

Section 15 - Billing Instructions



SECTION 15 - BILLING INSTRUCTIONS

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Section 15 - Billing Instructions**SECTION 15-BILLING INSTRUCTIONS****15.1 ELECTRONIC DATA INTERCHANGE**

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N 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 X12N Version 4010A1 and NCPDP Telecommunication V.5.1 & 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
- X12N Version 4010A1 or NCPDP Telecommunication V.5.1 & 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.

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 features of the Internet application include claim submissions, claim credits and eligibility verification.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, Version 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.

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15.3 CMS-1500 AND PHARMACY CLAIM FORMS

The CMS-1500 claim form is always used to bill MO HealthNet for professional services and the Pharmacy Claim form for pharmacy services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 and the Pharmacy Claim forms 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 Infocrossing Healthcare Services Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any claim or line item on a claim that resulted in a zero payment 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 or a Pharmacy Claim form. An example of a correctable error is the use of an invalid procedure code. 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, the units field (Field #24g) on the CMS-1500 claim form is blank and the system automatically plugs a 1, but the number of units provided should have been 5, the claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct the payment, the provider *must* submit an Individual Adjustment Request. 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, a paper claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice attached indicating the denial. The claim may also



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be submitted through the Internet at www.emomed.com or through the 837 electronic claims transmission. Reference Section 16.5 of this 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, the claim *must* be filed through the Internet at www.emomed.com or through the 837 electronic transmission. Reference Section 16 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 spenddown. 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:

Infocrossing Healthcare Services
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3.

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 or |

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| | 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 <i>in that order</i> 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 policy-holder's telephone number, if available. If no private insurance is involved, leave blank. |
| 8. Patient Status | Not Required. |
| **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 Name or Program Name | Enter the other insured's insurance plan name or program name. |
| | <i>If the insurance plan denied payment for the service provided, attach valid denial from the</i> |

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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.** (See Note)⁽¹⁾
- 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, Sex 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 valid denial from the insurance plan. (See Note)⁽¹⁾
- **11d.** Other Health Plan Indicate whether the patient has a 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 or MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.

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- **14.** Date of Current Illness, Injury or Pregnancy *This field is required when billing global prenatal, global OB 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.** Name of 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
- If the physician is nonparticipating in the MO HealthNet Program, enter “nonparticipating.”
- This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of “30” (radiology/radiation therapy).*
- **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.
- If the physician is nonparticipating in the MO HealthNet Program, enter “nonparticipating.”
- This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of “30” (radiology/radiation therapy).*
- **17b.** NPI Enter the NPI number of 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*

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field is required when the service is performed on an inpatient basis.

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| 19. Reserved for Local Use | Providers may use this field for additional remarks/descriptions. |
| **20. Lab Work Performed Outside Office | If billing for laboratory charges, mark appropriate box. The referring physician may not bill for lab work that was referred out. |
| *21. Diagnosis | Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as 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 | <p>Enter the date of service under “from” in month/day/year format, using six-digit format in the unshaded area of the field. All line items <i>must</i> have a from date.</p> <p>A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.</p> <p>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</p> |
| *24b. Place of Service | Enter the appropriate place of service code in the unshaded area of the field. See Section 15.8 for the list of appropriate place of service codes. |

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- **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 modifier(s), 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 Code** 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.
- Anesthesia**—Enter the total number of minutes of anesthesia.
- Consecutive visits**—Subsequent hospital visits 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.
- Injections**—Only for those providers *not* billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is "2."
- **24h. EPSDT/Family Planning** If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an

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EPSDT/HCY and Family Planning service enter "B."

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| **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 NPI for multiple legacy MO HealthNet provider numbers. |
| **24j. Rendering Provider ID | If the Provider Taxonomy qualifier was reported in Field #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. |
| 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 <i>not</i> to be entered in this field. |
| 30. Balance Due | Enter the difference between the total charge (Field #28) and the insurance 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 |

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facility location in Field #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 one NPI for multiple legacy MO HealthNet provider numbers.
- *33. Provider Name/ Number/Address** Affix the billing provider label or write or type the information *exactly* as it appears on the label.
- **33a. NPI#** Enter the NPI number of the billing provider in Field #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.

15.8 PLACE OF SERVICE CODES

| CODE | DEFINITION |
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| 03 School | A facility whose primary purpose is education. |
| 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 |

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| | ambulatory basis. |
| 12 Home | Location, other than a hospital or other facility, where the patient receives care in a private residence. |
| 20 Urgent Care Facility | Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. |
| 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 | The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do <i>not</i> require hospitalization or institutionalization. |
| 23 Emergency Room Hospital | The portion of a hospital in which emergency diagnosis and treatment of illness or injury are provided. |
| 24 Ambulatory Surgical Center | A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. |
| 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. |
| 26 Military Treatment Facility | A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF). |
| 31 Skilled Nursing Facility | A facility that primarily provides inpatient skilled nursing care and related services to patients who |

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require medical, nursing, or rehabilitative services that does *not* provide the level of care or treatment available in a hospital.

32 Nursing Facility

A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility

A facility that provides room, board and other personal assistance services, generally on a long-term basis, and that does *not* include a medical component.

34 Hospice

A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families is provided.

NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service should be used.

49 Independent Clinic

A location, *not* part of a hospital and *not* described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

50 Federally Qualified Health Clinic (FQHC)

A facility approved by the federal government to provide health care services in generally low income areas.

