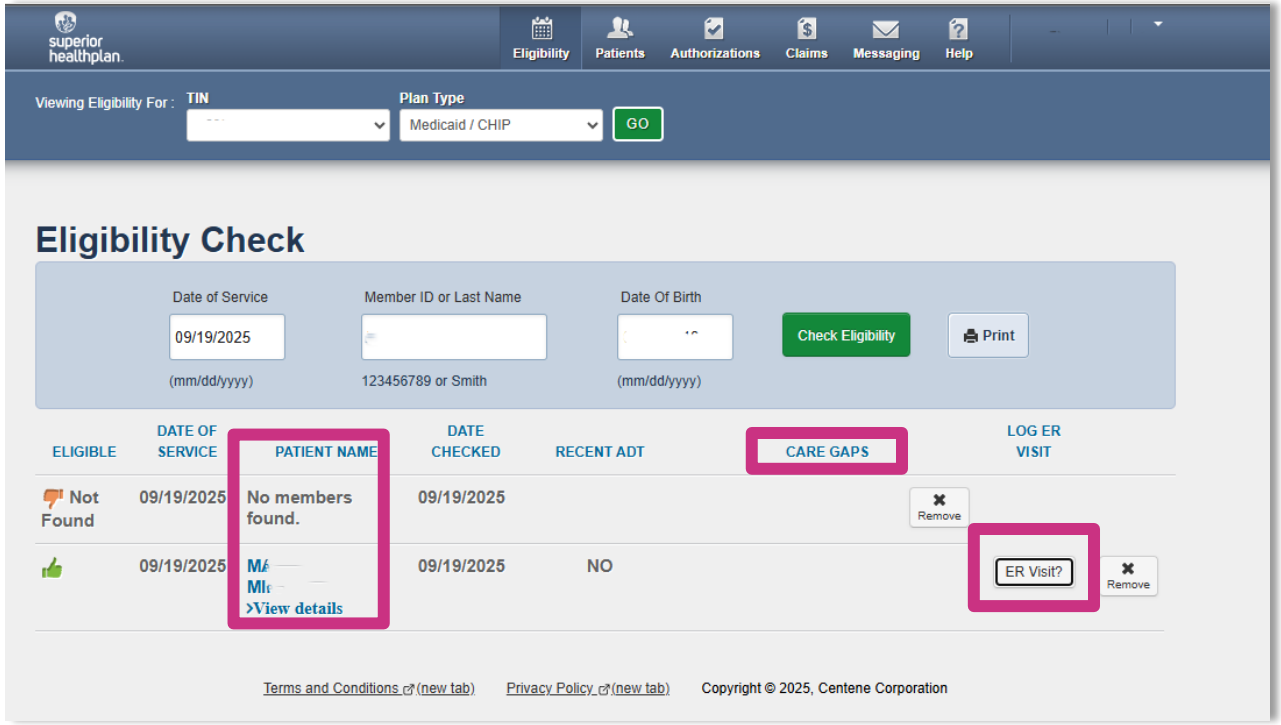
Secure Portal Eligibility Tab

- The **Eligibility** tab offers an Eligibility Check tool designed to quickly check the status of any member.



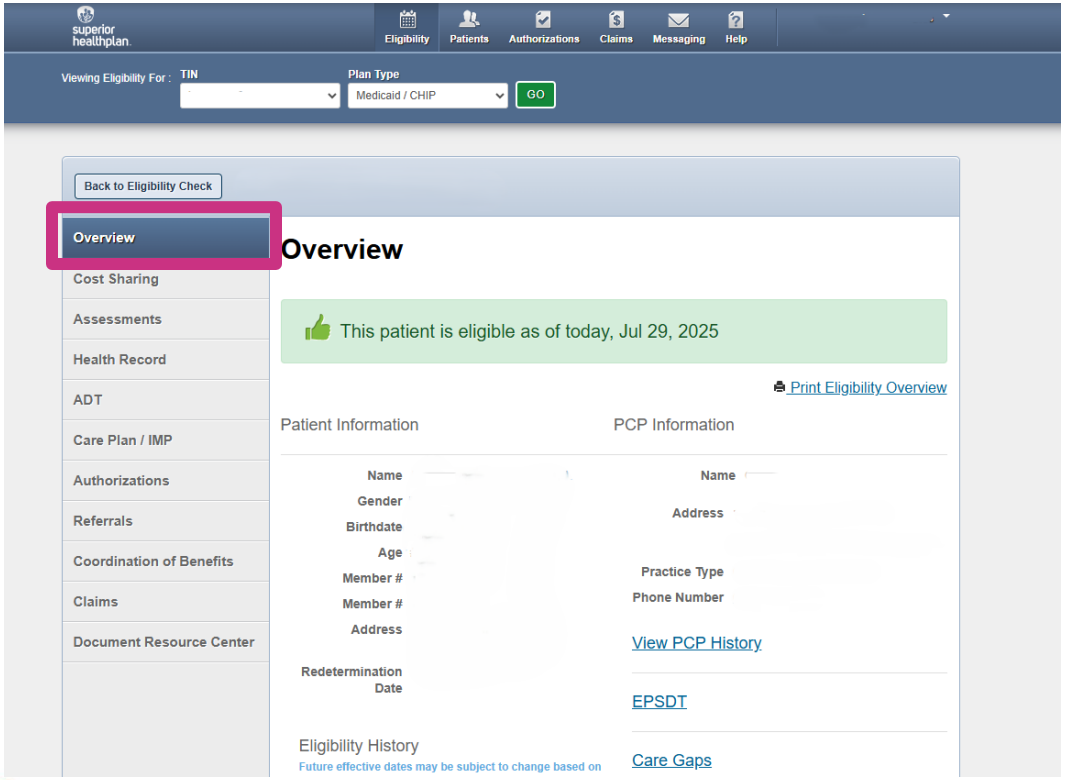
Eligibility Search

- Eligibility status is indicated by a green thumbs-up for eligible and an orange thumbs-down for ineligible.
- Details for any member can be viewed by clicking on the **Patient Name**.
- **Care Gaps** can also be seen within the search results.
- By clicking **ER Visit**, an ER visit can be added.



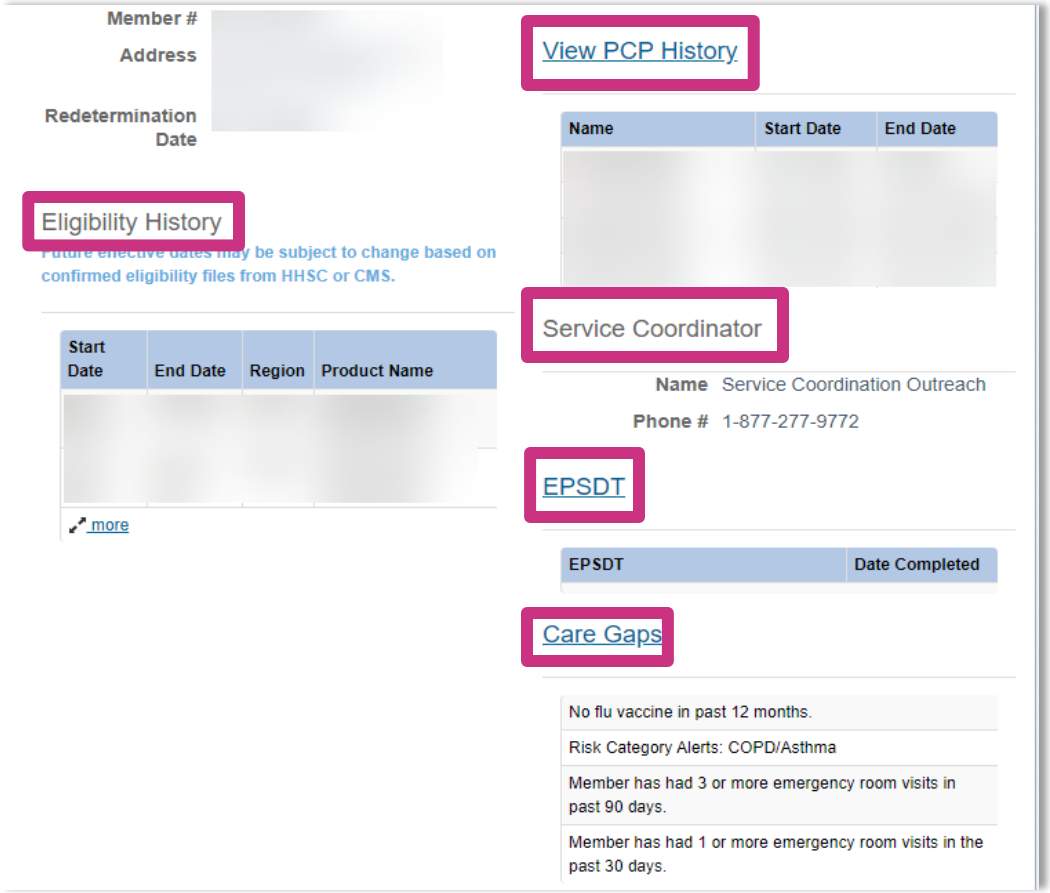
Eligibility Search

- Patient Information and PCP Information are displayed in the member's **Overview**.



Eligibility Search

- Overview also includes **Eligibility History**, **PCP History** and **EPSDT** for the respective member.
- **Care Gaps** and **Service Coordinator** information will only display when applicable.



Care Gap Alert Categories and Descriptions

- Adult Preventive
  - No mammogram in most recent 12 months.
  - No Chlamydia test in past 12 months in patient 16 - 25 years of age.
  - No PAP in past 12 months.

- Diabetes
  - DM - Not seen in past 6 months.
  - DM - No retinal eye exam in past 12 months.
  - DM - No HbA1C screening in past 12 months.

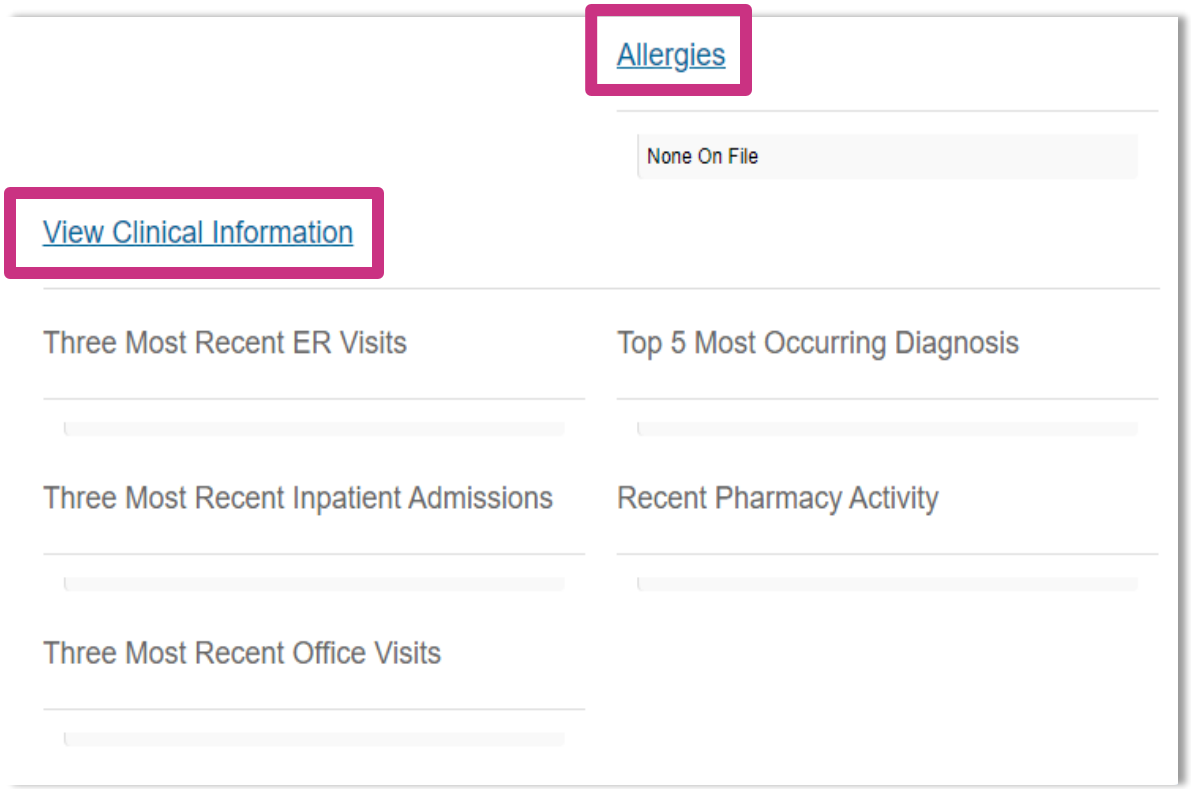
- Cardiac
  - CAD - Not seen in past 12 months.
  - HTN - Not seen in past 12 months.

Care Gap Alert Categories and Descriptions

- Flu Vaccine
  - No flu vaccine in past 12 months.
- Child Preventive
  - Immunizations not current for age.
- Texas Health Steps
  - Non-compliant for well child visits.
- Emergency Room Visits
  - Any ER visits in past 12 months.

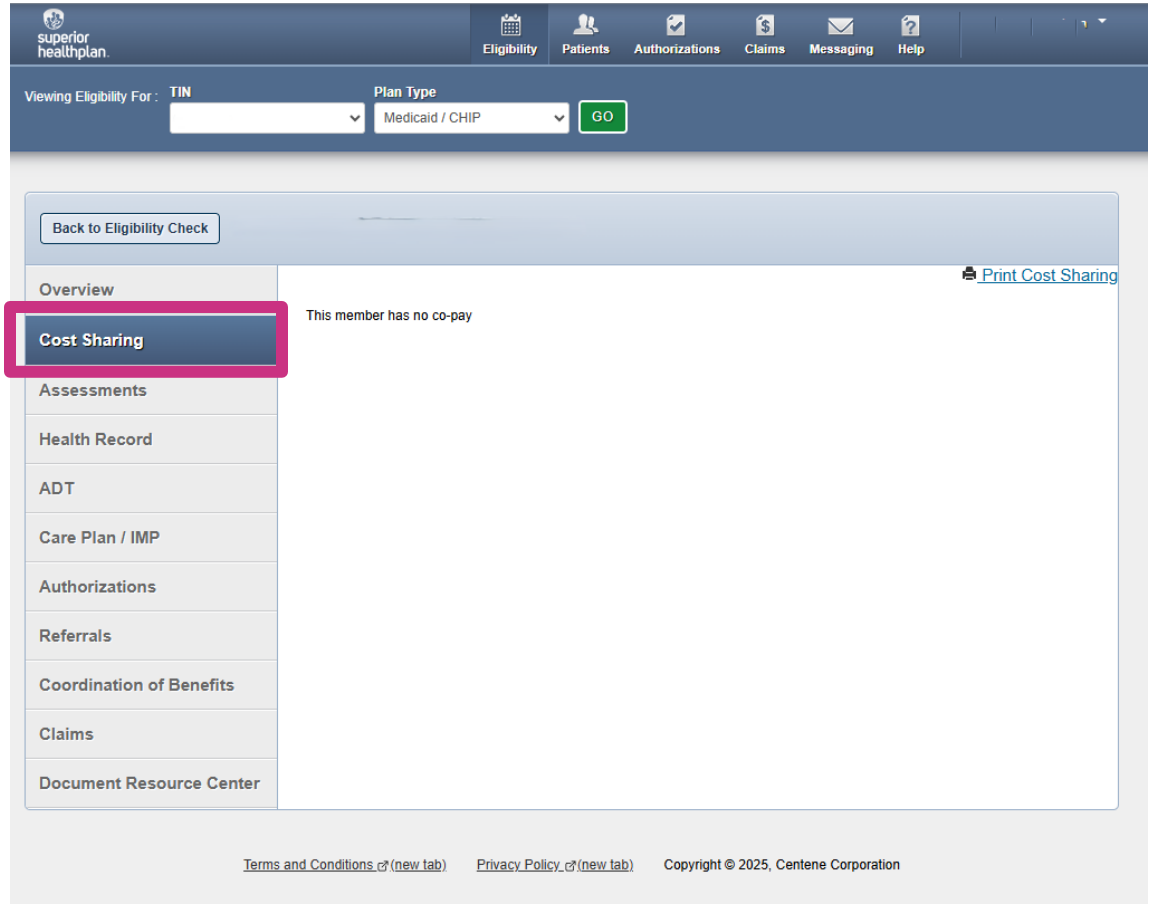
Eligibility Search

- Overview also includes **Allergies** and **View Clinical Information** option for the respective member.



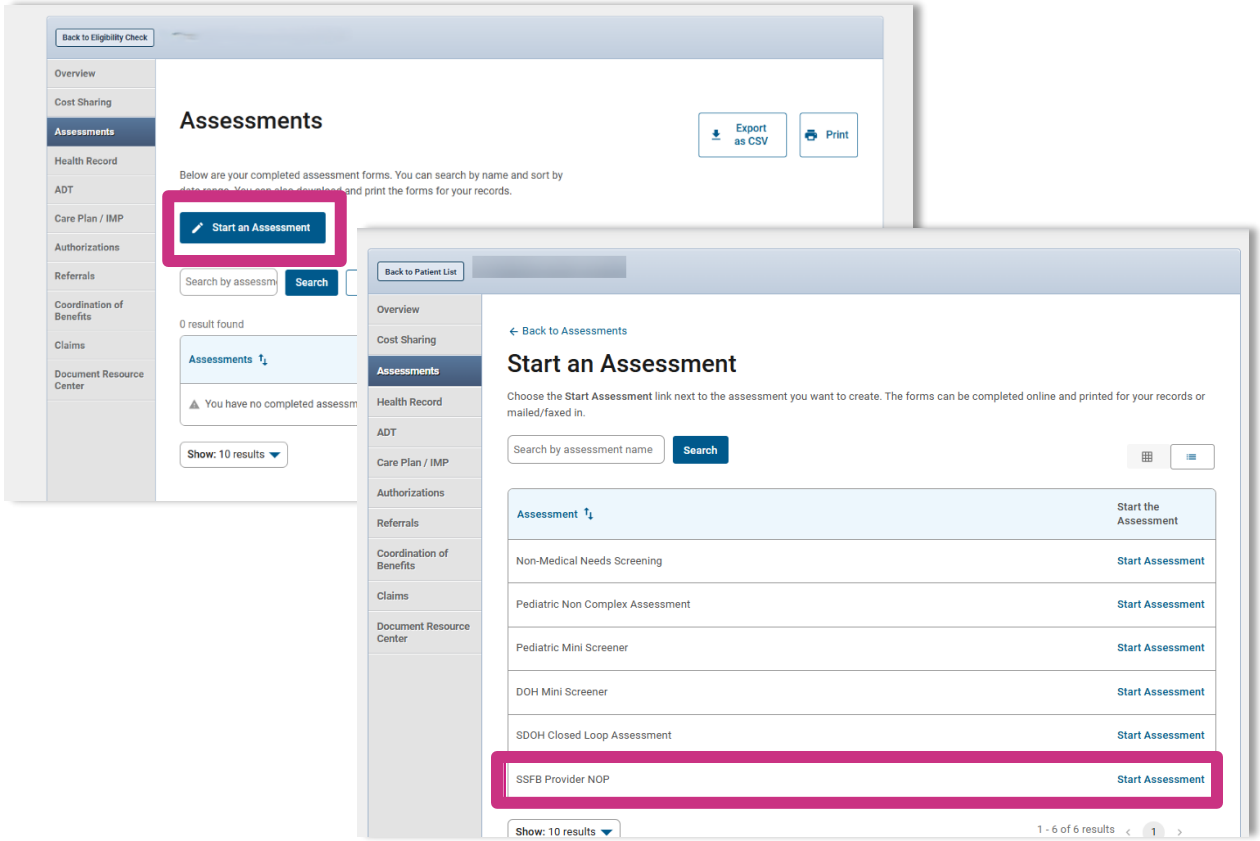
Eligibility Search

- **Cost Sharing** information is displayed for those CHIP members who have co-pays.
- This member has no co-pay is displayed when a member does not have cost sharing.



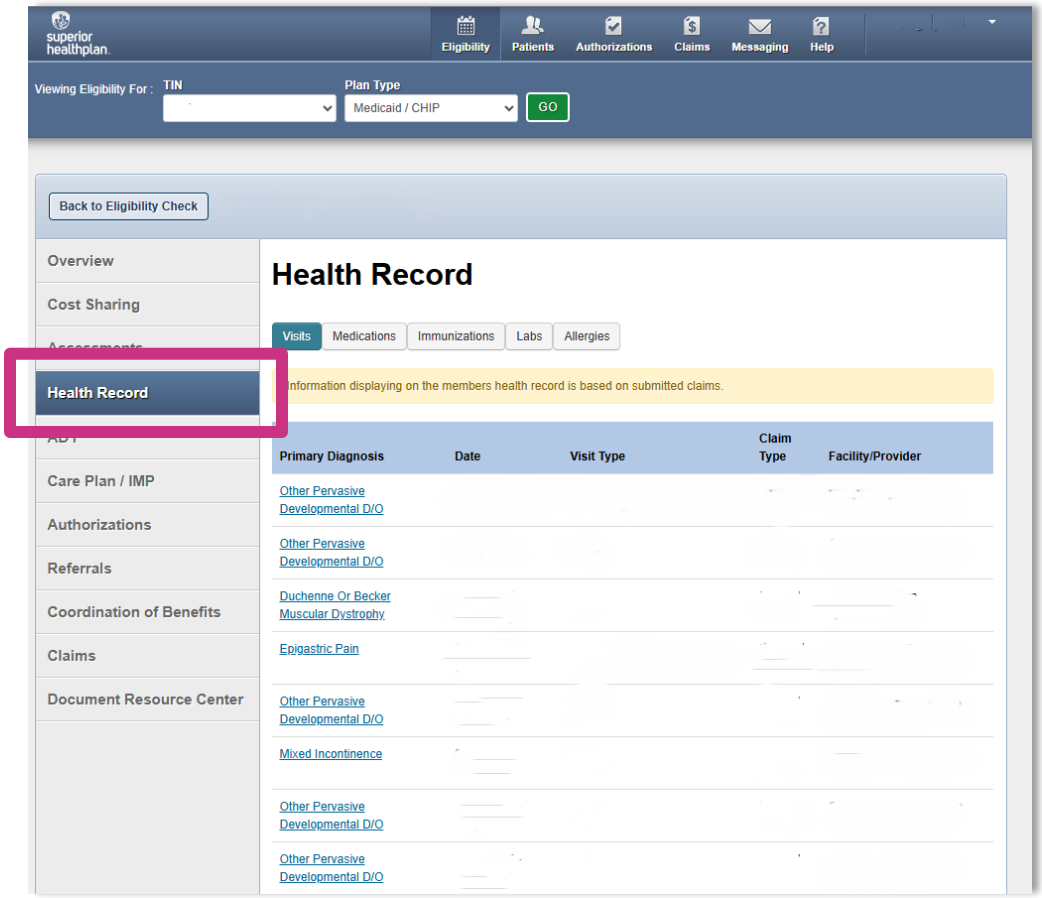
Eligibility Search

- Click **Start an Assessment** to begin your assessment.
- **SSFB Provider NOP (Notification of Pregnancy)** assessments can be completed online.



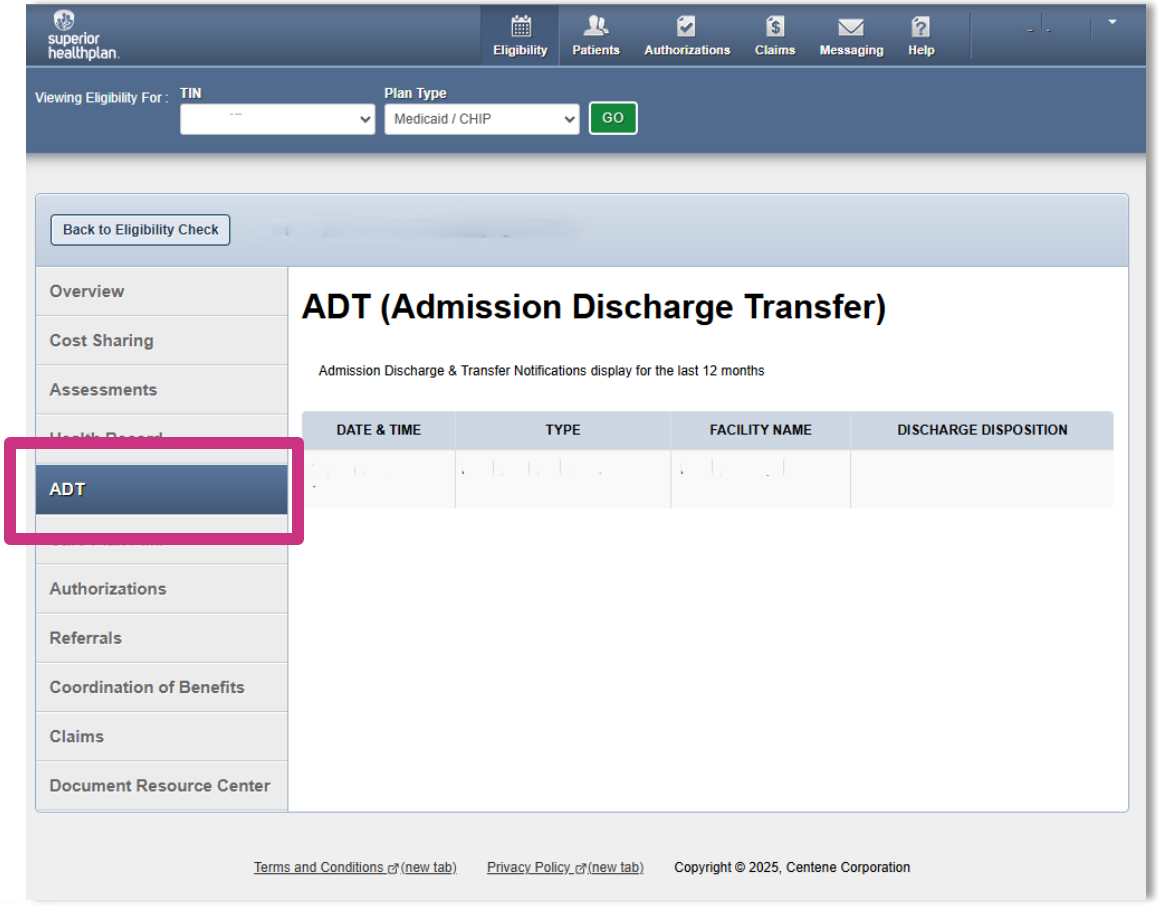
Eligibility Search

- **Health Record** will allow you to view the respective member's visits, medications, immunizations, labs and allergies if there are any listed.



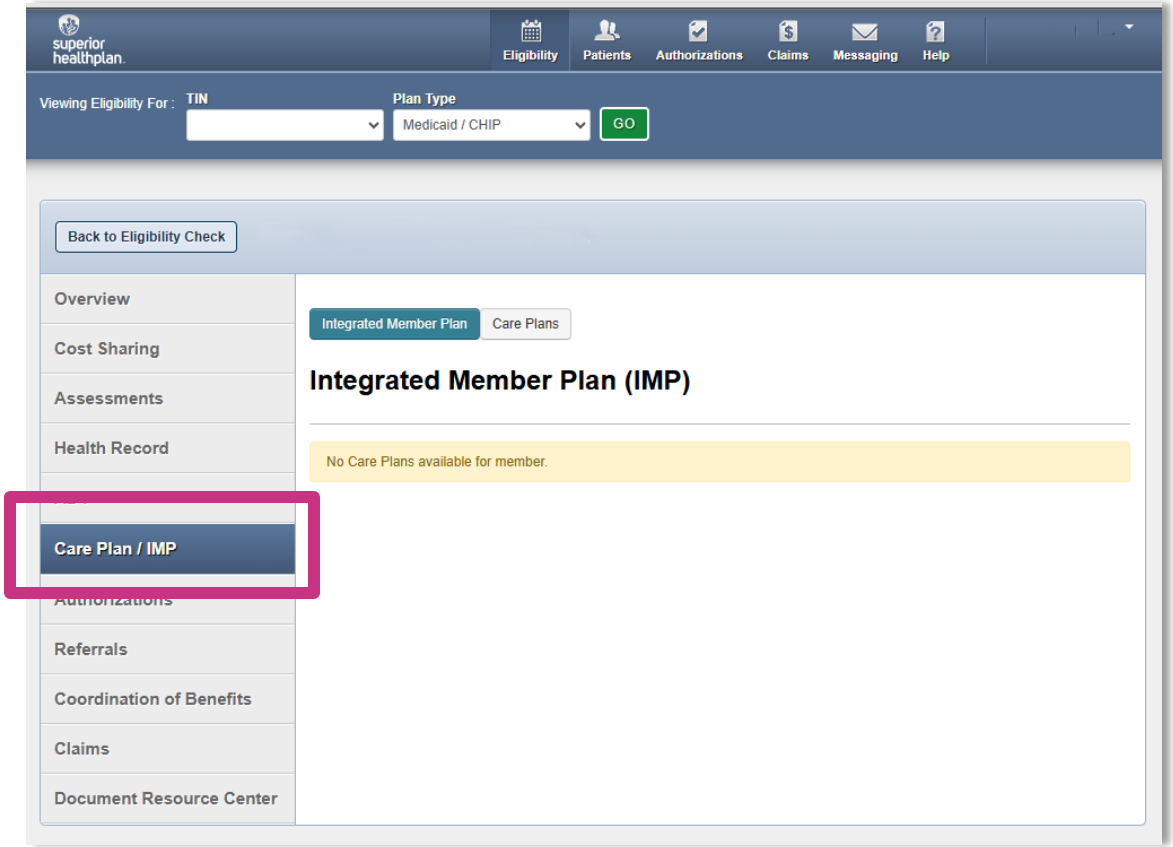
Eligibility Search

- **ADT (Admission Discharge Transfer)** will allow you to view the respective member's admission, discharge or transfer for the past 12 months.



