



Section 3 - Provider and Participant Services

SECTION 3 - PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES.....2

 3.1.A INFOCROSSING HEALTHCARE SERVICES HELP DESK 2

3.2 PROVIDER ENROLLMENT UNIT.....2

3.3 PROVIDER RELATIONS COMMUNICATION UNIT.....2

 3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM..... 3

 3.3.A(1) Using the Telephone Key Pad..... 6

 3.3.B MO HEALTHNET SPECIALIST 7

 3.3.C POINT OF SERVICE (POS) ELIGIBILITY VERIFICATION..... 8

 3.3.D INTERNET 9

 3.3.E FAMILY SUPPORT DIVISION 9

 3.3.F WRITTEN INQUIRIES 10

3.4 PROVIDER RELATIONS EDUCATION UNIT 10

3.5 PARTICIPANTS SERVICES 11

3.6 PENDING CLAIMS 11

3.7 FORMS REQUEST 11

 3.7.A RISK APPRAISAL FORM 12

3.8 CLAIM FILING METHODS..... 12

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET 12



Section 3 - Provider and Participant Services

SECTION 3-PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES

The MO HealthNet Division has staff to assist providers and potential providers with questions regarding enrollment, claims filing, payment problems, participant eligibility verification, prior authorization status, etc. Assistance can be obtained by contacting the appropriate unit.

3.1.A INFOCROSSING HEALTHCARE SERVICES HELP DESK

Infocrossing Healthcare Services provides a help desk for use by fee-for-service providers, electronic billers and managed health care plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

- front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission as well as assistance in the use and maintenance of billing software developed by the MO HealthNet Division.
- front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- front-line assistance to managed health care plans in establishing required electronic formats, network communications and ongoing operations.
- front-line assistance to providers in submitting claim attachments via the Internet.

3.2 PROVIDER ENROLLMENT UNIT

The Provider Enrollment Unit mails provider enrollment packets and processes enrollment applications and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained at providerenrollment@dss.mo.gov.

3.3 PROVIDER RELATIONS COMMUNICATION UNIT

This unit responds to specific provider inquiries concerning MO HealthNet eligibility, claim filing instructions, billing errors, etc. Routine questions, in most cases, can be handled by telephone. Providers should submit complex inquiries in writing.

A copy of a lost Remittance Advice can be obtained by contacting the Provider Relations Communication Unit's number (573) 751-2896. A minimal copy fee is required prior to release of the replacement. An old or lost RA can be requested at the billing web sight at www.emomed.com. In the section "Receive Provider Files" you can request and print a current RA by clicking on



Section 3 - Provider and Participant Services

"Printable Remittance Advice". To retrieve an older RA click on "Request Aged RA's", fill out the required information and submit. The RA will be under "Printable Aged RA's" the next day. The requested RA will remain in the system for 5 days.

Providers can access information through various methods, including the interactive voice response (IVR) system, point of service (POS) eligibility verification, Internet (www.emomed.com), Family Support Division, and written inquiries, which are described in this section.

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

The interactive voice response (IVR) system at (573) 635-8908 allows an active MO HealthNet provider five inquiry options:

- 1.Participant eligibility
- 2.Last two check amounts
- 3.Claim status
- 4.Procedure code status
- 5.MO HealthNet informational message

This system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service during their period of enrollment as an active MO HealthNet provider. The nine-digit MO HealthNet provider number *must* be entered each time any of the IVR options are accessed. *The provider should listen to all eligibility information, particularly the suboptions.*

Option 1. Participant Eligibility

The caller is prompted to supply the following information:

- MO HealthNet provider number
- MO HealthNet participant's ID, Social Security Number or casehead ID
- Date of birth (if inquiry by Social Security Number)
- Dependant date of birth (if inquiry by casehead ID)
- First date of service (mm/dd/yy)
- Last date of service (mm/dd/yy)

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may *not* exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may *not* inquire on dates that exceed one year prior to the current date. The caller is limited to ten inquiries per call.



