



**Behavioral Health  
Services  
Training Booklet  
2018**



# MO HealthNet Division Behavioral Health Training Booklet

## Preface

This Behavioral Health Services training booklet contains information to help providers with proper billing methods and procedures for MO HealthNet claims. This booklet is not all-inclusive of program benefits and limitations. Providers should refer to specific program manuals for the entire content. CPT (Current Procedural Terminology) codes, descriptions, are copyright by the American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association.

Behavioral Health webpage: <https://dss.mo.gov/mhd/cs/psych/>

Behavioral Health Provider Manual:  
[http://manuals.momed.com/collections/collection\\_psy/print.pdf](http://manuals.momed.com/collections/collection_psy/print.pdf)

## Table of Contents

Section 1: MO HealthNet Program Resources

Section 2: CMS-1500 Electronic Claim Filing Instructions

Section 3: The Remittance Advice

Section 4: Codes and Limitations

Section 5: Behavioral Health Services Precertification

Section 6: Adjustments and Resubmissions

Section 7: Medicare/MO HealthNet Crossover Claims

Section 8: Resource Publications for Provider

Section 9: Participant Liability

Section 10: Forms

**Section 1**  
**MO HealthNet Division (MHD)**  
**Program Contact Resources**

**Provider Education Unit**

Telephone: (573) 751-6683

Email: [mhd.provtrain@dss.mo.gov](mailto:mhd.provtrain@dss.mo.gov)

Fee-For-Service Providers page:

<https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>

Provider Education webpage: <https://dss.mo.gov/mhd/providers/education/>

The Provider Education Unit is available to educate providers, and other groups, on proper billing methods, policies and procedures for MHD claims. The education representatives provide Webinar and Workshop trainings to educate providers on current billing practices and program provisions. Contact this unit for training information and scheduling, and access the current training schedule from the provider pages accessed from the web links above.

When contacting this unit, please provide the contact person's name, telephone number, and email address, the provider's NPI, and (if applicable) participant's Departmental Client Number (DCN), Date of Service (DOS), Current Procedural Terminology (CPT) codes, and all other applicable information pertaining to the training.

**Provider Communications Unit**

Telephone: (573) 751-2896

Webpage: [www.emomed.com](http://www.emomed.com).

The Provider Communications Unit has a call center, which is available for MHD providers for inquiries, concerns or questions regarding claim filing, claims resolution and disposition, and participant eligibility questions and verification.

Phone calls are transferred automatically to the Interactive Voice Response (IVR) system. Please listen to the available options and select the appropriate option. The IVR system also addresses participant eligibility, last two check amounts and claim status inquiries.

**NOTE:** Please reference Section 3.3.A for details concerning the IVR.

**NOTE:** MHD eligibility inquiries need to be directed to your local Family Services Division (FSD) <http://dss.mo.gov/fsd/>

To access the MO HealthNet Web Portal page at [www.emomed.com](http://www.emomed.com) the user must sign up for a user name and password. The provider can **register** from the main page on eMOMED.

The screenshot displays the MO HealthNet Web Portal interface. At the top, there is a navigation bar with the eMOMED logo and links for Contact, Search Center, and Troubleshooting. Below this is a large banner image featuring a diverse group of healthcare professionals and patients. The main content area is divided into several sections:

- External Links:** A list of links including the State of Missouri Web site, Department of Social Services, MO HealthNet Division, Provider Information, Provider Enrollment Application, and Participant Information.
- Public News:** A section titled 'eNews' with a list of recent news items, including 'MO HealthNet Provider Hot Tip of the Week' (01/05/2018), 'Inbound Trading Partner Agreement (eMomed BATCH Users only)' (01/22/2016), 'Requesting & Accepting NPI Access' (03/24/2015), and 'eMOMED Training and Assistance Utilities' (03/24/2015).
- Welcome:** A central message titled 'Welcome to the New MO HealthNet Web Portal' stating it is the complete source for all MO HealthNet Participant and Provider related services. It includes a photo of a healthcare professional and the text 'Find everything you need from one convenient portal!'.
- Login:** A section with fields for 'User ID' and 'Password', a 'Login' button, and links for 'Click Here!' if having trouble logging in and 'Register Now!' if not registered.
- ERA Enrollment:** A section titled 'ERA Enrollment' with a link to 'Click Here!' for provider sign up for Electronic Remittance Advice (ERA).

A warning message is displayed at the bottom right of the main content area, stating: 'WARNING! THIS SYSTEM CONTAINS GOVERNMENT INFORMATION. BY ACCESSING AND USING THIS COMPUTER SYSTEM, YOU ARE CONSENTING TO SYSTEM MONITORING FOR LAW ENFORCEMENT AND OTHER PURPOSES. UNAUTHORIZED USE OF, OR ACCESS TO, THIS COMPUTER SYSTEM MAY SUBJECT YOU TO STATE AND FEDERAL CRIMINAL PROSECUTION AND PENALTIES AS WELL AS CIVIL PENALTIES.'

## **MHD Technical Help Desk**

Telephone: (573) 635-3559

Email: [internethelpdesk@momed.com](mailto:internethelpdesk@momed.com).

Providers may contact the technical help desk for assistance with the [eMOMED](http://www.emomed.com) Electronic claims internet billing system, Remittance Advice (RA) formats, network communication, and Health Insurance Portability and Accountability Act (HIPAA) trading partner agreements.

The Provider Communications Unit also processes written inquiries that should be sent to the following address:

MO HealthNet Division  
 Provider Communications Unit  
 PO Box 5500  
 Jefferson City, Missouri 65102-5500

Home / eProvider

**External Links**

- State of Missouri Web site
- Department of Social Services
- MO HealthNet Division
  - Provider Information
  - Provider Enrollment Application
  - Participant Information

**eProvider News**

**eNews**

- 09/30/2015  
ICD-10 MO HealthNet Provider Resources
- 08/31/2015  
835 Posting Dates based on 370 EFT & ERA REASSOCIATION (CCD+/835) RULE
- 07/02/2015  
HIPAA Compliant Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Code (CARC)
- 03/25/2015  
Removing a User's Access to an NPI
- 03/24/2015  
Requesting & Allowing NPI Access
- 03/24/2015  
eMOMED Training and Assistance Utilities

**eProvider Welcome**

**Welcome to eProvider**

- Claim Management**  
Submit new claims. View claim status. Void/Replace existing claims.
- Attachment Management**  
Submit new stand-alone attachments. View attachment status.
- Participant Eligibility**  
Verify participant eligibility.
- Prior Authorization Status**  
Check the prior authorization status for participants.
- Provider Communications Management**  
Send Your Inquiries...
- Participant Annual Review Date**  
View participant annual review dates.
- Nursing Home Management**  
Manage participants. Submit nursing home claims.
- File Management**  
Send and receive batch files. Print/View/Download Remittance Advice.
- Payment Information**  
View the payment information for the two most recent payments.
- Available Surveys**
- Provider Enrollment Status**  
Verify Provider Eligibility.

Once logged in and on the **Welcome to eProvider** page, select “Provider Communications Management.” This opens the “Manage Provider Communications” page.

- Select “**New Request**” to access the “**Create New Request**” form. Providers are limited to **one** inquiry per email.
- The user submitting the email inquiry will be notified via email, when a response is available to their inquiry.

### **Missouri Medicaid Audit and Compliance (MMAC)**

Telephone: (573) 751-3399

Send a Message to MMAC: <http://mmac.mo.gov/contact-us/>.

Webpage: <http://www.mmac.mo.gov/>.

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts, under the Medicaid program. MMAC mission is to prevent, detect, and investigate fraudulent, wasteful practices, and abuse of the Medicaid Title XIX, CHIP Title XXI, and waiver programs. MMAC is divided into four major organizational components:

- I. **Administration Section**
- II. **Financial Section**
- III. **Provider Review and Participant Lock-In Section**
- IV. **Investigations and Provider Enrollment Section**

Providers can contact MMAC by sending a message from the following web link:  
<http://mmac.mo.gov/contact-us/>.

MMAC written inquiries should be sent to the following address:

Missouri Medicaid Audit and Compliance Unit  
PO Box 6500  
Jefferson City, MO 65102-6500

### **Provider Enrollment**

Telephone: (573) 751-8619

Email: [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov)

Webpage: <http://mmac.mo.gov/providers/provider-enrollment/>.

The Provider Enrollment Section is responsible for screening and enrolling all Missouri Medicaid Providers. The Provider Enrollment staff is mandated with auditing and screening provider applications to ensure they meet Federal and State mandates, before they can be authorized to be a Missouri Medicaid Provider.

Providers may contact Provider Enrollment for questions, regarding enrollment applications, and changes to the Provider Master File; including: addresses, tax identification, ownership, individual's name or practice name, and National Provider Identification (NPI) numbers.

- **Apply to be a Missouri Medicaid Provider**
- **Provider Enrollment Guide** (Information and Requirements)
- **Civil Rights** (Compliance Information)
- **Home and Community Based Services** (Forms and Applications)
- **Provider Enrollment Applications and Forms**

Changes may be reported via email at [MMAC.ProviderEnrollment@dss.mo.gov](mailto:MMAC.ProviderEnrollment@dss.mo.gov),  
Or through the 'Contact Us Form' on the website <http://mmac.mo.gov/>.

Provider Enrollment written inquiries should be sent to the following address:

Missouri Medicaid Audit and Compliance Unit  
**Provider Enrollment Unit**  
P. O. Box 6500  
Jefferson City, Missouri 65102



**Behavioral Health Precertification Help Desk**

Telephone: (866) 771-3350

Behavioral Health webpage: <http://dss.mo.gov/mhd/cs/psych/>.

Behavioral Health Provider Manual:

[http://manuals.momed.com/collections/collection\\_psy/print.pdf](http://manuals.momed.com/collections/collection_psy/print.pdf).

The [Behavioral Health Services request for Precertification](#) form must be complete and include Provider National Provider Identifier (NPI) number, Departmental Client Number (DCN), and contact information in order to be processed. A Precertification **cannot** be processed, if the participant or provider identifying information is incomplete or inaccurate.

Every attempt is made by the Behavioral Health Services Help Desk to reconcile any incorrect or inaccurate information with providers. However, it remains the provider's responsibility to provide complete and accurate information when submitting a request for precertification.

**Third Party Liability (TPL)**

Telephone: (573) 751-2005

Fax: (573) 526- 1162

Providers and participants can contact the TPL Unit to report any third party payers. Contact the TPL Unit to report injuries sustained by MHD participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MHD participant.

Providers can complete the [Insurance Resource Report Form \(TPL-4\)](#) found at <http://manuals.momed.com/manuals/presentation/forms.jsp>.

**Pharmacy and Clinical Services**

Telephone: (573) 751-6963

Email: [clinical.services@dss.mo.gov](mailto:clinical.services@dss.mo.gov)

Webpage: <http://dss.mo.gov/mhd/cs/>.

This unit is responsible for program development and clinical policy decision-making for MHD. Policy development, benefit design, and coverage decisions are made by this unit using best practices and evidence-based medicine. This unit addresses provider and policy inquiries and issues, regarding the MHD clinical services programs, including Pharmacy, The Missouri Rx Plan (MoRx), Psychology, Exceptions (non-covered services/items), and Medical Precertification.

**MHD PHARMACY AND MEDICAL PRECERTIFICATION HELP DESK**

Telephone: (800) 392-8030

Email: [cyberaccesshelpdesk@conduent.com](mailto:cyberaccesshelpdesk@conduent.com)

MO HealthNet requires pre-certification for certain radiological procedures listed at:  
<https://portal.healthhelp.com/mohealthnet>

The MO HealthNet fax line for non-emergency service or equipment exception request is (573) 522-3061.

For Drug PA's fax line: (573) 636-6470.

The MO HealthNet fax line for Medicare Part D Emergency Override Authorization is (573) 522- 8514.

The Medicare Part D Emergency Override Authorization Form can be found at [http://dss.mo.gov/mhd/cs/pharmacy/pdf/partdoverride\\_form.pdf](http://dss.mo.gov/mhd/cs/pharmacy/pdf/partdoverride_form.pdf).

The MO HealthNet Exception Request form can be found at <http://manuals.momed.com/manuals/presentation/forms.jsp>.

Certain drugs require a Prior Authorization (PA) or Edit Override (EO) obtained prior to dispensing. CyberAccess is a web tool that automates the PA and EO process for MHD providers. Providers are encouraged to become a CyberAccess user; contact Conduent help desk by calling or emailing. The CyberAccess tool allows each request for pre-certification to automatically reference the individual participant's claim history, including diagnosis codes and CPT procedure codes.

Providers can call to request a pre-certification for a radiological procedure (MRI, MRA, CT, CTA, PET scans, cardiac imaging including Nuclear Cardiac (SPECT), EBCT/Calcium Scoring, Cardiac PET and PET/CT, diagnostic heart catheterization, and Stress ECHO); to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MHD program; to request information on Medicare Part D; or, to request a drug PA.

MHD has implemented pre-certification for certain radiological procedures. In order for providers to be reimbursed for these services, the participant must meet certain medical criteria and the physician must obtain the precertification for the procedure unless performed in an inpatient hospital or emergency room setting.

List of Medical Imaging Procedures that require Precertification:  
<https://dss.mo.gov/mhd/cs/medprecert/pages/radiology-benefit-management-information.htm>

List of Durable Medical Supplies that require Precertification:  
<https://dss.mo.gov/mhd/cs/dmeprecert/>



## **CyberAccess**

Telephone: (888) 581-9797 or (573) 632-9797

E-Mail: [cyberaccesshelpdesk@conduent.com](mailto:cyberaccesshelpdesk@conduent.com).

Webpage: <http://dss.mo.gov/mhd/cs/medprecert/pages/cyberaccess.htm>.

Login: <https://www.cyberaccessonline.net/cyberaccess/>.

CyberAccess Helpful Tips:

<https://dss.mo.gov/cd/info/forms/reference/cyberaccess-helpful-tips.pdf>

Providers are encouraged to sign up for the MO HealthNet web tool **CyberAccess**, which automates the **precertification** process. The [Cyber Access Tool](#) allows each request for precertification to automatically reference the individual participant's claim history, including International Classification Diseases (ICD) diagnosis codes and CPT procedure codes.

**CyberAccess**

Protect your patients by following a few simple rules

- Always choose passwords that are difficult for others to guess. You can change your password on the "My Account" screen after you log in.
- Never give your user name and password to others because it could be used without your knowledge.
- Never leave patient information unprotected on the computer screen while you step away.
- Place all printed documents containing patient information in secure storage or shred them daily to prevent accidental disclosure.
- Obey the golden rule: always handle information about your patients with the same care that you expect from your own physician.

NOTE: Any unauthorized use or access to the pages, or the computer systems on which the pages and information to be displayed reside, is strictly prohibited and may be a criminal violation. Your use of this Web site is governed by and conditioned on your acceptance of the terms of use referenced herein and such other terms and conditions as may be contained in this Web site. Your use of this Web site constitutes your agreement to the terms of use and all such additional terms and conditions.

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FREQUENTLY ASKED QUESTIONS SYSTEM REQUIREMENTS  
VERSION: 10.6

For technical support with CyberAccess please call 1-888-581-9797

## **MHD Services and Programs**

Email: [Ask.MHD@dss.mo.gov](mailto:Ask.MHD@dss.mo.gov)

Webpage: <http://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>

Contact MHD Services and Programs, for inquiries regarding program and policies that cannot be answered by any other contact information. Please provide the NPI, name and contact information, and complete details regarding the inquiry.

## **Managed Care Stakeholder Services Unit**

Email: [MHD.MCCommunications@dss.mo.gov](mailto:MHD.MCCommunications@dss.mo.gov)

Telephone: (573) 526-4274

Contact MHD Managed Care Stakeholder Unit, for provider and participant inquiries regarding Managed Care issues. Please provide the NPI, name and contact information, and complete details regarding the inquiry.

**Participant Services Unit**

Telephone: (800) 392-2161 or (573) 751-6527

Webpage: <http://dss.mo.gov/mhd/participants/>.

The Participant Services Unit assists participants, regarding access to providers, eligibility, covered and non-covered services, and unpaid medical bills. Participant Services Unit will assist participants with inquiries about payments received for Children’s Health Insurance Premiums (CHIP), spenddown, ticket to work, and electronic funds transfer requests.

The Participant Services Unit calls are transferred automatically to the IVR system. Participants listen to the available options and select the appropriate option.

**Family Support Division (FSD)**

Telephone: FSD Info Center: 855-FSD-INFO (855) 373-4636

FSD Info Center (IVR): (800) 392-1261

Webpage: <http://dss.mo.gov/fsd>

The FSD handles the eligibility determinations for MHD benefits. Contact FSD if you have questions about eligibility determinations and services available through FSD.