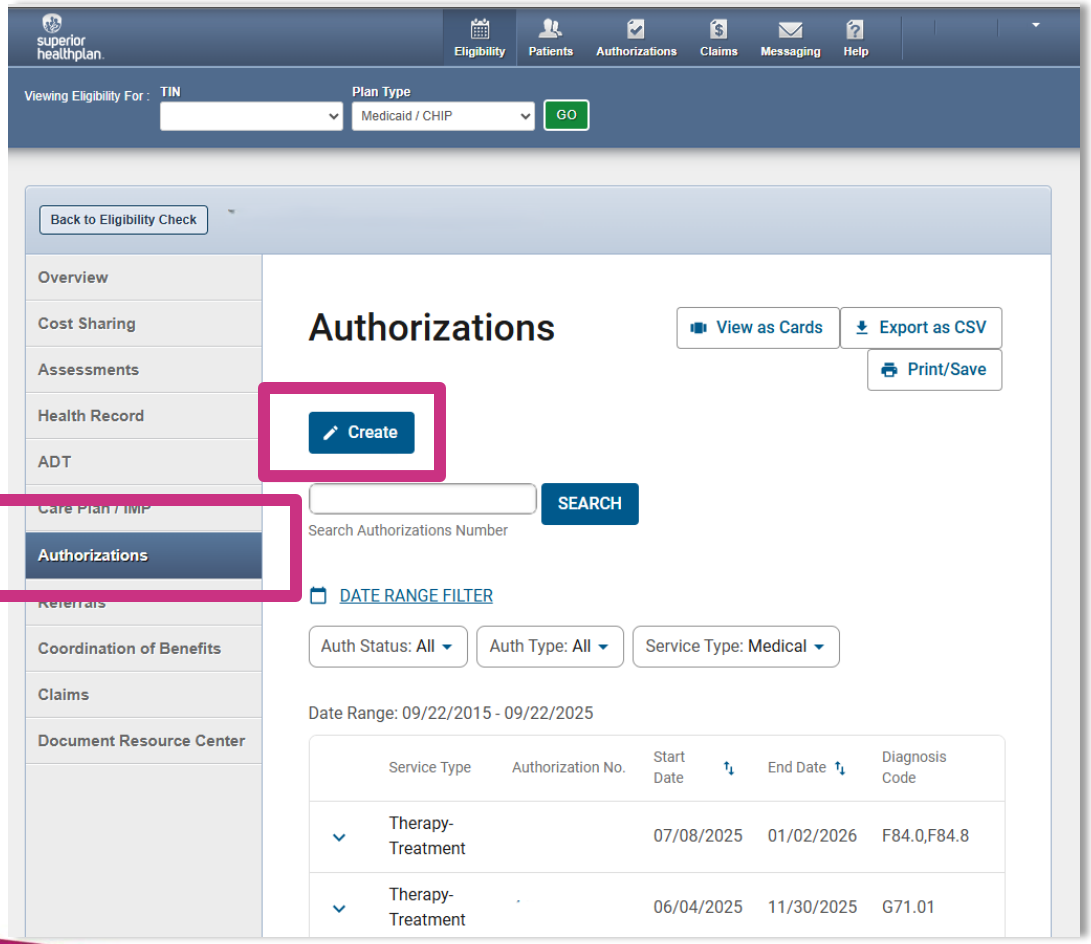
Eligibility Search

- Member/caregiver is called and offered Case Management or Care Coordination.
- If they accept, the Case Manager or Social Worker/Service Coordinator develops a plan of care with the member/caregiver.
- Goals are identified and a care plan or Integrated Member Plan (IMP) is formulated and seen here in the **Care Plan/IMP** module.



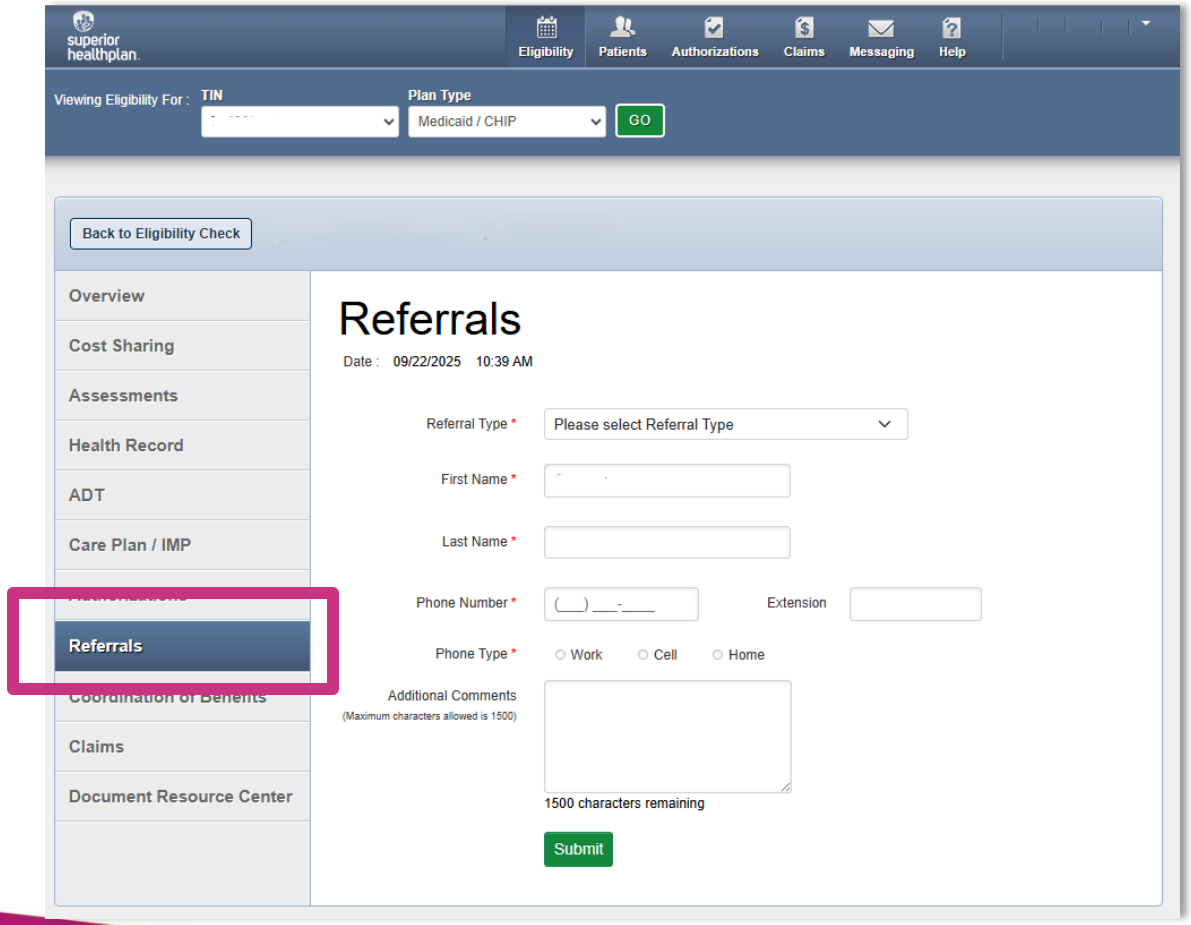
Eligibility Search

- The previous 12 months of **Authorizations** display for each member.
- New authorizations can be quickly generated for a member by clicking **Create**.



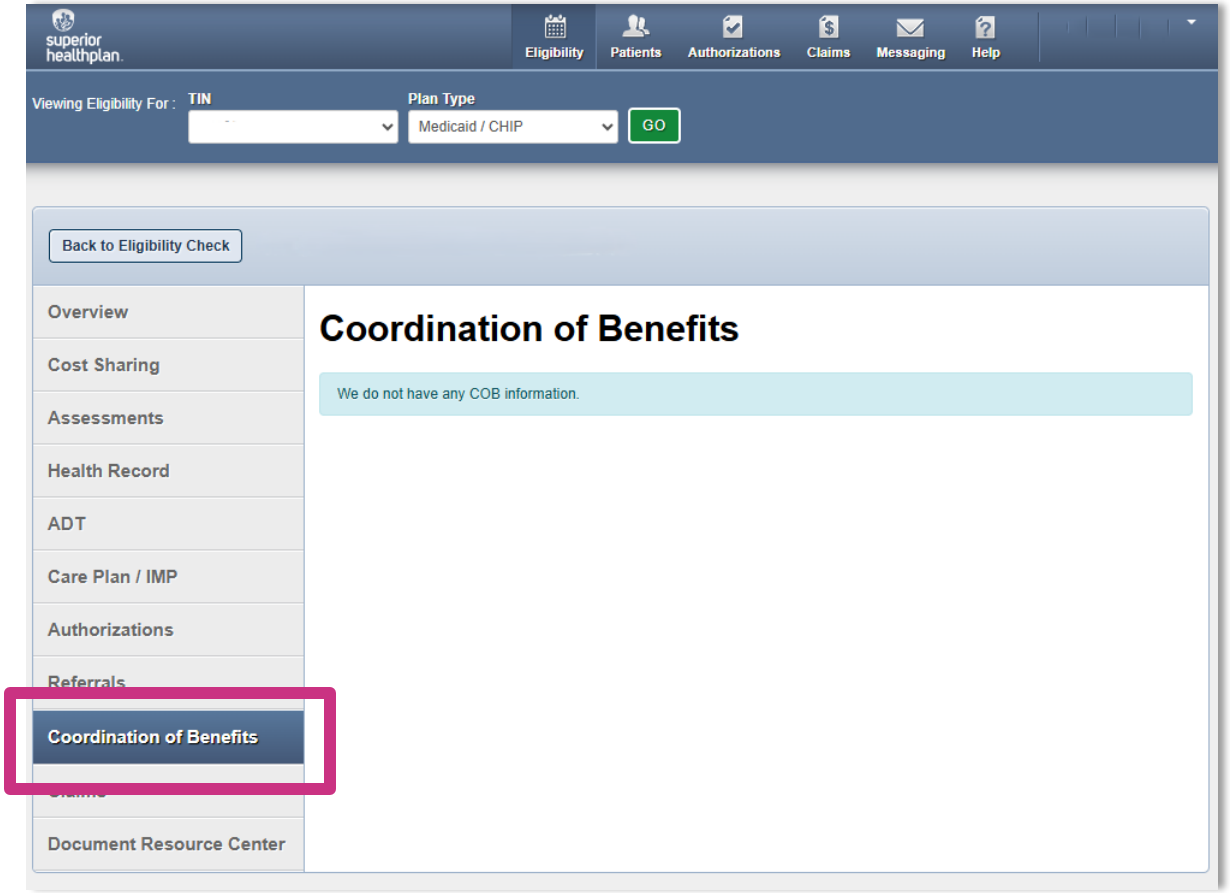
Eligibility Search

- Providers can now refer members to Case Management on the portal by clicking **Referrals**.



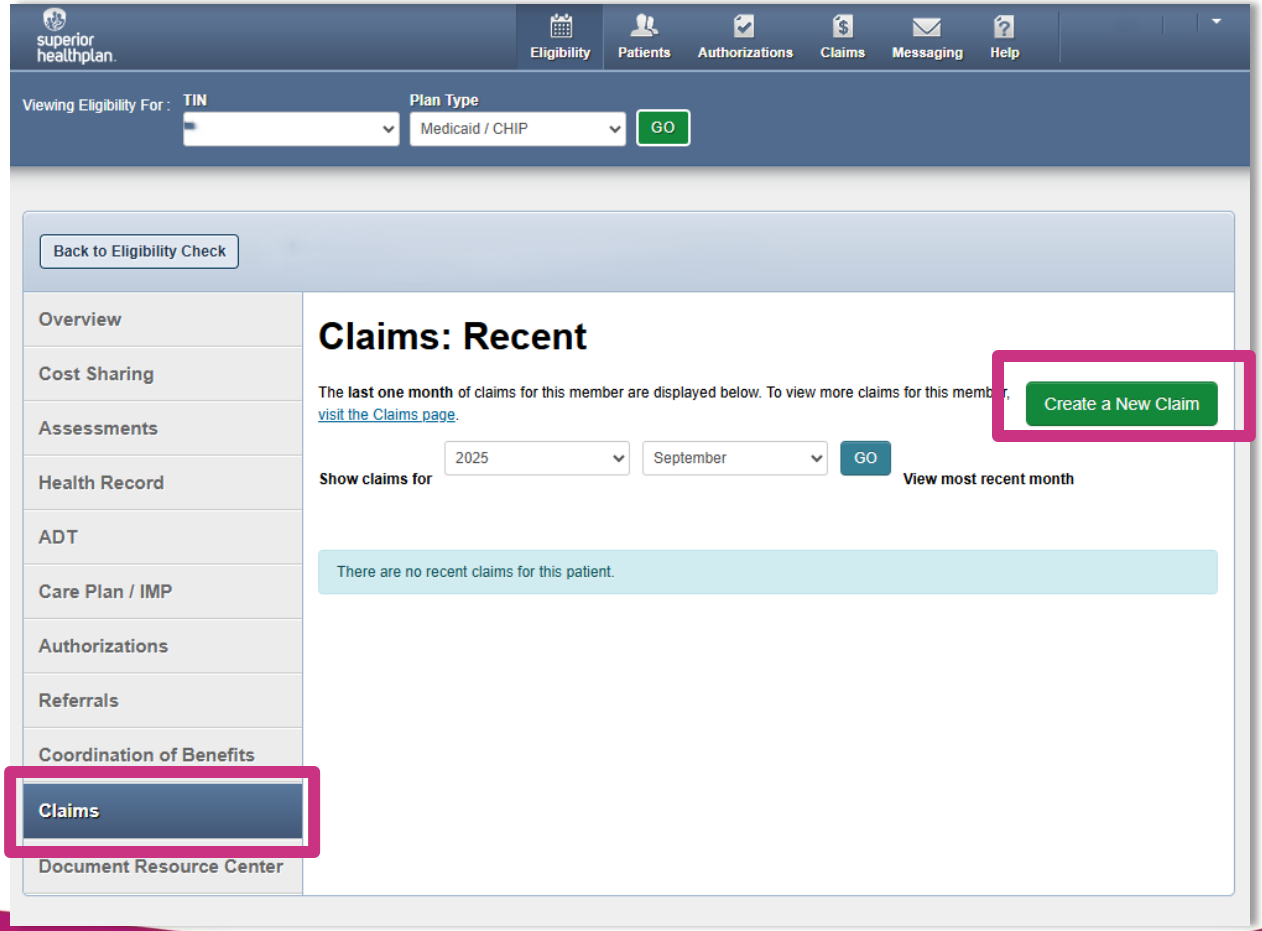
Eligibility Search

- **Coordination of Benefits** information will display for a member when applicable.



Eligibility Search

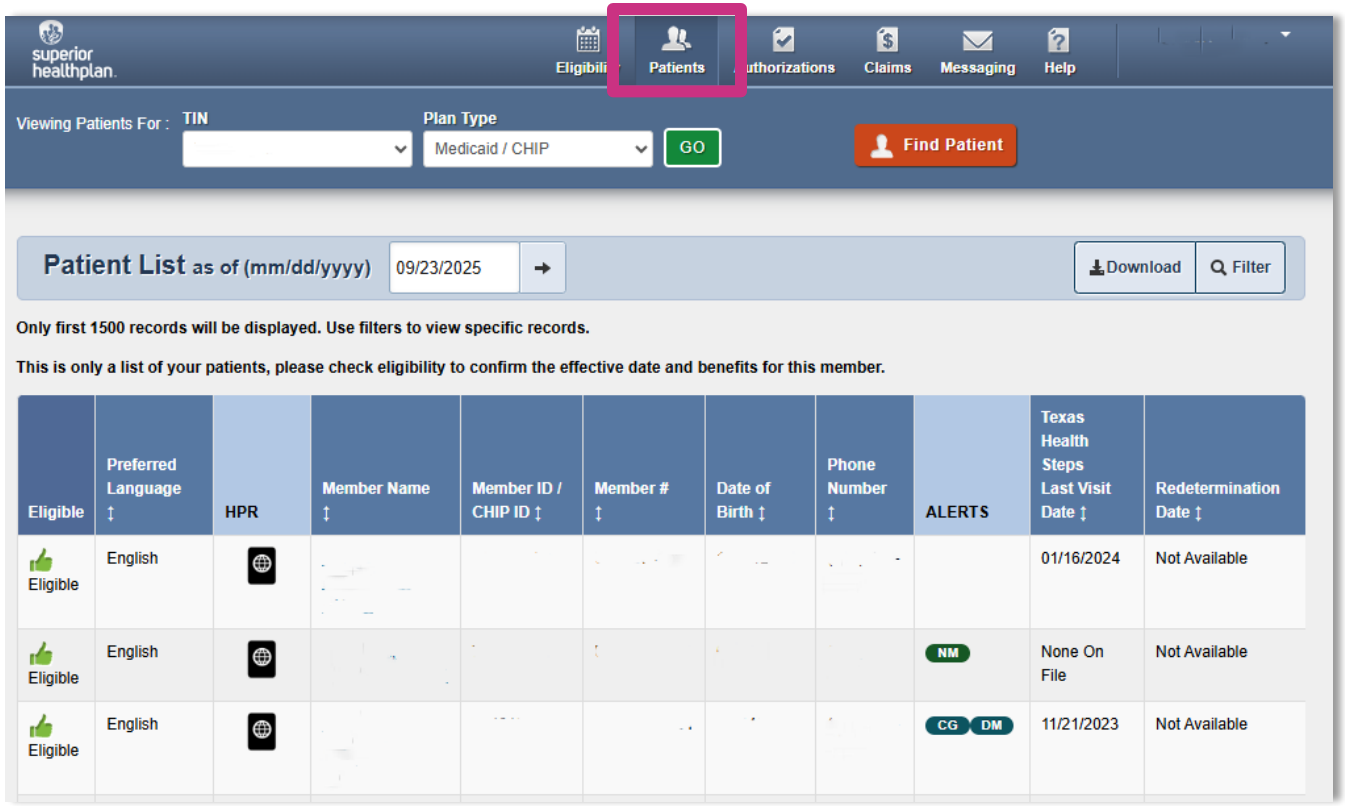
- The **Claims** display for each member for the past month. They are now searchable by year and by month for up to 30 days at a time.
- New claims can be quickly created for a member by clicking **Create a New Claim**.



Patient List

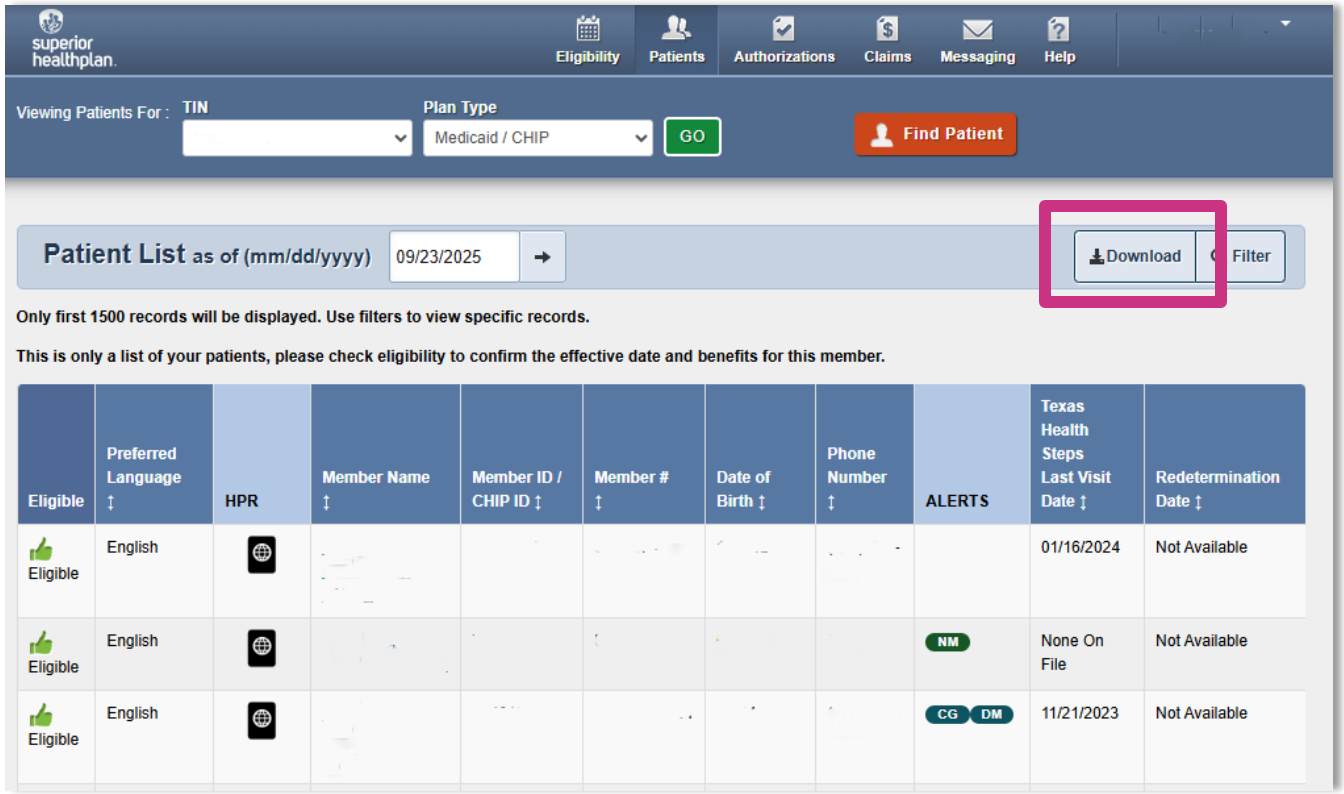
Patient List

- Click on **Patients** to display the patient list. These are members assigned to a provider under this TIN as their PCP.



Patient List

- **Download** the Patient List to Excel and save all of the relevant member and provider information.



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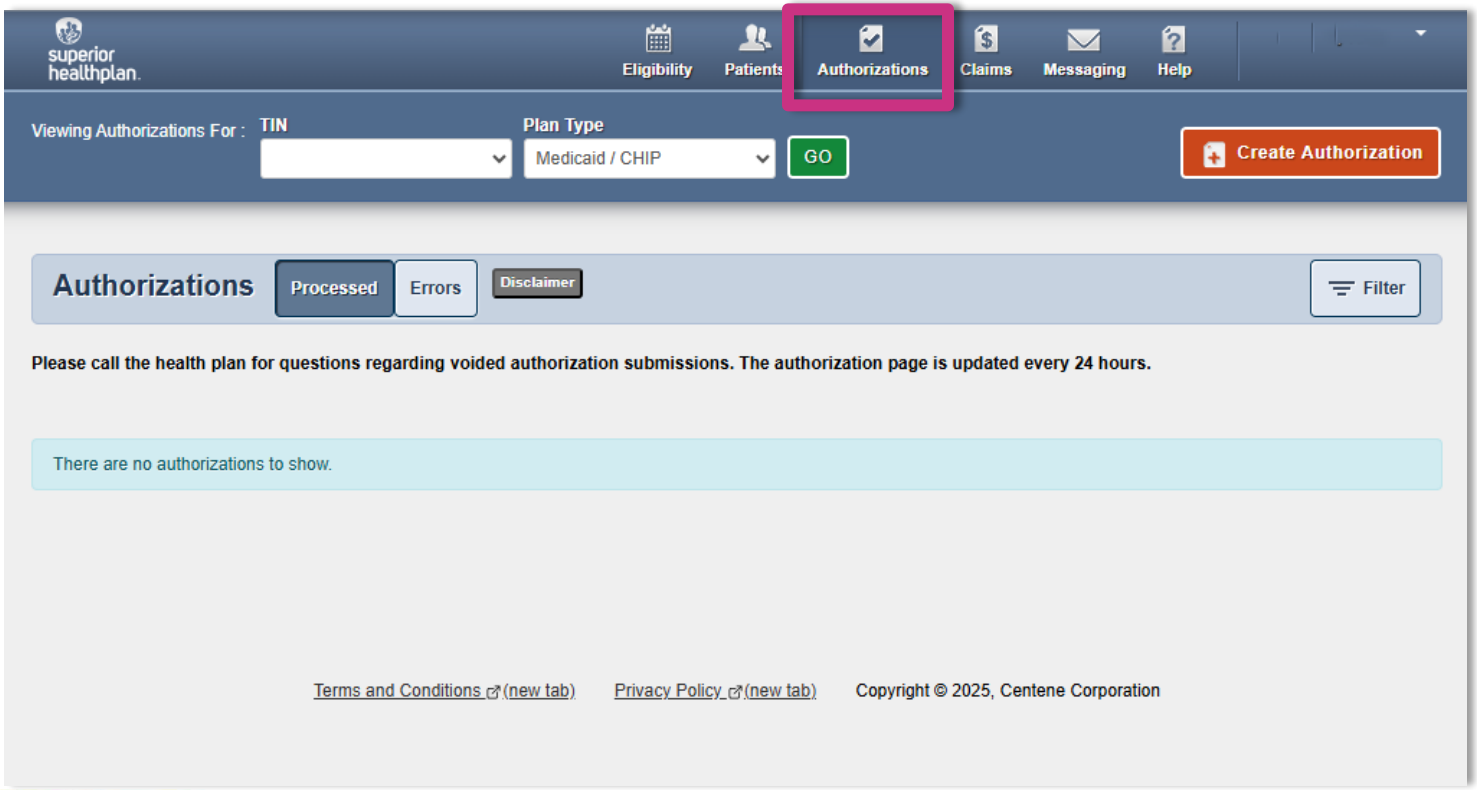
Authorizations

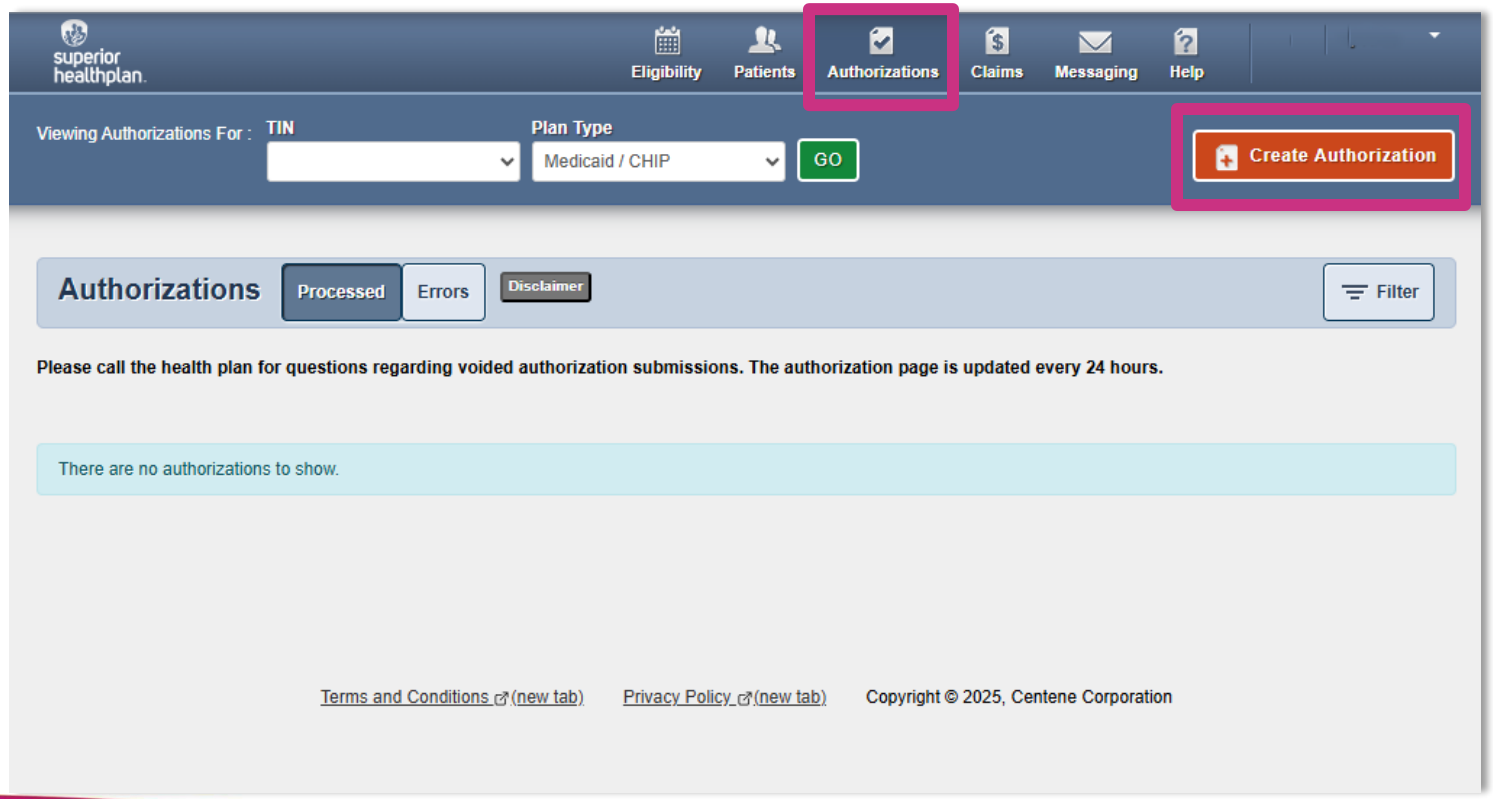
Member Overview

- The **Authorizations** tab offers a summary of all activity for the previous 90 days.



