SECTION 15-BILLING INSTRUCTIONS

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15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12 Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12 Version v5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12 Version v5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.missouri.gov/mhd/ and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The following claim types can be used in Internet applications: Medical (CMS 1500, Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

15.3 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for nurse midwife services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any claim or line item on a claim that resulted in a zero or incorrect payment can be retrieved and resubmitted at the billing website at www.emomed.com if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may retrieve and resubmit electronically or on a CMS-1500 claim form. A provider may also void a previously billed and paid claim at this site.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, if the provider billed $2,000 instead of $2,500 for Total Obstetric Care, that claim *cannot* be resubmitted. It will deny as a duplicate. Providers who are incorrectly paid for a claim should submit an individual adjustment request via the Internet at www.emomed.com. Section 6 of this manual explains the adjustment request process.

15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a patient has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payor. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, an electronic claim *may* be submitted to MO HealthNet along with the Medicare Remittance Advice attached indicating the denial. The claim may also be submitted through the Internet at www.emomed.com or through the 837 electronic claims transmission. Reference Section 16.5 of the Nurse Midwife Provider Manual for instructions for submission of claims to MO HealthNet.

If a claim was submitted to Medicare indicating that the patient also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), an electronic claim *must* now be filed on the Internet at www.emomed.com or with an 837 electronic claims transmission. Reference Section 16 of the Nurse Midwife Provider Manual for billing instructions.

MO HealthNet applies editing to Medicare/MO HealthNet crossover claims very similar to that used to process MO HealthNet only claims. The claims processing system can only process 25 edits or less on one claim. A crossover claim will deny with Remittance Advice Remark Code MA130 if processing of the claim results in more than 25 edits. The following edits will post to every line of a claim: timely filing, duplicate claim submission, third party liability, and spendown. The provider may bill a smaller claim to Medicare to avoid the 25 edit limit when claims crossover from Medicare.

15.7 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed check the Medicaid box and if the patient has both Medicare and MO HealthNet, check both boxes.

*1a. Insured's I.D. Number	Enter the patient's eight-digit MO HealthNet ID or MO HealthNet Managed Care Plan ID number (DCN) as shown on the patient's ID card.
*2. Patient's Name	Enter last name, first name, middle initial *in that order* as it appears on the ID card.
3. Patient's Birth Date	Enter month, day, and year of birth.
Sex	Mark appropriate box.
**4. Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13. If no private insurance is involved, leave blank.
5. Patient's Address	Enter address and telephone number if available.
**6. Patient's Relationship to Insured	Mark appropriate box if there is other insurance.
**7. Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8. Patient Status	Not used.
**9. Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. (See Note)(1)
**9a. Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. (See Note)(1)
**9b. Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. (See Note)(1)

**9c. Employer's Name	Enter the secondary policyholder's employer name. (See Note)(1)
**9d. Insurance Plan or Program Name	Enter the other insured's insurance plan or program name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
**10a-10c. Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are *not* related to an accident, leave blank.
10d. Reserved for Local Use	May be used for comments/descriptions.
**11. Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. (See Note)(1)
**11a. Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. (See Note)(1)
**11b. Employer's Name	Enter the primary policyholder's employer name. (See Note)(1)
**11c. Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
**11d. Other Health Plan	Indicate whether the patient has secondary health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. (See Note)(1)
12. Patient's Signature	Leave blank.

**13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
**14. Date of Current Illness, Injury or Pregnancy	*This field is required when billing global prenatal and delivery services.* The date should reflect the last menstrual period (LMP).
15. Date Same/Similar Illness	Leave blank.
16. Dates Patient Unable to Work	Leave blank.
**17. Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider
**17a. Other ID#	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field 17b.
**17b. NPI	Enter the NPI number of the referring, ordering, or supervising provider.

