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Section 23 - Claim Attachment Submission and Processing

## **SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING**

This section of the manual provides examples and instructions for submitting claim attachments. This section also contains instructions for the Claim Attachment Remittance Advice, which is the document used to inform the provider of the status of each attachment.

### **23.1 CLAIM ATTACHMENT SUBMISSIONS**

Six claim attachments required for payment of certain services are separately processed from the claim form. The six attachments are:

- Second Surgical Opinion Form
- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form
- Certificate of Medical Necessity (**only for the Durable Medical Equipment Program**)

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

Infocrossing Healthcare Services  
P.O. Box 5900  
Jefferson City, MO 65102

These attachments may also be submitted to Infocrossing Healthcare Services via the Internet when additional documentation is *not* required. The web site address for these submissions is [www.emomed.com](http://www.emomed.com).

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements. The status of the attachment(s) is reflected on a Claim Attachment Remittance Advice (RA) (Refer to Section 23.5) similar to claim disposition.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized on an Claim Attachment Remittance Advice before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 60 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 60 days a match is *not* found, the claim denies for the missing attachment.

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**Example:** Surgery that requires a Second Surgical Opinion Form is performed on a MO HealthNet participant, during an inpatient hospitalization, on December 5, 2001. The hospital submits a claim on December 21, 2001, without the Second Surgical Opinion Form. This claim does *not* deny based on the lack of the Second Surgical Opinion Form but suspends for up to 60 days. The system periodically checks to determine if an approved attachment can be located to link to the hospital's claim.

The physician submits the Second Surgical Opinion Form on December 22, 2001 and a claim on December 24, 2001. The data from the attachment is entered into the system and subsequently finalized in the system on December 31, 2001. During the next cycle the hospital's and the physician's claims are linked to the attachment, and both claims continue through the adjudication process.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

### **23.2 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ)**

The data from the OREMJ is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **Providers are required to include the correct modifier (NU, RR, RP) in the procedure code field with the corresponding procedure code.**

Once an OREMJ has been submitted and approved for 12 months from the prescription date, providers are *not* required to submit the OREMJ with each claim submission or resubmission when the information on the claim matches the criteria on the OREMJ. The claims link up with the approved OREMJ and continue to process.

### **23.3 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY**

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RP) in the procedure code field with the corresponding procedure code.**

Once the Certificate of Medical Necessity has been submitted by a DME provider and is approved for six months from the prescription date, any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed for payment, without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.

## 23.4 ELECTRONIC PA REQUEST AND CLAIM ATTACHMENTS SUBMISSION VIA THE INTERNET

Providers may submit PA Requests (Refer to Section 8.2) and certain claim attachments 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), OREMJ and Certificate of Medical Necessity (**for Durable Medical Equipment providers only**) when additional documentation is *not* required. The web site address for these submissions is [www.emomed.com](http://www.emomed.com).

## 23.5 CLAIM ATTACHMENT REMITTANCE ADVICE

The Claim Attachment Remittance Advice (RA) reflects the status of the attachment(s). When an attachment is approved, no EOB(s) or Exception(s) is reflected on the applicable line of the attachment status RA page. When an attachment is denied, the relevant EOB(s) and Exception(s) is indicated on the RA. Unless prohibited by the applicable program, the attachment can be corrected or additional information supplied on the attachment and resubmitted for consideration.

### 23.5.A CERTIFICATE OF MEDICAL NECESSITY

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do *not* appear on the Claim Attachment Remittance Advice received by the provider. The following lists the fields found on the Certificate of Medical Necessity Claim Attachment Remittance Advice:

FIELD REFERENCE & NAME	EXPLANATION OF FIELD
1. Provider Identifier	The provider's 9-digit MO HealthNet number.
2. Attachment Name	The name of the attachment.
3. Remittance Advice Date	The financial cycle date.
4. Remittance Advice Number	The Claim Attachment Remittance Advice number.
5. Page	The Claim Attachment Remittance Advice page number.
6. Participant Name	The participant's last name and first name. NOTE: If the participant's name and identification number are <i>not</i> on file, only the first two letters of the last name and first letter of the first name appear.

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7. MO HealthNet I.D.	The participant's 8-digit MO HealthNet identification number.
8. Attachment Internal Control Number(ICN)	<p>The 13-digit number assigned to the attachment for identification purposes. The first two digits of an ICN indicate the type of attachment:</p> <p>01—Second Surgical Opinion Form</p> <p>02—Medical Referral Form of Restricted Participant (PI-118)</p> <p>03—(Sterilization) Consent Form</p> <p>07—Certificate of Medical Necessity</p> <p>08—Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)</p> <p>09—Acknowledgment of Receipt of Hysterectomy Information</p>
9. Service Date From	The initial date of service in MMDDYY format.
10. Service Date To (Thru)	The final date of service in MMDDYY format.
11. Proc Code/Mod1/Mod2	The procedure code, including any modifier(s).
12. Msg/Sys Inf	A message code(s) for the line. When an attachment is approved, no EOB(s) or Exceptions(s) are reflected on the line. For a description of the code, reference the last page of the Remittance Advice.
13. Edit Message Numbers (Nbrs)	A list of all the edits the attachment failed, if the reason(s) for denial <i>cannot</i> all be explained by the Message Code in field 12. If edit numbers are printed in this area, they indicate errors for which the attachment will fail again if resubmitted unchanged. For a description of the code, reference the last page of the Remittance Advice.





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- 17. Not applicable to the Second Surgical Opinion Claim Attachment Remittance Advice

**23.5.C (STERILIZATION) CONSENT FORM**

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do *not* appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the (Sterilization) Consent Form Claim Attachment Remittance Advice:

FIELD REFERENCE & NAME	EXPLANATION OF FIELD
1-8.	Reference Section 23.5.A.
9-11.	Not applicable to the (Sterilization) Consent Form Claim Attachment Remittance Advice.
12-15.	Reference Section 23.5.A.
16.	Reference Section 23.5.B.
17.	Not applicable to the (Sterilization) Consent Form Claim Attachment Remittance Advice.

**23.5.D ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION**

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do *not* appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice:

FIELD REFERENCE & NAME	EXPLANATION OF FIELD
1-8.	Reference Section 23.5.A.
9-11.	Not applicable to the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice.



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- 12-15. Reference Section 23.5.A.
- 16. Not applicable to the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice.
- 17. Sign-Date Date of participant/participant's representative's signature in month/day/year format.

**23.5.E MEDICAL REFERRAL FORM OF RESTRICTED PARTICIPANT (PI-118)**

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do *not* appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the PI-118 Claim Attachment Remittance Advice:

FIELD REFERENCE & NAME	EXPLANATION OF FIELD
1-8.	Reference Section 23.5.A.
9-11.	Not applicable to the PI-118 Claim Attachment Remittance Advice.
12-15.	Reference Section 23.5.A.
16.	Not applicable to the PI-118 Claim Attachment Remittance Advice.
17. Sign-Date	Date of authorized provider's signature in month/day/year format.

**23.5.F OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ)**

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do *not* appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for the fields on the Oxygen and Respiratory Equipment Medical Justification Form Claim Attachment Remittance Advice.

**END OF SECTION**  
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