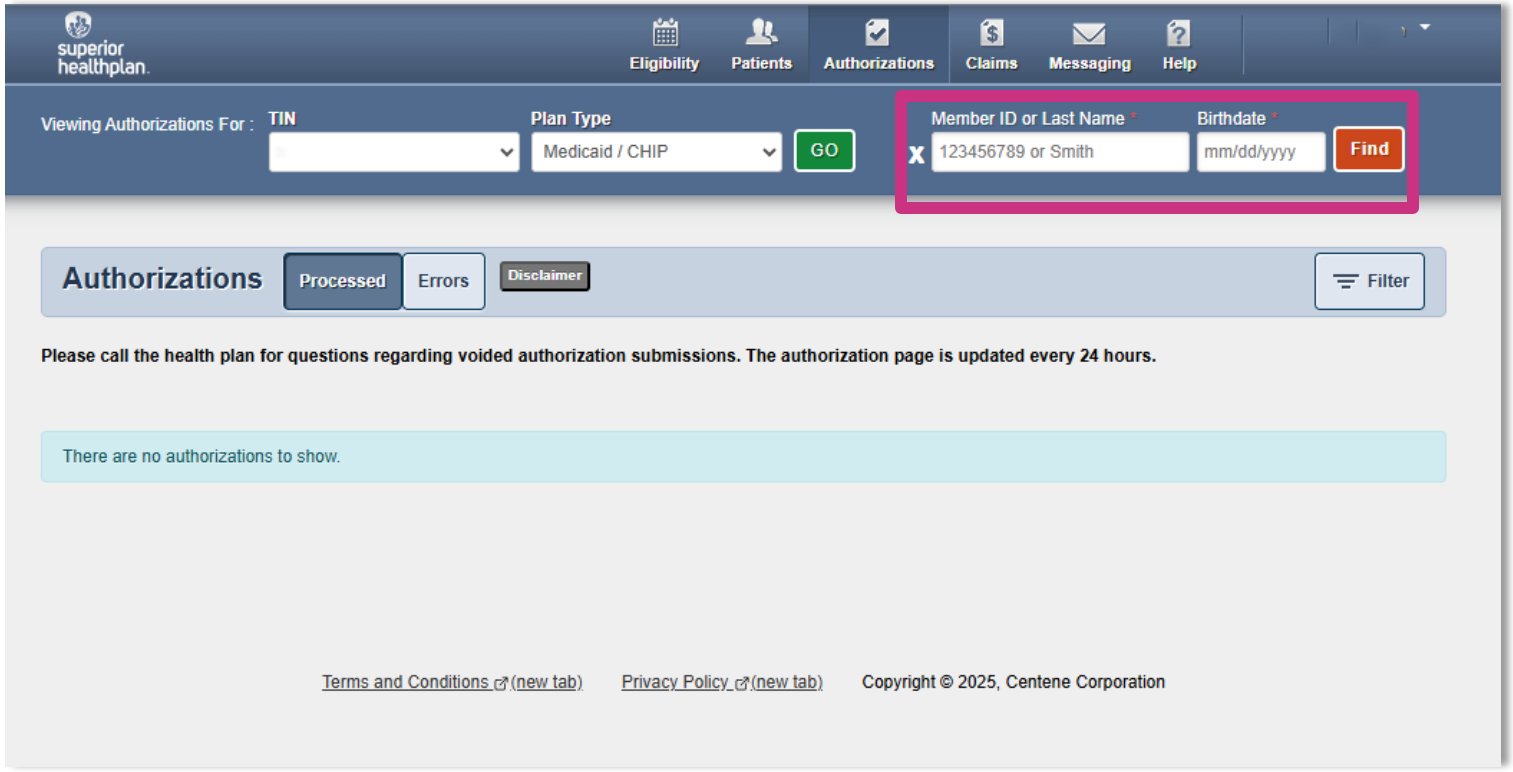
Authorizations

- Select **Create Authorization** from the **Authorizations** tab.



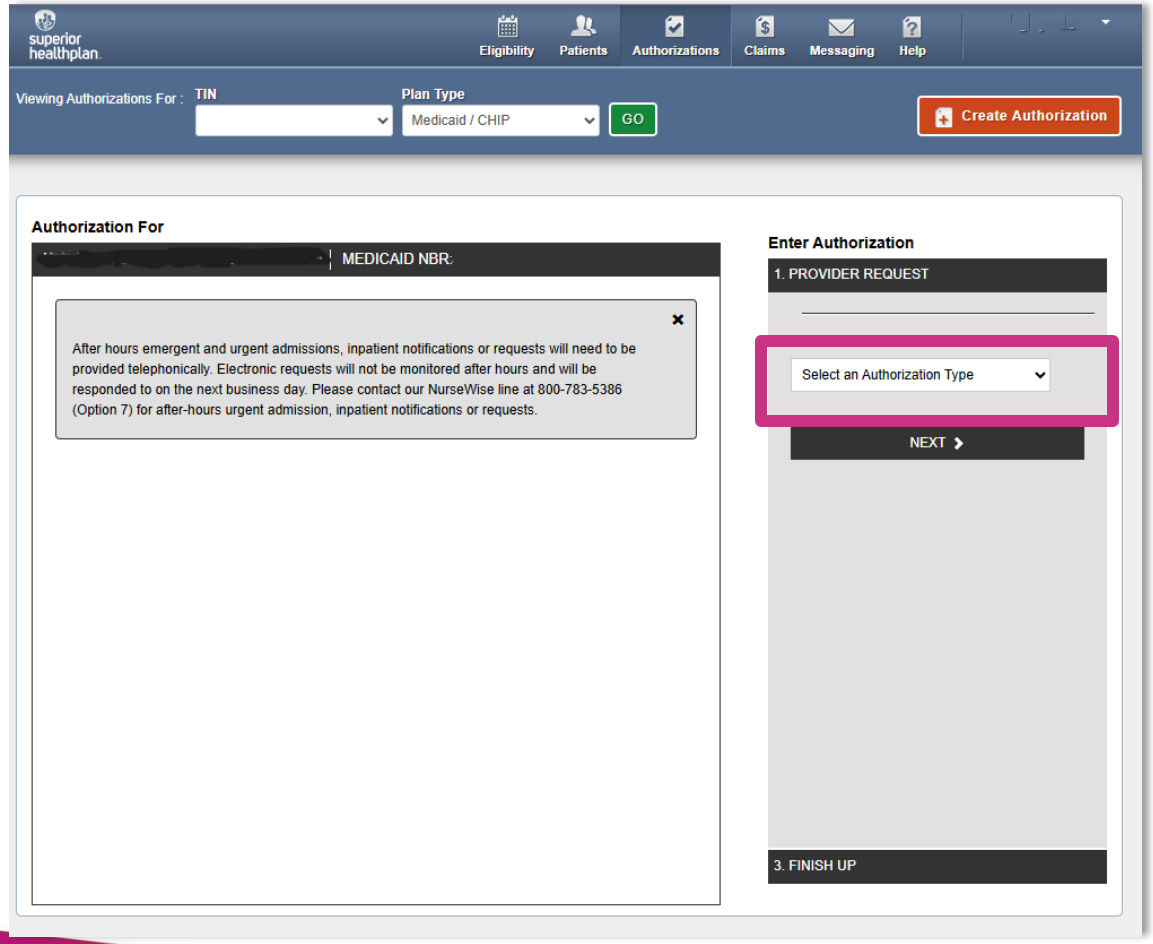
Authorizations

- Enter the **Member ID or Last Name** and **Birthdate** and click **Find**.



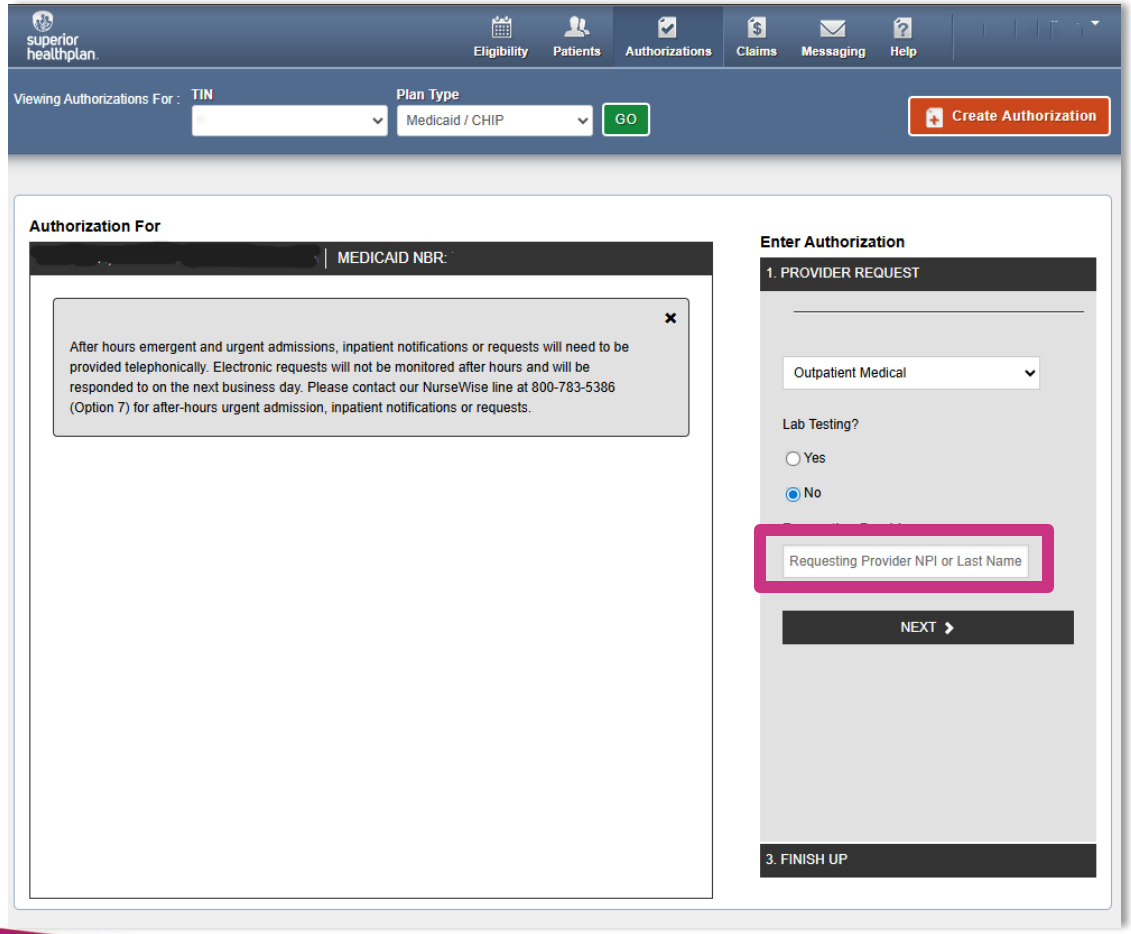
New Authorization Form

- **Select an Authorization Type** from the dropdown menu.



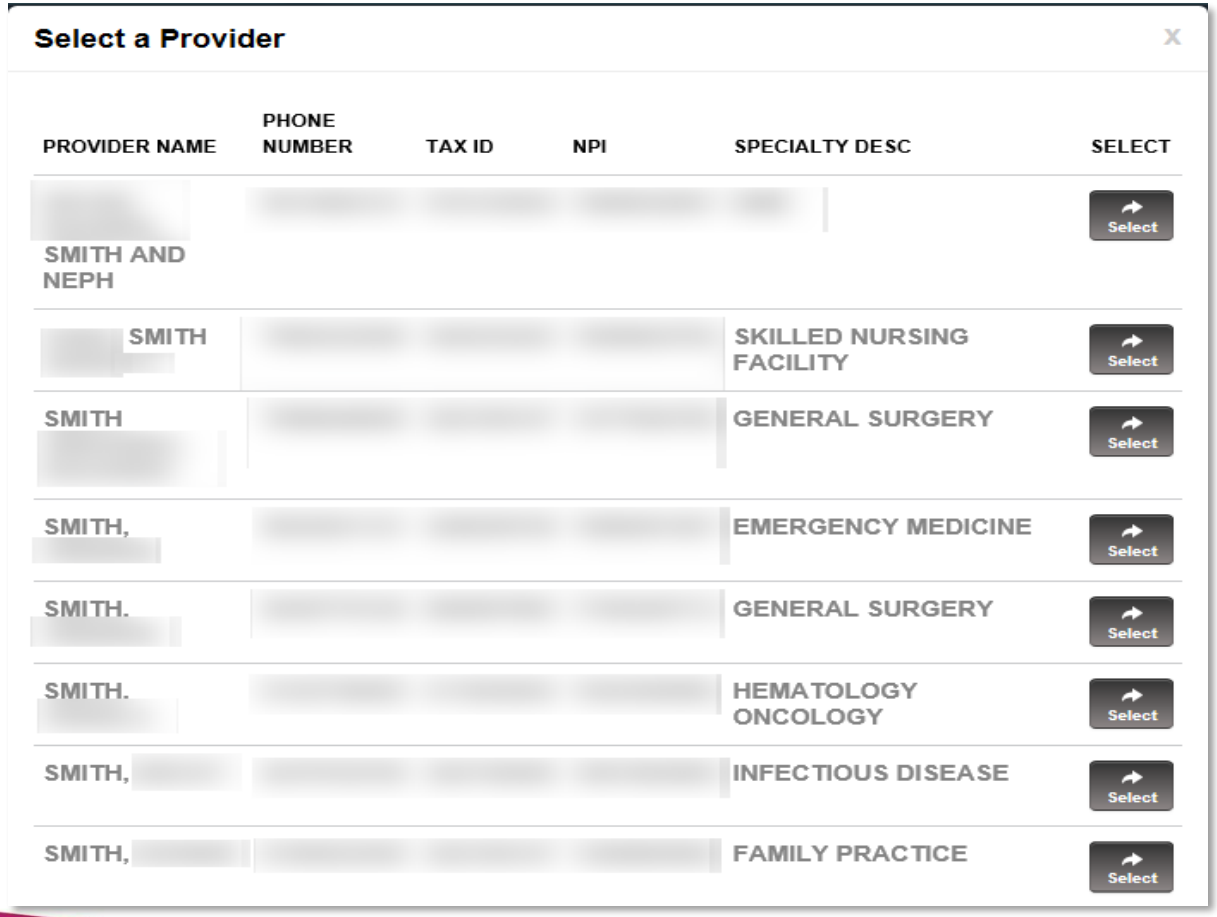
Authorization Type

- Can be searched by **Requesting Provider NPI or Last Name**.
- Enter requesting provider NPI in field. If you do not know the requesting provider NPI enter their last name.



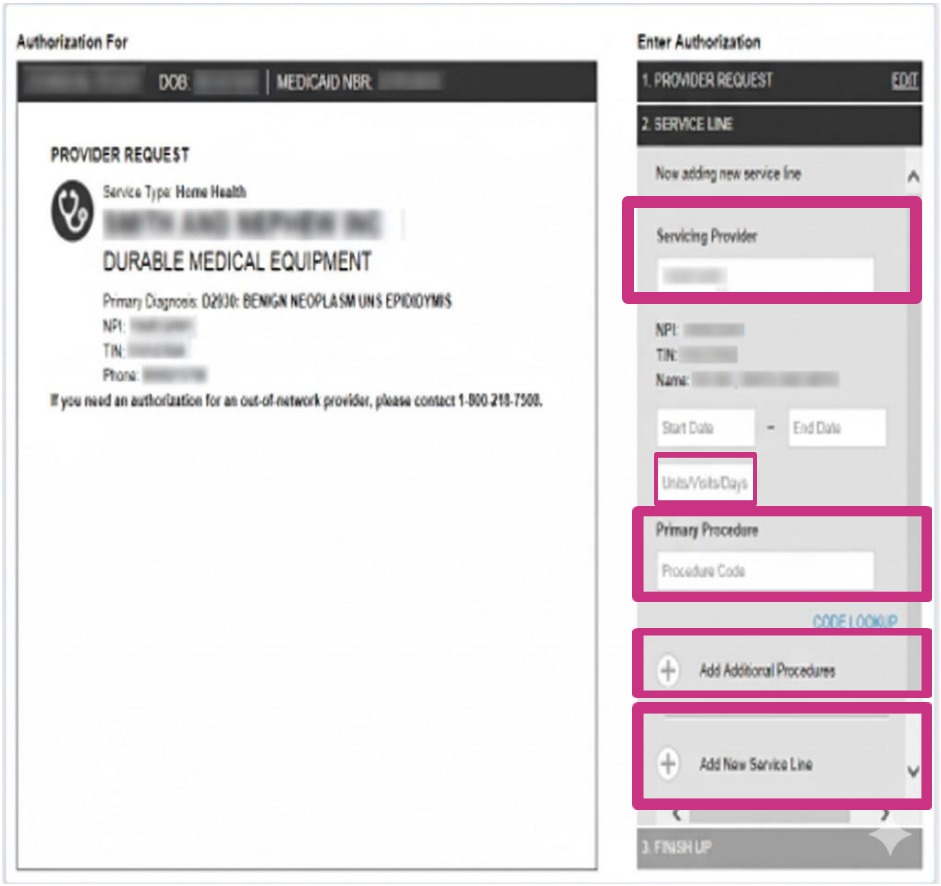
Requesting Provider – Search

- The search results will display all providers matching the search criteria and includes their specialty description in the **Specialty Desc** column.



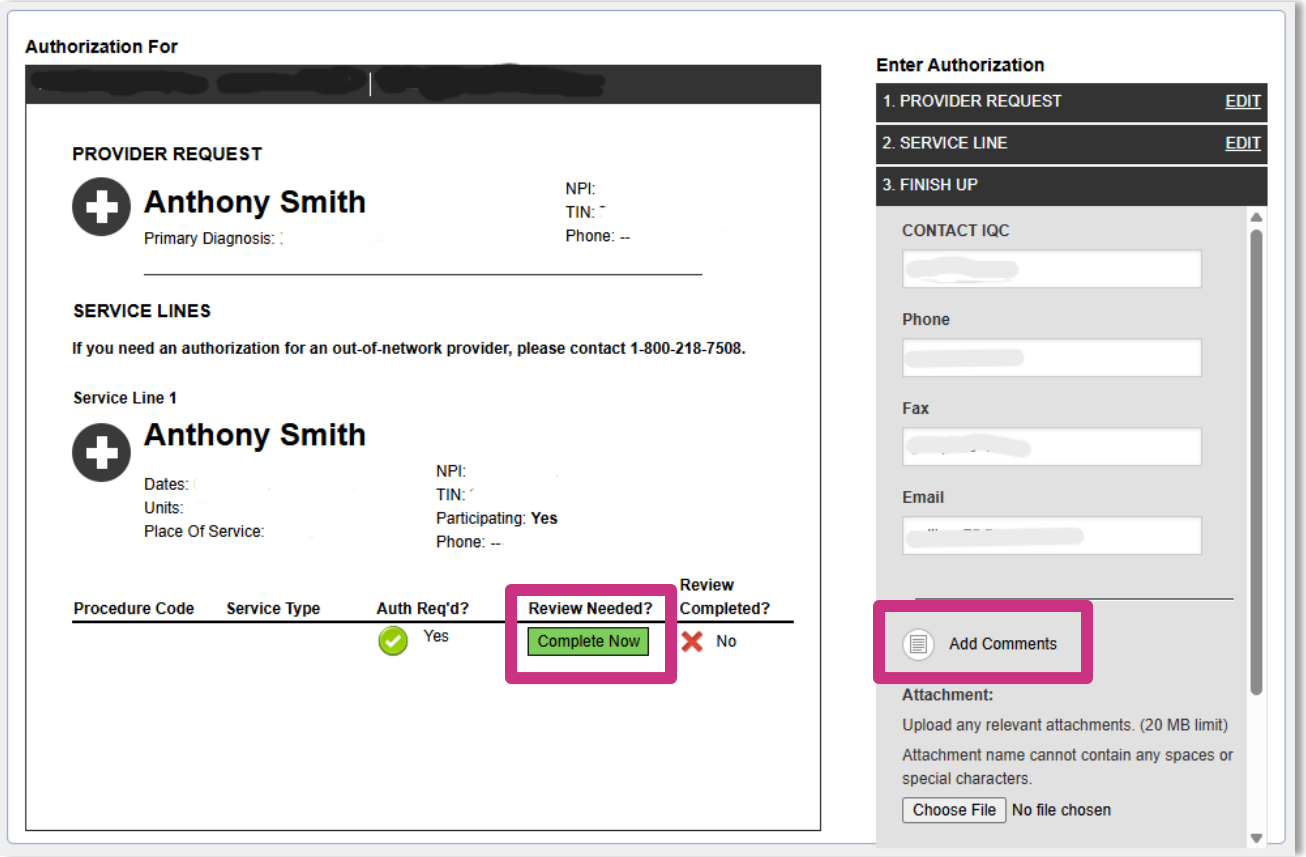
Same as Requesting Provider

- If the servicing provider is different from the requesting provider, use the **Servicing Provider** field to search by last name or NPI.
- Add service dates up to **30** days in advance, up to **6-month** span.
- The number of **Units/Visits/Days** can be entered here.
- Enter CPT code in **Primary Procedure** field.
- Additional CPT codes can be entered by clicking on the + icon beside **Add Additional Procedures**.
- For multiple lines of service, click the + icon to **Add New Service Line.**



Complete Now

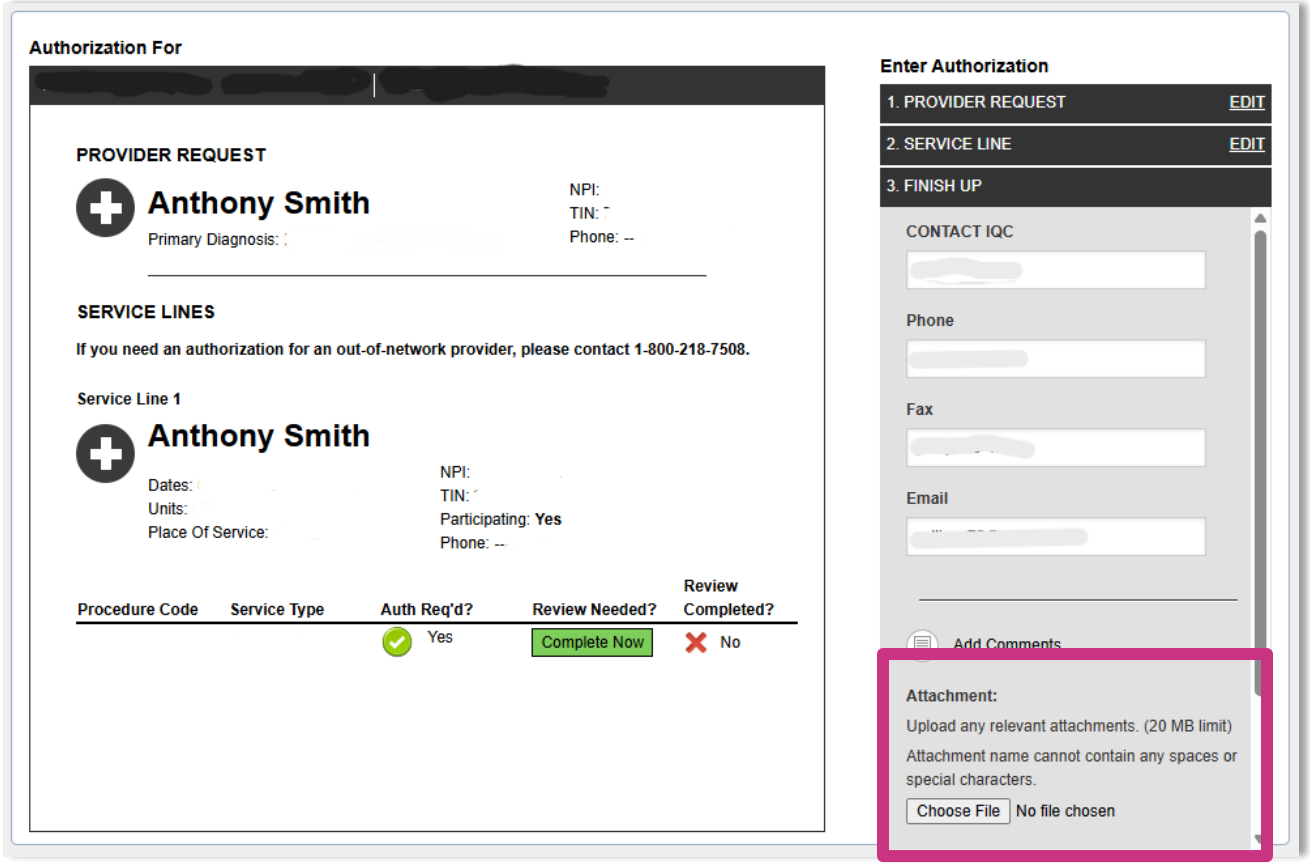
- Each service line will display with the provider information, procedure and place of service as they are added to the authorization.
- **Complete Now** will need to be reviewed.
- The portal user's name, phone, fax and email address will auto-populate into the contact information.
- **Add Comments** here if needed.



Attachments

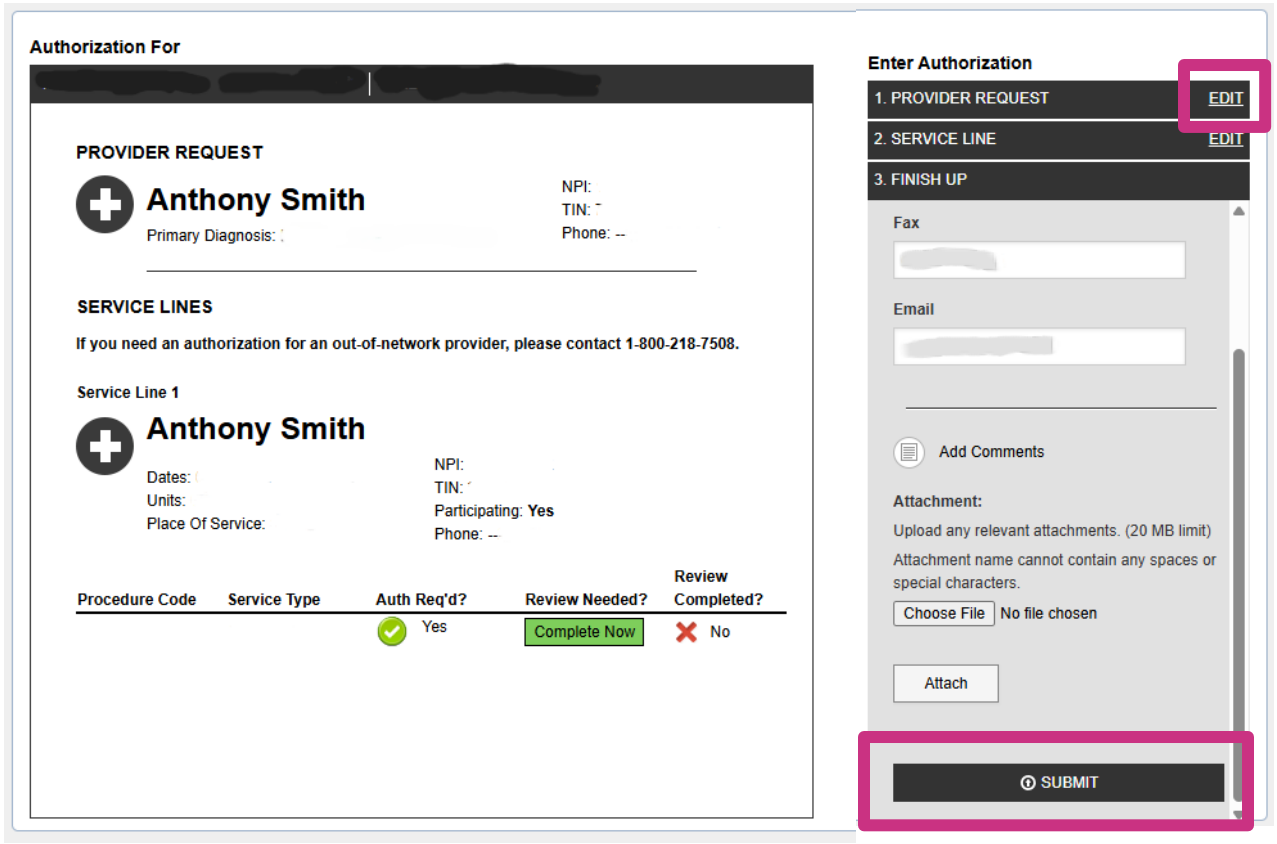
- Attach necessary documentation for a respective authorization here.
- Click on **Choose File** for the document, then click **Attach**.

Please note: There is an attachment upload limit of 20MB.