51 Inpatient Psychiatric Facility

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program

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- for patients who do *not* require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.
- 53 Community Mental Health Center
A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
- 54 Intermediate Care Facility/
Mentally Retarded
A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does *not* provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).
- 55 Residential Substance Abuse
Treatment Facility
A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do *not* require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
- 56 Psychiatric Residential
Treatment Center
A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
- 61 Comprehensive Inpatient
Rehabilitation Facility
A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology,



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social or psychological services, and orthotics and prosthetics services.

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| 62 Comprehensive Outpatient Rehabilitation Facility | A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services. |
| 65 End Stage Renal Disease Treatment Facility | A facility other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis. |
| 71 Public Health Clinic | A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician. |
| 72 Rural Health Clinic | A certified facility that is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician. |
| 81 Independent Laboratory | A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office. |
| 99 Other Place of Service | Other place of service <i>not</i> identified above. |

15.9 INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

The Pharmacy Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Infocrossing Healthcare Services
 P.O. Box 5400
 Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3.



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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 Provider Name and Number | Affix the preprinted provider label or enter the provider number, provider name and address EXACTLY as it appears on the label. |
| *2 Participant Last Name | Enter the patient's full last name. |
| *3 First Name Initial | Enter the first letter of the patient's first name. |
| *4 Participant Identification Number | Enter the MO HealthNet or MO HealthNet Managed Care Plan number EXACTLY AS SHOWN ON THE PATIENT'S ID CARD or new approval letter. |
| 5 Nursing Home | Leave blank. |
| **6 EPSDT | If the medication is administered as a result of an EPSDT/HCY screening or referral, enter the letter "Y". Otherwise, leave blank. |
| **7 Other Insurance | If the patient has other insurance that covers injections, enter the letter "Y". Otherwise, leave blank. If "Y" is entered in this field, enter the name of insurance and the amount of the other insurance payment in Field #18, Other Insurance Amount/Information. (See Note)(1) |
| *8 Prescription Number | Enter a sequential identification number in this field. (Note: This number is used to sort claims submitted electronically on the remittance advice.) If the provider chooses to use a patient account number, an additional unique identifying character <i>must</i> be added to identify different injections administered on the same date of service. If no unique identifying character is added, all but the first claim denies as a duplicate. |

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- *9 Prescribing Physician Enter the Missouri State Bureau of Narcotics and Dangerous Drugs (BNDD) or the MO HealthNet provider number for the provider performing the service. For injections given by advanced practice nurses/nurse midwives or other applicable health care professionals, enter the BNDD number (if registered with this agency), the MO HealthNet Provider Number, or the BNDD of the collaborating physician. *If the prescriber is not a MO HealthNet participant, enter the state abbreviation and phone number (without the area code) for the out of state provider.*
- *10 Date Dispensed Enter the date the injection was administered in MM/DD/YY numeric format.
- *11 National Drug Code Enter the precise NDC assigned to the product administered as it appears on the package dispensed from. Always enter the entire number, separated, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is *not* in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
- 12 Refill Code Leave blank.
- *13 Metric Quantity Enter the metric quantity used in administration, as follows:
 Products in Solution (ampule, IV bag, bottle, syringe, vial) - bill the number of cc's (ml's) administered.
 Vials Containing Powder for Reconstitution - bill the number of vials used.
 Immunizations - bill the number of does administered. (The quantity usually equals 1).

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Levonorgestrel Implant - bill a quantity of 1 (1 kit = 1 unit).

This field does *not* accept decimals. Enter only whole numbers as units. (For example, if 1.5 cc were administered, enter 2 in this field).

*14 Days Supply

As the process is for billing for medications administered in the physician's office, the value for this field should always equal 1.

Claims with a value other than 1 in this field are denied.

15 Copay Amount

Leave blank. Do *not* use this field to record insurance payments.

*16 Total Charge

Enter the provider's usual and customary charge for this service.

*17 Total Amount Billed

Enter the sum of the line items above.

**18. Other Insurance
Amount/Information

If payment from a private insurance company has been received, use the appropriate line number(s) of the claim(s) affected, enter the name of the insurance company and the amount of the insurance payment.

If the insurance company denied payment for the service, use the appropriate line number(s) of the claim(s) affected, enter the name of the other insurance, and state "denial attached". Attach a copy of the insurance explanation of benefits documenting the reason for the denial. If the insurance denied the claim because their claim filing requirements were *not* met, MO HealthNet also denies the claim. See Section 5 of the provider manual for further



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| | information about third party liability. |
| 19 Remarks | Leave blank. |
| 20 Prior Authorization Number | Leave blank. |
| 21 Signature | The physician or authorized representative may sign and date the form. Hand-written, computerized signature, or a signature stamp is acceptable. |

* These fields are mandatory on all Pharmacy 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, employer's name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

15.10 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on the interactive voice response (IVR) system, a point of service (POS) terminal, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability.

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) 635-8908, which allows the provider to inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR, POS terminal 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.

15.11 DOSE OPTIMIZATION

Pharmacy claims submitted are subject to edits to identify claims for pharmacy services that fall outside expected patterns of use for certain products. Overrides to these edit denials are processed through a help desk at (800) 392-8030. The help desk is available seven days a week, 8:00 a.m. to midnight. A menu directs callers to select options based on the nature of the call. Justification for



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utilization outside expected patterns, such as FDA approved labeling, is required for approval of such an override.

Reference the MO HealthNet Dose Optimization Edit list of drug products initially subject to the edit as well as patterns that are allowed without requiring an override to the edit.

END OF SECTION

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