**18. Hospitalization Dates	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. *This field is required when the service is performed on an inpatient basis.*
19. Reserved for Local Use	Providers may use this field may for additional remarks/descriptions.
**20. Lab Work Performed Outside Office	*If billing for laboratory charges, mark appropriate box.* The referring nurse midwife may *not* bill for lab work that was referred out. A nurse midwife may only bill lab procedures listed in this manual.
*21. Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
**22. Medicaid Resubmission	For timely filing purposes; if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank.
*24a. Date of Service	Enter the date of service under 'from" in month/day/year format, using six-digit format. All line items *must* have a "from" date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to

	support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. NOTE: When billing for global delivery, enter the date of delivery only. A "to" date is never used when billing for "global" prenatal or delivery services.
*24b. Place of Service	Enter the appropriate place of service code in the unshaded area of the field: See Section 15.8 for applicable place of service codes.
**24c. EMG-Emergency	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
*24d. Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifiers, if any, corresponding to the service rendered in the unshaded area of the field. (Field #19 may be used for remarks or descriptions.)
*24e. Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21 in the unshaded area of the field.
*24f. Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
*24g. Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a "1", if the field is left blank. **Consecutive visits**—Subsequent hospital visits (newborn only) may be billed on one line if they occur on consecutive days. The days/units *must* reflect the total number of days shown in Field #24a.

**24h. EPSDT/Family Planning	If the service is an initial newborn examination or other EPSDT/HCY screening service or referral, enter “E”. If the service is family planning related, enter "F". If the service is both and EPSDT/HCY and Family Planning enter "B".
**24i. ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet. A Provider Taxonomy code must be reported if providers have one N PI for multiple legacy MO HealthNet provider numbers.
**24j. Rendering Provider ID	If the Provider Taxonomy qualifier was reported in 24i; enter the 10-digit Provider Taxonomy code in the shaded area. Enter the 10-digit NPI number of the individual rendering the service in the unshaded area.
24k. Removed	
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on MO HealthNet claims.
*28. Total Charge	Enter the sum of the line item charges.
29. Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are *not* to be entered in this field.

30. Balance Due	Enter the difference between the total charge (Field #28) and the amount paid (Field #29).
31. Provider Signature	Leave blank.
**32. Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. *This field is required when the place of service is other than home or office.*
**32a. NPI#	Enter the 10-digit NPI number of the service facility location in 32.
**32b. Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code. A provider taxonomy code must be reported if providers have on NPI for multiple legacy MO HealthNet provider numbers.
*33. Provider Name/Number/ Address	Write or type the provider name, provider number and address information.
**33a. NPI#	Enter the NPI number of the billing provider in 33.
**33b. Other ID #	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.

* These fields are mandatory on *all* CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the Nurse Midwife Provider Manual for further TPL information.

15.8 PLACE OF SERVICE CODES

CODE	DEFINITION
11 Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12 Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
21 Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under the supervision of physicians to patients admitted for a variety of medical conditions.
22 Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do *not* require hospitalization or institutionalization.
25 Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.

15.9 CLAIM FILING FOR PHARMACY

The quantity to be billed for injectable medications dispensed to MO HealthNet participants *must* be calculated as follows:

- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) *must* be billed by exact cubic centimeters or milliliters (cc or ml) dispensed, even if the quantity includes a decimal (e.g., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill is 1.5 mls).

- Single dose syringes and single does vials *must* be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Ointments *must* be billed per number of grams even if the quantity includes a decimal.
- Eye drops *must* be billed per number of cubic centimeters or milliliters (cc or ml) in each bottle even if the quantity includes a decimal.
- Powder filled vials and syringes that require reconstitution *must* be billed by the number of vials.
- Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit for example Copaxone, Pegasys).
- The product Herceptin, by Genentech, *must* be billed by milligram rather than by vial.
- Immunizations and vaccines *must* be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

15.10 INSURANCE COVERAGE CODES

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Division's participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 of the Nurse Midwife Provider Manual for more information.

Patients *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PATIENT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.

END OF SECTION

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