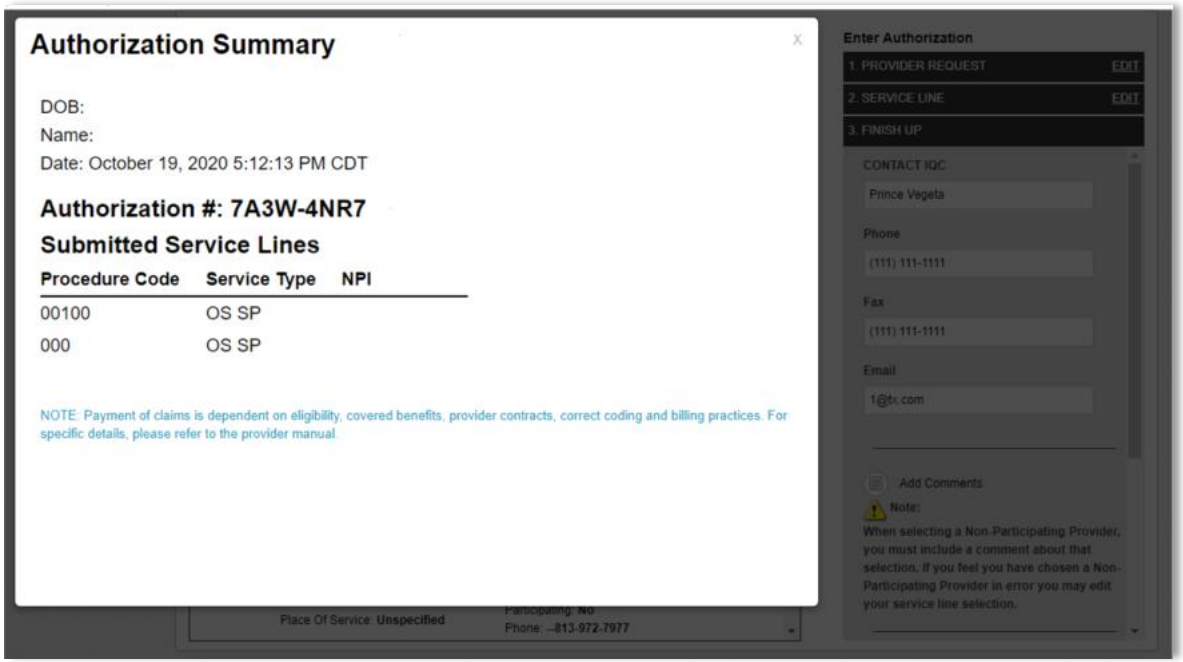
Submit

- Once actions 1 through 3 have been completed, review by scrolling on the left side of the screen.
- If all information is accurate, click **Submit**.
- To make corrections, click **Edit** on actions 1 or 2 on the right-hand side of the screen.



Confirmation

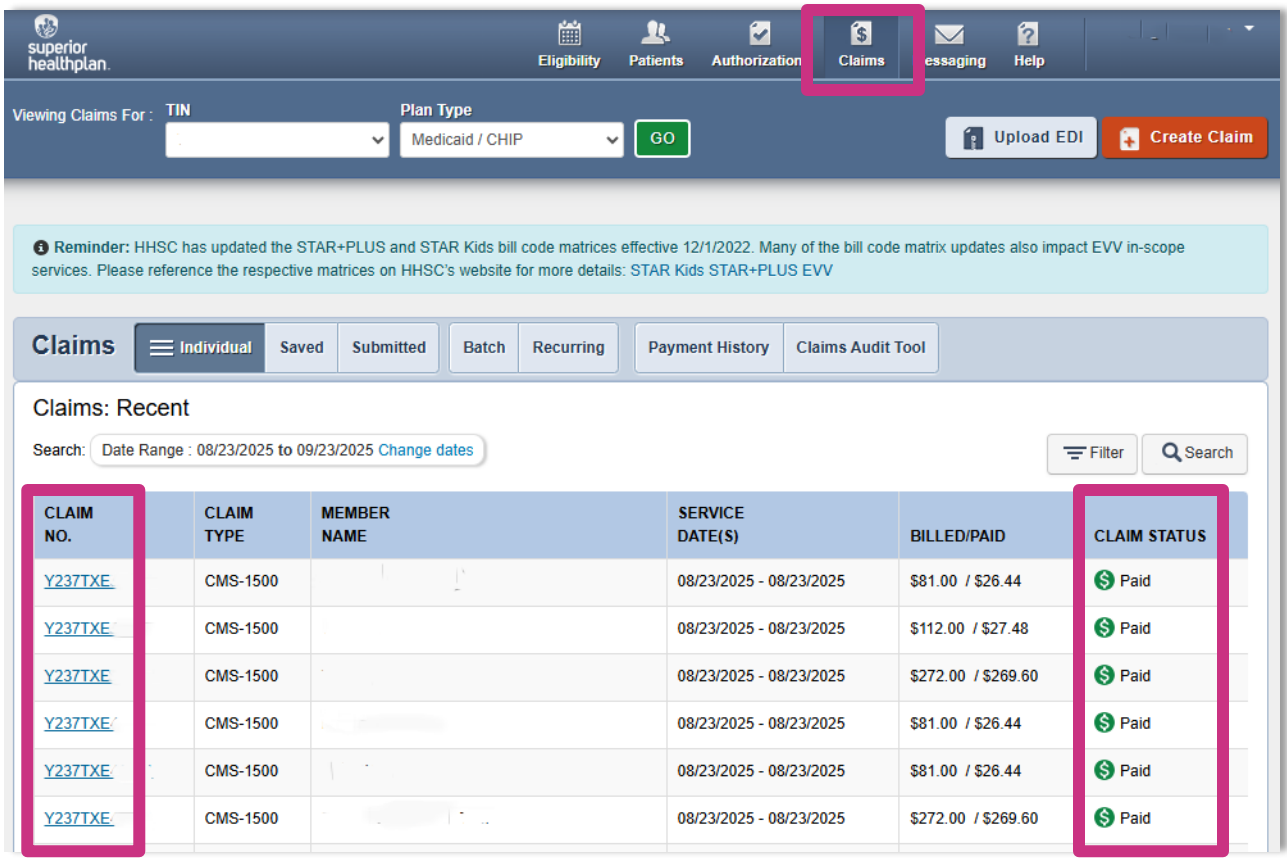
- A confirmation screen will appear once the prior authorization has been submitted successfully.
- Please keep record of this number to review status or for reference when calling Superior for assistance.



Claims

Claims

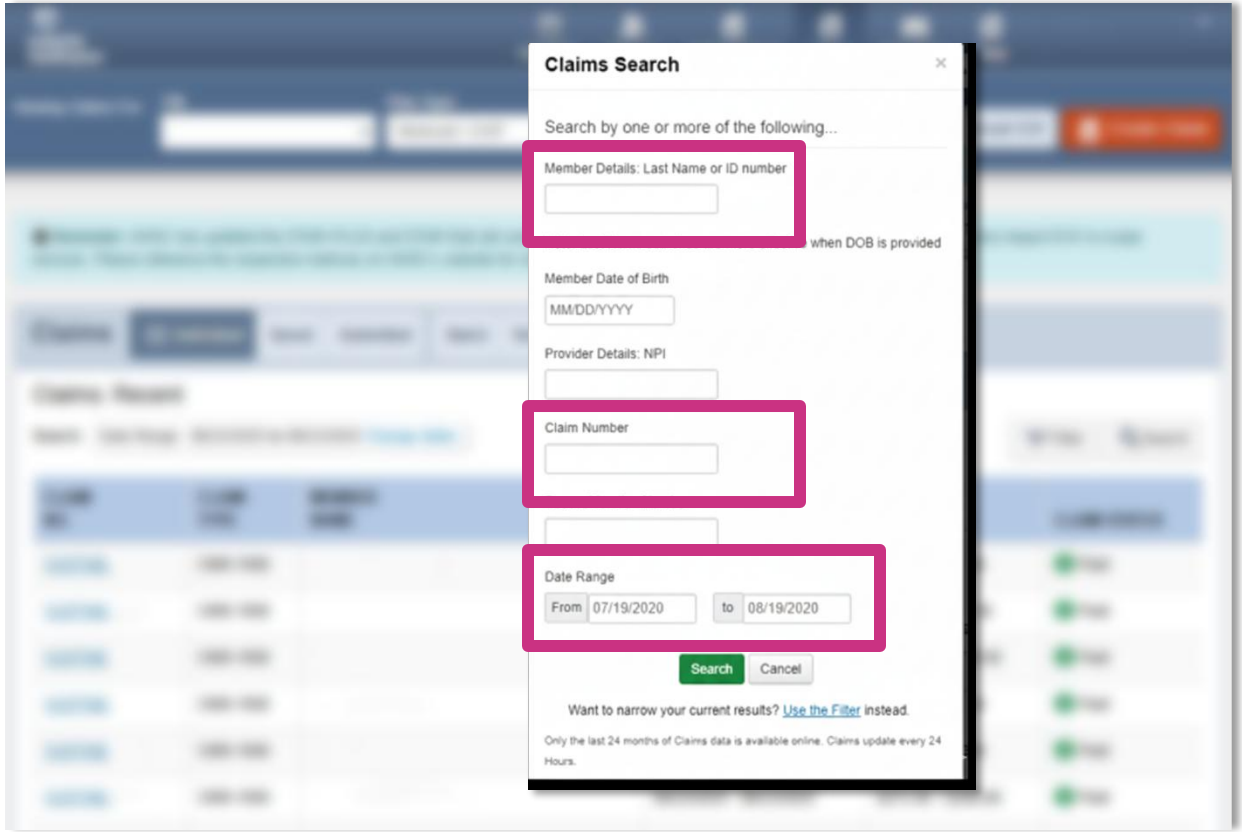
- The **Claims** tab offers a summary of all claims activity for the previous 30 days.
- View each claim's details by clicking on the claim number in the **Claim No.** column.
- View the status of each claim in the **Claim Status** column.



Claim Search

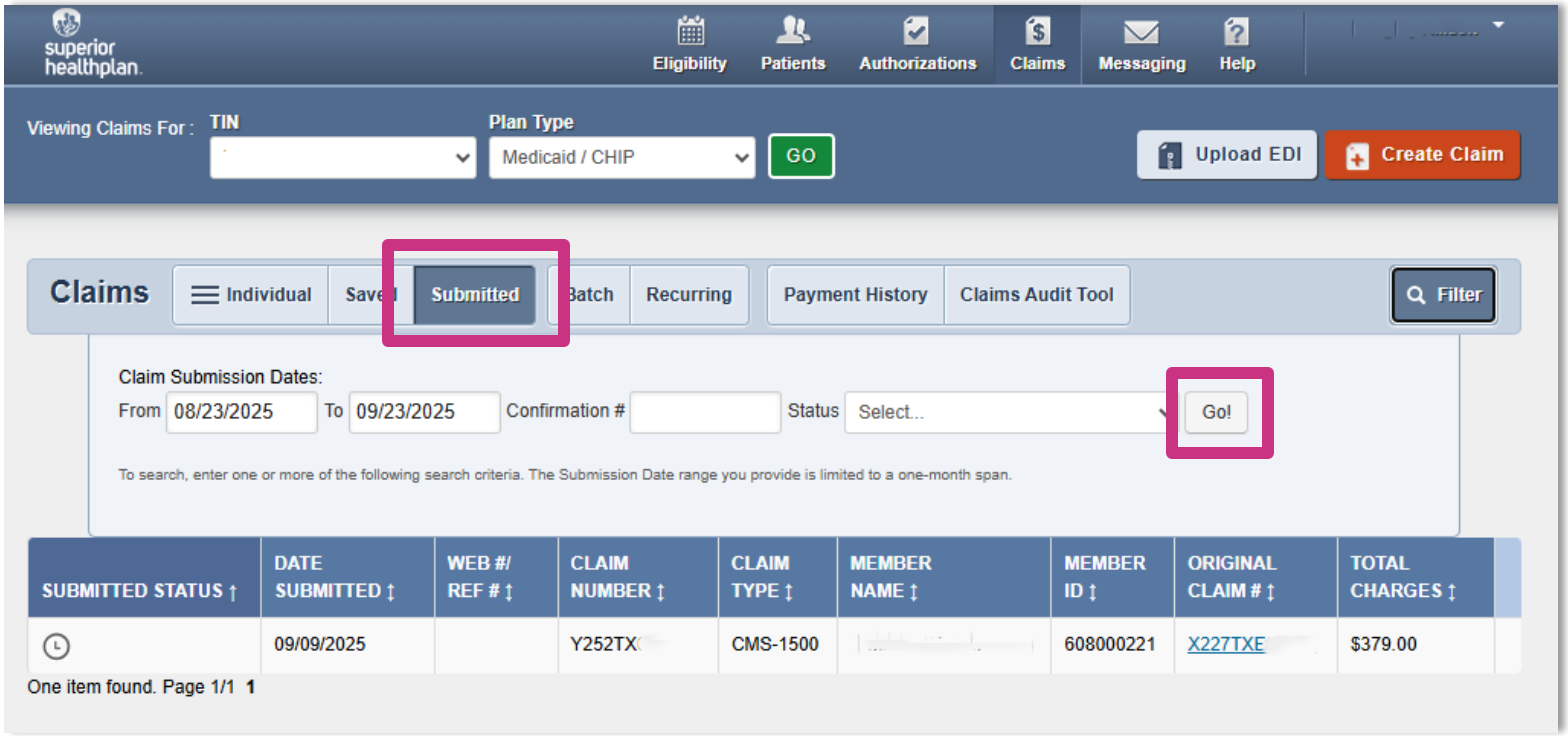
- Enter 1 or more of the following search criteria:
  - **Member Details: Last Name or ID number**
  - **Claim Number**
  - **Date Range** (limited to a 1-month span and only the last 24 months of claims data is available online)

Please note: Claims update every 24 hours.



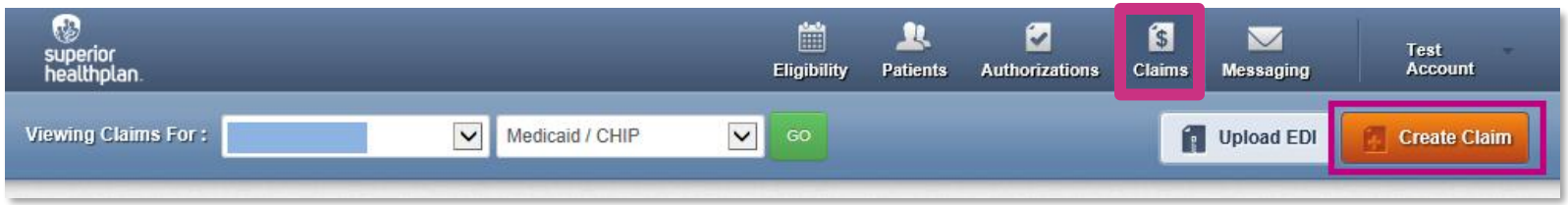
Claim Search

- When searching under the **Submitted** tab, you can enter the confirmation number, or search by a date range, and click **Go**.

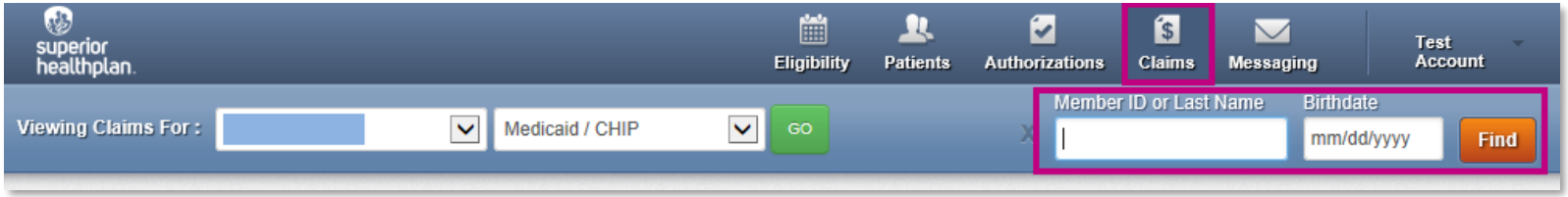


Claim Submission

- Select **Create Claim** from the **Claims** tab.



- Enter the **Member ID** or **Last Name** and **Birthdate** for whom the claim will be submitted then click **Find**.



- Choose either the **CMS 1500** or **CMS UB-04** claim type.

Claim Submission

- Required Fields:
  - **Patient Account Number**
  - **Statement Dates**
- Enter other pertinent information for the claim, as necessary.
- Use the field tabs to get additional details for entered information.

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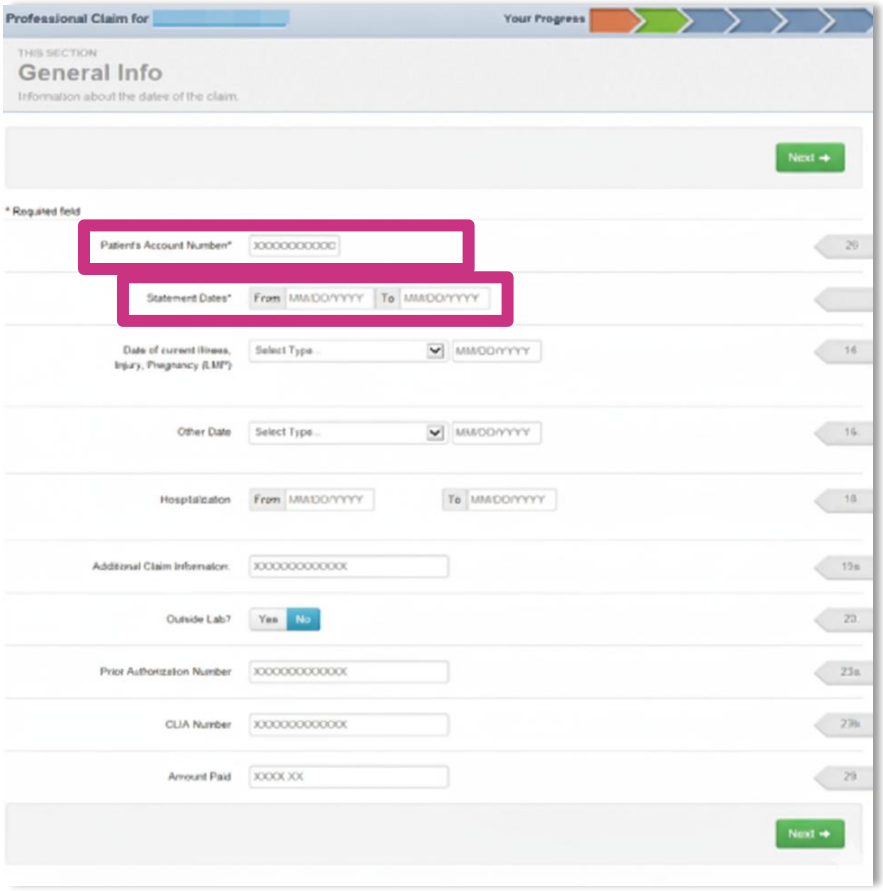
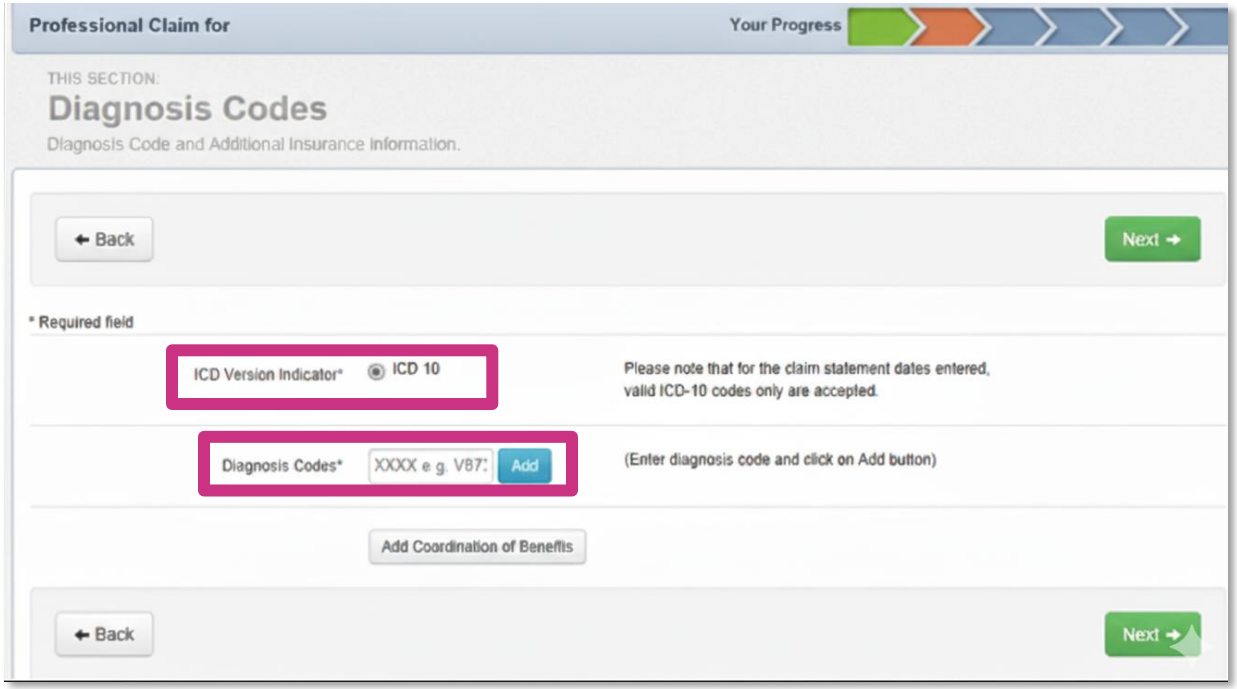


Claim Submission

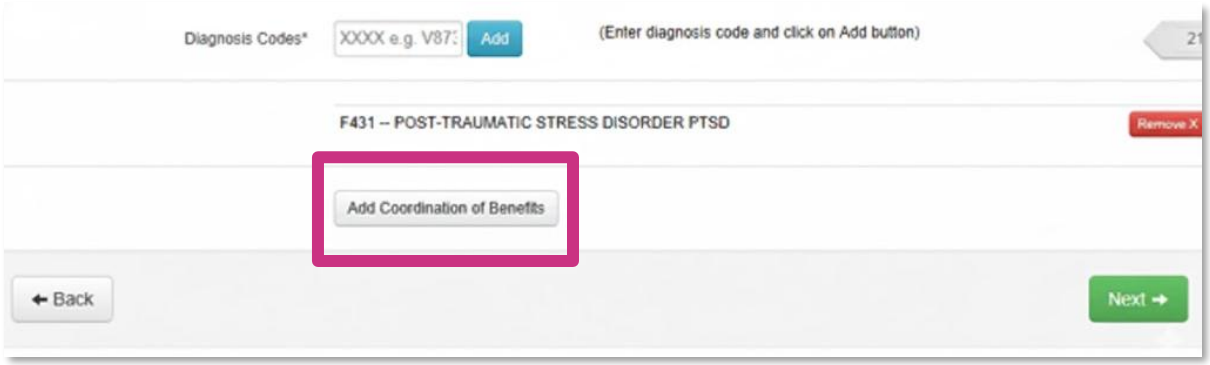
- Required Fields:
  - **ICD Version Indicator**
  - **Diagnosis Codes**

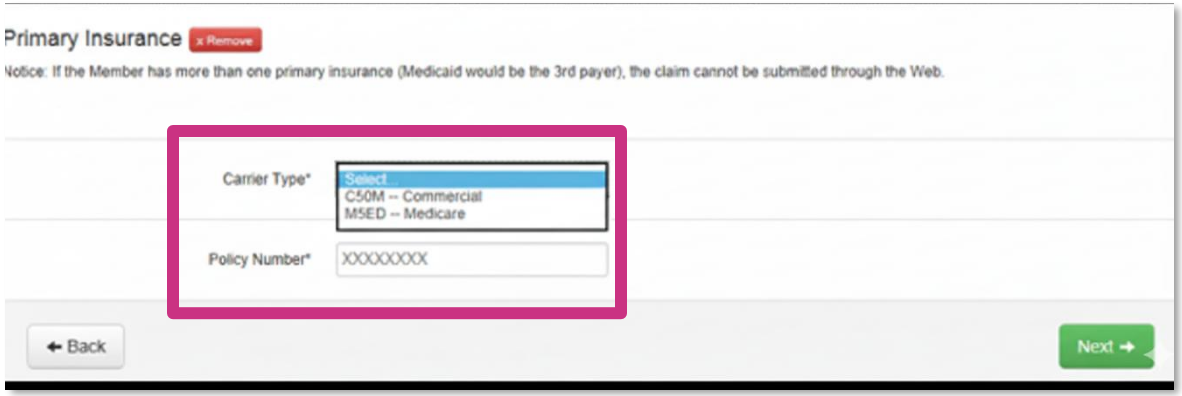


Coordination of Benefits Claims

- Click **Add Coordination of Benefits** to include primary insurance information when applicable.
- New fields will appear to enter the **Carrier Type** and the primary insurance **Policy Number**.

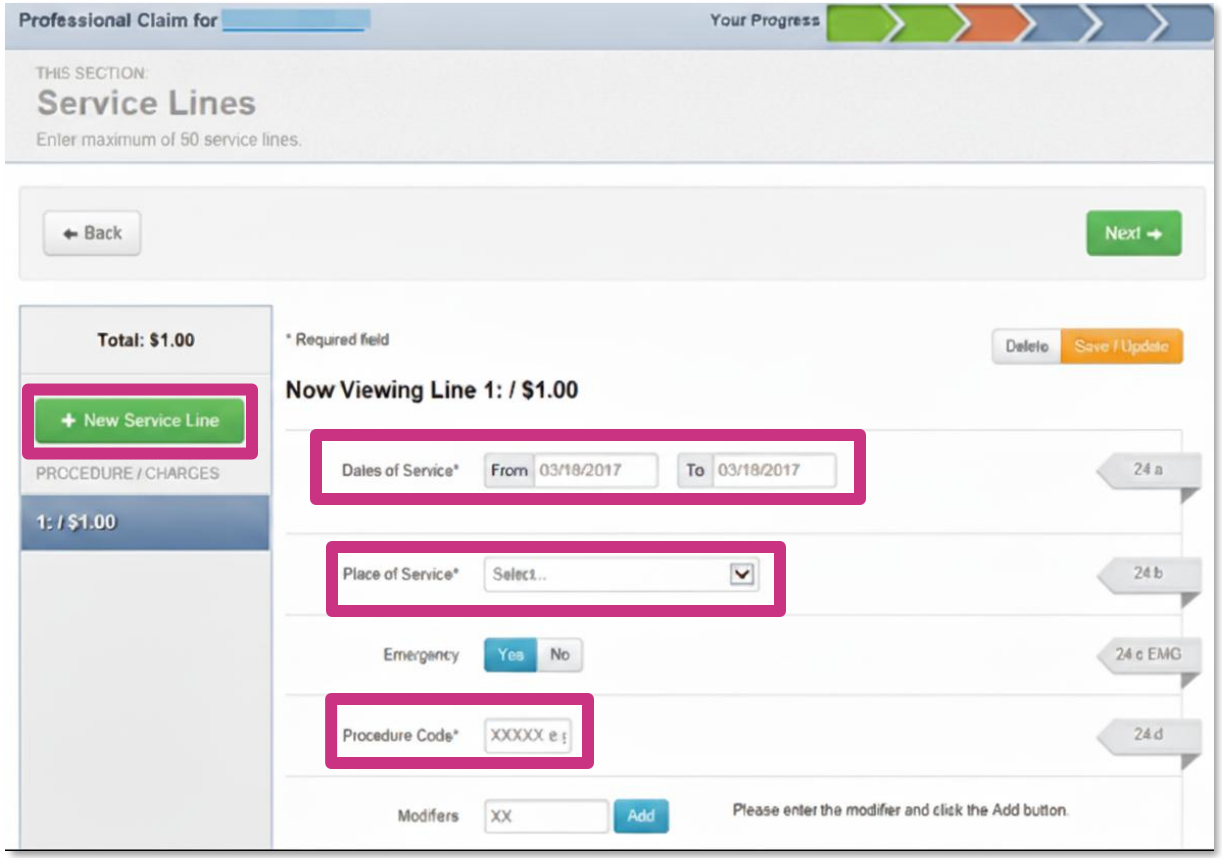
Please note: If the member has more than 1 primary insurance (Medicaid would be the third payer), the claim cannot be submitted on the portal.





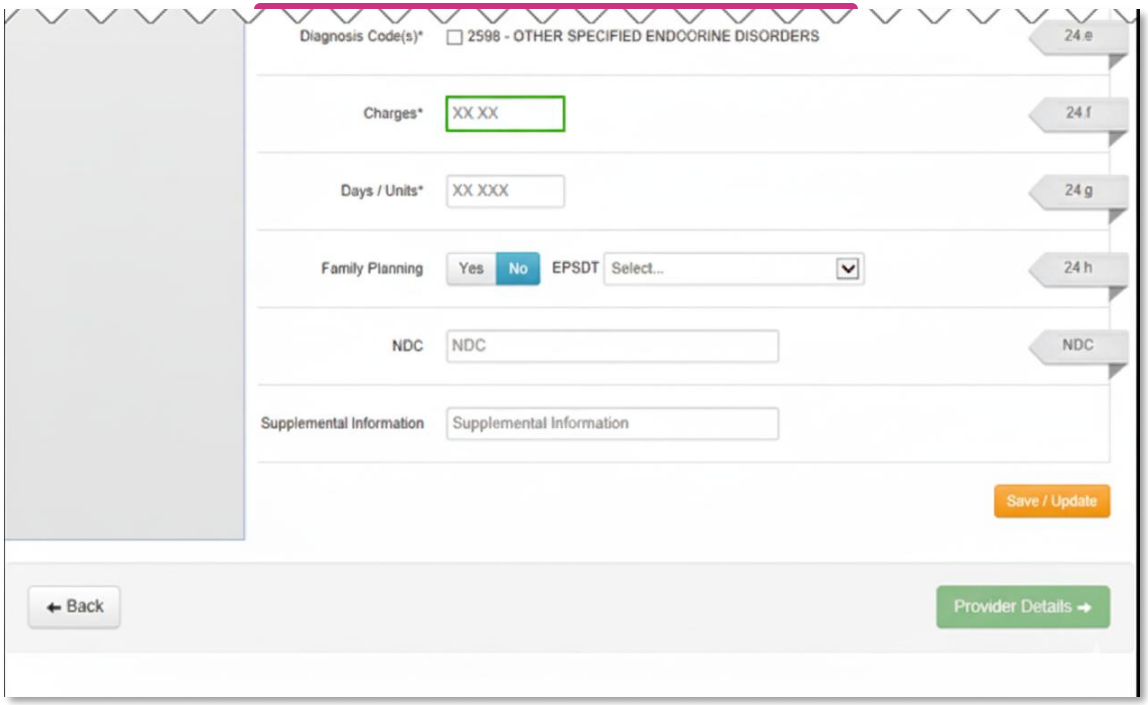
Claim Submission

- Required Fields:
  - **Dates of Service**
  - **Place of Service**
  - **Procedure Code**
- A maximum of 50 service lines can be entered for an individual claim.
- Additional service lines are entered using **+ New Service Line**.