Section 3 - Provider and Participant Services

The caller is given standard MO HealthNet eligibility coverage information including ME code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits. The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under QMB or the Presumptive Eligibility (TEMP) Program. Please reference the provider manual for a description of these services. Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Refer to Section 1 for more detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a sub-menu. The sub-menu options include:

- Managed care enrollment and health plan name and telephone number
- Eye exam and eyeglass information
- Third party liability information
- Medicare Part A, Part B and/or QMB coverage
- MO HealthNet ID, participant name, spelling of participant name
- Repeat of eligibility information
- Repeat of confirmation number
- Inquiry on another participant
- Return to the main menu
- End the call
- Transfer to a MO HealthNet hotline specialist

MO HealthNet eligibility information is confidential and must be used only for the purpose of providing services and for filing MO HealthNet claims.

Option 2. Last Two Check Amounts

The caller is prompted to supply their MO HealthNet provider number.

The caller is given the last two remittance advice (RA) dates, RA numbers and check amounts. Check amount inquiries are limited to ten provider numbers per call. The caller is told if the provider for which the inquiry being made is eligible to bill their claims electronically.

Option 3. Claim Status

The caller is prompted to supply the following:



Section 3 - Provider and Participant Services

- MO HealthNet provider number
- Participant ID
- First date of service (mm/dd/yy)
- Claim type (optional), valid values are:
 - zero (0) - any claim type
 - One (1) - medical
 - Two (2) - inpatient
 - Three (3) - outpatient
 - Four (4) - dental
 - Five (5) - home health
 - Six (6) - drug
 - Seven (7) - nursing home
 - Eight (8) - Medicare crossover

The caller is provided the status of the most current claim that matches the date of service and claim type entered. The caller is told whether the claim is paid, denied, approved to pay or being processed. The caller is given the amount paid, RA date and the internal control number (ICN). In cases where a claim has been denied, the IVR reads an explanation of the EOB assigned to the denied claim. Claim status inquiries are limited to ten inquiries per call.

Option 4. Procedure Code Status

The caller is prompted to supply the following:

- MO HealthNet provider number
- Procedure code
- Procedure code modifier 1 (if applicable)
- Procedure code modifier 2 (if applicable)

(Press * after the five digit procedure code if no modifiers are entered or after the first modifier if a second modifier is *not* entered. Refer to Section 3.3.A(1) for detailed instructions on how to enter procedure code inquiries.)

The caller receives the current status of the procedure code and current attachment requirements for that procedure. If the caller receives a response that the procedure is *not* found or is *not* covered, the caller should verify that the appropriate procedure code is being used. If the participant is under the age of 21, there may be expanded coverage through the

Section 3 - Provider and Participant Services



Healthy Children and Youth (HCY) Program. Please reference the provider manual for further information. Procedure code inquiries are limited to ten inquiries per call.

Option 5. MO HealthNet Informational Message

The caller is prompted to supply their MO HealthNet provider number.

The caller is given the option to select from a list of informational messages. The IVR tells the caller to which MO HealthNet Program or topic each informational message pertains. When a particular message option is selected, a detailed message is read to the caller by the IVR. The informational messages available through this option may include, but are *not* limited to, changes or additions to the MO HealthNet Program, areas of interest for specific provider types, changes to the managed care program, and special instructions for receiving additional information. The messages are similar to the types of informational messages occasionally appearing on the cover page of provider remittance advices. If no informational messages are currently available on the message area, callers are *not* able to select option 5 from the main menu.

3.3.A(1) Using the Telephone Key Pad

Both alphabetic and numeric entries may be required on the telephone key pad. In some cases, the IVR instructs the caller which numeric values to key to match alphabetic entries. However, in the instance of inquiring on procedure code status, there is no way to distinguish between alpha and numeric characters when one key stroke is made. A method has been devised, which requires two key strokes to indicate one character. For example:

- To indicate the letter "A," the caller *must* press the "ABC" key and then press "1." This is interpreted by the IVR as the letter "A" because the "1" key indicates the first letter of the preceding key pressed.
- To indicate the letter "E," the caller *must* press the "DEF" key and then press "2." This is interpreted by the IVR as the letter "E" because the "2" key indicates the second letter of the preceding key pressed.
- "Q" and "Z" may *not* appear on the key pad. Those values should be entered in relation to the other keys on the pad with values as if they were present.
- Since "Q" falls between "P" and "R" in the alphabet, and the values "P", "R" and "S" are present on the same key without "Q", enter each of those as if the "Q" were present on the key as well. Therefore, to indicate "P", the caller *must* press the "PRS" key and then press "1". To indicate "Q", the caller *must* press the "PRS" key and then press "1". To indicate "R", the caller *must* press the "PRS" key and then press "2". To indicate "R", the



Section 3 - Provider and Participant Services

caller *must* press the "PRS" key and then press "3". To indicate "S", the caller *must* press the "PRS" key and then press "4".

- Similarly, "Z" is indicated by the caller pressing the "WXY" key then pressing "4". This is valid since, if "Z" were present on the key as it appears in the alphabet, it would be the fourth letter on the "WXY" key.

To indicate numbers, press the number on the key pad followed by "0" or "OPER" key.

Below are examples of the necessary keystrokes for procedure codes with and without alpha characters. A complete list of combinations to indicate numbers and letters is included in Valid Alpha and Numeric Combinations for Procedure Code Inquiry.

PROCEDURE KEYSTROKES CODE

99203 9090200030**

17200 W1 -----1070200000 9110

E1381 -----3210308010**

A0100-----2100100000**

Please listen and follow the directions given by the IVR as it prompts the caller for the various information required by each option. Once familiar with the IVR, the caller does *not* have to wait for the entire voice prompt. The caller can enter responses before the prompts are given.

If needed information is *not* available through the above options, the IVR allows the caller to request to speak to a MO HealthNet hotline specialist. Please allow for a 15 to 20 second waiting period for the IVR to complete the call transfer process. If all specialists are busy, the caller may receive a busy signal even though the IVR initially answered the call. Please be patient and try the call again.

3.3.B MO HEALTHNET SPECIALIST

Specialists are on duty between the hours of 8:00AM and 5:00PM, Monday through Friday (except holidays) to provide information *not* available through the interactive voice response



Section 3 - Provider and Participant Services

(IVR) system. The IVR number is (573) 635-8908. The provider may also call (573) 751-2896.

Providers are urged to:

- Review the provider manual and bulletins before calling the IVR.
- Have all material related to the problem (such as Remittance Advice, claim forms, and participant information) available for discussion.
- Have the MO HealthNet provider number available.
- Limit the call, if possible, to three questions or three to four minutes. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.
- Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

3.3.C—POINT OF SERVICE (POS) ELIGIBILITY VERIFICATION

Providers can access MO HealthNet eligibility files via a POS terminal and a single line phone jack. For more information contact:

- Emdeon Business Service—(800) 933-6869
- Siemens—(610) 219-1569
- Passport Health—(866) 854-6796

The provider can receive the following information:

- Dates of eligibility
- Healthy children and youth screen date
- Medical eligibility code restrictions (QMB/TEMP)
- Medicare Part A and Part B coverage
- Third party liability information
- Managed care enrollees
- Last eyeglass purchase
- Hospice beneficiaries
- Lock-in restrictions
- QMB participant status.



Section 3 - Provider and Participant Services

The POS terminals provided by the Emdeon Business Service can also provide:

- Claim status.

Refer to Section 1 for more detailed information on participant eligibility.

3.3.D INTERNET

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.

For full functionality of the Internet application, either the Internet Explorer 5.0 or higher web browser or the Netscape 4.7 or higher web browser is recommended. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

The current inquiry options available through the interactive voice response (IVR) system is offered, with the exception of procedure code inquiry. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security Number and date of birth, claim status and check inquiry. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

Providers also have the capability to receive and download their Remittance Advice from the Internet. Access to this information is restricted to users with authorization. In addition to the Remittance Advice, the Explanation of Benefits Listing, Exception Listing and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this web site include: claim submission; claim attachment submission; prior authorization request submission; inquiries on claim status and check amounts; and credit adjustment(s).

Refer to Section 1 for more detailed information on participant eligibility.

3.3.E FAMILY SUPPORT DIVISION

The provider can contact the local Family Support Division's office for the following information:

- Eligibility status for a given date of service



Section 3 - Provider and Participant Services

- Medical eligibility code restrictions
- Lock-in restrictions.