**FSD Spenddown Unit**

Telephone: (855) 600-4412

EFax Option: 855-600-3754

Providers may submit incurred medical expenses to the spenddown unit on behalf of the participant. Providers may utilize the MO HealthNet Spenddown Provider Form located on the **MO HealthNet for the Aged, Blind and Disabled** page under quick links and spenddown <http://dss.mo.gov/fsd/health-care/mo-healthnet-for-people-with-disabilities.htm>.

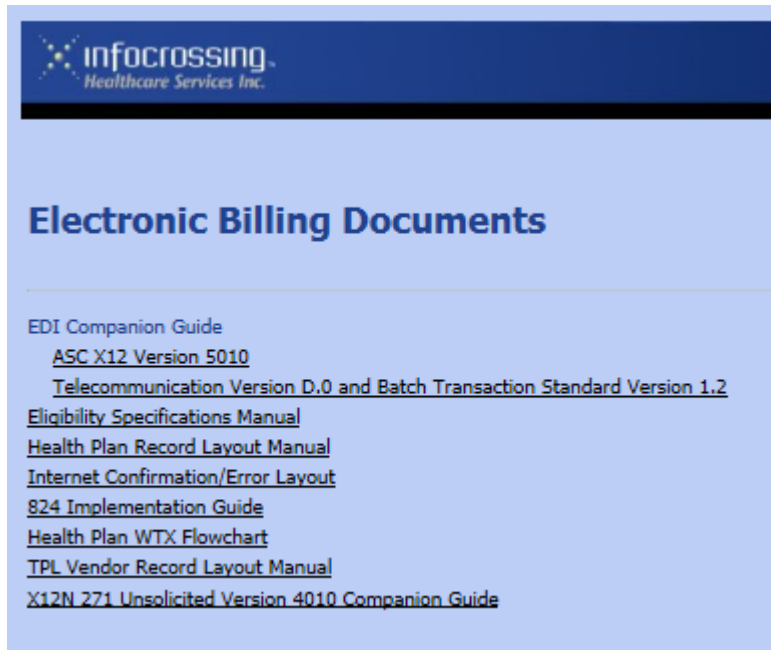
Providers may scan or email the form to [sesd@ip.sp.mo.gov](mailto:sesd@ip.sp.mo.gov) and include receipts, bills, and information related to the spenddown. Email questions or problems to [SpendDown.Unit@dss.mo.gov](mailto:SpendDown.Unit@dss.mo.gov), or fax the form to fax numbers above.

**Health Insurance Portability and Accountability Act (HIPAA) Information**

Billing providers, who want to exchange electronic information transactions with MHD, can access the **HIPAA - EDI Companion Guide** online.

- Accessing the MHD Web page at <http://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>
- Select the “**HIPAA - EDI Companion Guide**” link located under Billing. <http://manuals.momed.com/manuals/edb.jsp>.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Help Desk at (573) 635-3559.



## **MO HealthNet Interactive Voice Response (IVR)** **(573) 751-2896**

The IVR system requires a touchtone telephone. The ten-digit MHD NPI **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for DOS, during their active status. When contacting program resources, please provide the provider’s NPI, participant’s DCN, DOS, Current Procedural Terminology (CPT) codes, and the name and contact information of the person requesting the information.

### Option 1 Participant Eligibility

Participant eligibility **must** be verified **each** time a participant presents and should be verified **prior** to rendering the service. Eligibility information can be obtained by a participant’s DCN, social security number and date of birth; or if a newborn, using the mother’s DCN and the baby’s date of birth. Callers can only inquire on dates within one year of the current date. Callers will be given a confirmation number for their records.

- Option 2      Check Amount Information  
Using this option, the caller will be given the last two RA dates, RA numbers, and check amounts.
- Option 3      Claim Information  
After entering the participant's DCN and the DOS, the caller will be provided the status of the most current claim in the system containing the DOS entered. The caller will be notified of the claim status, paid, denied, approved to pay or being processed, and the amount paid, the RA date and the Internal Control Number (ICN).
- Option 4      Provider Enrollment Status  
The 10 digit National Provider Identifier (NPI) number is required. Follow the instructions of the automated voice prompts. Provide the 6 digit date of service following MM/DD/YY for verification of provider status. This information is also available on [www.emomed.com](http://www.emomed.com). EPassport is also available to update your provider information, such as your phone numbers or address.
- Option 5      Participant Annual Review Date  
The participant's annual review date can be obtained through this option. The only information retrieved is the annual review date. For specific information, call the Family Support Division at 1-855-373-4636.

## **Internet Services for MHD Providers**

MHD continues to improve their billing website [www.emomed.com](http://www.emomed.com) to provide real-time direct access for administrators, providers, and clearinghouse users. The following list describes the tools available on the electronic billing [emomed](http://emomed):

- Submit claims and receive claim confirmation files
- Verify participant eligibility
- Obtain Remittance Advices (RAs)
- Submit adjustments
- Submit attachments
- View claim, attachment and PA status
- View and download public files

Without proper authorization, providers are unable to access electronic billing website, [emomed](http://emomed). Only providers and designated staff, who are approved to be electronic billers, can enroll and utilize the Website services.

Each user is required to complete the online application in order to obtain a **user ID and password**. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID, and password. Once the user ID and password have been received, the user can begin using the emomed Website.

To participate in the service, apply online at <https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm> and select **Apply for Electronic/Internet system access** to complete the online [Application for MO HealthNet Internet Access Account](#).

Questions regarding the completion of the online Internet application should be directed to the Help Desk at (573) 635-3559.

**An authorization is required for each individual person within a provider's office or a billing service, who will be accessing the Internet site.**

The electronic billing Website emomed allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated.

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Claims Processing Schedule for the current fiscal year:

<http://manuals.momed.com/ClaimsProcessingSchedule.html>

The electronic billing system and services therein are free of charge, no charges applied from MHD. The provider may have costs associated with an Internet service access to the Internet. There are no special software requirements. The provider must have one of the following Web browsers: Internet Explorer 7.0 (IE7) or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

### **Verifying Participant Eligibility on eMOMED**

Functions include eligibility verification by participant DCN, case head ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the IVR System, which means an immediate response. Providers can access MHD participant eligibility files via [emomed](http://emomed.com). Select **“Participant Eligibility”** from the Welcome Provider page to access participant eligibility and coverage information. Batch eligibility verifications are returned to the user within 24 hours. A batch eligibility confirmation file can be downloaded for viewing purposes and printed.



Home / eProvider / Eligibility

Eligibility Request

NPI  Provider Name   
NPI is invalid.

Search

First Date Of Service *	Last Date of Service	
Participant DCN	Participant SSN	Participant Date of Birth
Participant Last Name	Participant First Name	Participant Middle Initial
Casehead DCN	Child's Date of Birth	Service Type Code

Search Finish

### **MHD Clams Submission through eMOMED**

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim Professional
  - Dental
  - Institutional  
(hospital inpatient and outpatient, nursing home, and home health care)
  - Pharmacy-National Council Prescription Drug Programs (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim 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.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

**Note:** Currently, some claims cannot be submitted electronically, if an attachment is required unless the attachment is one of the following that can be submitted via the eMOMED electronic internet Web service: Sterilization Consent, Acknowledgement of Receipt of Hysterectomy Information, and the PI-118 Referral (Lock-In) forms, Certificate of Medical Necessity or the Invoice of Cost.

### **Obtaining a Remittance Advice Through eMOMED**

The MHD does not mail provider paper RAs. All providers and billers must have Internet access to obtain the printable electronic RA, via the electronic internet [www.emomed.com](http://www.emomed.com).

Receiving the RA via the Internet is beneficial to the provider or biller's operation. Providers are responsible to verify the RA information to ensure proper claim filing and

payment and inappropriate overpayments in which the provider must repay. The RA is viewable and printable in a ready to use format.

The provider can conduct the following when accessing the RA on eMOMED:

- Retrieve the RA the Monday following the weekend claim processing cycle
- Have access to RAs for 62 days
- View and print the RA from the desktop
- Download the RA into the provider's operating system for retrieval at a later date.

**To sign up for this service, Click on the Electronic Remittance Advice (ERA) under the ERA Enrollment.**



### Receive Public Files through the Internet

Several public files are available for viewing or downloading from the eMOMED. Provider information under **External Links** includes the **Fee-For-Service Providers** website for the claims processing schedule for the State fiscal year, which begins July 1 and ends June 30. <http://manuals.momed.com/ClaimsProcessingSchedule.htm> Providers also have access to a listing of the HIPAA related Remittance Advice Remark Codes and Claim Adjustment Reason Codes and other HIPAA related codes. <http://www.wpc-edi.com/reference/>

### **Attachment Management**

Providers can submit **electronic attachments** via the Internet (emomed) as an alternative to mailing paper versions. The following forms can be submitted through **emomed**.

- Sterilization Consent
- Second Surgical Opinion (SSO)
- PI 118 Referral (Medical Referral Form of Restricted Recipient)
- Acknowledgment of Receipt of Hysterectomy Information
- Certificate of Medical Necessity

MHD attachments found on the following webpage:

<http://manuals.momed.com/manuals/presentation/forms.jsp>.

A paper copy of any attachment submitted via the Internet (emomed) must be kept with the patient's record.

Specific providers can submit **electronic forms** via the Internet (emomed) as an attachment to the electronic claim. The following forms:

- Certificate of Medical Necessity
- Invoice of Cost

### **MHD Provider Bulletins and Provider Manuals**

<https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>

MHD provider bulletins are also available at the MHD Website.

Provider Bulletins direct link: <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>.

The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

## Fee-For-Service Providers

[home](#) » [mo healthnet division](#) » [providers](#) » [fee for service providers](#)

If you provide services to people with disabilities, seniors, blind & visually impaired, or women with breast or cervical cancer who get their health care services through MO HealthNet, you can provide services through the Fee-For-Service Program. Providers must be enrolled in the MO HealthNet program to provide medical services through the Fee-For-Service Program.

If you participate in the MO HealthNet program, you agree to accept MO HealthNet payment as reimbursement in full for any services provided to MO HealthNet participants. A participant cannot be billed for the difference between the MO HealthNet payment and the provider's billed charges, sometimes called "budget or balance billing."



### ? Frequently Asked Questions

### Policies & Procedures

- [Provider Bulletins](#)
- [Provider Hot Tips](#)
- [Provider Manuals](#)
- [Out-of-state non-bordering services](#) 📄
- [Policy Updates](#)

### Billing

- [Apply for EMOMED](#)
- [EMOMED](#)
- [Claims processing and payment schedule](#)
- [Exempt diagnosis table](#) 📄 updated 10/13/17
- [HIPAA - EDI companion guide](#)
- [Radiology benefit management information](#)
- [Remittance Advice Remark Codes and Claim Adjustment Reason Codes](#)
- [School District Administrative Claiming \(SDAC\)](#)

### Provider Forms

- [MO HealthNet forms](#)
- [Nursing Facility Cost Report](#)
- [EBPT Invoice Form](#) 📄

### General Information

- [Electronic Health Records incentive program](#)
- [MO HealthNet provider search](#)
- [System maintenance schedule](#) 📄
- [Other links of interest](#)

### Fee Schedules & Rate Lists

- [Fee schedules](#)
- [IRHC Medicare/Medicaid Interim rate list](#)
- [Nursing facility rate list](#)
- [Outpatient hospital radiology fee schedule](#) 📄, updated 03/14/18
- [Outpatient hospital lab fee schedule](#) 📄, updated 3/27/18

### Education

- [Benefit Tables](#) (formerly Benefit Matrix) This shows the various benefits for each MO HealthNet programs, and if they have cost sharing or co-pays.
- [Provider Resource Guide](#) 📄 (formerly Puzzled by Terminology) This guide explains the various MO HealthNet terms and codes.
- [Training information](#) Offers provider webinar and workshop schedules, audio/visual trainings, and training booklets.
- [Contacting Provider Education](#) 📄

### Provider Enrollment

- [Civil rights](#) compliance information
- [Enrollment guide](#) information and requirements for new applicants and existing providers
- [Missouri Medicaid Audit & Compliance \(MMAC\)](#)
- [Provider enrollment application](#)

## MO HealthNet Division

### Who is Covered

### Managed Care Program

### Fee-For-Service Program

### Waiver Programs

### Clinical Services

### Information for Providers

### General Information

### MO HealthNet Division Home

## MO HealthNet Opioid Prescription Intervention (OPI) Program

### Email Updates

Click to sign up for MO HealthNet News.

#### Subscription Type

Email

#### Email Address

### Contact Us

#### Provider Communications:

(573) 751-2896

For questions about claim filing, claims resolution and disposition, and participant verification.

#### Provider Education:

(573) 751-6683 or [Email](#)

For education about proper billing methods, claim filing, and training information.

To contract with the **health plans**, contact them directly.

- Select the "Provider Manuals" link. <http://manuals.momed.com/manuals/>
- State of Missouri MO HealthNet Web portal page with an alphabetical listing of the MHD provider manuals. Select the appropriate manual link and the entire manual will display.



## State of Missouri MO HealthNet Manuals



Your complete source for all MO HealthNet related services and support for the State of MO  
Find everything you need - all from one convenient portal.

To learn more about the functions and features of the Provider Manuals website, [CLICK HERE](#)

**HOME      RESOURCE CENTER      FORMS      QUICK LINKS      ABOUT WIPRO INFOCROSSING**

- AIDS Waiver
- Adult Day Care Waiver
- Adult Day Health Care - Note: This program ended June 30,2013
- Aged and Disabled Waiver
- Ambulance
- Ambulatory Surgical Center
- Behavioral Health Adult Targeted Case Management
- Behavioral Health Services
- CSTAR
- Community Psych Rehab Program
- Comprehensive Day Rehab
- DD Waiver Manual
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- Home Health
- Hospice
- Hospital
- Medically Fragile Adult Waiver
- Nurse Midwife
- Nursing Home
- Optical
- Personal Care
- Pharmacy
- Physician
- Private Duty Nursing
- Rehabilitation Centers
- Rural Health Clinic
- School District Administration Claiming
- School District Administrative Claiming Manual - Effective April 1, 2015
- Therapy
- Transplant
- Youth Targeted Case Management



Claims Processing and Payment Schedule:  
<http://manuals.momed.com/ClaimsProcessingSchedule.html>

**MO HEALTHNET CLAIMS PROCESSING SCHEDULE FOR FISCAL YEAR 2018**  
 JUNE 30, 2018

FINANCIAL CYCLE DATE	PROVIDER CHECK DATE	BEGINNING CLAIM CAPTURE CURRENT CYCLE	ENDING CLAIM CAPTURE <sub>1</sub>
Friday 06/23/2017	Thursday 07/06/2017	Wednesday 06/07/2017	Friday 06/23/2017
Friday 07/07/2017	Tuesday 07/18/2017	Saturday 06/24/2017	Friday 07/07/2017
Friday 07/21/2017	Thursday 08/03/2017	Saturday 07/08/2017	Friday 07/21/2017
Friday 08/04/2017	Wednesday 08/16/2017	Saturday 07/22/2017	Friday 08/04/2017
Friday 08/18/2017	Friday 09/01/2017	Saturday 08/05/2017	Friday 08/18/2017
Friday 09/08/2017	Friday 09/15/2017	Saturday 08/19/2017	Friday 09/08/2017
Friday 09/22/2017	Thursday 10/05/2017	Saturday 09/09/2017	Friday 09/22/2017
Friday 10/06/2017	Thursday 10/19/2017	Saturday 09/23/2017	Friday 10/06/2017
Friday 10/20/2017	Friday 11/03/2017	Saturday 10/07/2017	Friday 10/20/2017
Friday 11/03/2017	Thursday 11/16/2017	Saturday 10/21/2017	Friday 11/03/2017
Friday 11/17/2017	Friday 12/01/2017	Saturday 11/04/2017	Friday 11/17/2017
Friday 12/08/2017	Friday 12/15/2017	Saturday 11/18/2017	Friday 12/08/2017
Friday 12/22/2017	Friday 01/05/2018	Saturday 12/09/2017	Friday 12/22/2017
Friday 01/05/2018	Tuesday 01/16/2018	Saturday 12/23/2017	Friday 01/05/2018
Friday 01/19/2018	Friday 02/02/2018	Saturday 01/06/2018	Friday 01/19/2018
Friday 02/09/2018	Friday 02/16/2018	Saturday 01/20/2018	Friday 02/09/2018
Friday 02/23/2018	Thursday 03/08/2018	Saturday 02/10/2018	Friday 02/23/2018
Friday 03/09/2018	Thursday 03/22/2018	Saturday 02/24/2018	Friday 03/09/2018
Friday 03/23/2018	Thursday 04/05/2018	Saturday 03/10/2018	Friday 03/23/2018
Friday 04/06/2018	Tuesday 04/17/2018	Saturday 03/24/2018	Friday 04/06/2018
Friday 04/20/2018	Thursday 05/03/2018	Saturday 04/07/2018	Friday 04/20/2018
Friday 05/04/2018	Friday 05/18/2018	Saturday 04/21/2018	Friday 05/04/2018
Friday 05/18/2018	Friday 06/01/2018	Saturday 05/05/2018	Friday 05/18/2018
Friday 06/08/2018	Friday 06/15/2018	Saturday 05/19/2018	Friday 06/08/2018

Note 1: Ending Claim Capture date - Closeout is 5:00 p.m. on the date shown

Revised : 05/17/2017



**Additional Helpful Contact Information**

Department of Social Services (DSS)	(573) 751-4815
Family Support Division State Office (FSD)	(573) 751-3221
FSD Information Line	(800) 392-1261
MO HealthNet Division (MHD)	(573) 751-3425
Participant Services Unit (PSU)	(800) 392-2161 or (573) 751-6527
Third Party Liability Unit (TPL)	(573) 751-2005
Department of Mental Health (DMH)	(573) 751-4122
Division of Developmental Disabilities (MRDD)	(800) 207-9329
Department of Health & Senior Services (DHSS)	(800) 235-5503 or (573) 751-6400
Special Health Care Needs	(573) 751-6246
Long-Term Care Ombudsman	(800) 309-3282 (573) 526-0727
Missouri Care Options (MCO) Adult Abuse Hot Line	(800) 235-5503 or (800) 392-0210

## Section 2

### Behavioral Health

# Electronic CMS-1500 Claim Form Filing Instructions

[www.emomed.com](http://www.emomed.com).