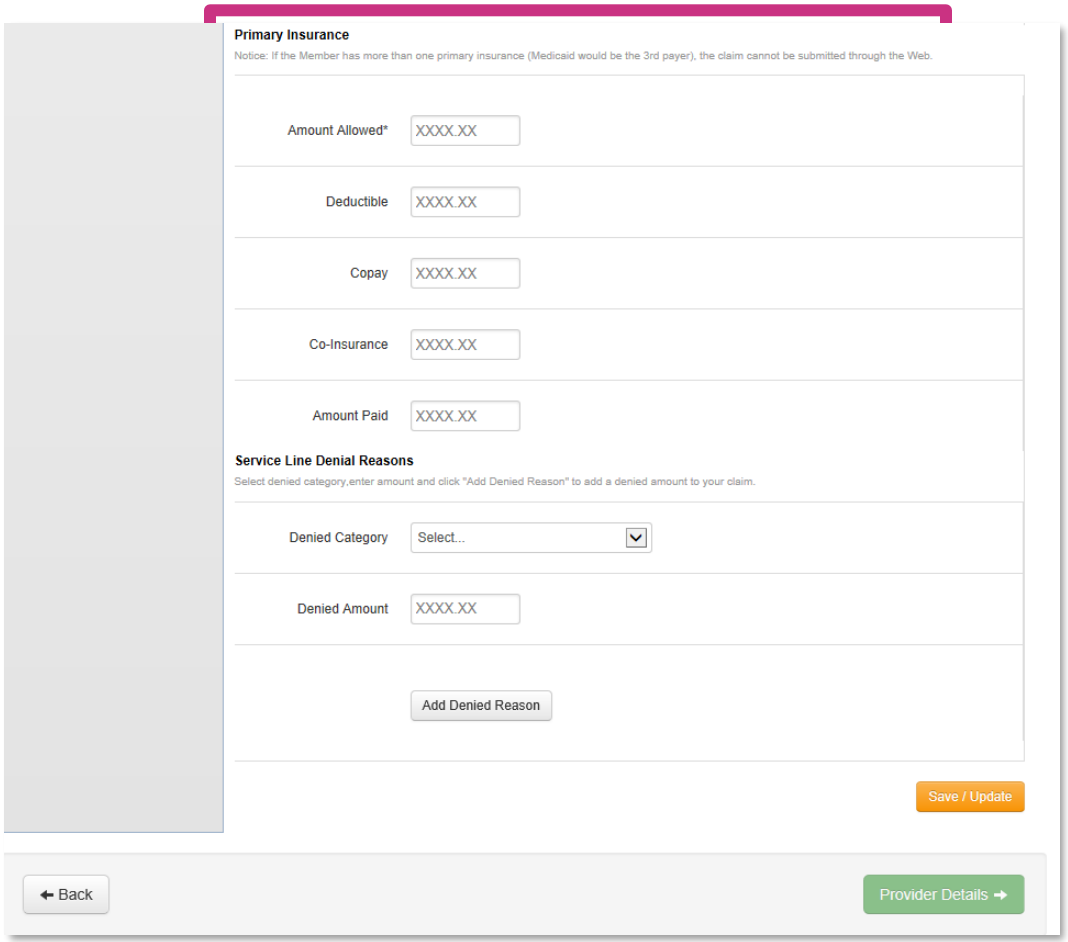
Claim Submission

- Required Fields:
  - **Diagnosis Code(s)**
  - **Charges**
  - **Days/Units**



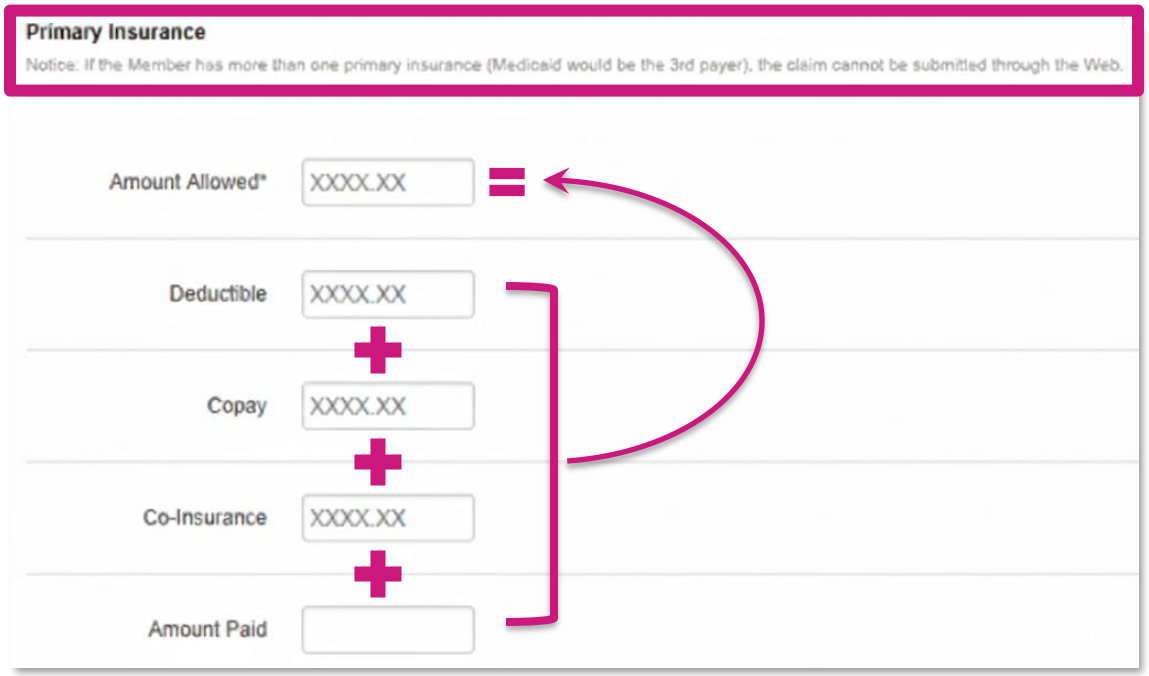
Coordination of Benefits Claims

- The **Primary Insurance** and **Service Line Denial Reasons** fields will be present when Coordination of Benefits is selected at step 1.
- Complete based on the primary insurance Evidence of Payment (EOP).



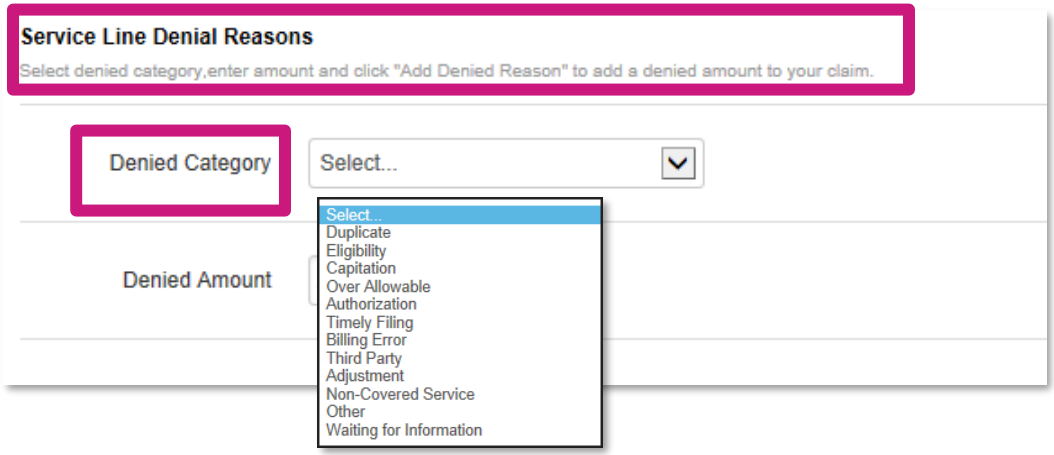
Coordination of Benefits Claims

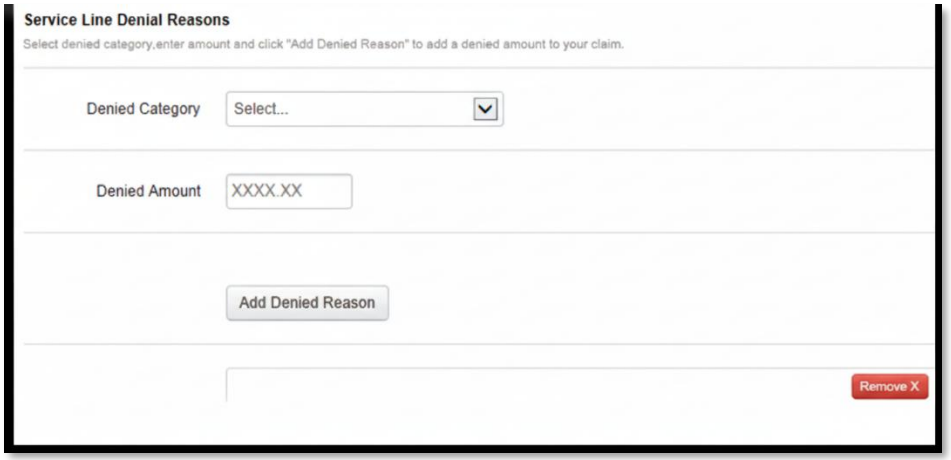
- The **Primary Insurance** fields perform a calculation to ensure accuracy when billing.
- **Deductible** + **Copay** + **Co-Insurance** + **Amount Paid** = **Amount Allowed**



Coordination of Benefits Claims

- **Service Line Denial Reasons** are used to indicate instances where the amount allowed is less than the charges. These can be indicated using the dropdown menu and entering the denied amount.
- **Add Denied Reason** must be clicked to include the **Denied Category** and **Denied Amount**.
- A new line will be created when the **Denied Category** has been successfully added to the service line.

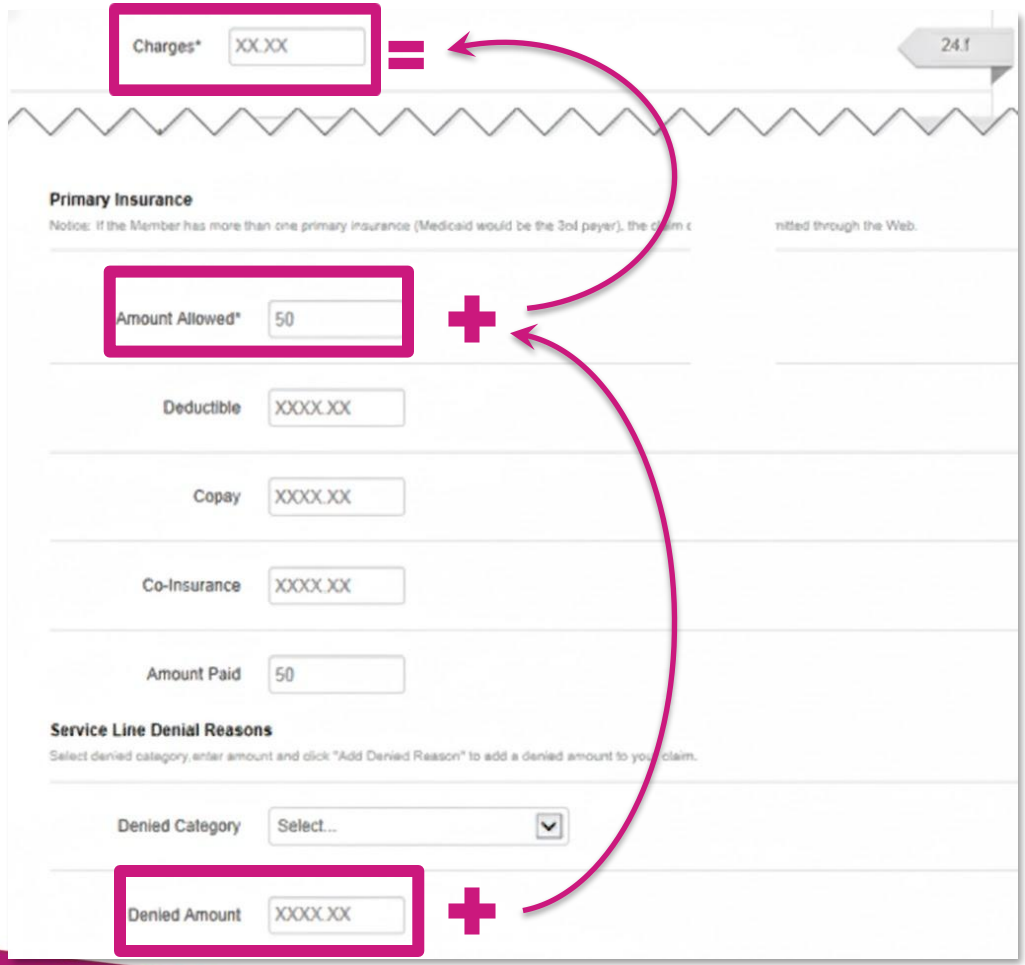




Coordination of Benefits Claims

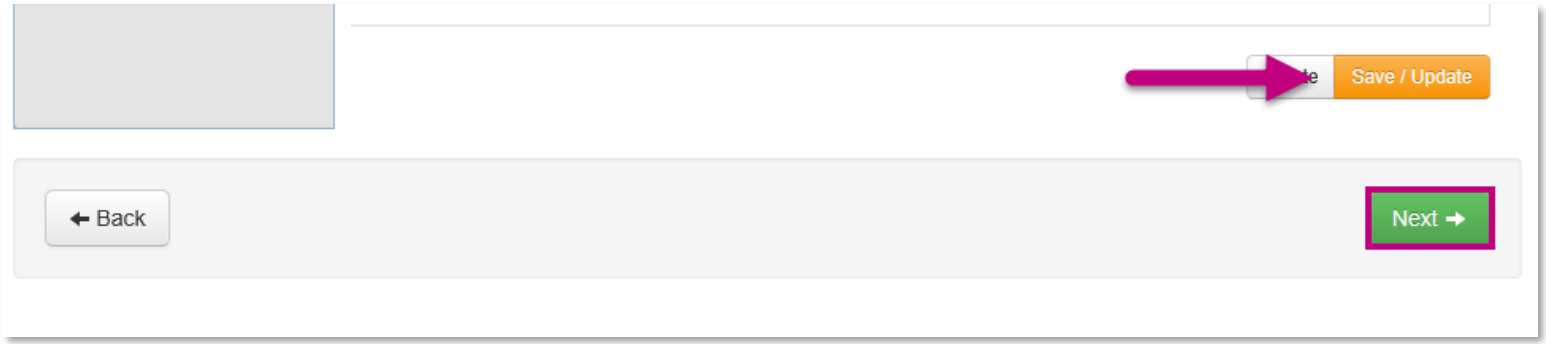
- Final Calculations:
  - Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

Please note: Denied Category and Denied Amount are not required and can be left blank when appropriate.



Claim Submission

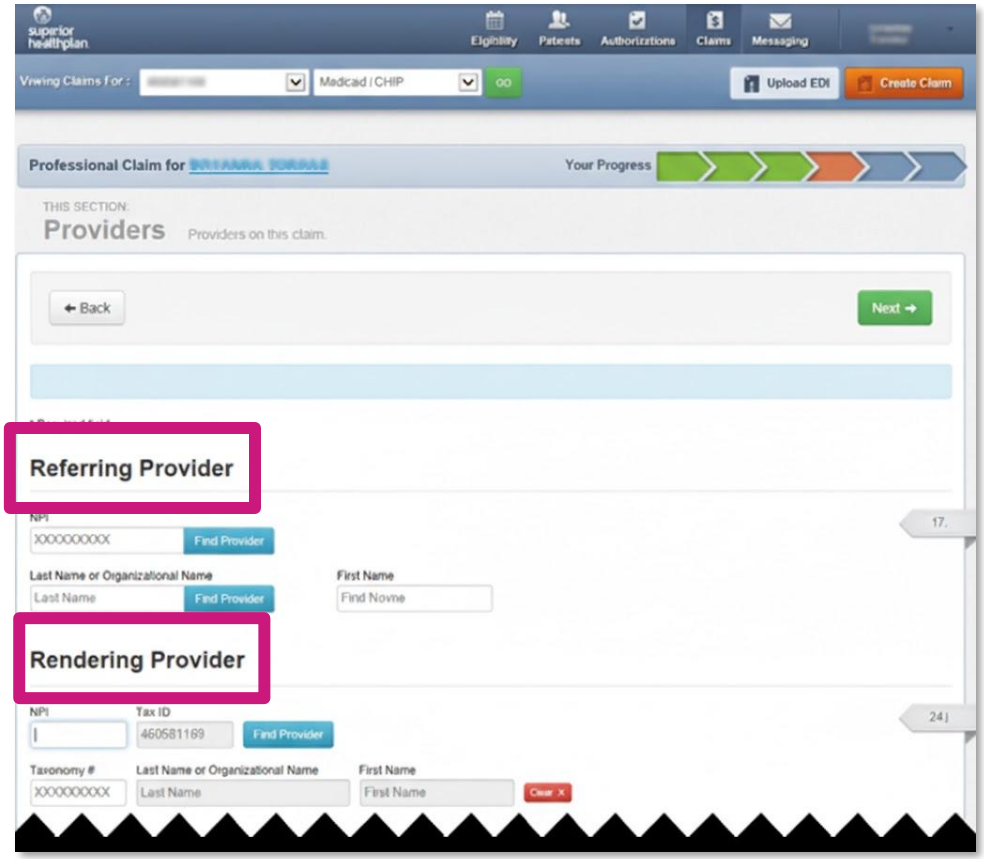
- **Save/Update** must be clicked to enter each service line.
- **Next** will be greyed out and un-clickable until the first service line is saved.



Claim Submission

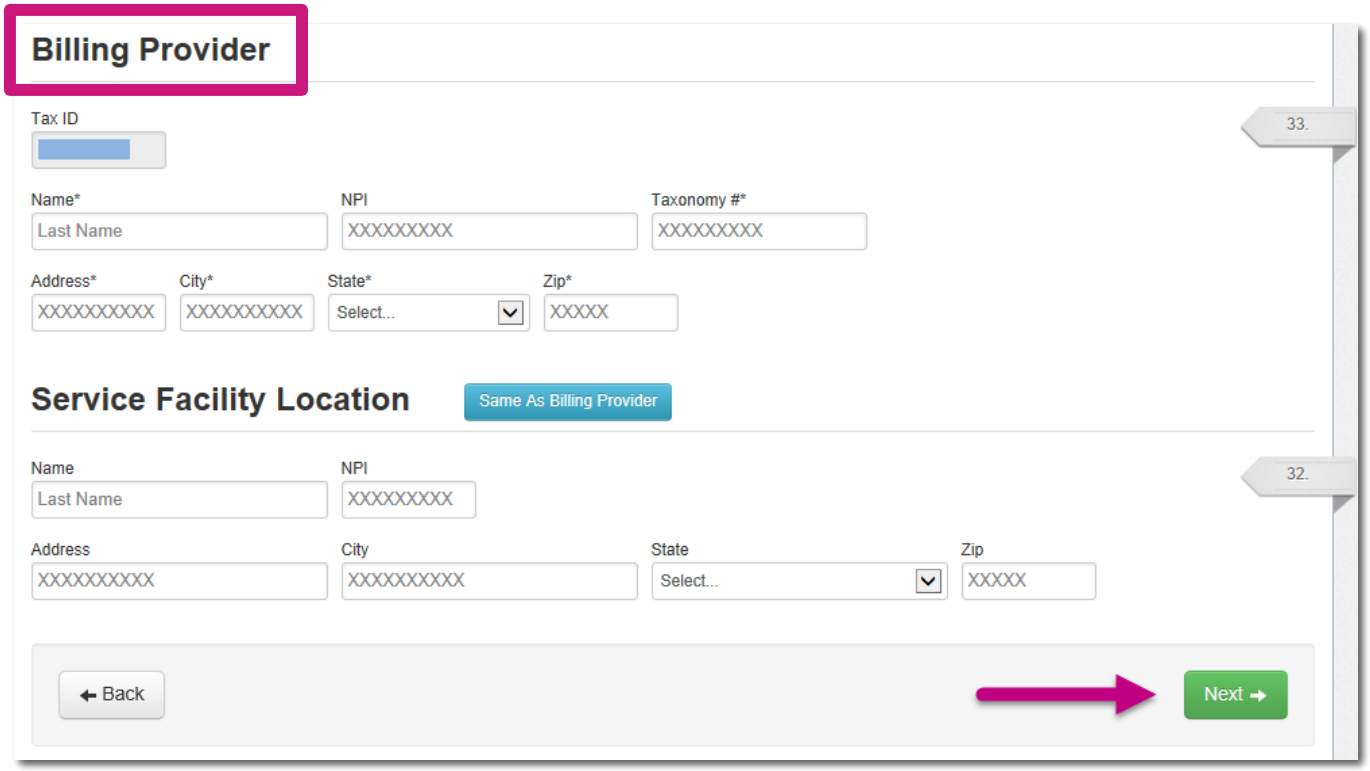
- Enter pertinent provider information for **Referring Provider** and **Rendering Provider**.

Please note: Only enter Rendering Provider information if it is not the same as Billing Provider information.



Claim Submission

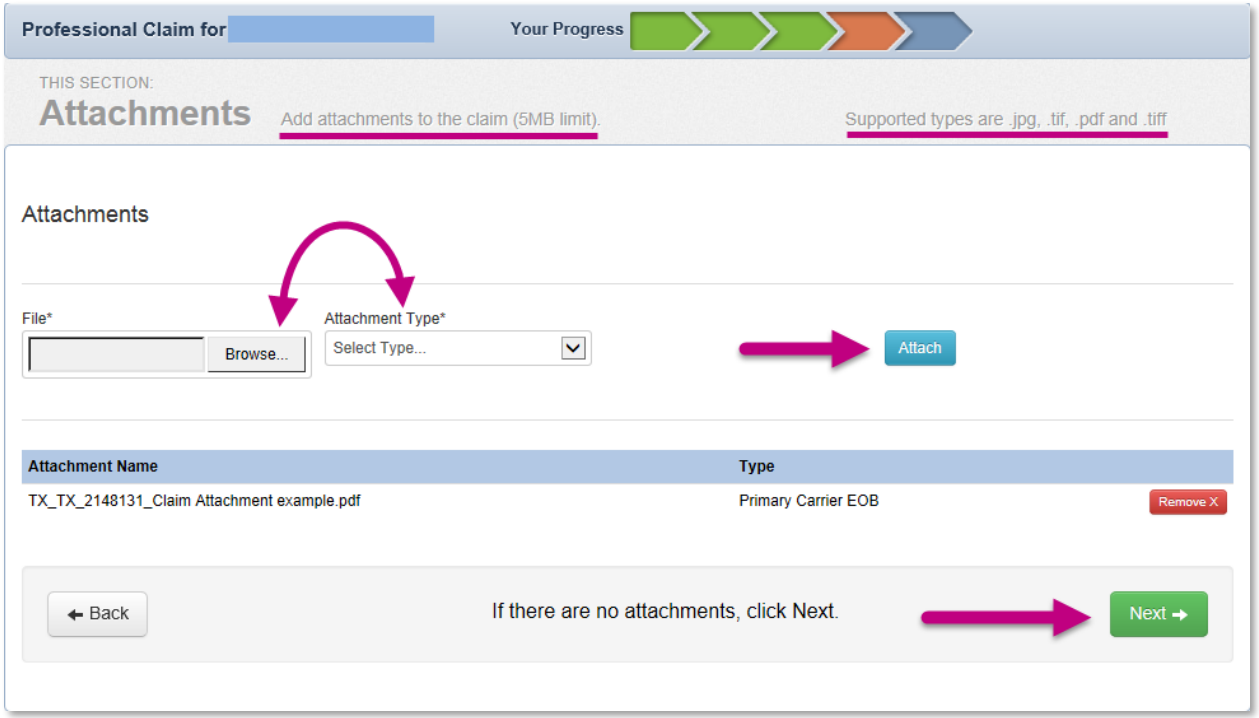
- **Billing Provider** information is required and must be completed for each claim submission.
- Click on the **Next** button to continue.



Claim Submission

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

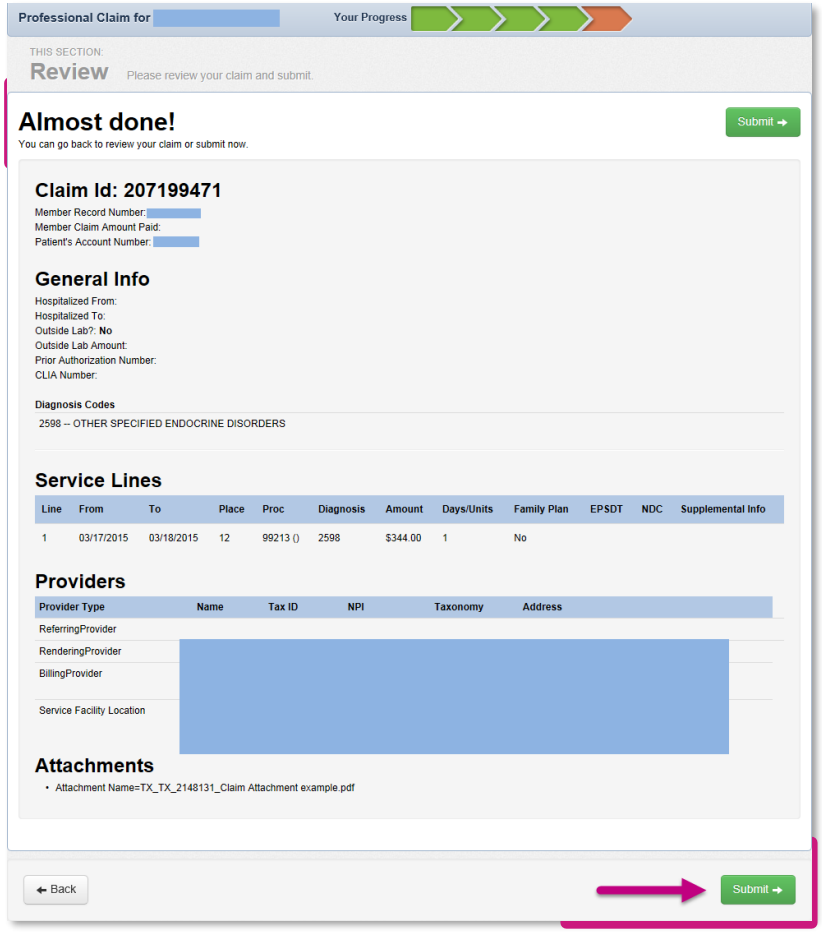
Please note: There is a 30MB limit and only .jpg, .tif, .pdf and .tiff are supported file types for attachments



Claim Submission

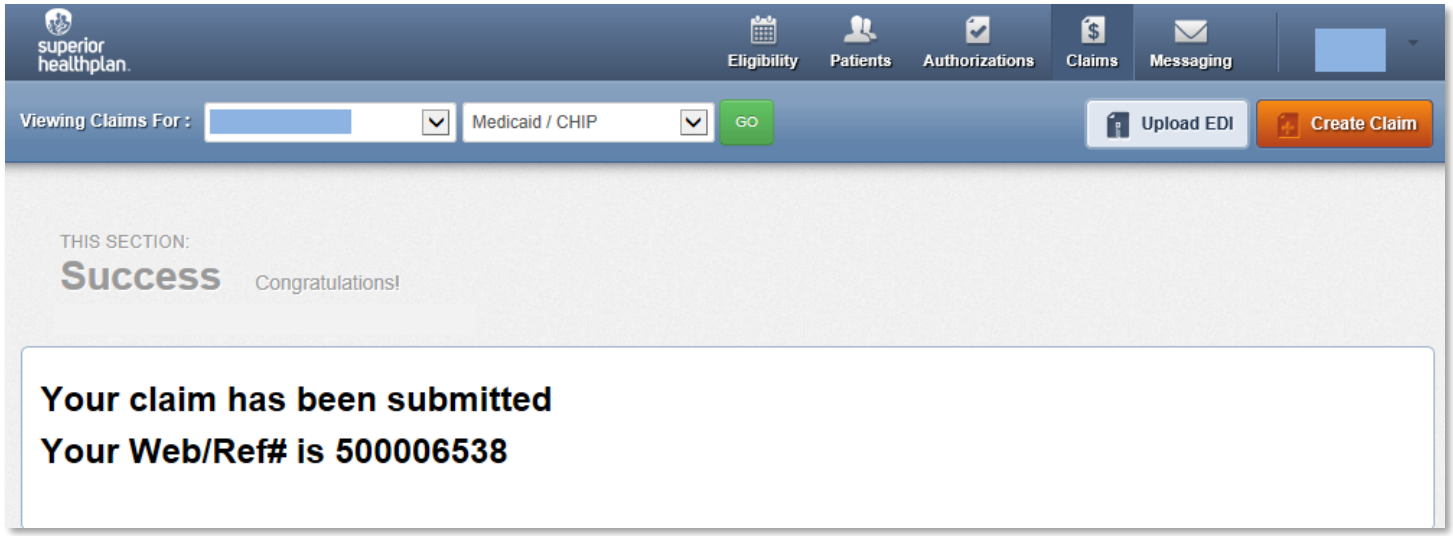
Almost done!