3.3.F WRITTEN INQUIRIES

Letters directed to the Provider Relations Communication Unit are answered by trained MO HealthNet specialists. Written or telephone responses are provided to all inquiries.

A provider who encounters a complex billing problem; numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage; or wishes to lodge a complaint should submit the inquiry or complaint in writing to:

Provider Communications Unit
MO HealthNet Division
P.O. Box 5500
Jefferson City, MO 65102-5500

A written inquiry should state the problem as clearly as possible and should include the provider's name, MO HealthNet provider number, address, and telephone number. Written inquiries should also include the MO HealthNet participant's full name, MO HealthNet identification number, and birthdate. A copy of all pertinent information, such as Remittance Advice forms, invoices, participant information, form letters, and timely filing documentation *must* be included with the written inquiry.

3.4 PROVIDER RELATIONS EDUCATION UNIT

This unit serves as a major link of communication and assistance between The MO HealthNet Division and the provider community. Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MO HealthNet Program. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to furnish assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, computer-to-computer trainings and both individual and associational meetings to provide instructions on procedures, policy changes, benefit changes, etc., which affect the provider community.

Representatives are available, when in the state office, to talk with providers in person or by telephone. The Provider Relations Education Unit is located at 615 Howerton Court, Jefferson City, Missouri. Providers may call (573) 751-6683 to arrange an appointment.

Section 3 - Provider and Participant Services



3.5 PARTICIPANTS SERVICES

Providers may direct participants to the MO HealthNet Participant Services Unit for questions regarding such things as MO HealthNet-covered services, the denial or payment of claims filed with the MO HealthNet Program, and the location of participating providers in their areas of the state. This unit can be helpful, for example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

Participants who have problems or questions concerning MO HealthNet should be directed to call (800) 392-2161 or to write:

MO HealthNet Division
Participant Services Unit
P.O. Box 3535
Jefferson City, MO 65102

All calls or correspondence from providers are referred to the Provider Relations Communication Unit. Please *do not* give participants the Provider Relations telephone number.

3.6 PENDING CLAIMS

The "Suspended Claims" Section of the Remittance Advice (RA) includes those claims that, although in the fiscal agent's system, are in suspense and have *not* processed to pay or deny during the current payment cycle.

If payment or status information, for a submitted MO HealthNet claim, is *not* received within 60 days, providers may resubmit a new claim to the fiscal agent. Refer to Section 17 of this manual for further discussion of the RA and Suspended Claims.

3.7 FORMS REQUEST

Use the Forms Request supplied by Infocrossing Healthcare Services (IHS) to reorder claim forms (A to E) and attachments such as Prior Authorization Request (F), Healthy Children and Youth Screening (J), HCY Lead Screening Guide (K), Certificate of Medical Necessity (P), Individual Adjustment Request (Q), and Second Surgical Opinion Form (S).

IHS offers both claim forms with and without a preprinted label. Provider labels may be ordered for use with blank claim forms. Labels include the MO HealthNet provider ID number, name, and address. Use the labels in the appropriate field on all claim forms filed only as MO HealthNet claims and those crossover claims requiring refiling to MO HealthNet. Use of this label serves to eliminate



Section 3 - Provider and Participant Services

errors and facilitate the processing of the claim. Providers may also order claim forms with the provider information preprinted in the correct field.

3.7.A RISK APPRAISAL FORM

See Section 13.66 of the Physician's Manual for information on the Risk Appraisal for Pregnant Women.

3.8 CLAIM FILING METHODS

Providers have a choice in how claims are submitted to the fiscal agent. Some providers may still submit paper claims. All claim types may be submitted electronically through the MO HealthNet billing site at www.emomed.com. Most claims that require attachments may also be submitted at this site. Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in Section 15.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include: Second Surgical Opinion Form; (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of Restricted Participant (PI-118) and Certificate of Medical Necessity (for Durable Medical Equipment providers only). These attachments may *not* be submitted via the Internet when additional documentation is required. The web site address for these submissions is www.emomed.com.

END OF SECTION

[TOP OF PAGE](#)