Apply online via the [Application for MO HealthNet Internet Access Account](#) link, to utilize the internet for eligibility verification, electronic claim submissions, and RA retrieval. Each user is required to complete this online application to obtain a user ID and password. The application process only takes a few minutes and provides a real-time confirmation response, user ID, and password. Once the user ID and password has been obtained, the user can begin accessing the [www.emomed.com](http://www.emomed.com) website.

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

Any questions regarding the completion of the on-line Internet application, contact the MHD Help Desk at (573) 635-3559.

The screenshot displays the MO HealthNet Web Portal interface. It includes a navigation menu on the left with sections for External Links, Public News, ERA Enrollment, Public Survey, and Clinical Scenarios. The main content area features a 'Welcome' message, a login form, and a 'Public Survey' section.

**External Links**

- State of Missouri Web site
- Department of Social Services
- MO HealthNet Division
  - Provider Information
  - Provider Enrollment Application
  - Participant Information

**Public News**

**eNews**

- 10/19/2015 Medicare Part C Batch claims can be submitted starting 10/19/15.
- 10/01/2015 Date Changes For ICD-10 Testing
- 09/30/2015 ICD-10 MO HealthNet Provider Resources
- 07/05/2015 ERA Process for 835s posting to INET eMOMED
- 03/24/2015 eMOMED Training and Assistance Utilities
- 03/24/2015 Requesting & Accepting NPI Access
- 12/23/2013 ERA Enrollment Form - Enrolling Through eMOMED
- 12/20/2013 Inbound Trading Partner Agreement (eMomed BATCH Users only)
- 12/17/2013 370 EFT & ERA REASSOCIATION (CCD+/835) RULE

**Welcome**

*Welcome to the New MO HealthNet Web Portal*

The complete source for all MO HealthNet Participant and Provider related services.

Find everything you need from one convenient portal!

**ERA Enrollment**

Provider Sign up for Electronic Remittance Advice (ERA)  
[Click Here!](#)

**Login**

User ID:  Password:

If you are having trouble logging in, [Click Here!](#)  
Not registered? [Register Now!](#)

WARNING! THIS SYSTEM CONTAINS GOVERNMENT INFORMATION. BY ACCESSING AND USING THIS COMPUTER SYSTEM, YOU ARE CONSENTING TO SYSTEM MONITORING FOR LAW ENFORCEMENT AND OTHER PURPOSES. UNAUTHORIZED USE OF, OR ACCESS TO, THIS COMPUTER SYSTEM MAY SUBJECT YOU TO STATE AND FEDERAL CRIMINAL PROSECUTION AND PENALTIES AS WELL AS CIVIL PENALTIES.

**Public Survey**

**List of available surveys**

[ICD-10 Readiness Survey](#)

As part of our ongoing assessment of ICD-10 readiness, MHD asks all enrolled providers to complete this very short survey.

**Clinical Scenarios**

Attention : Coders ICD-10 Survey  
Clinical Scenarios to assist in gauging readiness for ICD-10 [Click Here!](#)

**External Links**

- State of Missouri Web site
- Department of Social Services
- MO HealthNet Division
  - Provider Information
  - Provider Enrollment Application
  - Participant Information

**eProvider News**

- 09/30/2015 ICD-10 MO HealthNet Provider Resources
- 08/31/2015 835 Posting Dates based on 370 EFT & ERA REASSOCIATION (CCD+/835) RULE
- 07/02/2015 HIPAA Compliant Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Code (CARC)
- 03/25/2015 Removing a User's Access to an NPI
- 03/24/2015 Requesting & Allowing NPI Access
- 03/24/2015 eMOMED Training and Assistance Utilities

**eProvider Welcome**

### Welcome to eProvider

- Claim Management**: Submit new claims. View claim status. Void/Replace existing claims.
- Attachment Management**: Submit new stand-alone attachments. View attachment status.
- Participant Eligibility**: Verify participant eligibility.
- Prior Authorization Status**: Check the prior authorization status for participants.
- Provider Communications Management**: Send Your Inquiries...
- Participant Annual Review Date**: View participant annual review dates.
- Nursing Home Management**: Manage participants. Submit nursing home claims.
- File Management**: Send and receive batch files. Print/View/Download Remittance Advice.
- Payment Information**: View the payment information for the two most recent payments.
- Available Surveys**
- Provider Enrollment Status**: Verify Provider Eligibility.

**Welcome to eProvider**

**Select Claims Management**

Select New Claim  
 Select Medical (CMS 1500) form from the drop down list to begin a new claim.

**Claim Management**

NPI: M492174503 - CORRECTIVE ACTION PAYMENT

Medical(CMS1500) *rch* Results

Participant DCN: [ ] Submitted Charges: [ ]

Dates of Service: [ ] To: [ ]

Claim Type: All

Claim Status: All

Submission Date: [ ]

Show My Claims Only

Search Clear

Finish

**NOTE:** An asterisk (\*) beside field numbers indicate 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 indicates a field is required in specific situations.

eProvider ePassport | Welcome, Rhonda Log Out  
Home / eProvider / Claim Management

Medical(CMS1500) Claim

Billing NPI: M492174503  
CORRECTIVE ACTION PAYMENT

**Claim Header Information**

**Participant Information**

Participant DCN \*      Participant Last Name \*      Participant First Name \*

Patient Account Number

**Service Information**

Referring Provider NPI      Hospitalization Dates      To

Service Facility Location      Service Facility Name

**Cause and Diagnosis Details**

Related Cause Codes      Last Menstrual Cycle Date      Diagnosis Codes \*

Save Claim Header    Reset

Save claim header to continue.

Submit Claim    Printer Friendly    Reset    Cancel

### **Claim Header Information**

Participant's DCN\*

### **Instructions for completion**

Enter the participant's eight-digit MO HealthNet Departmental Client Number (DCN) as shown on the participant's ID card.

Participant's Last Name\*

Enter last name as it appears on the participant's ID card.

Participant's First Name\*

Enter first name as it appears on the participant's ID card.

Patient Account Number

Enter the participant's account number used by the billing provider's office.

### **Service Information**

Referring Provider NPI

### **Instructions for completion**

Enter the referring physician's MO HealthNet National Provider Identifier (NPI) and Taxonomy code (if applicable). This field is required for independent laboratories and independent radiology groups and physicians

with a specialty of “30” (radiology/radiation therapy).

Hospitalization Dates

If services are provided in an inpatient hospital setting, enter the hospital From and To date of the hospitalization. Otherwise leave blank.

Service Facility Location

If billing for laboratory charges, choose the appropriate value. The referring physician may not bill for lab work that was referred out. If services were provided in the physician’s office/clinic please leave blank.  
The valid values are:  
77- Service Location

Service Facility Name

If services were rendered in a facility other than the home or office, enter the name of the facility. Otherwise, leave blank.

**Cause and Diagnosis Details**

**Instructions for completion**

Related Cause Codes

If services on the claim are related to participant’s employment, auto accident or other accident, chose the appropriate value. If the services are not related to an accident, leave blank.  
The valid values are:  
AA- Auto accident  
AB- Abuse  
AP- Another Party Responsible  
EM- Employment  
OA- Other accident

Last Menstrual Cycle Date

This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).

Diagnosis Codes

Enter the complete diagnosis code(s) without decimals. The primary diagnosis in Field 1, the secondary diagnosis in Field 2, etc.

**Save Claim Header**

Select Save Claim Header tab to save the header information.

Reset / Cancel (claim header)

Select Reset or Cancel tab to clear all the data from the header.

Add Detail Line							
Detail Line Summary							Total Charges : 0.00
Line #	Date of Service	Place of Service	Procedure Code	Modifiers	National Drug Code	Billed Charges	Action
<b>Add Detail Line #1</b>							
Dates of Service *		Place of Service *					
10/01/2015 To 10/01/2015		[Dropdown]					
Procedure Code *			Modifiers				
[Text]			[Text] [Text] [Text] [Text]				
National Drug Code			Decimal Quantity (9999999.999)		Prescription Number		
[Text]			[Text]		[Text]		
Diagnosis Code *			Billed Charges *		Days/Units Billed *		
[- Select One -]			[Text]		[Text]		
Conditions			Performing Provider NPI				
<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Family Planning			[Text]				
Save Detail Line to Claim			Reset				

Save Detail Line to Claim to continue.

Submit Claim Printer Friendly Reset Cancel

**Add Detail Line Summary****Instructions for completion**

Date(s) of Service\*

Enter the From Date / To Date of Service.

Place of Service\*

Enter the appropriate place of service (POS) code for the services billed.

Note: Reference **program specific provider manuals** for appropriate POS codes.

The valid POS codes are:

- 03 Public Schools
- 04 Homeless Shelters
- 11 Office
- 12 Home
- 13 Assisted Living Facility
- 14 Group Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room Hospital
- 32 Nursing Facility
- 33 Custodial Care Facility
- 50 Federally Qualified Health Center (FQHC)
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 55 Residential Substance Abuse Trmt. Facility
- 56 Psychiatric Residential Treatment Center
- 57 Non-Residential Substance Abuse Trmt.
- 61 Comprehensive Inpatient Rehab Facility
- 62 Comprehensive Outpatient Rehab Facility
- 72 Rural Health Clinic (RHC)
- 97 Private/Parochial Schools
- 98 Schools
- 99 Other Unlisted Facility



Procedure Code*	Enter the appropriate procedure code.
Modifiers**	Enter the applicable modifier, if any, corresponding to the service rendered.
National Drug Code	Procedure Code (Current Procedural Terminology (CPT) / Health Care Procedure Coding System (HCPCS)) entered represents a drug, enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. Enter the 5-4-2 format, if the drug code on the package is not in 5-4-2 format, enter zeros in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
Decimal Quantity	Procedure Code (CPT/HCPCS) entered represents a drug, enter the decimal quantity dispensed or used in administration, as follows:  Number of tablets dispensed, Number of grams for ointments or powders. Number of cc's (ml's) administered for solution products (ampule, I.V. bag, bottle, syringe, vial). Number of vials used containing powder for reconstitution. Immunizations and vaccines need to be billed by the ml/cc not by the dosed administered (ampule, I.V. bag, bottle, syringe, vial) Number of Kits administered 1 Kit = 1 unit (Implants, Pegasys, Copaxone)
Prescription Number	Procedure Code (CPT/HCPCS) entered represents a drug, enter the number assigned by the pharmacy, outpatient facility or physician's office or enter a sequential identification number in this field. If the billing provider chooses to use the patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service.

**Note:** This number is used to sort claims submitted electronically on the remittance advice.

- Diagnosis Code\*** Select the desired Diagnosis Code.
- Billed Charges\*** Enter the provider’s usual and customary charge per detail line. This should be the total charge if multiple days or units are shown.
- Days/Units Billed\*** Enter the number of days or units of service provided for detail line.
- Conditions** Check the box for service provided involving one or more of the following:  
Emergency Services;  
Early and Periodic Screen for Diagnosis and Treatment (EPSDT) of children services;  
Family Planning services
- Performing Provider NPI\*\*** This field is required for a clinic, radiology, teaching institution or **group practice** only. Enter the Missouri MO HealthNet Provider Identifier (NPI)
- Taxonomy Code\*\*** Enter the performing Provider taxonomy code, (if applicable) of the physician or other professional who performed the service.
- Save Detail Line to Claim** Select Save Detail Line to Claim tab to save the detail line information. This **only saves the current detail line**, the claim must still be submitted.
- Reset / Cancel (claim detail)** Select Reset or Cancel button to clear the data from the Claim Detail Line section.

Other Payers						
Header Summary						
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action	
<b>Add/Edit Details</b>						
Filing Indicator *			Payer Responsibility Sequence Number *			
[Dropdown]			P - Primary [Dropdown]			
Other Payer ID *	Other Payer Name *		Paid Date *			
1	Primary Payer		[Text Box]			
Paid Amount *	Total Denied Amount *		Remittance Advice Remark Codes			
0.00	0.00		[Text Box] [Text Box] [Text Box] [Text Box]			
<input type="checkbox"/> Payer at Header Level						
Save Other Payer Data and Manage Codes						
Save Other Payer To Claim    Reset						

**Other Payer Attachment \***

Enter the Other Payer (insurance) information reported from the Other Payer Explanation of Benefits (EOB) or the Other Payer (insurance) Remittance Advice

The screenshot shows the 'Other Payers' form with a dropdown menu open for the 'Filing Indicator' field. The dropdown list includes the following options:

- AM - Automobile Medical
- BL - Blue Cross/Blue Shield
- CH - Champus
- CI - Commercial Insurance Co.
- DS - Disability
- HM - Health Maintenance Organization
- LJ - Liability
- LM - Liability Medical
- OF - Other Federal Program
- TV - Title V
- VA - Veteran Administration Plan 2376 Refers to Veterans Affairs Plan
- WC - Workers Compensation Health Claim
- ZZ - Mutually Defined - Unknown
- 09 - Self Pay
- 10 - Central Certification
- 11 - Other Non-Federal Programs
- 12 - Preferred Provider Organization (PPO)
- 13 - Point of Service (POS)
- 14 - Exclusive Provider Organization (EPO)
- 15 - Indemnity Insurance
- 16 - Health Maint Org Medicare Risk
- MA-Medicare
- MB-Medicare
- MC-MO HealthNet

Other visible fields in the form include: Payer ID, Payer Name, Paid Date, Filing Indicator, Paid Amount, Action, Payer Responsibility Sequence Number, Paid Date, and Remittance Advice Remark Codes. Buttons for 'Friendly', 'Reset', and 'Cancel' are also present.

**Filing Indicator\***

Select the filing indicator that defines the other payer type.

The screenshot shows the 'Other Payers' form with a dropdown menu open for the 'Payer Responsibility Sequence Number' field. The dropdown list includes the following options:

- P - Primary
- S - Secondary
- T - Tertiary
- A - Payer Responsibility Four
- B - Payer Responsibility Five
- C - Payer Responsibility Six
- D - Payer Responsibility Seven
- E - Payer Responsibility Eight
- F - Payer Responsibility Nine
- G - Payer Responsibility Ten
- H - Payer Responsibility Eleven

Other visible fields in the form include: Filing Indicator, Other Payer ID, Other Payer Name, Paid Amount, Total Denied Amount, Payer at Header Level, Save Other Payer Data and Manage Codes, Save Other Payer To Claim, Reset, Submit Claim, Printer Friendly, and Cancel.

**Payer Responsibility Sequence Number \***

Indicate which other payer processed the claim. Select primary, secondary, tertiary, etc.

**Other Payer ID\***

Enter the unique identifier of the other payer as provided on the other payer remittance advice. This field may contain numeric or alphanumeric data up to 20 characters in length.

**Note:** If not provided, use sequential numbering starting with one (1) for the first payer, two (2) for the second other payer, and etc.

**Note: The payer ID in the header must correspond to the payer ID in the detail.** For example, if payer has a payer ID of 1234 on the header, must also have a payer ID of 1234 on the detail.

Other Payer Name*	Enter the name of the Other Payer.
Paid Date*	Enter the date the other payer paid.
Paid Amount*	Enter the amount paid including decimals by the Other Payer.
Total Denied Amount**	Enter the <b>total</b> denied amount including decimals processed by the Other Payer.
Remittance Advice Remark Codes	Enter the Health Insurance Portability and Accountability Act (HIPAA) approved X12 remittance remark code reported for this claim on the remittance advice or claim status response received from the other payer.
Payer at Header Level (checkbox)	Check the box if the other payer is at the header level.
Save Other Payer Data and Manage Codes	Select Save Other Payer Data to Claim to save the <b>Header Summary</b> information.