- Portal claims follow the same submission guidelines and standards as any other claim. Improper coding can result in claim denials.
- Please take this time to review the claim before submitting.
- Click **Submit** when the claim is complete.



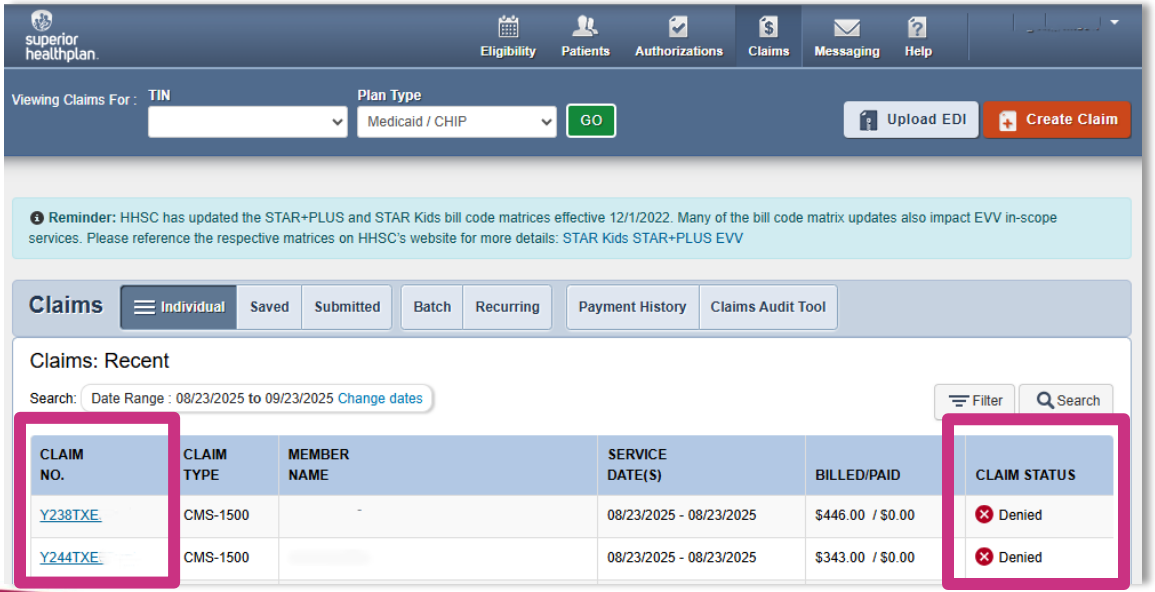
Claim Submission

- **Your Web/Ref#** (Web Reference Number) will be useful when discussing a claim that has been submitted through the portal with your Provider Representative.
- The number given here is not a claim number but merely helps to identify a claim submitted using the secure portal.



Claim Corrections/Appeals

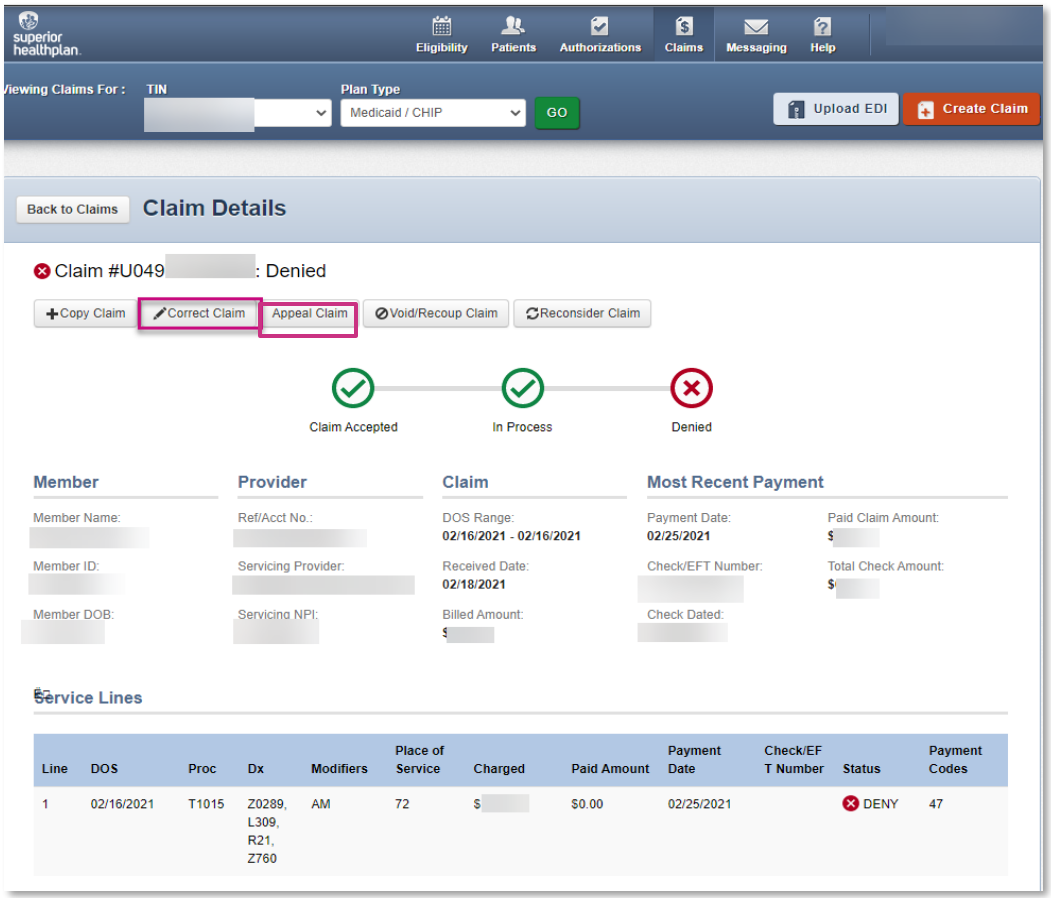
- Denied or partially paid claims can be corrected/appealed online.
- Click on the **Claim No.** to see the details and begin the correction/appeal process.
- Use the **Claim Status** to easily identify those claims that have been denied.



Claim Corrections/Appeals

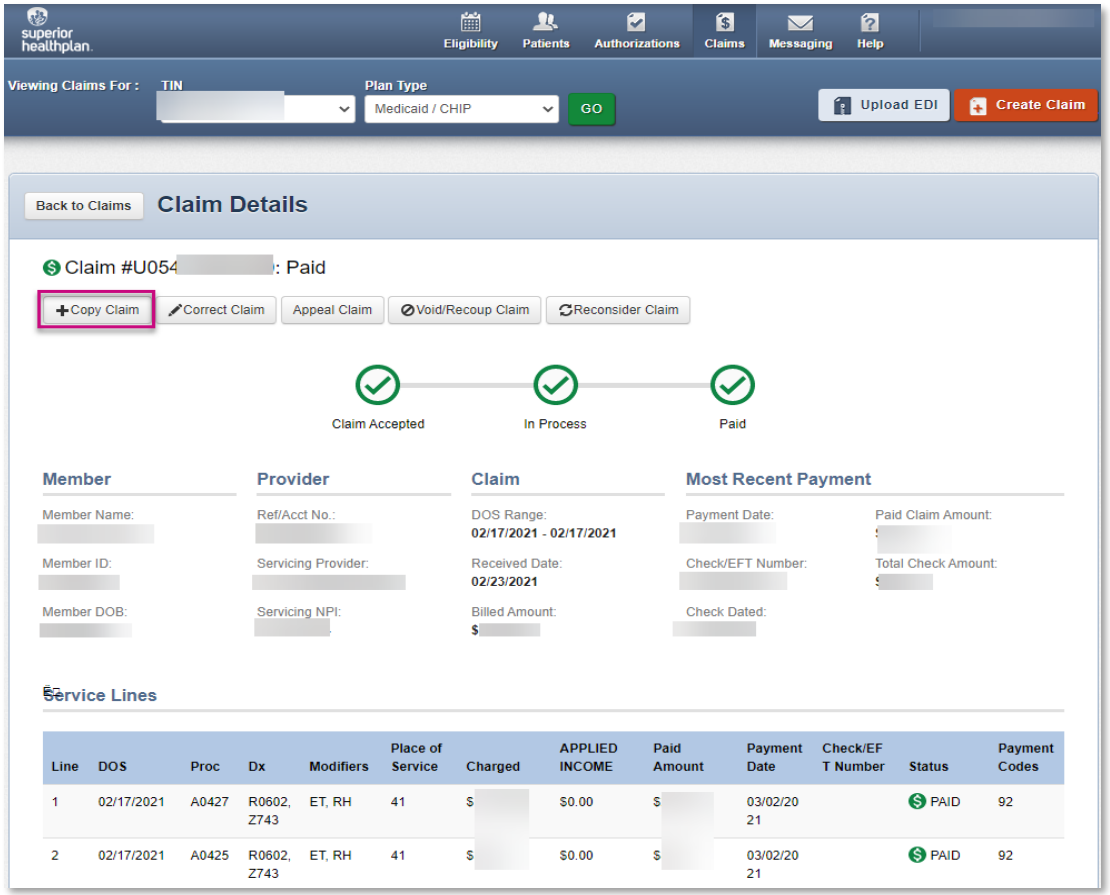
- Use the **Correct Claim** or **Appeal Claim** button to begin the process. Each screen of the claim will be visible so updates can be made as necessary, then re-submitted.

*Please note: The **Providers** section will be visible, but changes can no longer be made. If this section needs to be modified, a new claim must be submitted.*



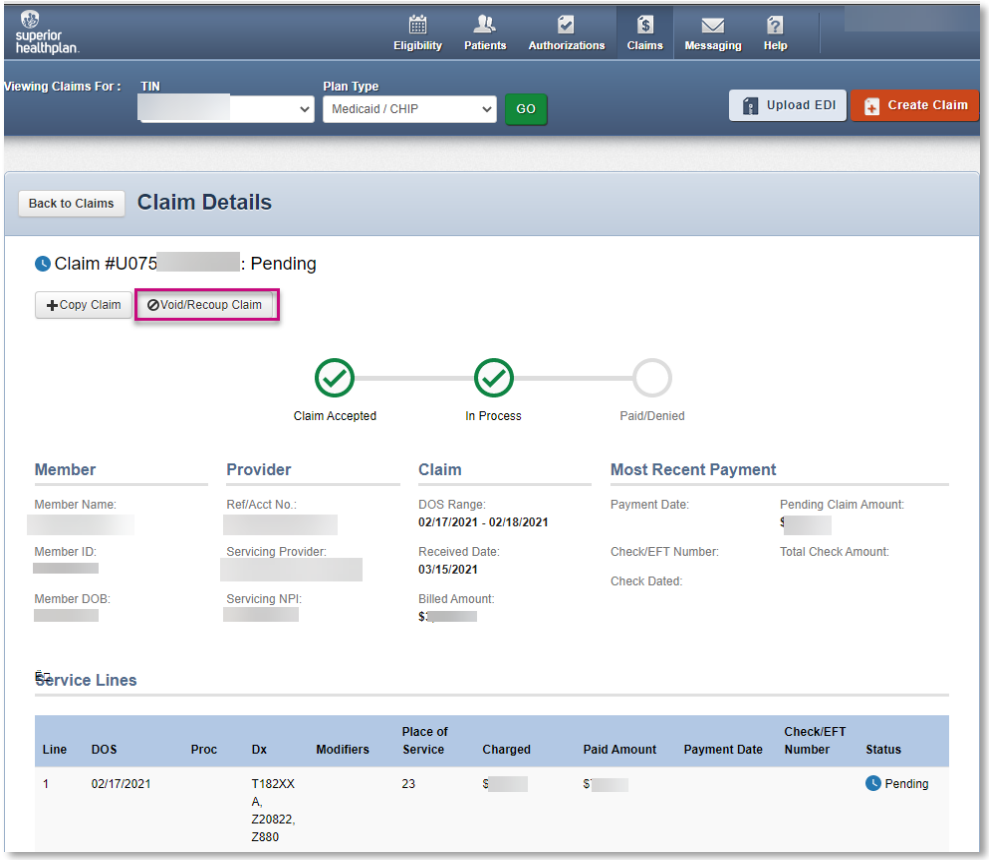
Copy Claim

- Click **Copy Claim** to copy, edit or resubmit claims for the same member.
- The information from the claim being copied is entered into a new claim submission form.



Void/Recoup Claims

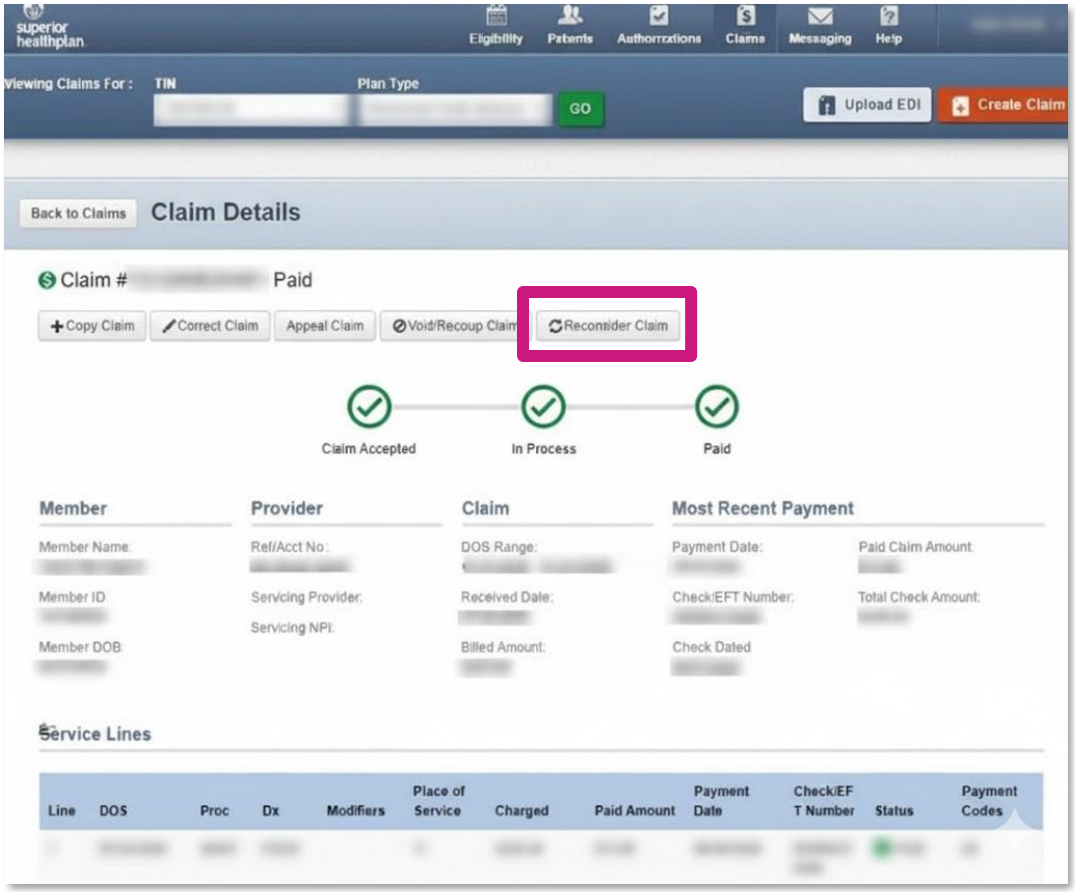
- Select **Void/Recoup Claim** to:
  - Void a submitted claim.
  - Recoup any over-payments.



Reconsider Claim

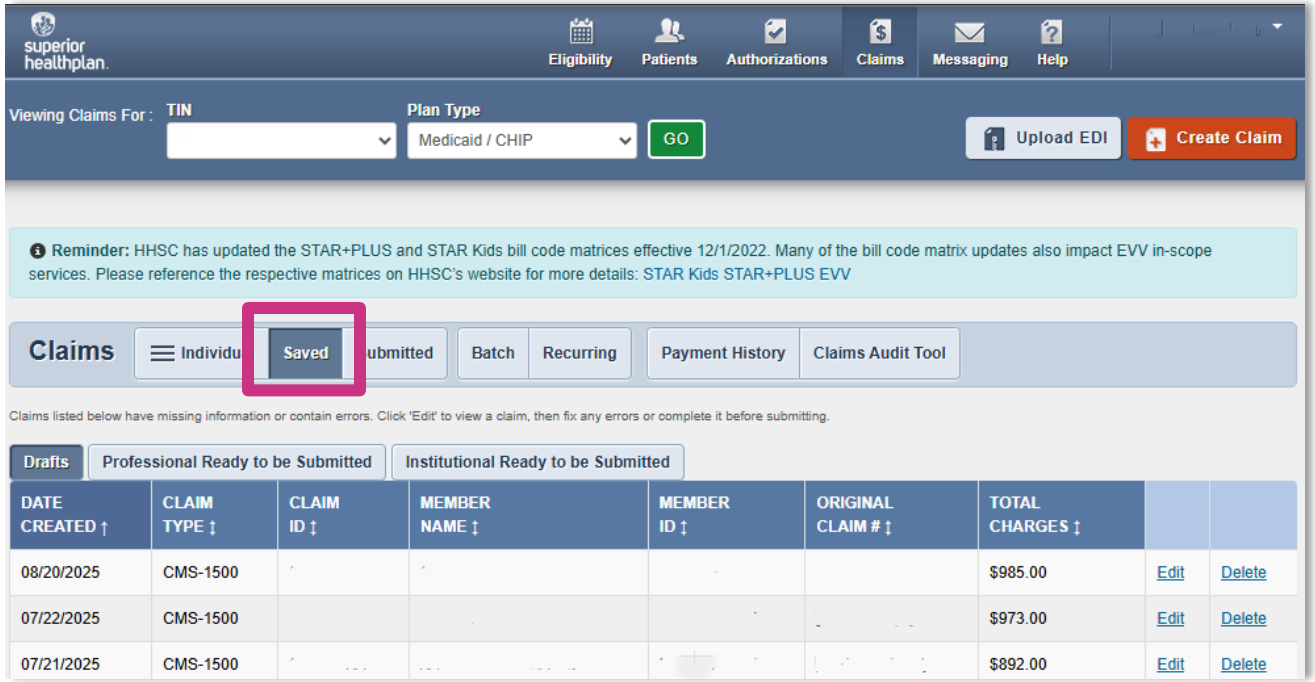
- Select **Reconsider Claim** to submit the claim for reconsideration.

Please note: Information cannot be updated on the claim. Only attachments are allowed for submitting a reconsideration.



Saved Claims

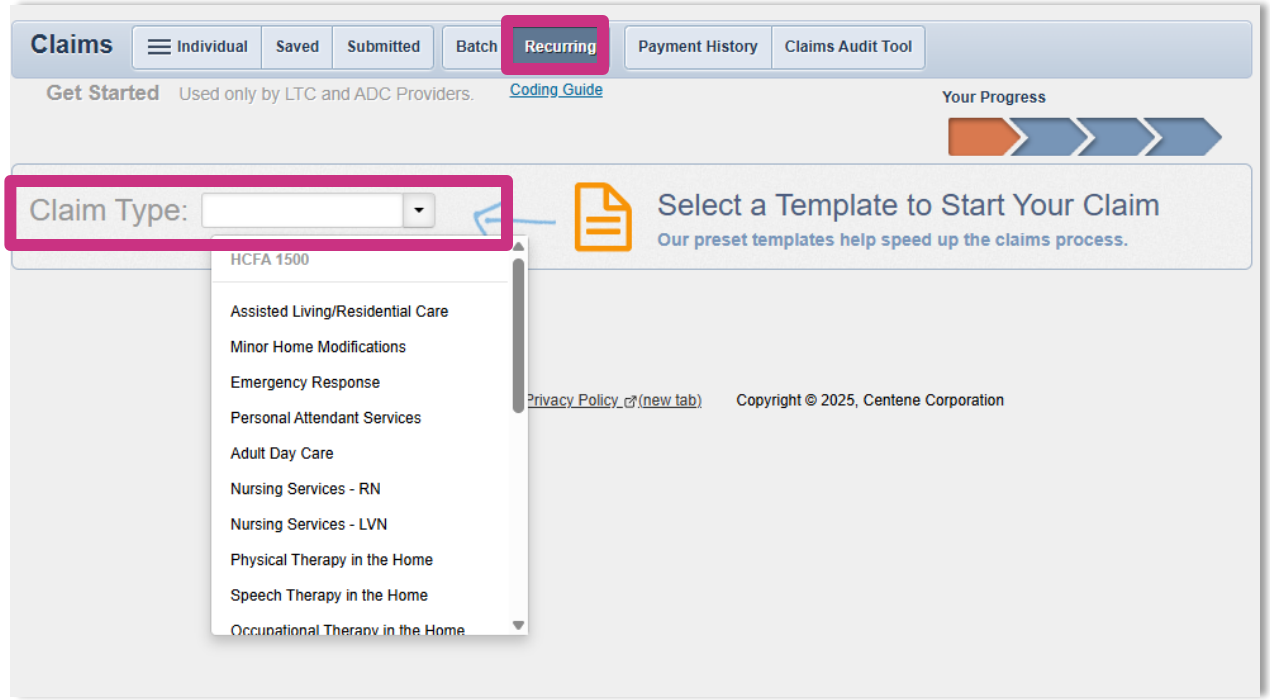
- Every claim that has been started but not submitted can be found in the **Saved** claims section.
- The portal automatically saves claim submission progress to ensure no work is lost.



Recurring Claims

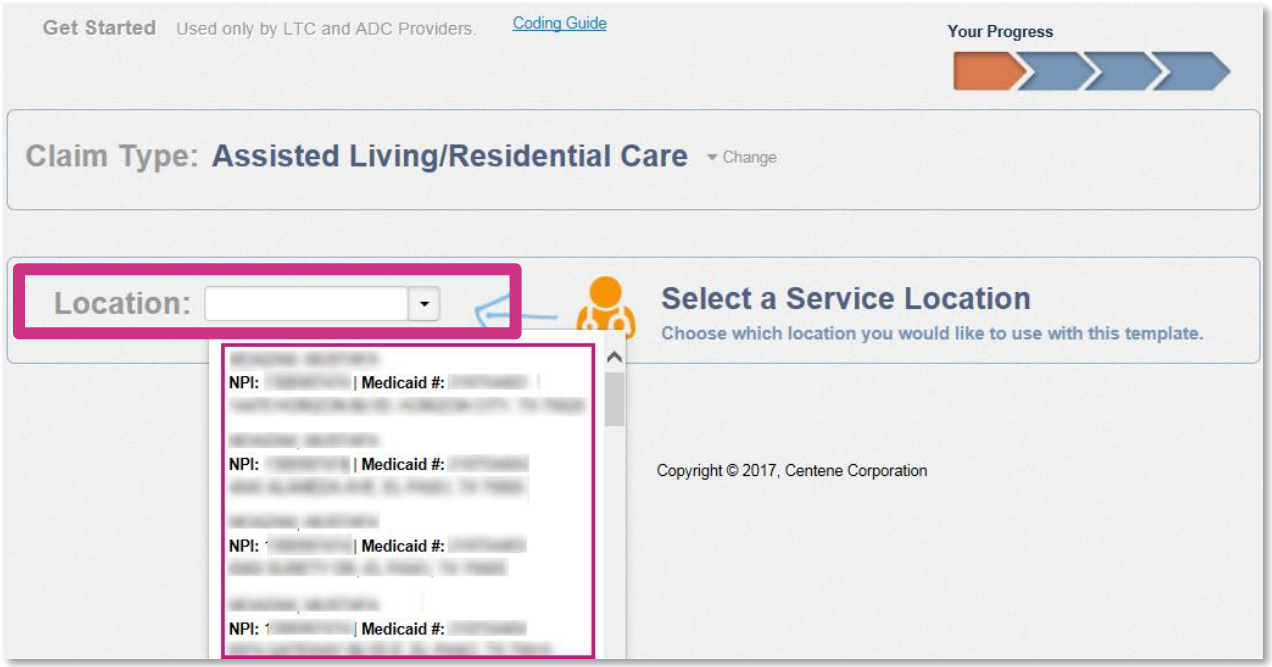
- Use the **Recurring** claim button to create multiple claims with pre-made templates for more efficient billing.
- Start by selecting a **Claim Type** from the dropdown.
- Refer to the Coding Guide for a list of pre-coded items.

Please note: This tool is to be used only by Long Term Care (LTC) and Adult Day Care (ADC) providers.



Recurring Claims

- Select the desired service **Location** from the dropdown.

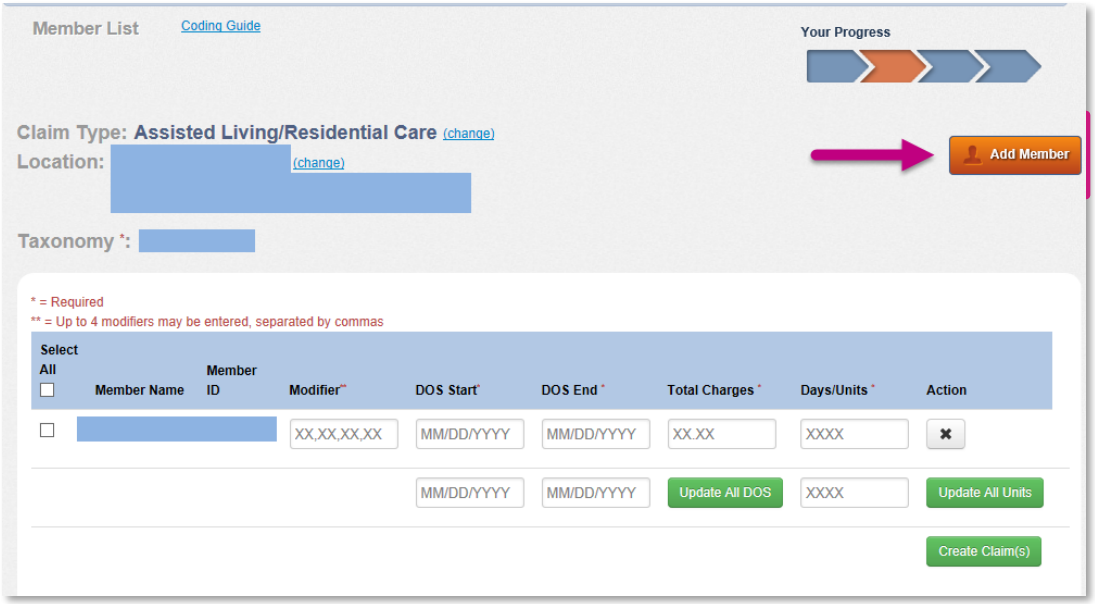


Recurring Claims

- Click on **View Member List**.
- Member lists only need to be created once during your first time using the tool.

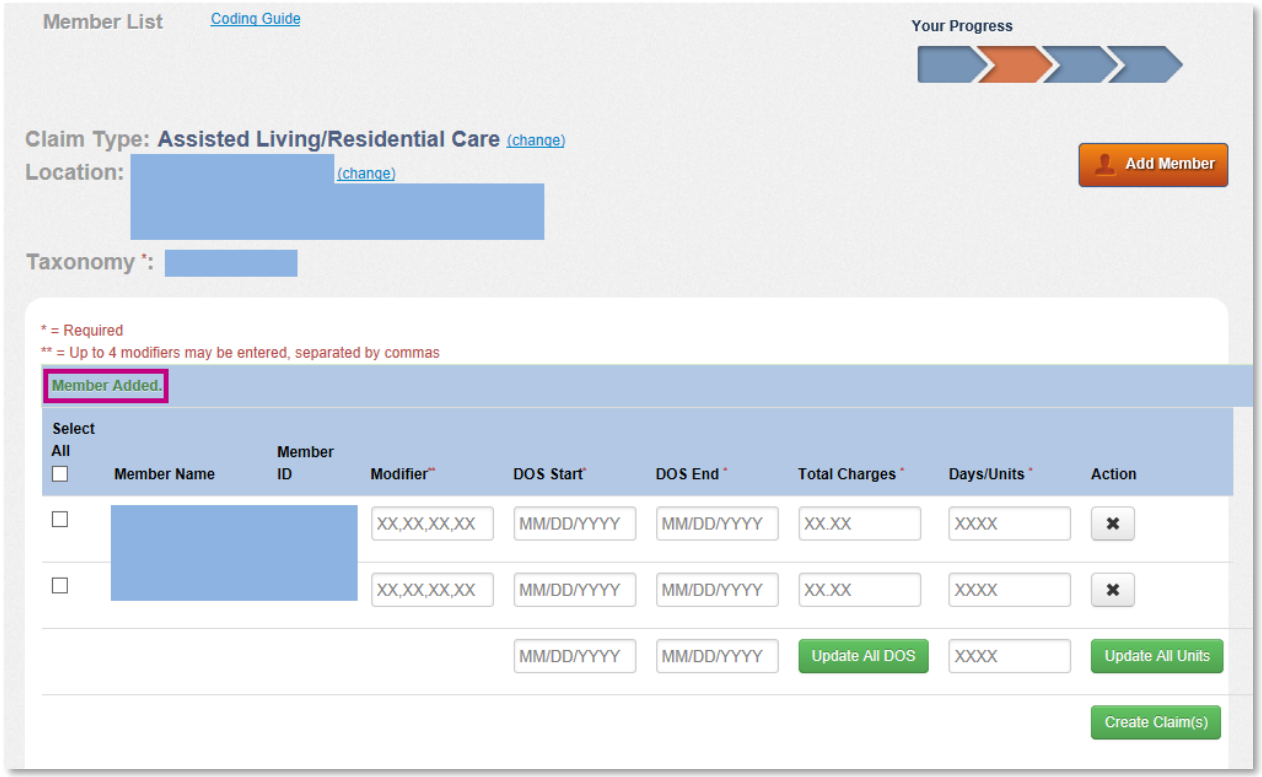
Recurring Claims

- To **Add Member**, enter the **Member ID or Last Name** and **Birthdate**.



Recurring Claims

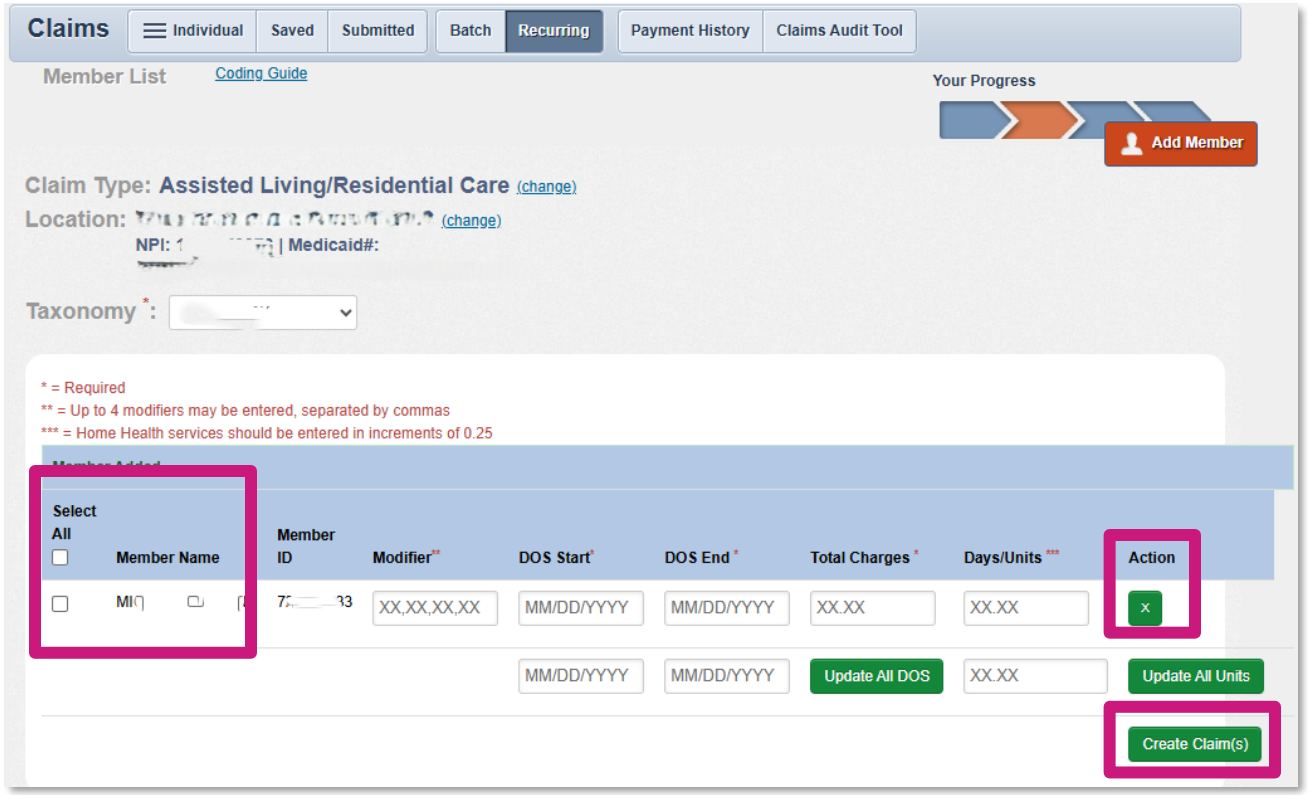
- Once members are added, you will be alerted with a **Member Added** remark.
- Members will be listed in alphabetical order by last name.
- Under **Action**, click the **X** to remove a member from your list.



Recurring Claims

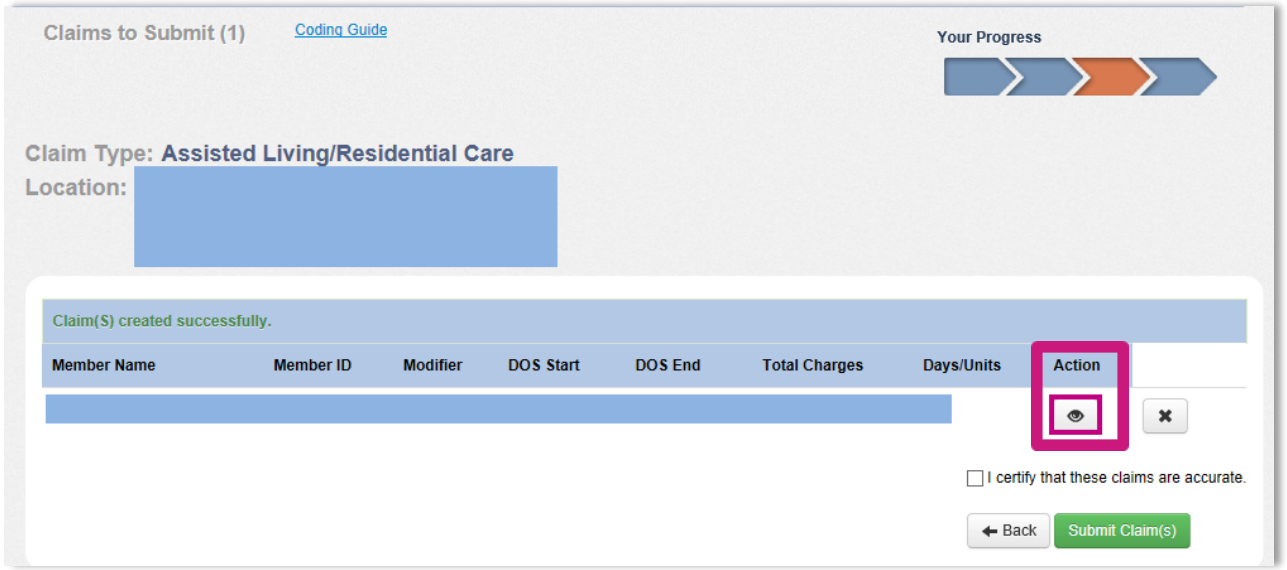
- **Create Claim(s)** by selecting the appropriate **Member Name** from the Members Listed.
- Enter all required information and click **Create Claim(s)**.
- Click on **X** under **Action** to delete the claim.

Please note: To save time, if the DOS Start and DOS End are the same for all checked members, enter at bottom and click Update All DOS.



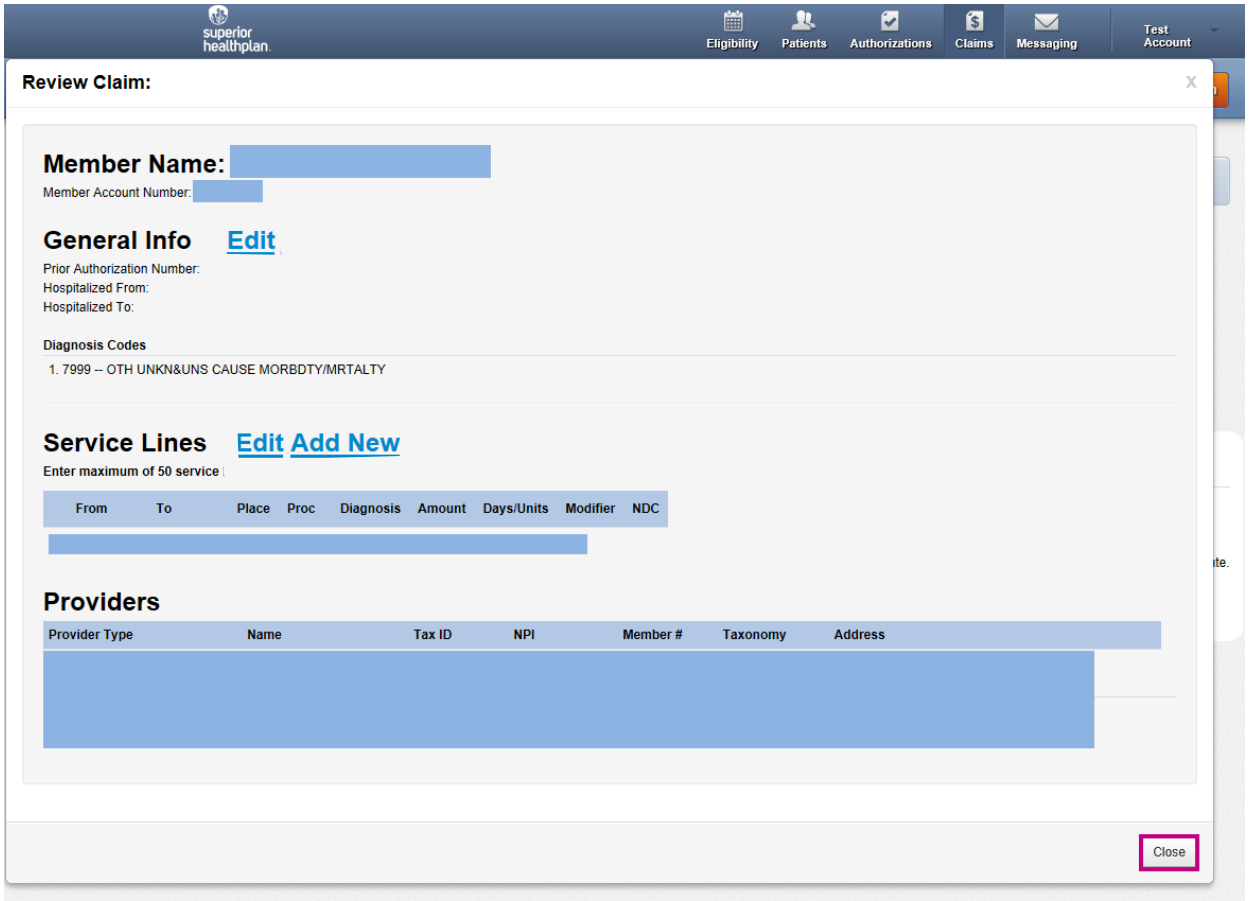
Recurring Claims

- Certify the claims being submitted are accurate.
- You can review claims prior to submitting. To review, click on the **eye icon** under **Action**.



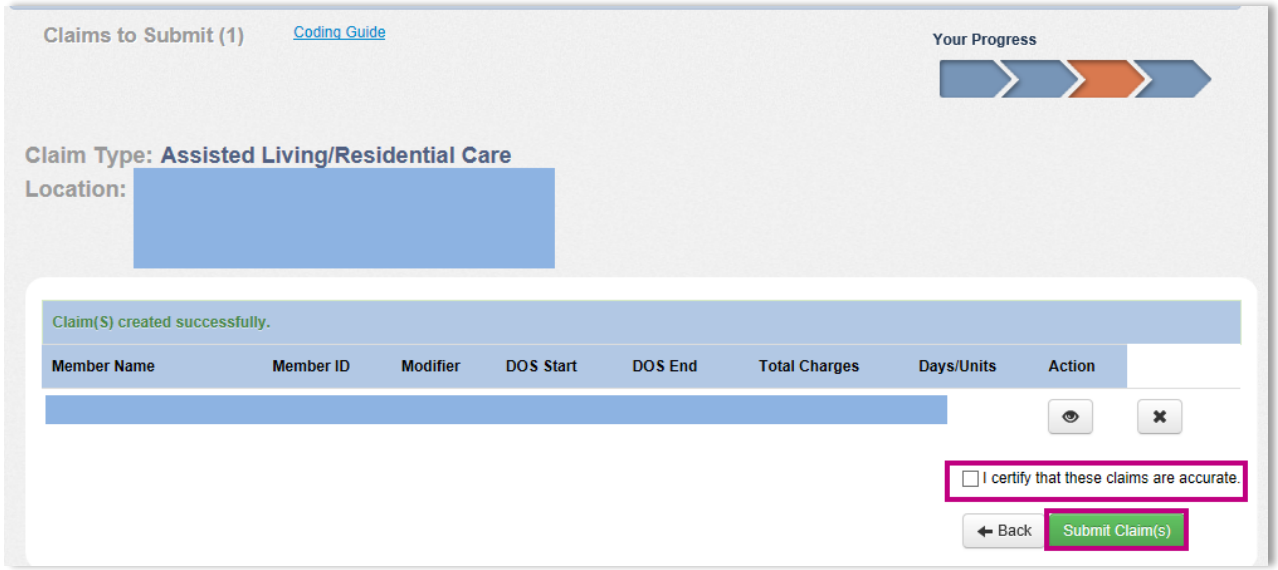
Recurring Claims

- You can review the claim or change some of the fields pre-coded for you.
- Some fields may not allow edits. If those fields need to be changed, you will need to delete the claim and start over.
- Click the **Close** button once you are finished reviewing/editing the claim.



Recurring Claims

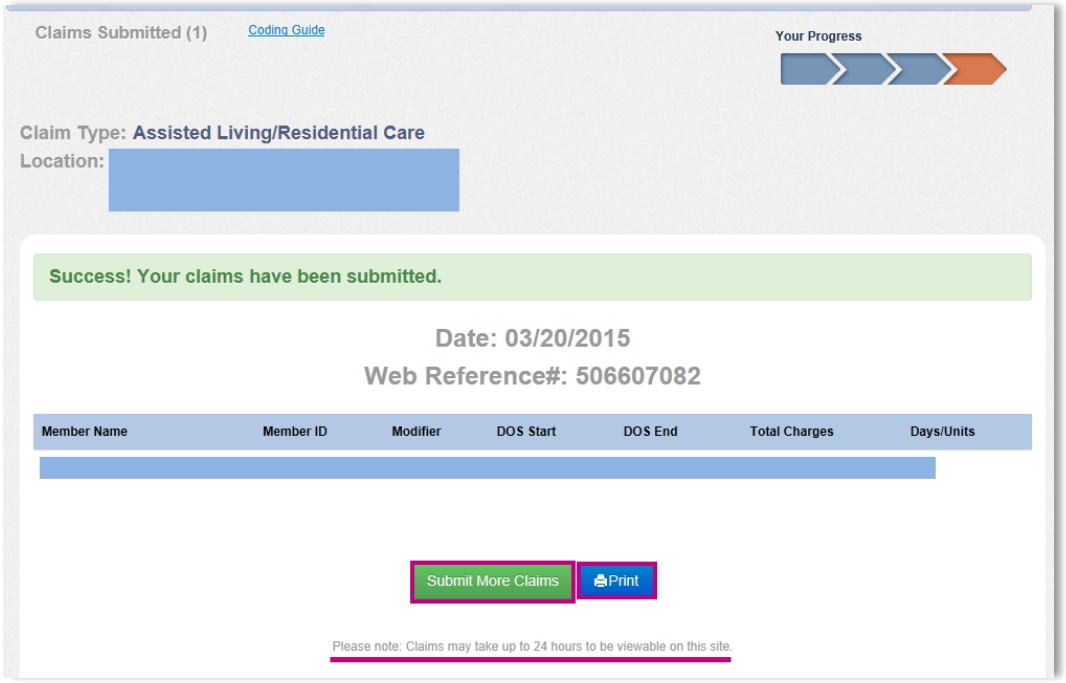
- After the claims have been reviewed for accuracy, select **I certify that these claims are accurate** and click **Submit Claim(s)**.



Recurring Claims

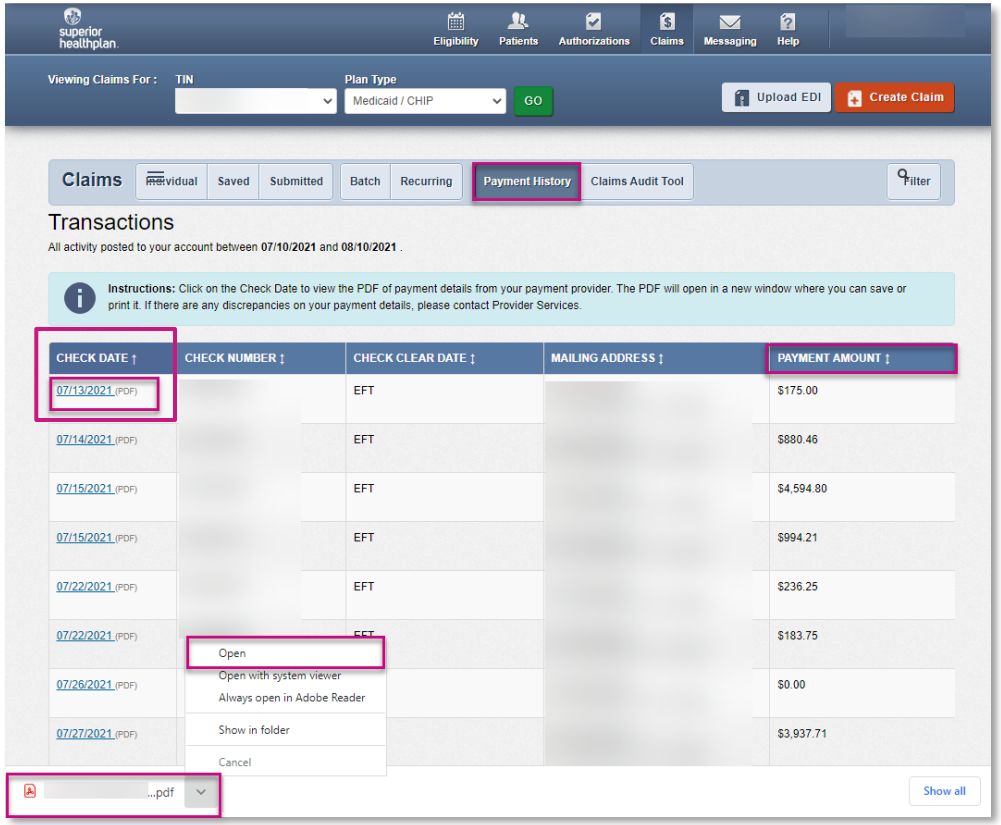
Success! Your claims have been submitted!

- The **Web Reference#** (web reference number) will be useful when discussing claims submitted through the portal with your Provider Representative.
- The number given here is not a claim number. This number merely helps to identify a claim submitted using the portal.
- Click **Print** to print a copy of the claims submitted, including the web reference number.
- Click **Submit More Claims** to request a new template or to move on to other functions.



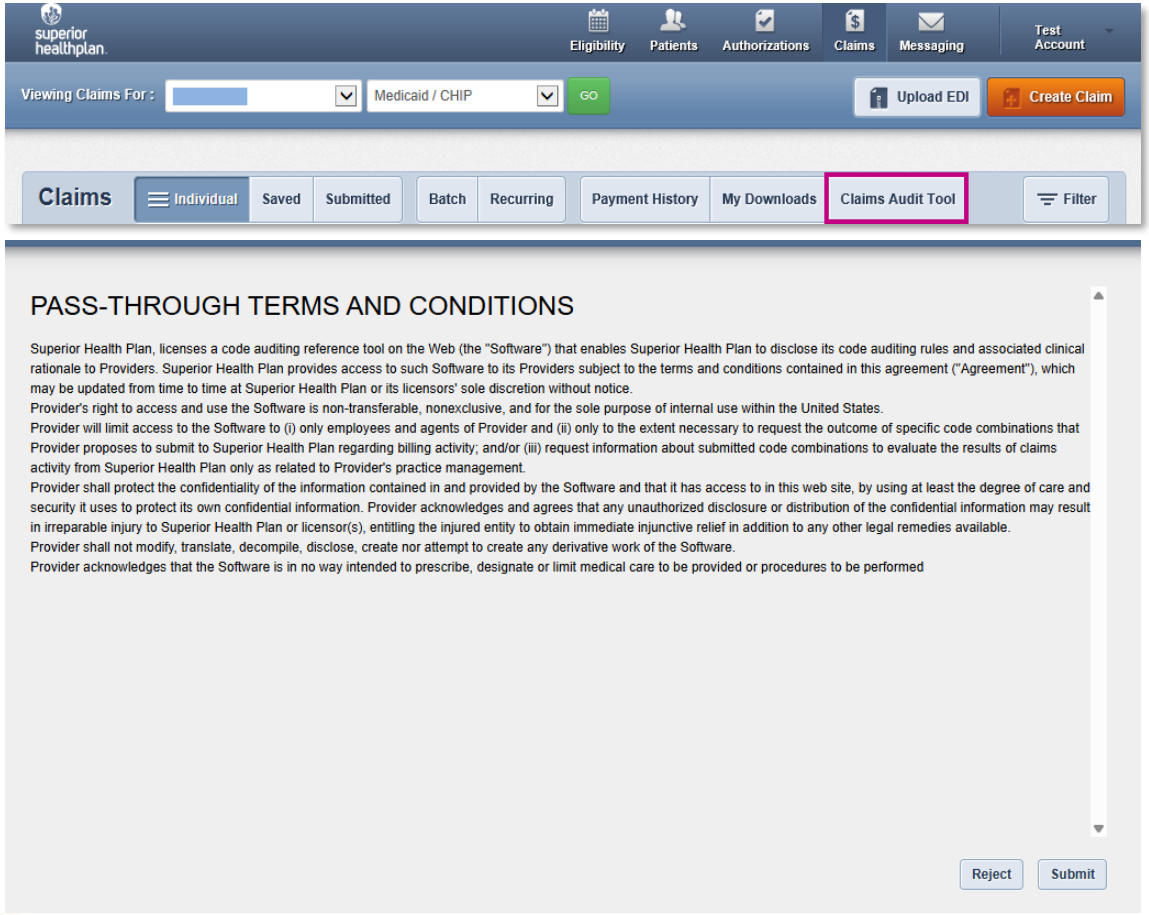
Payment History

- Recent payment activity can be found in **Payment History**.
- The **Check Date** is also a link to view the EOP for the **Payment Amount**.
- The selected EOP will appear in **PDF** format at the bottom left-hand side; click to **Open** the PDF file.



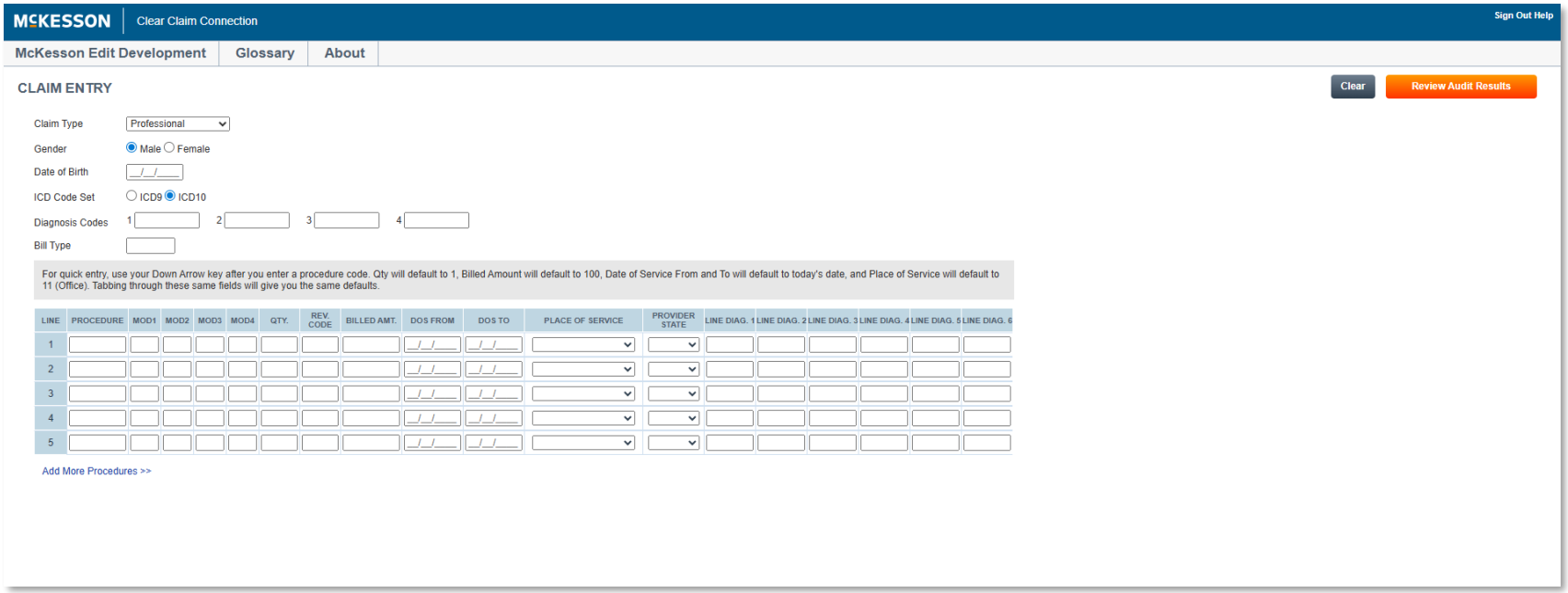
Claims Audit Tool

- Select the **Claims Audit Tool**.
- Click **Submit** to enter McKesson's Clear Claim Connection page.



Claims Audit Tool

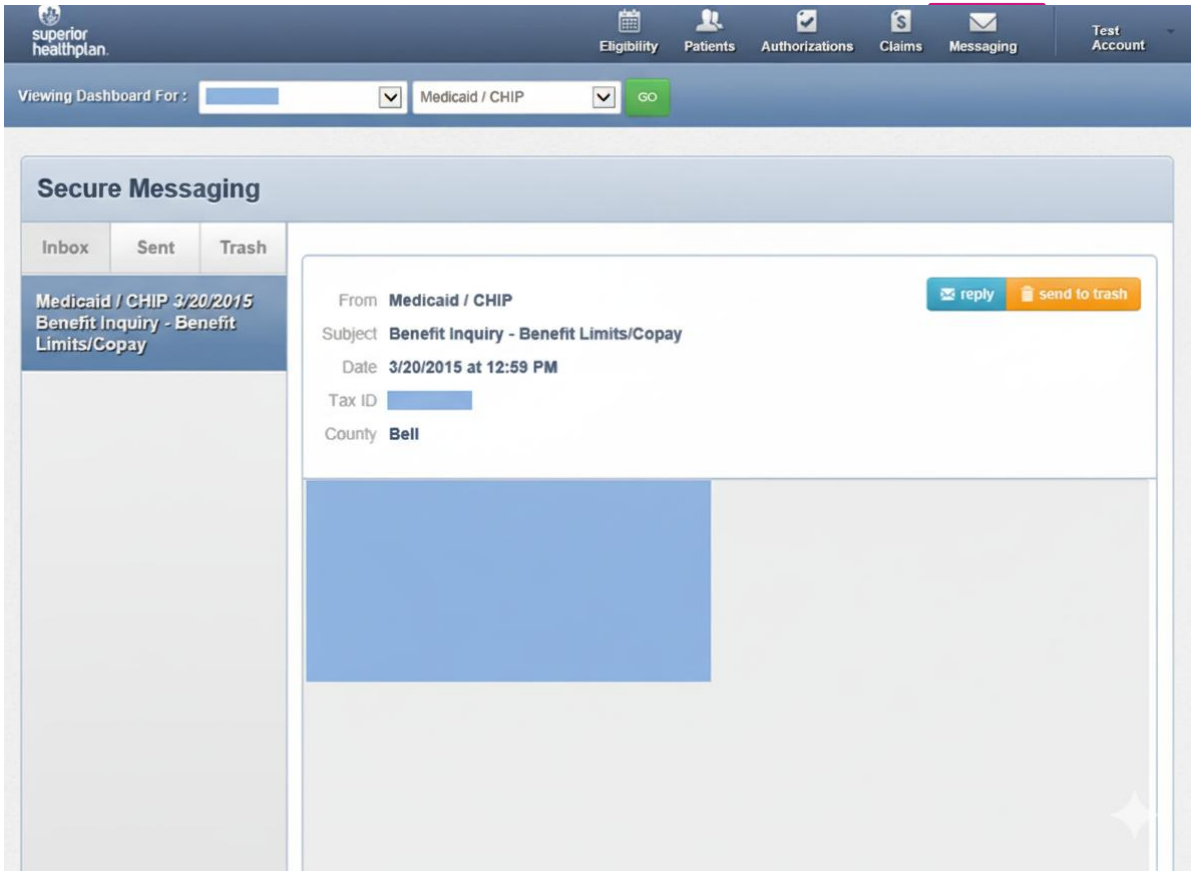
- Test claim coding by entering core information to be audited before submitting the live claim.