The screenshot shows a web-based form titled "Add/Edit Group Code, Reason Code, Adjust Amount For This Payer". It features a table with the following columns: "Line Item(s)", "Claim Group Code", "Claim Adjustment Reason Code", "Adjustment Amount", and "Action". Below the table, there is a section for "Associated Line Items" with a checkbox and the number "1". There are also dropdown menus for "Claim Group Code \*" and "Claim Adjustment Reason Code \*", and input fields for "Adjustment Amount \*". At the bottom of the form, there are buttons for "Save Codes to Other Payer", "Reset", "Save Other Payer To Claim", and "Reset".

**Note:** The next step is to complete the Group Code, Reason Code, and Adjust Amount for this Payer. The claim must still be submitted.

Associated Line Item (checkboxes)*	Select the appropriate checkboxes to enter the detail lines the other payer codes apply.
Claim Group Code*	Enter the HIPAA- approved X12 adjustment group code assigned by the other payer. If other payer does not use HIPAA- approved

adjustment group codes, you must determine which approved code would be appropriate to submit.

**Note:** Each adjustment **group code** should be entered if multiple adjustment group codes are reported on the Explanation of Benefits (EOB) or Remittance Advice (RA).

**Note:** Other Payer adjustments reported to the claim’s **total billed** amount at the **header level (one total sum)** must be reported on the Other Payer Header.

**Note:** Other Payer adjustments reported to the claim’s **detail line** billed amounts must be reported on the **Other Payer Detail**.

**Note:** If **both** header and detail line level adjustments were made by the other payer, **both** the Other Payer Header and the Other Payer Detail must be completed.

ONLY approved Health Insurance Portability and Accountability Act (HIPAA) X12 codes are acceptable. These codes can also be found in the [HIPAA Related Code List](#) under the Quick Links at <http://www.dss.mo.gov/MHD>.

Claim Adjustment Reason Code\*      Other payer paper remittance advices do not show adjustment reason code for the deductible and coinsurance. Enter “**001**” for billing deductible and “**002**” for coinsurance. Part C-NON QMB paper remittance advices do not show adjustment reason code for the copay. Enter “**003**” for billing copay.

Adjustment Amount\*      Enter the **Adjustment Amount(s)**, including decimals, assigned on the claim by the other payer. The Adjustment Amount(s) is the amount that was NOT paid by the other payer, thus adjusting the reimbursement or covered amount from the submitted charge.

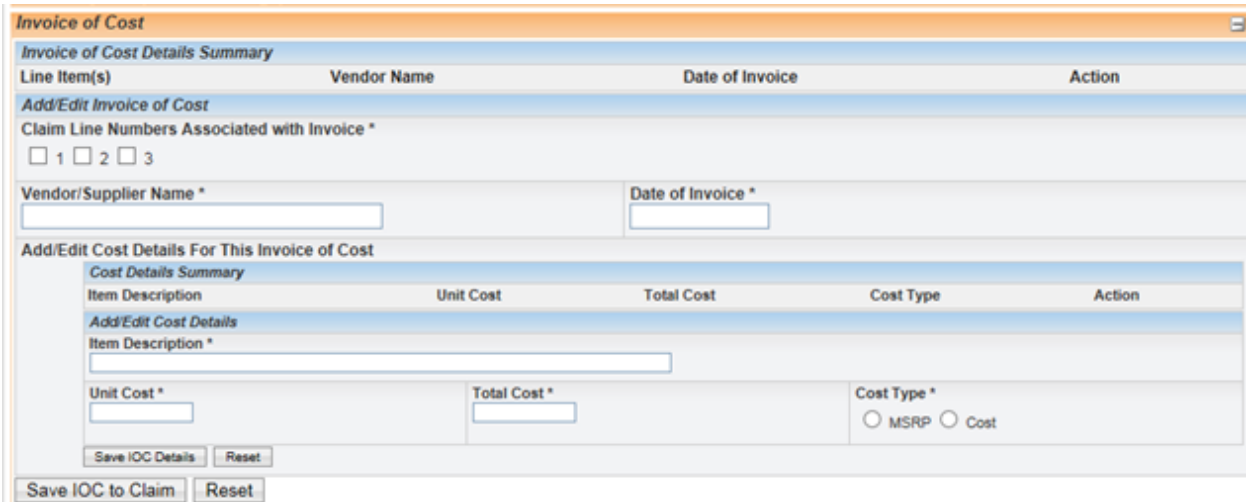
Save Codes to Other Payer      Select Save Codes to Other Payer to save the Codes to Other Payer information to the claim. Note: The claim must still be submitted.

Save Other Payer to Claim      Select Save Other Payer to Claim to save Other Payer to Claim information to the claim. Note: The claim must still be submitted.



Invoice of Cost Attachment

Complete the Invoice of Cost attachment, If applicable.



Medical Necessity Attachment

Complete the Certificate of Medical Necessity attachment, if applicable.



Submit Claim

Select Submit Claim to submit the claim.

Printer Friendly

Select Printer Friendly to open the claim in a printer friendly PDF format.

Reset

Select Reset to discard all of the previously entered medical claim information.



Cancel

Select Cancel to discard all of the previously entered medical claim information.

**Claim Status**

Claim received.

This claim has a status of K - To Be Denied, therefore some functions are not available.

**Claim Details**

Void Replacement Timely Filing Copy Claim View Claim Details Printer Friendly

Participant Details	Claim Data	Payment Details
Participant Name IMA PATIENT	ICN 4915326000950	Total Paid 0.00
Participant DCN 01010101	Claim Submission Date 11/22/2015	RA Date
	First Date Of Service 10/01/2015	Check Number
	Last Date of Service 10/01/2015	
	Claim Type MEDICAL	
	Bill Type	
	Total Charges 100.00	

Provider Details	Claim Status Details
NPI M492174503	Claim Status 33
Taxonomy Code	Category Code F0
	Entity Identifier Code
	Status Effective Date 11/22/2015
	Adjudication Date 11/22/2015

Claim Status

Processed claim has a status of K - to be **Denied**.

Processed claim has a status of I - to be **Paid**.

Processed claim has a status of C - **Captured** claim is still processing. (i.e. attachment, authorization, consultant review) This claim should not be resubmitted until it has a status of I or K.

Internal Control Number (ICN) Number

Each processed claim is assigned an ICN.

## Electronic CMS-1500 Medicare Professional Crossover Claim Form Filing Instructions

The screenshot shows the eProvider interface. At the top, there are tabs for 'eProvider' and 'ePassport', and a user greeting 'Welcome, Rhonda' with a 'Log Out' link. The main content area is titled 'Welcome to eProvider' and features a central image of a doctor. To the left, there are two sidebars: 'External Links' with links to the State of Missouri Web site, Department of Social Services, and MO HealthNet Division; and 'eProvider News' with a list of recent news items including 'Date Changes For ICD-10 Testing', 'ICD-10 MO HealthNet Provider Resources', '835 Posting Dates based on 370 EFT & ERA REASSOCIATION (CCD+/835) RULE', 'HIPAA Compliant Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Code (CARC)', 'Removing a User's Access to an NPI', 'Requesting & Allowing NPI Access', and 'eMOMED Training and Assistance Utilities'. The main content area contains ten functional links, each with an icon and a brief description: Claim Management (submit/view claims), Attachment Management (submit/view attachments), Participant Eligibility (verify eligibility), Prior Authorization Status (check status), Provider Communications Management (send inquiries), Participant Annual Review Date (view dates), Nursing Home Management (manage participants), File Management (send/receive batch files), Payment Information (view recent payments), and Available Surveys (view surveys).

### Welcome to eProvider

### Select Claims Management

Select New Medicare Crossover Claim  
Select the appropriate crossover claim type  
from the drop down list to begin a new  
crossover claim.

**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 indicates a field is required in specific situations.

### Claim Header Information

### Instructions for completion

**Note:** Previous instructions for the Claim Header Information apply to CMS-1500 Medicare Part B and Medicare Part C-QMB Professional claim with the addition of two required fields.

Participant Medicare ID (HIC)\*  
Health Insurance Claim Number

Enter the Medicare beneficiary identification number that consists of 9 numbers immediately followed by an alpha suffix.

Medicare Provider NPI\*

Enter the Medicare Provider NPI number used to bill this claim to Medicare.

**Add Detail Line Summary**

**Instructions for completion**

**Note:** Previous instructions for the Add Detail Line Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Performing Provider NPI\*

Enter the MO HealthNet Provider Identifier (NPI) / Taxonomy code (if necessary) of the Performing Provider for each detail line.

**Other Payer Attachment \*****Instructions for completion**

**Note:** Previous instructions for the Add Other Payer Header Summary Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Filing Indicator\*

Select the filing indicator that defines the type of other payer. For Crossover claims, at least one Other Payer Header Information form must be completed for Medicare with an **MB** (Medicare Part B) or **16** (Medicare Part C-QMB eligible participants only) in this field.

**Note:** Eligibility benefit of Insurance Type HN **with** QMB indicates Medicare Part C coverage (crossover claim).

**Note:** Eligibility benefit of Insurance Type HN **without** QMB indicates Medicare Part C coverage (coordination of benefits claims).

Paid Date\*

Enter the date Medicare payer paid.

**Note:** Medicare Part B and B of A claims should have at least one group, reason, or adjustment amount at the detail. These claims are paid off of detail only.

Remittance Advice Remark Codes

Enter the HIPAA approved X12 remittance remark code reported from this claim on the remittance advice or claim status response received from the other payer.

Payer at Header Level (checkbox)

Check the box if the other payer is at the header level.

Add/Edit Group Code, Reason Code, Adjust Amount For This Payer

Other Payer Detail Summary				
Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount	Action
<b>Add / Edit Other Payer Detail Information</b>				
Associated Line Items *				
<input checked="" type="checkbox"/> 1				
Claim Group Code *		Claim Adjustment Reason Code *	Adjustment Amount *	
CO - Contractual Obligations		045		
PR - Patient Responsibility		001		
PR - Patient Responsibility		002		
- Select One -				
<input type="button" value="Save Codes to Other Payer"/>		<input type="button" value="Reset"/>		
<input type="button" value="Save Other Payer To Claim"/>		<input type="button" value="Reset"/>		

**Note:** If you select a **Group Code**, you must complete the **Reason Code** field and the **Adjustment Amount** field. If you do not have information to enter in these fields, this field should be blank. Adjustment amount of zero is acceptable when appropriate.

#### MEDICARE ONLY

Part B paper remittance advices do not show an adjustment **group code** for the deductible and coinsurance. Enter group code “**PR**” to report the deductible and coinsurance. Part C paper remittance advices do not show adjustment group code for the copay; enter group code “**PR**” to report the copay.

Claim Adjustment Group Code\*

Enter the HIPAA-approved X12 (Medicare) adjustment **group code** reported for this claim on the remittance advice.

Claim Adjustment Reason Code\*

Part B paper remittance advices do not show adjustment **reason** code for the deductible and coinsurance. Enter “**001**” for billing deductible and “**002**” for coinsurance.

Part C paper remittance advices do not show adjustment reason code for the copay. Enter “**003**” for billing copay.

Adjustment Amount\*

Enter the Adjustment Amount(s), including decimals, reported for this claim on the remittance advice or claim status response received from Medicare.

The Adjustment Amount(s) is the amount that was NOT paid by Medicare, thus adjusting the reimbursement or covered amount from the submitted charge.

The adjustment amount(s) reflects the difference between the submitted charge and the amount that was paid by Medicare.



When multiple adjustments are reported each adjustment amount should be entered as reported.

Example:

Submitted Charge \$100.00

Medicare Paid \$ 70.00

---

Adjustment Amt. \$ 30.00

Save Code to Other Payer

Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.

Reset / Cancel  
(Other Payer Detail)

Select Reset/Cancel to clear all entered data from the Other Payer detail form.

Save Other Payer to Claim

Select Save Other Payer to claim to save the Other Payer claim dependent attachment.

Cancel  
(Other Payer Attachment)

Select Cancel to clear all unsaved data from the Other Payer Attachment.

**MEDICARE WITH OTHER PAYER (Insurance)** - An Other Payer form must be completed in addition to the Medicare related Other Payer form when there is **another payer** (supplemental insurance) involved.

Other Payers						
Header Summary						
Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action	
<b>Add/Edit Details</b>						
Filing Indicator *			Payer Responsibility Sequence Number *			
			S - Secondary			
Other Payer ID *	Other Payer Name *		Paid Date *			
2	Other Payer Name					
Paid Amount *	Total Denied Amount *		Remittance Advice Remark Codes			
0.00	0.00					
<input type="checkbox"/> Payer at Header Level						
Save Other Payer Data and Manage Codes						
Save Other Payer To Claim		Reset				

Add/Edit Group Code, Reason Code, Adjust Amount For This Payer				
Other Payer Detail Summary				
Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount	Action
<b>Add / Edit Other Payer Detail Information</b>				
Associated Line Items *				
<input checked="" type="checkbox"/> 1				
Claim Group Code *	Claim Adjustment Reason Code *	Adjustment Amount *		
OA - Other Adjustments	023			
CO - Contractual Obligations	045			
PR - Patient Responsibility	001			
PR - Patient Responsibility	002			
Save Codes to Other Payer		Reset		
Save Other Payer To Claim		Reset		

Claim Adjustment Group Code\*

Enter the HIPAA-approved X12 adjustment **group code** reported for this claim on the remittance advice or claim status response received from the Other Payer.

Claim Adjustment Reason Code\*

When billing supplemental insurance, you must use a **group code/reason code** such as OA/023 to report the Medicare Paid Amount. Enter the HIPAA codes assigned by the other insurer or determined to be appropriate such as CO/045 to show any amount that was not paid by the insurer. These amounts must be reported for the claim to process.

Adjustment Amount(s)\*

Enter the adjustment amount(s), including decimals, reported on the HIPAA compliant remittance advice. In the following example \$950.00 is the sum of the adjustment amount(s) for the other payer.

Example: Calculation of Other Payer Adjustment

Amount billed to Medicare	\$2000.00
Medicare Paid-	\$1000.00
<hr/>	
	\$1000.00
Other Payer Paid-	\$ 50.00
<hr/>	
Adjustment Amount	\$ 950.00

Payment by MO HealthNet, using the information provided above, and \$110.00 as the deductible amount is shown below.

Medicare deductible amount	\$110.00
Other payer paid-	\$ 50.00
<hr/>	
MO HealthNet payment amt.	\$ 60.00

Save Code to Other Payer	Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.
Reset   (Other Payer Detail)	Select Reset to discard Claim Group Codes, Claim Adjustment Reason Codes and Adjustment Amounts which have not previously been saved.
Save Other Payer to Claim	Select Save Other Payer to claim to save the Other Payer claim detail summary.
Reset	Select Reset to discard all other payer information entered which has not been previously saved.
Cancel (Other Payer Attachment)	Select Cancel to clear all unsaved data from the Other Payer Attachment.
Submit Claim (tab)	Select Submit Claim to submit the claim.
Printer Friendly (tab)	Select Printer Friendly to open the claim in a printer friendly PDF format.
Reset	Select Reset to discard all of the previously entered medical claim information.
Cancel	Select Cancel to discard all of the previously entered medical claim information and go back to the Claim Management page.

## CMS-1500 Paper Claim Filing Instructions

The Centers for Medicare & Medicaid Services (CMS) -1500 (02-12) claim form should be legibly written or filled out electronically. The [Behavioral Health Provider Manual Section 15](#) details the paper claim filing requirements.

MO HealthNet Division (MHD) paper claims should be mailed to the following address:

MO HealthNet Division  
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 and 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.   |
| 1a. | Insured's I.D.*                   | Enter the patient's eight-digit MO HealthNet DCN (Departmental Client Number) as shown on the patient's identification card.   |
| 2.  | Patient's Name*                   | Enter last name, first name, middle initial <i>in this order</i> as it appears on the patient's ID card.   |
| 3.  | Patient's Birth Date, Sex         | Enter month, day, and year of birth. 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.   |

<u>Field number and name</u>	<u>Instructions for completion</u>
6. Patient Relationship to Insured**	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
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. Reserved for NUCC Use (National Uniform Claim Committee)	Leave Blank.
9. Other Insured's Name**	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Field Number 2. If no private insurance is involved leave blank. [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. If no private insurance is involved, leave blank. [See Note (1)]
9b. Reserved for NUCC Use	Leave Blank
9c. Reserved for NUCC Use	Leave Blank
9d. Insurance Plan Name**	Enter the other insured's insurance plan or program name.  <i>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.</i>  If no private insurance is involved, leave blank. [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. <b>If the services are not related to an accident, leave blank.</b> [See Note (1)]

<b><u>Field number and name</u></b>	<b><u>Instructions for completion</u></b>
10d. Claim Codes (Designated by NUCC)	Leave Blank.
11. Insured's Group Policy or FECA 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. If no private insurance is involved, leave blank. [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. If no private insurance is involved, leave blank. [See Note (1)]
11b. Other Claim ID** (Designated by NUCC)	Enter the "Other Claim ID". Applicable claim identifiers are designated by the NUCC.
11c. Insurance Plan Name or Program Name**	Enter the primary policyholder's insurance plan name.  <i>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. [See Note (1)]</i>
11d. Other Health Benefit Plan**	Indicate whether the patient has a secondary health insurance plan; if so, complete Field 9, 9a and 9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)]
12. Patient's or Authorized Person's Signature	Leave blank.
13. Insured's or Authorized Person'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



<b><u>Field number and name</u></b>	<b><u>Instructions for completion</u></b>
	benefits from the policyholder.
14. Date of Current Illness, Injury or Pregnancy**	<i>This field is required when billing global prenatal and delivery services.</i> The date should reflect the last menstrual period (LMP).
15. Other Date	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.  <i>This field is required for independent laboratories and independent radiology groups and physicians with a specialty of "30" (radiology/radiation therapy).</i>
17a. Other ID Number**	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: OB State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)  <i>This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).</i>
17b. National Provider Identifier**	Enter the National Provider Identifier (NPI) number of the referring, ordering or supervising provider.

<u>Field number and name</u>	<u>Instructions for completion</u>
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. Additional Claim Information (Designated by NUCC)	Providers may use this field for additional remarks/descriptions.
20. Outside Lab**	If billing for laboratory charges, mark the appropriate box. The referring physician may <b>not</b> bill for lab work that was referred out.
21. Diagnosis*	Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Enter the diagnosis in the same order on all pages of claims with multiple lines. The International Classification of Diseases (ICD) indicator is not used.
22. Resubmission Code**	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 the six digit format in the unshaded area of the field. 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 is shaded and is the location for reporting

<u>Field number and name</u>	<u>Instructions for completion</u>
24b. Place of Service*	<p>supplemental information. It is <b>not</b> intended to allow the billing of 12 lines of service.</p> <p>Enter the appropriate place of service code in the unshaded area of the field.</p>
24c. EMG-Emergency**	<p>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.</p>
24d. Procedure Code*	<p>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.)</p>
24e. Diagnosis Pointer*	<p>Enter A, B, C, D or the actual diagnosis code(s) from field 21 in the unshaded area of the field.</p>
24f. Charges*	<p>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.</p>
24g. Days or Units*	<p>Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank.</p>
24h. EPSDT/Family Planning**	<p><u>Consecutive visits</u>—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.</p> <p>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 EPSDT/HCY and Family Planning service enter "B."</p>

<u>Field number and name</u>	<u>Instructions for completion</u>
24L. ID Qualifier**	Enter in the shaded area of 24L the qualifier identifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shades area.
24j. Rendering Provider ID**	The individual rendering the service is reported in this field.  Enter the NPI number of the provider in the unshaded area of the field.  This field is required for a clinic, radiology, teaching institution or a group practice only.
25. Federal Tax ID Number	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	Leave Blank.
28. Total Charge*	Enter the sum of the line item charges.
29. Amount Paid	Enter the total amount received by all other insurance resources. <b>Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.</b>
30. Reserved for NUCC Use	Leave Blank.
31. Provider Signature	Leave Blank.
32. Service Facility Location Information**	If the 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.

<u>Field number and name</u>	<u>Instructions for completion</u>
32a. NPI Number**	Enter the NPI number of the service facility location reported in field 32.
32b. Other ID Number**	Enter number.
33. Provider Name/ Number /Address*	Affix the billing provider label or write or type the information <b>exactly</b> as it appears on the label.
33a. NPI Number*	Enter the NPI number of the billing provider listed in field 33.
33b. Other ID Number**	Enter number.

\* 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 MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PCIA NON

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FROM EMPLOYER <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Programs in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
6. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
CITY STATE		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S DATE OF BIRTH <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SEX <input type="checkbox"/> <input type="checkbox"/>	
12. RESERVED FOR NUCC USE		13. AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
14. RESERVED FOR NUCC USE		14. OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
15. INSURANCE PLAN NAME OR PROGRAM NAME		15. OTHER CLAIM ID (Designated by NUCC)	
16. INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 10, and 14.	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who submits and/or pays the claim.			
SIGNED DATE		SIGNED DATE	
18. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL		19. OTHER DATE (MM/DD/YY)	
20. NAME OF PRIMARY PROVIDER OR OTHER SOURCE 17a. 17b. NPI		21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM TO	
22. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. OUTSIDE LAB <input type="checkbox"/> YES <input type="checkbox"/> NO 2 CHARGE	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to ICD-9 to service line below (fill) ICD-9-Ext		23. ICD-9-Ext ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.		24. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(s) OF SERVICE From To B. ICD-9-Ext C. PROCEDURES, SERVICES, OR SUPPLIES (include Unusual Circumstances) D. MODIFIER E. DURATION F. CHARGE G. DATE OF SERVICE H. ICD-9-Ext I. CPT CODE J. RECEIVING PROVIDER ID #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPTANCE OF LIABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. PAID FOR NUCC USE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in good faith.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ( )			
SIGNED DATE		SIGNED DATE	
NPI		NPI	



## Section 3

### The Remittance Advice (RA)

The RAs, both **current and aged**, are available through the MHD web portal at [www.emomed.com](http://www.emomed.com) . Some providers utilize an electronic HIPAA 835 transaction to retrieve their RA.

Using [www.emomed.com](http://www.emomed.com) , under File Management providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run
- View and print the RA from your desktop
- Download the RA into your computer system for future reference
- Request Aged RA's

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an “**Adjustment Reason Code**” to explain a payment, denial, corrected claim, voided claim or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim and the payer's reimbursement for it.

The RA may also list a “**Remittance Remark Code**,” which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the MO HealthNet Division Web site, <https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm> , and clicking on the link “Remittance Advice Remark Codes and Claim Adjustment Reason Codes” . Or access the HIPPA related codes lists through the internet at: <http://www.wpc-edi.com/reference/>

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through direct bank deposit approximately two weeks after the cycle run date. (Refer to the Claims Processing Schedule <https://manuals.momed.com/ClaimsProcessingSchedule.htm> )

The RA is grouped first by paid claims and followed by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a **13-digit Internal Control Number (ICN)** assigned for identification purposes. The **first two digits** of an ICN indicate the type of claim.

- 15 – CMS 1500 paper claim
- 49 – Internet claim

- 50 – Individual Adjustment Request
- 55 – Mass Adjustment
- 75 – Reversal of a Mass Adjusted Claim
- 70 – Adjudicated or Voided Claim

The **third and fourth digits** indicate the year the claim was received. **The fifth, sixth, and seventh digits** indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from “001” (January 01) to “365” or “366” in a leap year (December 31). The **last digits** of an ICN are for internal processing.

The ICN 1518001000000 is read as a CMS-1500 paper medical claim entered in the processing system on January 1, 2018.

When a claim denies for other insurance, the commercial carrier information can be retrieved when participant’s eligibility is checked.

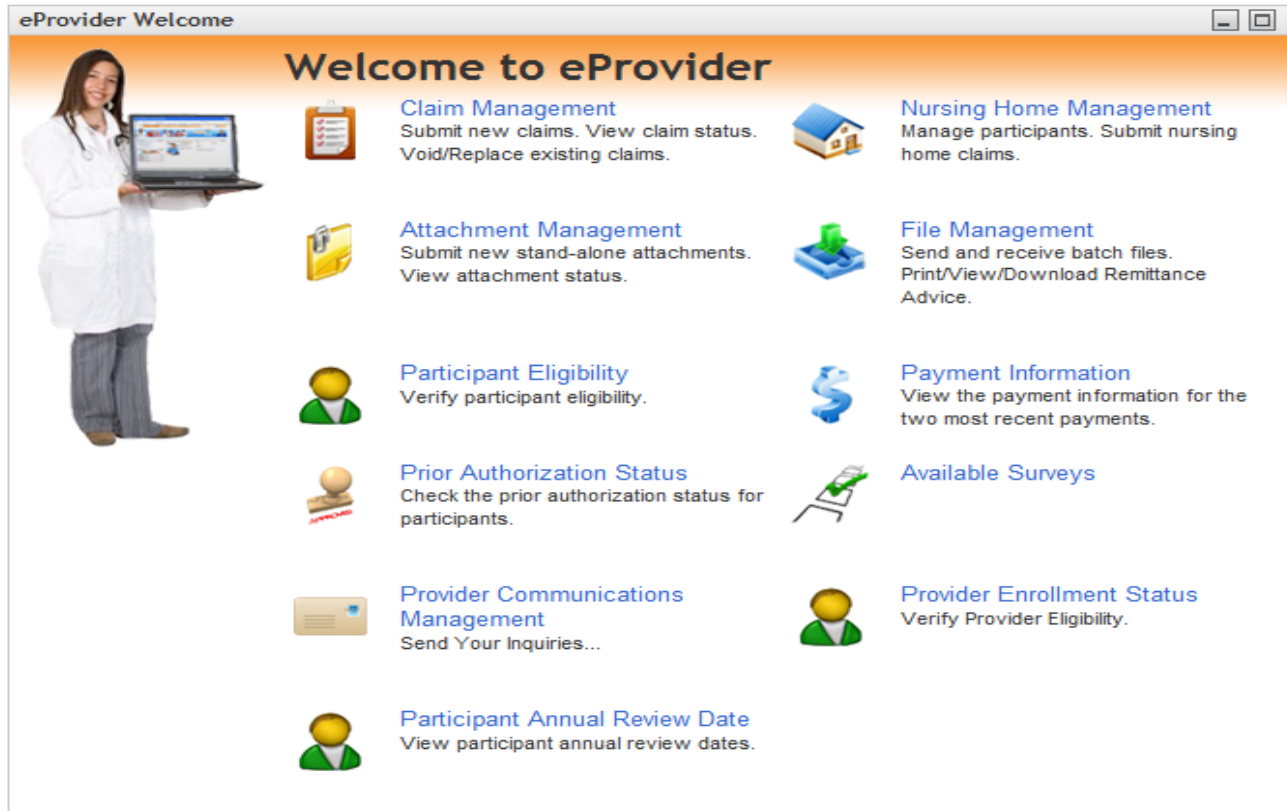
The screenshot shows the WPC (Washington Publishing Company) website. At the top, there are navigation links: Store, Careers, Help, Reference, and Contact. The main header features the WPC logo and the text "Washington Publishing Company". Below this, a "Reference" tab is selected. The page title is "Code Lists". On the right side, there are links for "Sign In", "My Cart", and "Checkout". The main content area is titled "Code Lists" and contains a paragraph explaining that ASC X12 assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. Below this, there are three main categories of code lists, each with a list of sub-categories: "Health Care Code Lists" (including Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), Claim Status Category Codes, Claim Status Codes, Service Type Codes, Health Care Services Decision Reason Codes, Health Care Provider Taxonomy Code Set, Provider Characteristics Codes, and Insurance Business Process Application Error Codes), "Health Insurance Exchange Code Lists" (including Payment Type Codes and Report Type Codes), and "Property & Casualty Code Lists" (including Several EDI-Related Property & Casualty Code Lists). On the right side of the page, there is a promotional graphic for "Code Lists for Purchase" showing three boxes labeled "CS Co", "All Se", and "Complete". Below the graphic, it states: "Code Lists can be purchased as electronic CSV files, email change alert subscription, or printed lists."

## PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at [www.emomed.com](http://www.emomed.com). A provider must be enrolled with emomed to access the web portal and the printable RA. To apply online go to the MO HealthNet web portal [www.emomed.com](http://www.emomed.com) and select Provider Sign up for **Electronic Remittance Advice (ERA)**.

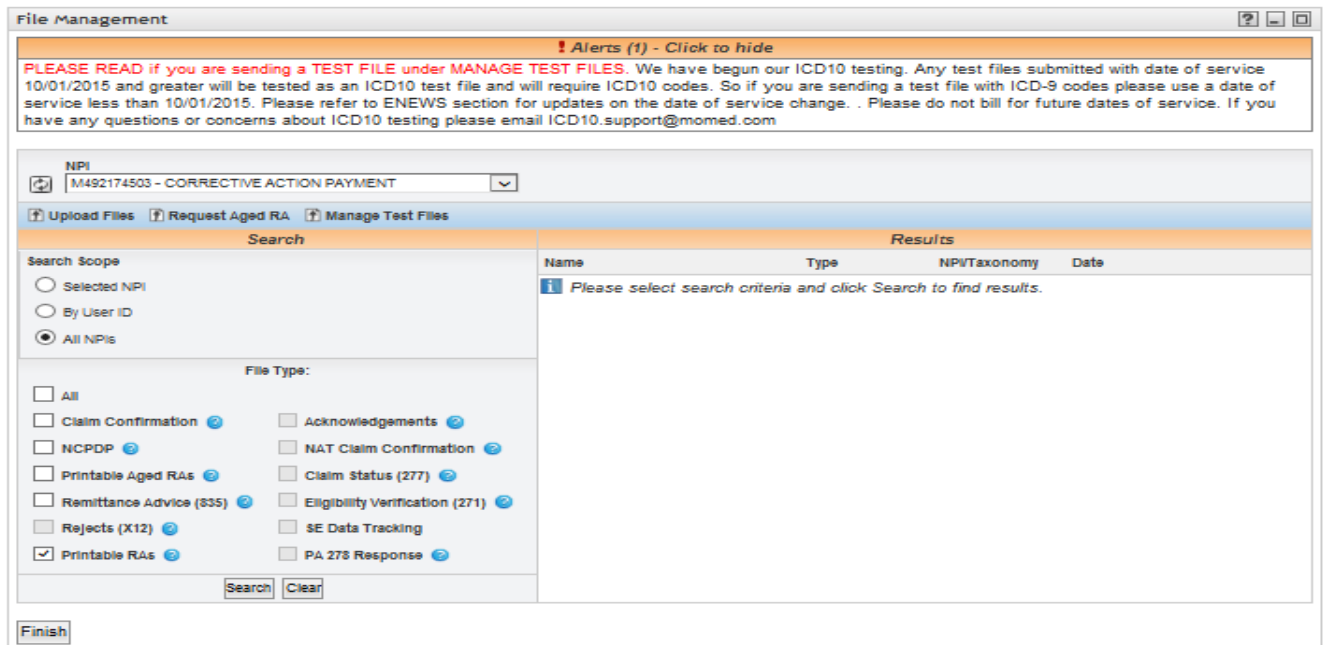
The screenshot shows the MO HealthNet web portal interface. It includes a navigation menu on the left with 'External Links' (State of Missouri Web site, Department of Social Services, MO HealthNet Division) and 'Public News' (eNews). The main content area has a 'Welcome' message: 'Welcome to the New MO HealthNet Web Portal. The complete source for all MO HealthNet Participant and Provider related services. Find everything you need from one convenient portal!' Below this is an 'ERA Enrollment' section with a 'Click Here!' link. On the right, there is a 'Login' section with 'User ID' and 'Password' input fields, a 'Login' button, and a 'Public Survey' section with a 'List of available surveys' link and an 'ICD-10 Readiness Survey' link. A 'Finished' button is also visible. A warning message is present: 'WARNING! THIS SYSTEM CONTAINS GOVERNMENT INFORMATION. BY ACCESSING AND USING THIS COMPUTER SYSTEM, YOU ARE CONSENTING TO SYSTEM MONITORING FOR LAW ENFORCEMENT AND OTHER PURPOSES. UNAUTHORIZED USE OF, OR ACCESS TO, THIS COMPUTER SYSTEM MAY SUBJECT YOU TO STATE AND FEDERAL CRIMINAL PROSECUTION AND PENALTIES AS WELL AS CIVIL PENALTIES.'

On the **Welcome to eProvider** page, select **File Management**, then select **Printable RAs** and the date to view; print or upload files to your system. The RA is in the PDF file format. The browser will open the file directly, if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to <http://www.adobe.com/products/acrobat/readstep2.htm> to download it to your computer.



RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest RA becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.




The provider can request the RA through the “Aged RA Request” by selecting the File Management option, for RA’s that are not available. Aged RA Request will take overnight to download and retrievable by selecting “Printable Aged RA’s”. Aged RA’s will be only available for 5 days. Requested RA’s can be prompted for retrieval within the past 3 rolling years.

**Upload Files** **Request Aged RA** **Manage Test Files**

From: June 2018  Cycle 1  Cycle 2 To: June 2018  Cycle 1  Cycle 2

**Save** **Cancel** **Finished**

 File requested will only be available for 5 days after the original request date. Please download the files as soon as possible.