Secure Messages

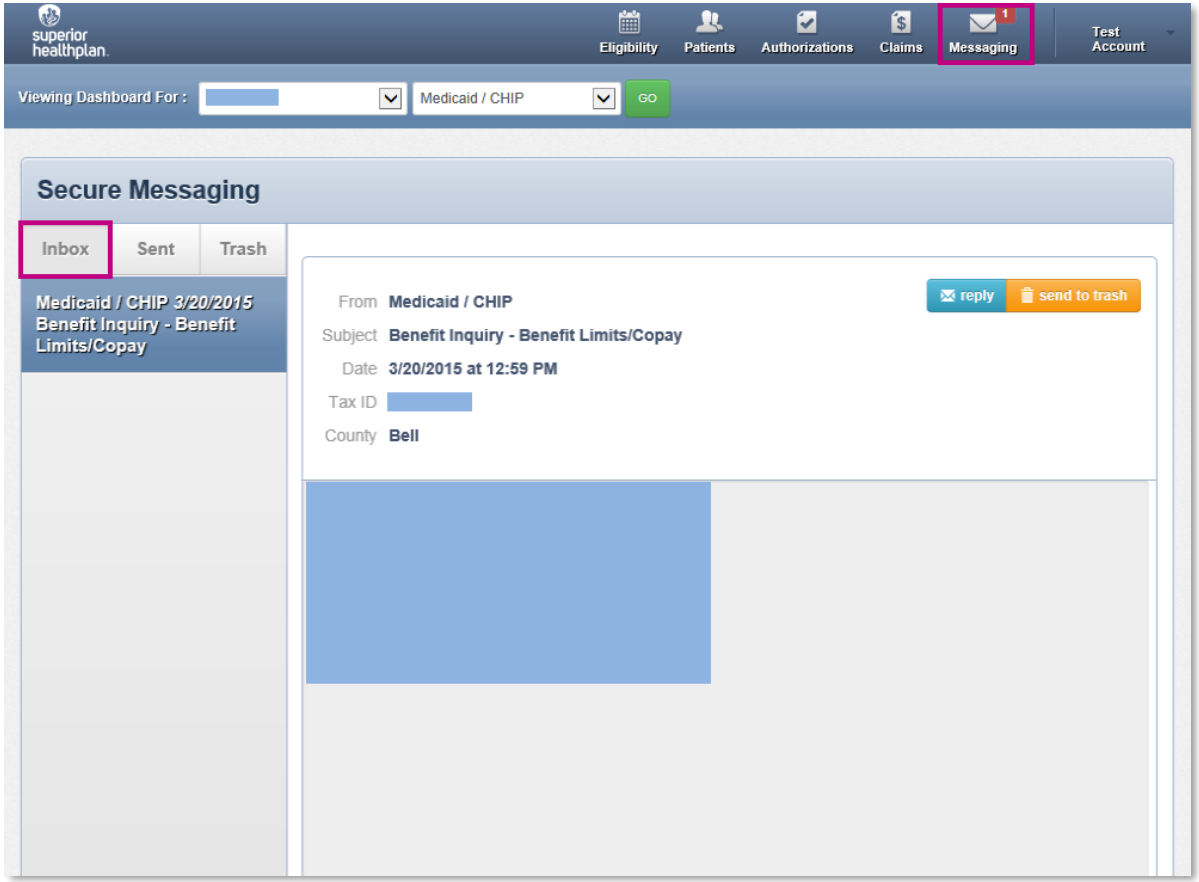
Secure Messages

- Click on **Messaging** to access Secure Messaging which offers another way for safe communication between the plan and provider.
- Specific questions related to eligibility, authorizations and claims can be asked directly online.



Secure Messages

- The **Inbox** displays any new messages. Click on a message subject to read its contents.
- New messages are indicated by a number in red to the upper-right of the **Messaging** tab.

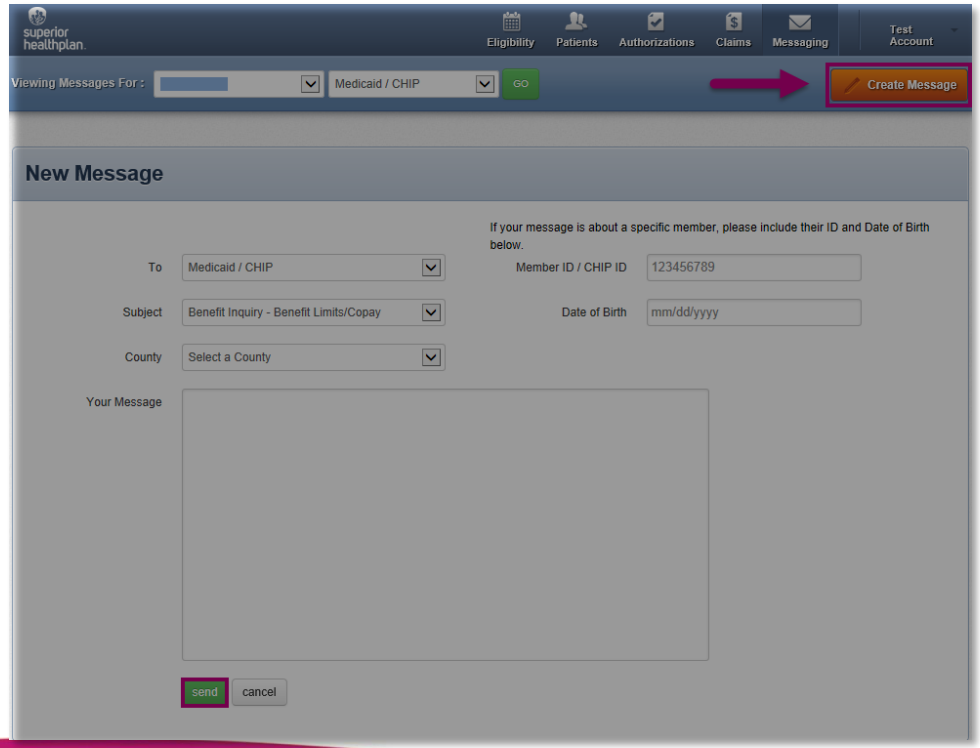


Secure Messages

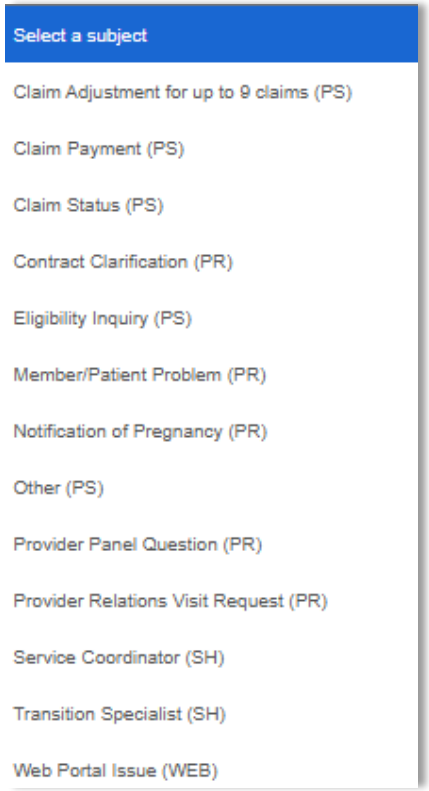
- All sent messages can be viewed under the **Sent** messages section.
- Any deleted messages are sent to **Trash**. If needed, these messages can still be recovered.

Secure Messages

- Click **Create Message** to compose a new secure message.
- When you have finished creating your message, click the **Send** button.

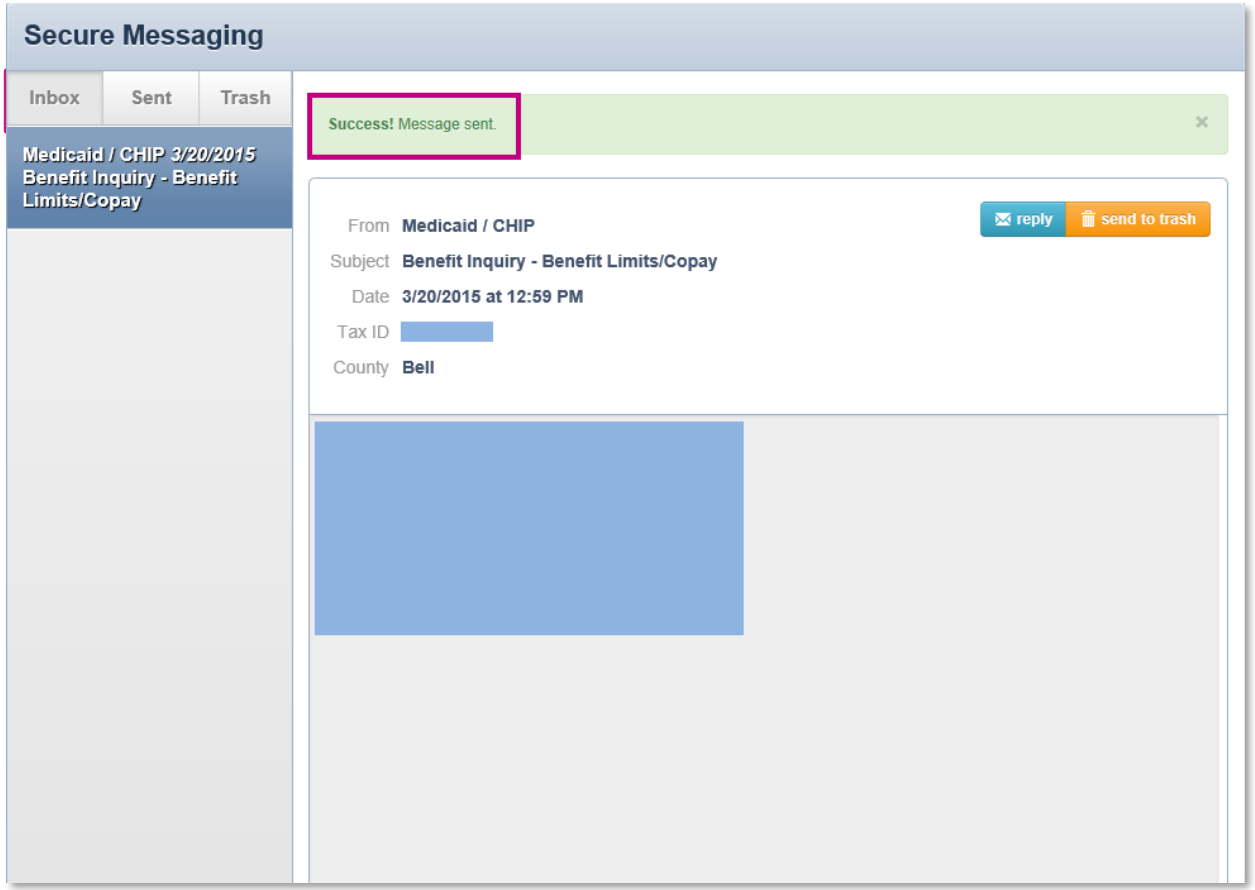


Secure Message Subjects



Secure Messages

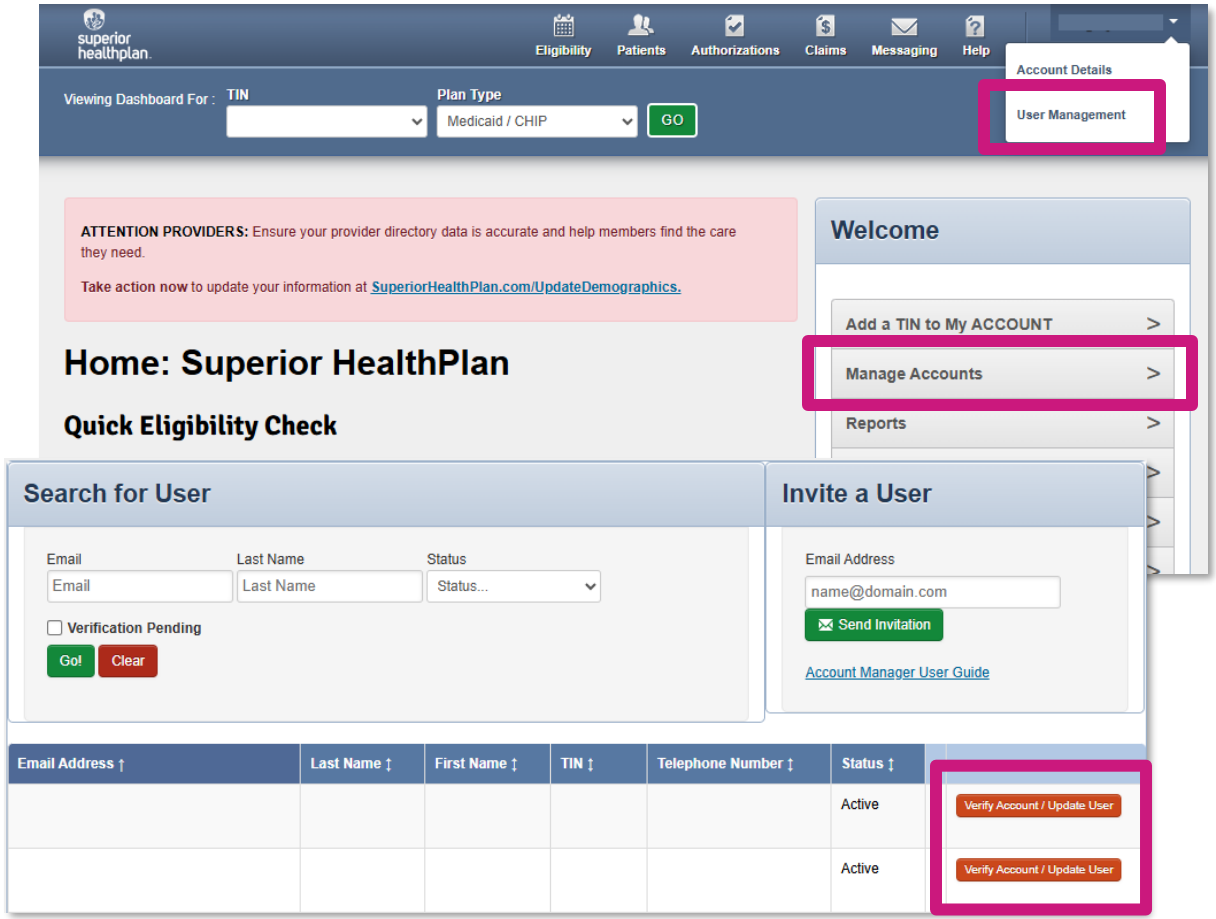
- **Success! Message Sent** will display at the top of the **Inbox** when the message has been sent.



User Management

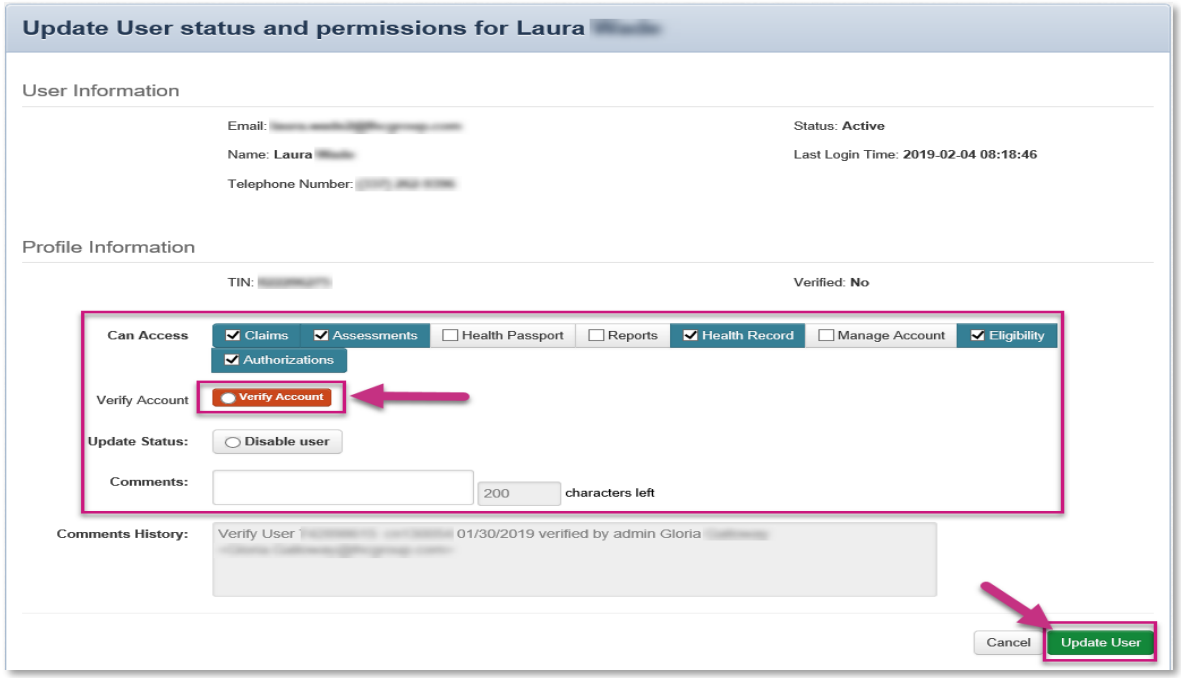
User Management

- It is the responsibility of the Account Administrator to manage the accounts.
- You can access his feature by clicking **User Management** in the dropdown beside your name or by clicking **Manage Accounts**
- Using this feature you can **Verify Account/Update User** to disable and manage permissions for other users under the TINs in your account.



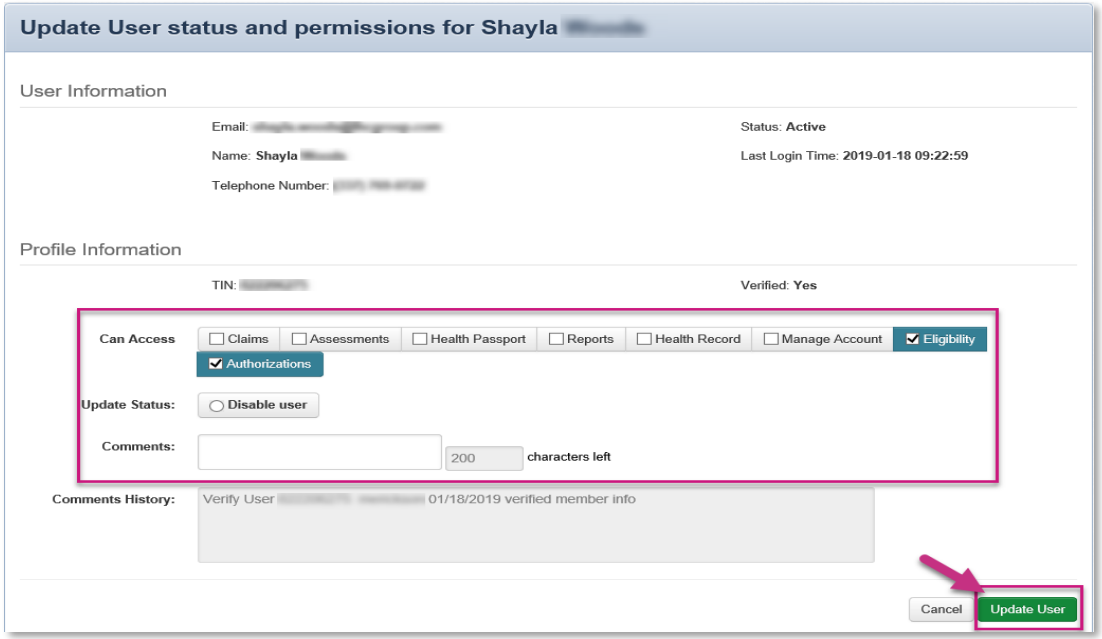
User Management

- To verify and activate new accounts, click on the orange button **Verify Account/Update User**.
- From this screen, authorized users can grant access and modify permissions for each user.
- Be sure to click on the **Verify Account** button once you modify permissions.
- Add notes and finish by clicking on the **Update User** button.



User Management

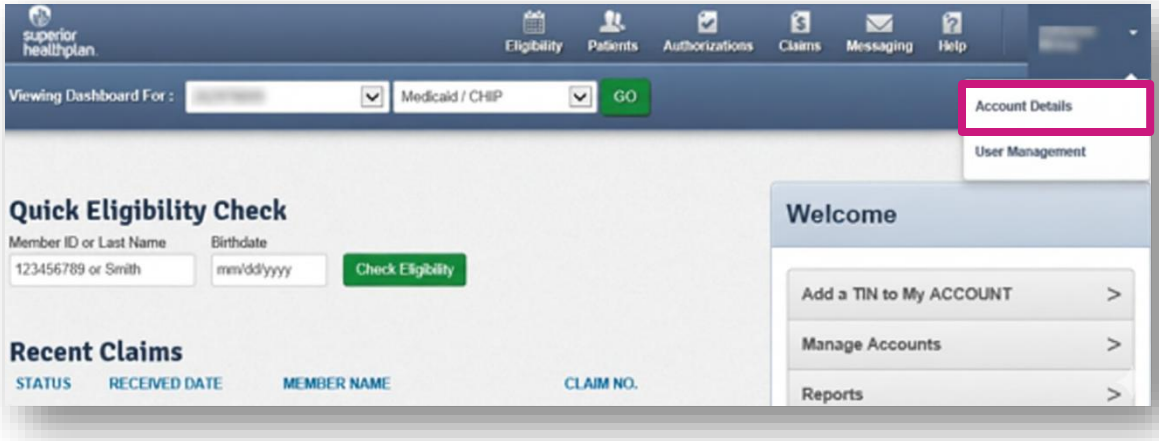
- To disable or modify permissions for an existing user, select **Update User**.
- Make changes, add notes and finish by clicking on the **Update User** button.



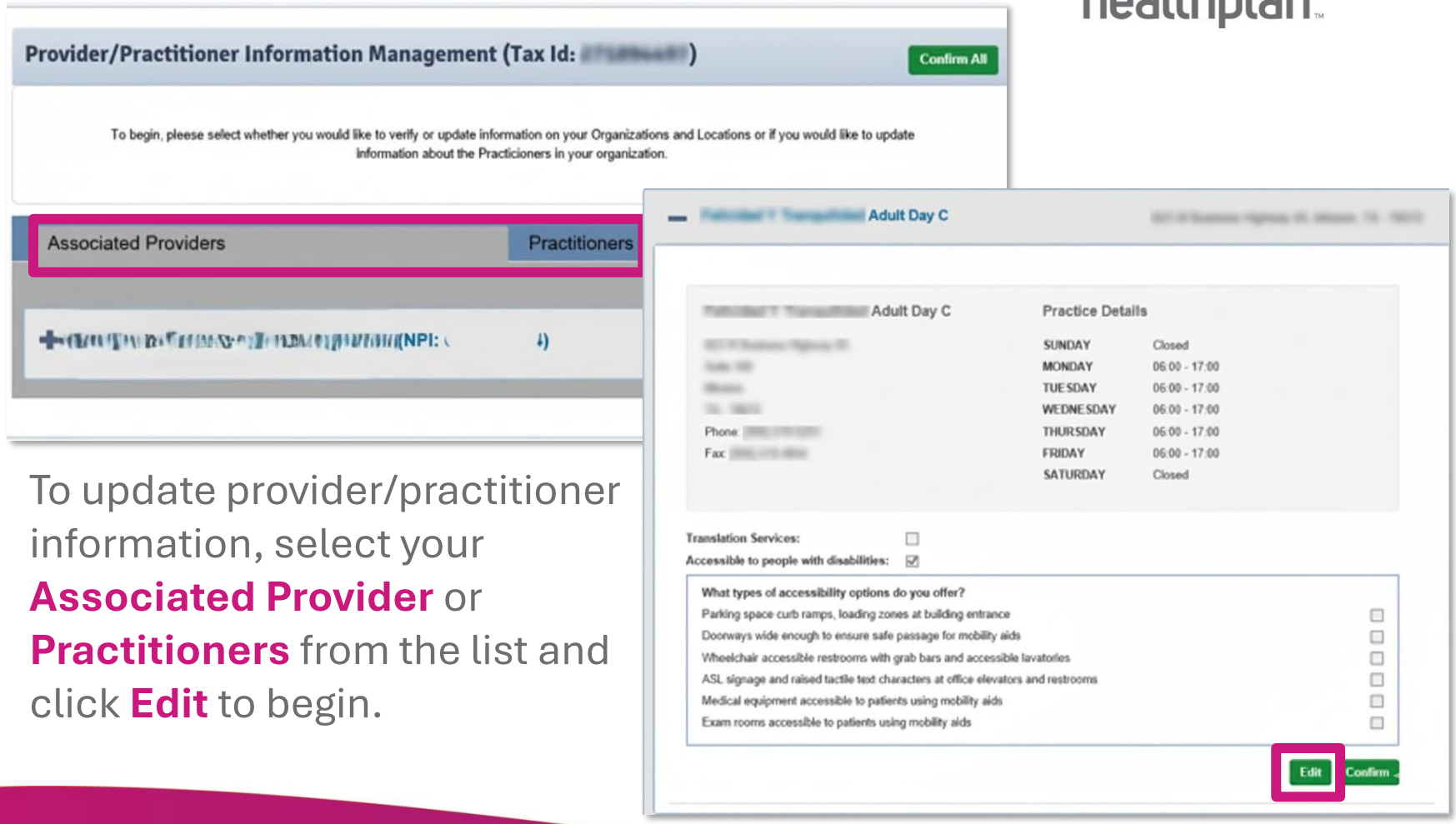
Provider/Practitioner Info Management

Provider/Practitioner Information Management

- To confirm or update provider/practitioner information, go into **Account Details** and select your Primary TIN in the list.



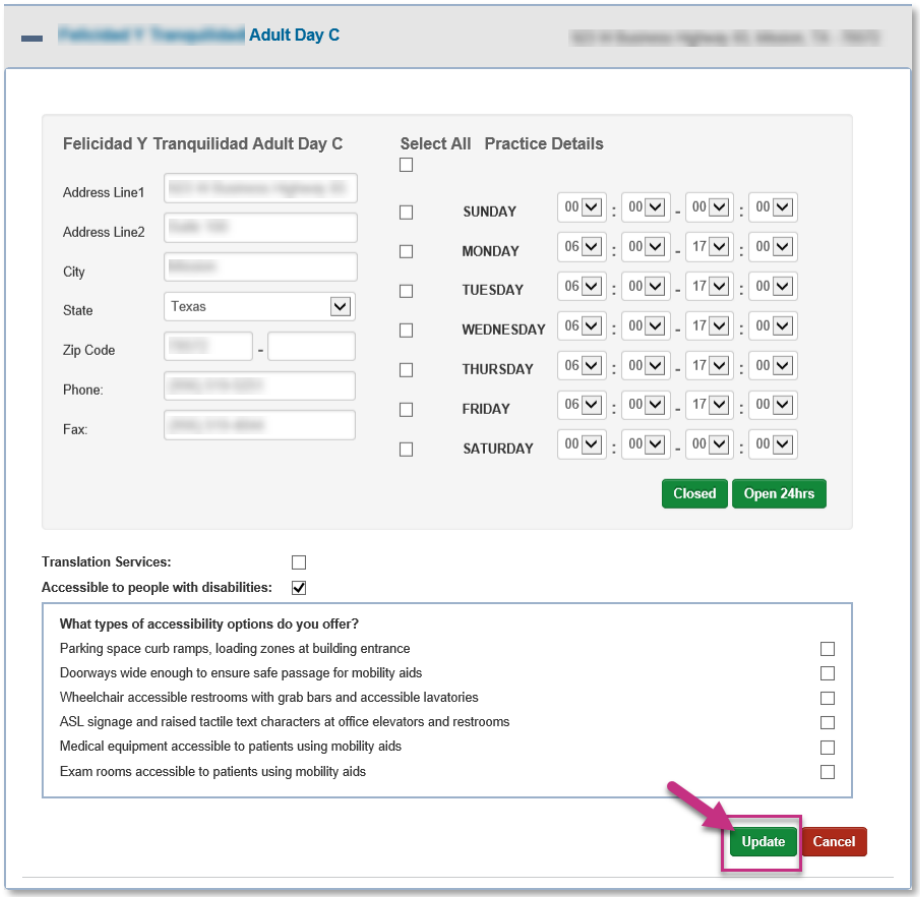
Provider/Practitioner Information Management



- To update provider/practitioner information, select your **Associated Provider** or **Practitioners** from the list and click **Edit** to begin.

Provider/Practitioner Information Management

- From this screen, you can **update** the provider's/practitioner's physical address, phone numbers, office days and hours and accessibility details.



Provider Relations

- Responsible for provider orientation and education:
  - Billing requirements.
  - New products, programs or processes.
- Liaison for claims issues or concerns.
- Provider Representatives offers online webinar trainings, in addition to local group training sessions. To view the updated training calendar, visit Superior' Provider Training Calendar.
- To locate your local Provider Representative, visit Find My Provider Representative webpage.

Contact Information

Department	Contact	Phone/Fax
Provider Services	Claims Inquiry	1-877-391-5921
Medical Management	Prior Authorization	1-800-218-7508 / Fax: 1-800-690-7030
Secure Provider Portal	Support Team	1-866-895-8443
EDI Department	Support Team	1-800-225-2573, ext. 25525

**Please have Tax ID or NPI available.*

Claims Address

Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

Claim Appeals Address

Superior HealthPlan
P.O. Box 3000
Farmington, MO 63640-3800

For more information and resources, visit us at SuperiorHealthPlan.com.

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Questions and Answers