**File Management** ? ▢ ▢

**! Alerts (1) - Click to hide**

**PLEASE READ if you are sending a TEST FILE under MANAGE TEST FILES.** We have begun our ICD10 testing. Any test files submitted with date of service 10/01/2015 and greater will be tested as an ICD10 test file and will require ICD10 codes. So if you are sending a test file with ICD-9 codes please use a date of service less than 10/01/2015. Please refer to ENEWS section for updates on the date of service change. . Please do not bill for future dates of service. If you have any questions or concerns about ICD10 testing please email ICD10.support@momed.com

NPI:

**Upload Files** **Request Aged RA** **Manage Test Files**

Search	Results								
<p>Search Scope</p> <p><input type="radio"/> Selected NPI</p> <p><input type="radio"/> By User ID</p> <p><input checked="" type="radio"/> All NPIs</p> <p>File Type:</p> <p><input type="checkbox"/> All</p> <p><input type="checkbox"/> Claim Confirmation </p> <p><input type="checkbox"/> NCPDP </p> <p><input checked="" type="checkbox"/> Printable Aged RAs </p> <p><input type="checkbox"/> Remittance Advice (835) </p> <p><input type="checkbox"/> Rejects (X12) </p> <p><input type="checkbox"/> Printable RAs </p> <p><input type="checkbox"/> Acknowledgements </p> <p><input type="checkbox"/> NAT Claim Confirmation </p> <p><input type="checkbox"/> Claim Status (277) </p> <p><input type="checkbox"/> Eligibility Verification (271) </p> <p><input type="checkbox"/> SE Data Tracking</p> <p><input type="checkbox"/> PA 278 Response </p> <p><b>Search</b> <b>Clear</b></p>	<table border="1"><thead><tr><th>Name</th><th>Type</th><th>NPI/Taxonomy</th><th>Date</th></tr></thead><tbody><tr><td colspan="4"><b>i</b> Please select search criteria and click Search to find results.</td></tr></tbody></table>	Name	Type	NPI/Taxonomy	Date	<b>i</b> Please select search criteria and click Search to find results.			
Name	Type	NPI/Taxonomy	Date						
<b>i</b> Please select search criteria and click Search to find results.									

**Finish**

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
PARTICIPANT'S NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MO HealthNet ID	The participant's 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient co-pay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is <u>not</u> present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The National Provider Identifier (NPI) number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim <b>Adjustment Group Code</b> is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim <b>Adjustment Reason Code</b> is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The <b>Code List Qualifier Code</b> and the Health Care Remark Code ( <b>Remittance Advice Remark Codes</b> ). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes.  The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.



## Healthy Children and Youth (HCY) Screenings

Behavioral Health Provider Manual:

[http://manuals.momed.com/collections/collection\\_psy/print.pdf](http://manuals.momed.com/collections/collection_psy/print.pdf).

### **Behavioral Health Provider Manual: Section 13.20.A**

**Developmental and Mental Health Partial Screens** are billable by a provisionally licensed psychologist, psychologist, psychiatrist, psychiatric mental health practitioner (PMHNP), psychiatric clinical nurse specialist (PCNS), LCSW, LMSW, LPC, or PLPC. These screening codes do **not** use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a **59 modifier** and if the child is referred on for further care a **UC modifier**. The diagnosis code Z00.129 is the only valid diagnosis code for a **partial** HCY screening.

99429 59

99429 59 UC

\***Modifier “UC”** must be used if child was referred for further care as a result of the screening. Modifier “UC” must always appear as the last modifier.

## Modifiers

### **Behavioral Health Provider Manual: Section 13.23**

Claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist / Provisionally Licensed Psychologist

AJ – Licensed Clinical Social Worker / Licensed Master Social Worker

UD – Licensed Professional Counselor / Provisionally Licensed Professional Counselor

U8 – in home (12)

(The U8 modifier is not appropriate when billing 90853 regardless of POS)

CR – Catastrophe/Disaster Related

A modifier may be required to track services provided to patients identified as catastrophe/disaster victims in any part of the country. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

With the implementation of **National Correct Coding Initiative (NCCI)**, multiple services rendered on the same date by the same performing provider require an additional modifier. A list of modifiers may be found at the fee schedule link on the MHD Web site.

## Frequently Used Place of Service (POS) Codes

### Behavioral Health Provider Manual: Section 13.24

03 – Public School	21 – Inpatient Hospital	51 – Inpatient Psychiatric Facility
04 – Homeless Shelter	22 – Outpatient Hospital	56 – Psych Residential Treatment
11 - Office	33 – Residential Treatment Center	61 – Comprehensive Inpatient Rehab Facility
12 – Participant Home	50 – FQHC	72 – Rural Health Clinic
14 – Group Home		99 – Other Unlisted Facility

### PLACE OF SERVICE CODE

Place of service 99 **cannot** be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. **Providers must use the appropriate place of service code for the setting in which services are rendered.** If there is no place of service code that matches the setting, services may not be billed to MO HealthNet. Although there is a place of service 15 for mobile unit, MO HealthNet does **not** cover services provided in this setting.

Place of service 11 (office) is to be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) have defined an **office** as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

**Travel time is not reimbursable and must not be included as part of the scheduled appointment time.**

### SCHOOL BASED SERVICES

Services provided on public school grounds or provided due to an **Individualized Education Plan (IEP)** are billed by the **school district using their National Provider Identifier number (NPI)** and the individual's NPI as the performing provider. Reimbursement is paid to the school district. IEP services are **exempt** from Managed Care but must be prior authorized by MHD based on the ME code. The only appropriate place of service for a **public school setting is 03.**

## PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only behavioral health codes billable by an LCSW, LMSW, LPC, or PLPC. The appropriate **AJ** or **UD** must be used for **all** codes.

Procedure Code	Modifier	Maximum Quantity	Description
90791		6	Psychiatric diagnostic eval
90791	U8	6	Psychiatric diagnostic eval - home
90832		1	Individual therapy – 30 mins.
90832	U8	1	Individual therapy – home – 30 mins.
90834		1	Individual therapy – 45 mins.
90834	U8	1	Individual therapy – home – 45 mins.
90846		2	Family therapy without patient present
90846	U8	1	Family therapy without patient present - home
90847		1	Family therapy with patient present
90847	U8	1	Family therapy with patient present - home
90853		3	Group therapy (other than multi-family)
90839		6	Psychotherapy for Crisis – 60 mins.
90839	U8	6	Psychotherapy for Crisis – home – 60 mins.
99406**		1	Smoking behavior change 3-10 mins.
99407**		1	Smoking behavior change over 10 mins.

## PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only behavioral health codes billable by a provisional licensed psychologist, or psychologist. The **AH** modifier must be used on ***all*** codes.

Procedure Code	Modifier	Maximum Quantity	Description
90791		6	Psychiatric diagnostic eval
90791	U8	6	Psychiatric diagnostic eval - home
90832		1	Individual therapy – 30 mins.
90832	U8	1	Individual therapy – home – 30 mins.
90834		1	Individual therapy – 45 mins.
90834	U8	1	Individual therapy – home – 45 mins..
90846		2	Family therapy without patient present
90846	U8	2	Family therapy without patient present - home
90847		2	Family therapy with patient present
90847	U8	2	Family therapy with patient present - home
90853		3	Group therapy (other than multi-family)
90839		6	Psychotherapy for Crisis – 60 mins.
90839	U8	6	Psychotherapy for Crisis – home – 60 mins.
90880		1	Hypnotherapy
90885		1	Psychiatric eval of records-inpatient only
96101		4	Psychological test by professional
96101	U8	4	Psychological test by professional – home
96103		4	Psychological test by computer
96103	U8	4	Psychological test by computer-home
96105		1	Assessment of Aphasia
96111		1	Developmental testing
96116		1	Neurobehavioral status exam
99406**		1	Smoking behavior change 3-10 mins.
99407**		1	Smoking behavior change over 10 mins.

**PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC,  
PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS  
AND RHC**

<b>Procedure Code</b>	<b>Modifier</b>	<b>Maximum Quantity</b>	<b>Description</b>
90791		6	Psychiatric diagnostic evaluation
90791	U8	6	Psychiatric diagnostic evaluation - home
90792		6	Psychiatric diagnostic evaluation with medical services
90792	U8	6	Psychiatric diagnostic evaluation with medical services – home
90832*		1	Individual therapy – 30 mins.
90832*	U8	1	Individual therapy – home – 30 mins.
90834*		1	Individual therapy – 45mins.
90834*	U8	1	Individual therapy – home – 45 mins.
90846		2	Family therapy without patient present
90846	U8	2	Family therapy without patient present – home
90847		2	Family therapy with patient present
90847	U8	2	Family therapy with patient present – home
90853		3	Group therapy (other than multi-family)
90839		6	Psychotherapy for Crisis – 60 mins.
90839	U8	6	Psychotherapy for Crisis – home – 60 mins.
90865		1	Narcosynthesis
90870		1	Electroconvulsive therapy
90880		1	Hypnotherapy
90885		1	Psychiatric evaluation of records – inpatient only
96101		4	Psychological test by professional
96101	U8	4	Psychological test by professional – home
96103		4	Psychological test by computer
96103	U8	4	Psychological test by computer - home
96105		1	Assessment of Aphasia
96111		1	Developmental testing
96116		1	Neurobehavioral status exam
99406**		1	Smoking behavior change 3-10 mins.
99407**		1	Smoking behavior change over 10 mins.

When **multiple services** are rendered on the **same day** by the **same performing provider an NCCI modifier is required** on the **second service**. The NCCI modifier is in addition to the specialty modifier and, when appropriate, the U8 modifier. Providers should reference the **Fee Schedule** link on the MHD Web site for a list of NCCI modifiers and use the appropriate modifier for billing.

- \* Psychiatrists and/or nurses should utilize **either** the appropriate Evaluation and Management (E & M) code **or** the appropriate psychotherapy code listed above. The billing of a combination of Psychotherapy and E & M code will not be allowed. Please refer to the fee schedule for E & M reimbursement amounts.
- \*\* MO HealthNet will cover two (2) quit attempts of up to 12 weeks of intervention per lifetime, including behavioral and pharmacologic interventions.
- **PHARMACOLOGIC MANAGEMENT:** MHD will allow the utilization of the appropriate E & M code when pharmacologic management is provided. Providers will have to include all components associated with the appropriate E & M code including documentation that supports the service.

Providers must use the appropriate procedure code when billing for testing, 96101 or 96103.

**Psychological Testing may NOT be performed by an LCSW, LMSW, PLPC or LPC.**

**Psychological Testing administered by a technician (96102) is NOT a covered service.**

**Neuropsychological Testing (96118, 96119, and 96120) are NOT covered services.**

## Precertification

When Behavioral Health Services are rendered through any type of clinic or group practice and the **clinic/group National Provider Identifier (NPI) is used** as the billing provider, the clinic/group is considered the provider and not each individual in the group. Refer to Behavioral Health Manual Section 13.9.A requesting precertification.

### Psychologist, Psychiatrist, Psychiatric Mental Health Nurse Practitioners (PMHNP), Psychiatric Clinical Nurse Specialists (PCNS), Rural Health Care (RHC), Federally Qualified Health Care (FQHC)

#### Adults

Behavioral Health Manual Section 13.1.B

Precertification approves the medical necessity of the requested service and does not guarantee payment. **The patient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.**

Many Behavioral Health Services provided to adults, who are 21 years of age or older, will require precertification when performed by a licensed Psychiatrist, licensed or provisionally licensed Psychologist, licensed PCNS, licensed PMHNP, RHC, or FQHC or Community Mental Health Center (CMHC) setting when provided by a Psychiatrist, PCNS, PMHNP, licensed or provisionally licensed Psychologist, LCSW, or LMSW.

Independent Provisional Licensed Clinical Social Workers (LCSWs), Licensed Clinical Social Workers (LCSWs), Provisionally Licensed Professional Counselors (PLPCs), and Licensed Professional Counselors (LPCs) may **not** see adults or should not request precertification for Behavioral Health Services for participants 21 years of age or older.

**NOTE:** Independent refers to providers in a private practice and those in a non-FQHC or non-RHC group or clinic practice.

LCSWs and PLCSWs, who are members of an FQHC or RHC, may provide adult services as part of the clinic. These services will require precertification but the request is made using the FQHC or RHC facility NPI. PLPCs and LPCs may **not** see adults in any setting.

**Family Therapy without the Patient Present (CPT 90846) requires precertification regardless of age, ME code, or residential placement.**

Refer to Behavioral Health Manual Section 13.9



**Children**

Behavioral Health Manual Section 13.1. A

Precertification is required for children, 0 through 20 years of age, who are **not** in state custody or residing in a residential treatment facility.

Precertification is required for children, 0 through 20 years of age, who are **in state custody** with an ME code of 07, 08, 37, 88, who are **not** residing in a residential treatment facility.

Precertification is required for non-state custody and state custody children when services are provided by a Psychiatrist, Provisional Licensed Psychologist, Psychologist, PCNS, PLCSW, PMHNP, LCSW, LMSW, PLPC, LPC, RHC, or FQHC.

**Codes Requiring Precertification**

**ADULTS AND CHILDREN**

**Provisional Licensed Psychologist, Psychologist, Psychiatrist, PMHNP, PCNS, RHC, and FQHC**

**ALL** Behavioral Health services for **children under the age of three (3), regardless of placement and ME code** with the exception of Diagnostic Assessment.

Individual Therapy – 90832 (30 minute session)

Individual Therapy – 90834 (45 minute session)

Maximum of 1 unit, either 30 minute or 45 minute session per day;

Maximum of 5 units, any combination of 30 minute or 45 minute sessions per month

Family Therapy – 90846 / 90847 (50 minute unit)

Maximum of 1 unit per day;

Maximum of 5 units per month

Group Therapy – 90853 (30 minute unit)

Maximum of 3 units per day;

Maximum of 15 units per month

Hypnotherapy - 90880 (no time frame noted)

**The three codes below only require a Precertification for children under the age of three (3):**

Aphasia Assessment – 96105 (60 minute session)

Developmental testing – 96111 (60 minute session)

Neurobehavioral testing – 96116 (60 minute session)

The **AH** modifier must be included when billing claims for Provisional Licensed Psychologist or Psychologists.

## **Codes Not Requiring Precertification**

### **Provisional Licensed Psychologist, Psychologist, Psychiatrist, PMHNP, PCNS, RHC and FQHC**

Behavioral Health Manual Section 13.4.A

Assessment – 90791 / 90792 (30 minute session)  
Maximum of 6 units per rolling year

Testing – 96101 / 96103 (60 minute session)  
Maximum of 4 sessions per rolling year

Psychotherapy for Crisis – 90839 (60 minute session)  
Maximum of 6 sessions per calendar year

Evaluation Inpatient Hospital Records – 90885 (no time frame noted)

Evaluation and Management codes

The codes shown below do not require Precertification for children three (3) years of age or older or for adults. **Precertification is required for children less than three (3) years of age.**

Aphasia Assessment – 96105 (60 minute session)

Developmental testing – 96111 (60 minute session)

Neurobehavioral testing – 96116 (60 minute session)

**NOTE:** Regardless of Precertification, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will not be reimbursed.

## **Codes Requiring Precertification**

### **PLCSW, LCSW, PLPC, LPC**

#### **Children**

Behavioral Health Manual Section 13.1. A

### **All Behavioral Health services for children under the age of three (3), regardless of placement / ME code with the exception of Assessment**

Individual Therapy – 90832 (30 minute session)

Individual Therapy – 90834 (45 minute session)

Maximum of 1 unit, either 30 minute or 45 minute session per day;  
Maximum of 5 units, any combination of 30 minute or 45 minute sessions per month

Family Therapy – 90846 / 90847 (50 minute session)

Maximum of 1 unit per day;  
Maximum of 5 units per month

Group Therapy – 90853 (30 minute session)

Maximum of 3 units per day;  
Maximum of 15 units per month

## **Codes Not Requiring Precertification**

### **PLCSW, LCSW, PLPC, LPC**

Assessment – 90791 / 90792 (30 minute session)

Maximum of 6 units per rolling year

Psychotherapy for Crisis – 90839 (60 minute session)

Maximum of 6 sessions per calendar year.

**NOTE:** Regardless of precertification, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will not be reimbursed.

### **Behavioral Health Providers**

Behavioral Health Manual Section 13.10

Testing and Diagnostic Evaluation CPT Codes 90791 or 90792 do not require precertification for most participants.

Testing is **limited** to independent Psychiatrists, PCNS, PMHNP, Provisional Licensed Psychologist and Psychologists and those providing services through an RHC or FQHC. MO HealthNet does not reimburse for testing when performed by an LPC, PLPC, LCSW, and LMSW or regardless of the setting.

Precertification is required for participants residing in a nursing home (NH) but the Behavioral Health services may **not** be provided at the nursing home.

Psychiatrists, PMHNP and PCNS may provide a Diagnostic Evaluation, Current Procedural Terminology (CPT) Codes 90791 or 90792 in the **nursing home** setting in addition to the appropriate NH visit code for evaluation of pharmacologic.

Precertification is required for Behavioral Health services provided on public **school district** grounds, when billing to MO HealthNet. Services are billed under the school district MO HealthNet provider National Provider Identifier (NPI) with the individual NPI listed as the performing provider.

Providers may only bill for services they personally provide. MO HealthNet does not cover services provided by someone other than the enrolled Behavioral Health provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Services provided by an individual under the direction or supervision of an enrolled Behavioral Health provider may **not** be billed under the supervisor's NPI.

**NOTE:** With the exception of Assessment, Behavioral Health services for all children under the age of three (3), including those in state custody and residential care facilities continue to require Precertification. This includes Testing.

## **Definitions**

Behavioral Health Section 13.10

### **Psychotherapy for Crisis**

The definition of Psychotherapy for Crisis is: “A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient’s well-being or is a danger to him/herself or others”. Psychotherapy for Crisis services cannot be scheduled nor can they be authorized.

### **Family Therapy**

Family therapy is the treatment of the members of a family together, parent(s) and child(ren) rather than an individual “patient”. A family may be defined as

biological, foster, adoptive or other family configuration. The family unit is viewed as a social system that affects all its members. A parental figure must be present to be considered Family Therapy.

## **Group Therapy**

Group Therapy uses group dynamics and peer interactions to increase understanding and improve social skills. Group therapy is a medically necessary, time-limited, goal-specific, face-to-face interaction based upon planned interventions documented in the Treatment Plan. Groups are limited to a minimum of three (3) but no more than ten (10) who are not members of the same family.

## **Guidelines - Adults**

### Behavioral Health Section 13.1.B

Independent PLCSWs, LCSWs, PLPCs, and LPCs may not see adults and should not request Precertification for Behavioral Health services for clients 21 year of age or older.

**NOTE:** Independent refers to providers in private practice and those in a non-FQHC or non-RHC clinic practice.

LCSWs and PLCSWs who are members of an FQHC, RHC or CMHC may be reimbursed for behavioral health services for adults (age 21 and older) as part of the clinic encounter/visit. These services will require Precertification but the request is made using the clinic NPI number.

PLPCs and LPCs may not be reimbursed for behavioral health services provided to adults, ages 21 and older with the exception of participants with ME code 38, through age 25. Extended Coverage for Independent Foster Care Adolescents [Bulletin dated October 8, 2013 Volume 36 Number 04](#)

The **first four (4) hours** of Behavioral Health services for adults do not require Precertification. These four (4) hours are intended to assist a provider seeing a participant for the first time to make the transition to Precertification should more than four (4) hours be required for treatment.

The first four (4) hours are per patient, per **billing** provider, and may include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are not able to deliver four (4) non-Precertification hours of each type of therapy.

**NOTE:** If the provider belongs to clinic billing provider the “per billing provider” would include all individual providers billing under that clinic billing provider. This means that the four (4) hours are per the specific participant and for any of the individual providers within the clinic. Each

individual provider within the one clinic billing provider **do not** receive four (4) non-Precertification hours per individual provider within the clinic.

These four (4) non-Precertification hours do **not** include Family Therapy without the Patient Present. All hours of Family Therapy without the Patient Present **must** be authorized before rendering services. Claims for the four (4) non-Precertification hours should be submitted and payment established prior to submitting claims for any authorized hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having **used** their four (4) non-Precertification hours. There must be a minimum of **365 days** since the provider last rendered services to the participant before the four (4) non-Precertification hours may be utilized again.

After the initial four (4) hours, when it is determined that ongoing services are medically necessary, Precertification must be obtained. This Precertification must be requested **before** rendering additional services. In order not to interrupt services it would be best to request authorization before all four (4) hours are used.

Behavioral Health services will be covered if they are determined medically necessary when using the current edition ICD diagnosis code. For precertification, the diagnosis code **must** be a valid ICD, current edition, diagnosis code and **must** be mental health or substance use disorder related (excluding for HBAI services). This does **not** include developmental disabilities. **Section 18** provides table lists of valid codes for the Behavioral Health Services Program. The ICD diagnosis must be reported when submitting claims (required for compliance with the Health Insurance Portability and Accountability Act (HIPPA)).

Precertification hours are issued based on the participants age, diagnosis, type of therapy, and ME code. The documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the Precertification process.

The MHD recognizes there are rare instances when Behavioral Health services may be needed beyond the precertification guidelines established for adults and children. For participants requiring therapy beyond these guidelines, **Clinical Exceptions** may be granted based upon documentation of extenuating circumstances.

**Clinical Exceptions documentation** must include:

- Behavioral Health Services Request for Precertification form
- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three (3) Progress Notes reflective of therapy type requested

(i.e. requests for additional Family Therapy should include Progress Notes from the three most recent Family Therapy sessions attended by the patient)

Precertification's for psychotherapy services for adults are issued for a maximum of ten (10) hours per rolling year for adjustment disorder, Z-code, or unspecified current version ICD diagnostic does. All precertifications expire six months from the date requested. Once the six-month period ends, the provider can again request precertification up to the maximum limit. **Section 13.11 Precertification Guidelines- Adults**

All documentation submitted must meet the requirements as stated in [Code of State Regulation, 13 CSR 70-3.030, Section \(2\)\(A\)](#) defines "adequate documentation" and "adequate medical records" . Requests submitted with non-compliant documentation as outlined above will result in denial of the request. **Section 13.4 Adequate Documentation.**

The requirement to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is stated in MO HealthNet state regulation (13 CSR 70-3) Conditions of Provider Participation, Reimbursement and Procedure of General Applicability. These requirements are also repeated in the Title XIX Participation Agreement, which is a document signed by all providers upon enrollment as a MO HealthNet provider.

### **PARTICIPANT APPEAL RIGHTS**

When a request is denied, the participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The State Fair Hearings Process may be requested by the participant, in writing, to the MO HealthNet Division, Participant Services Unit (PSU), and P.O. Box 3535, Jefferson City, MO 65102-3535. The Participant Services Unit may also be called toll free at 1-800-392-2161 or 573-751-6527 at the caller's expense. The participant must contact PSU within 90 days of the date of the denial letter if they wish to request a hearing. After 90 days, requests to appeal are denied.

### **Guidelines - Children**

Behavioral Health Manual Section 13.1.A

Medically necessary behavioral health services are available to MO HealthNet eligible children under the age of 21 (0-20). The MO HealthNet Division has a precertification process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility. The Precertification process includes services provided by a Psychiatrist, Provisional Licensed Psychologist, Psychologist, PCNS, PLCSW, LCSW, LMSW, PLPC, LPC, RHC, and FQHC.



Individual Psychotherapy is limited to 1 unit per day/5 units per month.

- **90832 –Psychotherapy**, approximately 16 to 37 minutes face-to-face with the patient.
- **90834 –Psychotherapy**, approximately 38 to 52 minutes face-to-face with patient.

**Child under the age of three (3)**, any therapy services, including Testing performed by any MO HealthNet enrolled provider, must obtain Precertification (with exception of Assessment). **This age group does not get the 4 non-Precert hours.** A Precertification request for services for a child under the age of three (3) **must** include clinical justification. **Family Therapy without Patient Present** will require Precertification. Documentation must include:

- Behavioral Health Precertification Form
- Current Diagnostic Evaluation
- Current Treatment Plan
- Last three (3) Progress Notes

Precertification has always been required for Individual Therapy, Family Therapy with the Patient Present, and Group Therapy for **children under the age of three (3)** when services are provided by an LCSW, LPC, PLCSW, LMSW, PLPC, RHC, FQHC, psychologist, provisionally licensed psychologist, or psychiatrist.

Psychological testing services are **not** covered when provided by a PLCSW, LCSW, PLPC or LPC regardless of the age of the client. Testing services are only reimbursed when provided by a Psychiatrist, Psychologist, or PLP. Psychological testing services may be provided in addition to a Diagnostic Assessment when warranted for proper evaluation. This procedure is limited to a maximum of four (4) hours per patient per provider per rolling year.

#### **Section 13.10.B Psychological Testing.**

### **Precertification Policy for Children 0 through 20**

The first four (4) hours of Behavioral Health services for most children do not require Precertification. These four (4) hours are intended to assist a provider seeing a patient for the first time to make the transition to Precertification should more than four (4) hours be required for treatment. The first four (4) hours are per patient, per **billing** provider, and may include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are **not** able to deliver four (4) non-Precert hours of each type of therapy. Claims for the four (4) non-Precert hours should be submitted and payment established prior to submitting claims for any Precertification hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having used their four (4) non-Precert hours. There

must be a minimum of 365 days since the provider last rendered services to the participant before the four (4) non-Precert hours may again be used.

A change in the child's medical eligibility (ME) code from non-state custody to a state custody code of 07, 08, 37, or 88 does not allow a provider an additional four (4) non-Precert hours.

This does not apply if providing services to children under the age of 3 or Family Therapy without the Patient Present. All hours of these services require precertification, regardless of placement and Medical Eligibility (ME) code.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, Precertification must be obtained. This Precertification must be requested **before** rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used.

Precertification for Behavioral Health services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for Precertification can include Individual, Family, and Group Therapy.

**All services for all children under the age of three (3), (with the exception of Diagnostic Evaluation) including those in state custody and residential care facilities, continue to require Precertification. Testing for a child under the age of 3 must have a precertification and providers must submit clinical justification for providing these services.**

Precertification does not allow the provider to exceed the unit limitations for these services.

Approved hours will be based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to establish diagnosis code. The corresponding diagnostic code from the current edition of the International Classification of Diseases (ICD) must be used when requesting precertification and submitting claims. The authorized number of hours is based on the primary diagnosis and documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the Precertification process.

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many behavioral health disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies are the treatment of the individual with more than one therapy such as Individual and Family, simultaneously within the same authorization period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

If a child's age changes during the Precertification period, the Precertification will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if precertification.

## **GUIDELINES – State Custody Children** **State Custody MO HealthNet Eligibility (ME) Codes**

Refer to Behavioral Health Manual Section 13.12.B

Precertification is required for children in state custody with an **ME code of 07, 08, 37, or 38**, who are not residing in a residential treatment facility.

Behavioral Health services for a child residing in or under the management of a residential care facility have always been exempt from the Precertification process when the services were provided at the facility. If the services were rendered off the facility site, a Precertification was required. Residential care facilities routinely allow children to be seen off site for therapy services. Some children residing in or under the management of a residential care facility are exempt from the Precertification requirement when therapy services are provided off site. The child must be 3 years of age or older and have an ME code of 07, 08, 37 or 88. If this criterion is not met, a Precertification is still required when therapy services are provided off the facility site. Providers must work closely with the facility and Children's Division to ensure the child is still residing in or under the management of the residential care facility. Therapy services meeting these criteria are billed with the appropriate place of service code, applicable provider specialty modifier, U8 (home) modifier if necessary, and the NCCI 59 modifier if multiple therapy services are provided on the same day. In addition to these modifiers, when therapy services are provided to a child off site of the residential care facility, a TJ modifier must also be used.

At this time ME codes 29, 30, 36, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70, are exempt from Precertification requirements due to the child being in state custody. When verifying eligibility, if the ME code is **not** one of these, regardless of other source information, you **must** request Precertification.

**Regardless of the ME code, children under the age of 3 years even in state custody require Precertification for testing and behavioral health services; Diagnostic Evaluation does not require Precertification. Children under the**

**age of 3 years in state custody also do not receive the four (4) non-precert hours.**

The first four (4) hours of Behavioral Health services do not require Precertification. The first four (4) hours are per patient, per provider, and may include any combination of Individual Therapy, Family Therapy, or Group Therapy. Providers are not able to deliver four (4) non-Precert hours of each type of therapy. Claims for the four (4) non-Precert hours should be submitted and payment established prior to submitting claims for any Precertification hours.

Providers who have rendered therapy services to a participant within the past 12 months will be considered as having used their four (4) non-Precert hours. There must be a minimum of 365 days since the provider last rendered services to the participant before the four (4) non-Precert hours may again be used.

A change in the child's ME code of 07, 08, 37, 38 from state custody to non- state custody does not allow a provider an additional four (4) non-Precert hours.

If a child's age changes during the Precertification period, the Precertification will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if authorized.

Family Therapy without the Patient Present and all Behavioral Health services for patients' age birth through 2 years are **not** included in the four (4) non-Precert hours. These services continue to require Precertification regardless of ME code or placement.

If more than the four (4) non-Precert hours are needed, a Precertification must be obtained. The Precertification must be obtained **prior** to rendering the services. In order to insure continuity of service, providers should request a Precertification before all of the first four (4) hours are used.

The authorized number of hours is based on the primary diagnosis and your documentation must support the diagnosis code. Providers are urged to choose the most accurate and appropriate diagnosis code to receive the maximum hours allowed through the Precertification process.

**The FQHC, RHC, clinic, or group is considered the provider. The FQHC, RHC, clinic, or group receives the 4 non-Precert hours as well as testing and assessment time, not each individual within these group settings.**

### **REQUESTING PRECERTIFICATION**

If services are required beyond the initial four (4) non-Precert hours, the provider must request a Precertification. Telephoned requests will receive an approval or

denial at the time of the call. **(If additional information is needed, the caller will be instructed to fax or mail the Behavioral Health Services Request for Precertification form and required documentation. This Precertification request will not be approved during the phone call.)**

**Behavioral Health Services Help Desk phone (866) 771-3350**

## **Precertification Tips**

When a Precertification request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call the following number to check on the status of a Precertification request:

**Provider Communication (573) 751-2896**

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the Behavioral Health Services Request for Precertification form and attachments will receive a disposition letter after review. When Precertification requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give participants the provider Behavioral Health Help Desk telephone number or fax number. Their contact information will be listed in the participant denial letter.**

Providers are reminded that a Precertification request cannot be processed if the participant or provider identifying information is incomplete or inaccurate (including provider NPI, DCN, etc.). Every attempt is made to reconcile any incorrect/inaccurate information with providers; however, it remains the provider's responsibility to provide complete and accurate information when submitting a request for Precertification. Authorizations are approved effective the date **all** completed correct information and documentation is received.

When faxing Precertification requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Please do not fax questions to the Behavioral Health Services Help Desk. Send questions by email to [mhd.provtain@dss.mo.gov](mailto:mhd.provtain@dss.mo.gov). Review the documentation requirements to insure all aspects have been included, are easily identified, and that appropriate documentation is being submitted with your Precertification request.

**Daily and monthly limitations still apply even though an authorization has been approved.**

To request behavioral health services beyond the precertification guidelines established for adults and children, a **Clinical Exception** may be considered

based upon documentation of extenuating circumstance. **Must** include clinical justification with documentation:

- Behavioral Health Precertification Form
- Current Diagnostic Evaluation
- Current Treatment Plan
- Last three (3) Progress Notes for each therapy type being requested

If the services being requested are court ordered, a copy of the court order must also be attached.

This documentation may be faxed to: **(573) 635-6516**

or mailed to: Wipro InfoCrossing  
PO Box 4800  
Jefferson City, MO 6510

The Precertification approves the delivery of the requested services only and does not guarantee payment. The Precertification **must** be obtained prior to delivery of services. The participant must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

For children 12 years of age and younger current documentation is six (6) months old or less. For children 13 years of age and older, as well as adults, current documentation is one (1) year old or less.

If the participant is changing providers, the provider listed on the current Precertification must close the **Open Precertification** before the new provider can be issued a Precertification. If the current provider refuses to close the Precertification, the new provider must submit a **signed release from the participant**, requesting a change in provider, in order to close the current Precertification. The signed release must include:

- Participant name and DCN
- Type of therapy to be closed (discharge date)
- Name of the therapist whose authorization is to be closed
- Dated and signed by the participant

If a provider needs to change a Precertification, the provider may call or fax in the information to request a change. Must include:

- Participant name and DCN
- Type of therapy (approval on the current Precertification)
- Description of the desired change

A client may have an open Precertification with one provider for Individual Therapy and/or Family Therapy and a second Precertification open with a different provider for Group Therapy. **Only one Family Therapy Precertification per family will be open at a time.**

When client changes providers, documentation is required to authorize a new Precertification. The new provider will be authorized any balance of **unused** hours on the original Precertification, **not** receive an additional 10 or 20 hours for therapy. The intent is to limit therapy services for any participant regardless of provider. However, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

Do not request overlapping dates from a previous Precertification; overlapping dates will cause the new Precertification request to deny. Do not indicate the four (4) non-Precert hours as used hours on the Precertification request.

Individual providers that are not seeing a participant through an RHC, FQHC, or other clinic/group must request a Precertification using their individual NPI. Providers seeing participants in an FQHC or other clinic/group setting must request a Precertification using the FQHC or other clinic/group NPI. Providers seeing participants in a RHC setting must use the RHC NPI when requesting a Precertification.

Precertification is required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no precertification and Medicare does not cover the service, MO HealthNet cannot pay.

### **Precertification Exceptions**

Inpatient hospital stays

Psychotherapy for Crisis

Testing

Diagnostic Evaluation

Evaluation and Management codes

Narcosynthesis

Electroconvulsive Therapy

Medicare primary



## SECTION 6 ADJUSTMENTS & RESUBMISSIONS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the web portal at, [www.emomed.com](http://www.emomed.com). [Behavioral Health Provider Manual](#) Section 6 details the adjustment process.

Adjustments for claim credits submitted via the Internet receive an immediate confirmation after submission to confirm the acceptance and indicate the status of the adjustment.

Refer to [Behavioral Health Provider Manual](#), Section 4 for timely filing requirements for adjustments and claim resubmissions.

### PAID CLAIM OPTIONS on [www.emomed.com](http://www.emomed.com)

Paid claim(s) on the MO HealthNet emomed system can be either replaced or voided.

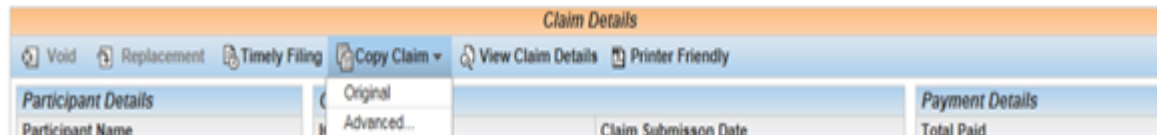


**VOID** - To void a claim from the claim status screen on emomed, choose the void option. This will bring up the paid claim in the system; scroll to the bottom of the claim and click on the highlighted 'submit claim' tab. The claim now has been submitted to be voided or credited in the system.

**REPLACEMENT** – To replace a claim from the claim status screen on emomed, choose the replacement option. This will bring up the paid claim in the system; corrections can be made to the claim by selecting the appropriate **edit (pencil icon)**, then saving the changes. Scroll to the bottom of the claim and select the highlighted 'submit claim' tab. The replacement claim with corrections has now been submitted.

### DENIED CLAIM OPTIONS on [www.emomed.com](http://www.emomed.com)

Denied claim on the MO HealthNet emomed system, can be resubmitted as a New Claim or can be resubmitted by choosing Timely Filing, Copy Claim-original, or Copy Claim-advanced.



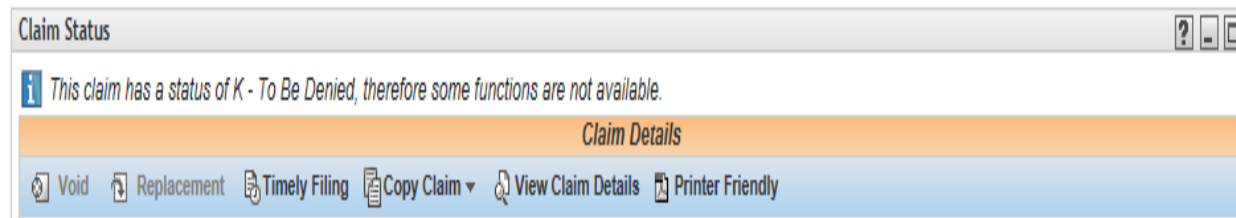
**TIMELY FILING** – To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically plugs the Original Internal Control Number (ICN) of the claim retrieved (process within the timely filing guidelines).

Scroll to the bottom and select the highlighted 'submit claim' tab to prompt the claim to reprocess for payment.

**COPY CLAIM- Original-** This option is used to retrieve the original claim and recopy so corrections can be made to the claim by selecting the appropriate **edit (pencil icon)**, and then saving the changes. Scroll to the bottom of the claim and select the highlighted submit claim tab. The claim has now been submitted with the corrections made.

**COPY CLAIM – Advanced-** This option is used when the claim was filed using the **wrong NPI number or wrong claim form**. Example would be if the claim was entered under the individual provider NPI and should have been submitted under the clinic provider NPI. If the claim was originally filed under the wrong claim form, only the participant DCN and Name information will transfer over to the new claim form. Example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

### CLAIM STATUS IS REPORTED AFTER THE CLAIM IS SUBMITTED



**C** – This status indicates that the claim has been **captured** and suspends process. This claim should not be resubmitted until it has a status of I or K.

**K** – This status indicates that the claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

**I** – This status indicates that the claim is to be **Paid**.

## SECTION 7

# MEDICARE/MO HEALTHNET CROSSOVER CLAIMS

Medicare/MO HealthNet (crossover) claims that do not automatically cross from Medicare to MO HealthNet must be filed through the MO HealthNet billing web site, [www.emomed.com](http://www.emomed.com), or through the 837 electronic claims transaction. Providers should wait thirty (30) days from the date of Explanation of Medicare Benefits (EOMB) showing payment before filing an electronic claim to MO HealthNet.

Claims do not cross over from Medicare to MO HealthNet for various reasons. Two of the most common are as follows:

- ▶ Invalid participant information on file causes many claims to not cross over electronically from Medicare. Participants not going by the **same** name with Medicare as they do with MO HealthNet will not cross over electronically. Additionally, the participant's Medicare Health Insurance Claim number (HIC) in the MO HealthNet eligibility file must match the HIC number used by the provider to submit to Medicare. It is the responsibility of the participant to keep this information updated with their Family Support Division.
- ▶ MO HealthNet enrolled providers who have not provided the Provider Enrollment Unit with their National Provider Identifier (NPI) used to bill Medicare. Providers should contact the Provider Enrollment Unit by e-mail at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov). Providers who have not submitted their Medicare NPI number may fax a copy of their Medicare approval letter showing their NPI, provider name and address, to Provider Enrollment at 573-526-2054.

Following are tips to assist you in successfully filing crossover claims on the MO HealthNet billing web site at [www.emomed.com](http://www.emomed.com).

- Providers must submit claims to MO HealthNet with the same NPI they used to bill Medicare.
- From Claim Management choose the Medicare CMS-1500 Part B Professional form under the 'New Xover Claim' column.
- There is a 'Help' feature available by clicking on the question mark in the upper right hand corner of the screen.
- Select MB-Medicare as the 'Filing Indicator' from the drop down box.
- On the Header Summary screen, the 'Other Payer ID' is a unique identifier on the other payer remittance advice. If not provided, it is suggested using a simple, easy to remember ID. This field may contain numeric and/or alpha-numeric data up to 20 characters.
- All fields with an asterisk are required and should be completed with the same information submitted to Medicare. Data entered should be taken directly from your Medicare EOMB with the exception of the participant's name and HIC; these must be entered as they appear in the MO HealthNet participant eligibility file.

- The Other Payer Detail Summary must contain the same number of line items as the number of detail lines entered. Do not check the 'Payer at Header Level' box on the Header Summary for Medicare crossover claims.

The screenshot shows the 'Claim Management' interface in the eProvider ePassport system. The NPI is set to 'MS02174501 - CORRECTIVE ACTION PAYMENT'. The 'New Xover Claim' dropdown menu is open, displaying a list of Medicare claim types: Medicare CMS-1500 Part B Professional, Medicare CMS-1500 Part C Professional, Medicare UB-04 Part A Institutional, Medicare UB-04 Part C Institutional, Medicare UB-04 Part B Professional, and Medicare UB-04 Part C Professional. The 'Advanced' radio button is selected. Below the dropdown, there are input fields for 'Participant DCN', 'Charges', 'Dates of Service', 'Claim Type', 'Claim Status', and 'Submission Date'. A 'Search' button is located at the bottom of the form. The footer of the page includes navigation links for Home, Contact, Training, Search Center, and Troubleshooting, along with the Missouri Department of Social Services logo.

## MEDICARE ADVANTAGE/PART C CROSSOVER CLAIMS FOR QMB OR QMB PLUS PARTICIPANTS

Medicare Advantage/Part C plans do not forward electronic crossover claims to MO HealthNet. Therefore, providers must submit these claims through the MO HealthNet billing web site, [www.emomed.com](http://www.emomed.com). The following tips provide assistance in successfully filing Medicare Advantage/Part C crossover claims:

- From "Claim Management" choose the Medicare CMS-1500 Part C Professional under the 'New Xover Claim' drop down box.
- Select 16-Medicare Part C Professional as the 'Filing Indicator' from the drop down box on the Header Summary screen.
- Always verify eligibility either through the 'Participant Eligibility' link on [www.emomed.com](http://www.emomed.com) or access the Interactive Voice Response (IVR) at 573-751-2896 to see if the participant is a **Qualified Medicare Beneficiary (QMB)** on the date of service. Eligibility must be checked prior to each date of service. The Medicare CMS-1500 Part C professional form can only be used if the participant is QMB eligible on the date of service.

**Other Payers**

**Header Summary**

Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
<b>Add/Edit Details</b>					
<ul style="list-style-type: none"> <li>AM - Automobile Medical</li> <li>BL - Blue Cross/Blue Shield</li> <li>CH - Champus</li> <li>CI - Commercial Insurance Co.</li> <li>DS - Disability</li> <li>HM - Health Maintenance Organization</li> <li>LI - Liability</li> <li>LM - Liability Medical</li> <li>OF - Other Federal Program</li> <li>TV - Title V</li> <li>VA - Veteran Administration Plan 2376 Refers to Veterans Affairs Plan</li> <li>WC - Workers Compensation Health Claim</li> <li>ZZ - Mutually Defined - Unknown</li> <li>09 - Self Pay</li> <li>10 - Central Certification</li> <li>11 - Other Non-Federal Programs</li> <li>12 - Preferred Provider Organization (PPO)</li> <li>13 - Point of Service (POS)</li> <li>14 - Exclusive Provider Organization (EPO)</li> <li>15 - Indemnity Insurance</li> <li>16 - Health Maint Org Medicare Risk</li> <li>MA - Medicare</li> <li>MB - Medicare</li> <li>MC - MO HealthNet</li> </ul>			Payer Responsibility Sequence Number * <input type="text"/>		
			Paid Date *		
			Remittance Advice Remark Codes		
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="button" value="Friendly"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/>					

powered by Symantec

Providers must **not** use the crossover claim forms to submit claims for **non-QMB** participants enrolled in a Medicare Advantage/Part C plan. These services are to be filed as regular medical claims with the Part C information shown as though it is commercial insurance information. Under “Other Payers” Filing Indicator, select “16 –Health Maintenance Organization Medicare Risk” from the drop down box.

Under **no** circumstances are providers to submit crossover claims, Medicare or Medicare Advantage/Part C QMB, as paper claims.

## **SECTION 8 RESOURCE PUBLICATIONS FOR PROVIDERS**

### **CURRENT PROCEDURE TERMINOLOGY (CPT)**

MO HealthNet uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department  
American Medical Association  
P.O. Box 74008935  
Chicago, IL 60674-8935  
Telephone Number: 800/621-8335  
Fax Orders: 312/464-5600  
[www.amabookstore.com](http://www.amabookstore.com)

### **International Classification of Diseases-CM**

The *International Classification of Diseases, Clinical Modification* is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Optum  
P.O. Box 88050  
Chicago, IL 60680-9920  
800/464-3649  
Fax Orders: 801/982-4033  
[www.optum360coding.com](http://www.optum360coding.com)

### **HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)**

MO HealthNet also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation (PMIC)  
4727 Wilshire Blvd. Suite 302  
Los Angeles, CA 90010  
800/633-7467  
Fax Orders: 800/633-6556  
<http://pmiconline.com>

## **SECTION 9**

### **PARTICIPANT LIABILITY**

#### **State Regulation 13CSR 70-4.030**

If an enrolled MO HealthNet provider does not want to accept MO HealthNet as payment but instead wants the patient (participant) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that MO HealthNet will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Precertification, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

## **MO HealthNet PARTICIPANT REIMBURSEMENT**

The [MO HealthNet Participant Reimbursement \(MPR\) program](#) is devised to make payment to those participants whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Participants are reimbursed at the MO HealthNet allowed amount for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. [Family Support Division](#) (FSD) will furnish to the participant the required form to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call Participant Services Unit (800) 392-2161.

[Participant Handbook](#) can be located on MHD website at <http://dss.mo.gov/mhd/participants/>.

Family Support Division website can be located at <http://dss.mo.gov/fsd/>.



## **SECTION 10**

### **Behavioral Health Forms**

The MHD Forms Webpage has various forms used by the MHD Behavioral Health Services program. Access this page to find **all** the MHD forms. This Behavioral Health Services Request for Precertification form can be access from the list of forms, which are in alphabetical order.

- Go to the MO HealthNet Web site,  
<https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm>  
under Provider Forms select MO HealthNet forms, or the direct link:  
[http://manuals.momed.com/forms/Behavioral\\_Health\\_Services\\_Request\\_%20for\\_Precertification.pdf](http://manuals.momed.com/forms/Behavioral_Health_Services_Request_%20for_Precertification.pdf)

**The Behavioral Health Services Request for Precertification form**



STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES

**BEHAVIORAL HEALTH SERVICES REQUEST FOR PRECERTIFICATION**

PARTICIPANT NAME (LAST, FIRST, MI)		PROVIDER NAME
PARTICIPANT NUMBER	BILLING PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE (IF REQUIRED)
DATE OF BIRTH	PROVIDER FAX NUMBER	PROVIDER PHONE NUMBER
PROVIDER SIGNATURE		DATE
NUMBER OF HOURS USED ON CURRENT PRECERTIFICATION (IF MULTIPLE CURRENT PRECERTIFICATIONS, PLEASE LIST TYPE)		

1. Service Requested (if requesting Family Therapy please see reminder in instructions)

<input type="checkbox"/> Testing (ages 0-2)	Hours	_____	Precertification Start Date	_____
<input type="checkbox"/> Individual Therapy	Hours	_____	Precertification Start Date	_____
<input type="checkbox"/> Family Therapy*	Hours	_____	Precertification Start Date	_____
<input type="checkbox"/> Group Therapy	Hours	_____	Precertification Start Date	_____
<input type="checkbox"/> Family Therapy without patient present	Hours	_____	Precertification Start Date	_____

\*If requesting Family Therapy, please list all members of the family, relationship to patient and DCN if available.  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this request for  PCIT  PMT  TF-CBT or  DBT? If so, have you been appropriately trained/certified?  Yes  No  
 If age is less than 5, will services provided be developmentally appropriate?  Yes  No

2. Has the patient/guardian agreed to his/her treatment plan?  Yes  No

3. Is the therapy court ordered?  Yes  No

4. Have you communicated with other involved therapist/health care practitioners about treatment?  Yes  No

5. If child is in state custody, have you provided a copy of the treatment plan to the Children's Division case manager or contracted case manager? If yes, date \_\_\_\_\_  Yes  No  
 Case manager name \_\_\_\_\_  Child not in state custody

6. Is therapy the result of an EPSDT screen? If yes, date of screen \_\_\_\_\_

**BEHAVIORAL HEALTH DIAGNOSTIC CODE**

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

IS THERE EVIDENCE OF SUBSTANCE ABUSE?  
 Yes  No

**GENERAL MEDICAL CONDITIONS**

DOES THE PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE ABOVE DIAGNOSTIC CODE(S)?

Yes  No If yes, list condition: \_\_\_\_\_

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

**INSTRUCTIONS FOR COMPLETION****HEADER INFORMATION**

**Participant Name** - Enter the participant's name as it appears on the MO HealthNet ID card.

**Participant Number** - Enter the participant's number as it appears on the MO HealthNet ID card.

**Date of Birth** - Enter the participant's date of birth as it appears on the MO HealthNet ID card.

**Provider Name** - Enter the provider name.

**Billing Provider Identifier** - Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

**Provider Fax Number** - Enter the fax number of the provider making the request.

**Provider Taxonomy Code** - Enter the provider taxonomy code (if required).

**Provider Phone Number** - Enter current phone number of the provider making the request.

**Signature/Date** - The provider of services must sign the request and indicate the date the form was completed.

**Number of Hours Used on Current Precertification** - List the number of hours used on current precertification. If there is more than one current certification, list the therapy type along with the number of hours used.

**QUESTIONS 1 THROUGH 6 MUST BE COMPLETED FOR THERAPIES REQUESTED.**

**\*REMINDER:** When requesting family therapy, please list all members of the family. Only one (1) precertification will be approved and open at a time for family therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN **MUST** be used for precertification and billing purposes. **PROVIDERS SHOULD NOT REQUEST MORE THAN ONE (1) FAMILY THERAPY PRECERTIFICATION PER FAMILY.** Each child may not be seen separately with parents and billed as family therapy.

**Precertification Start Date** - Please indicate the date you would like for your precertification to begin. **NOTE:** The authorized start is the date of receipt or noted subsequent date.

If therapy is the result of a court order a copy should be kept in the patient's file.

**DIAGNOSTIC CODES**

Enter current version ICD code for behavioral health diagnosis. List general medical conditions diagnostic codes only if applicable.

Precertification requests may be phoned, faxed or mailed into the call center (see below)

Wipro InfoCrossing  
P.O. Box 4800  
Jefferson City, MO 65102  
Phone (toll free): 866-771-3350  
FAX: 573-635-6516

**AN APPROVED PRECERTIFICATION APPROVES ONLY THE MEDICAL NECESSITY OF THE SERVICE AND DOES NOT GUARANTEE PAYMENT.**

Direct link:

[http://manuals.momed.com/forms/Request\\_for\\_Applied\\_Behavior\\_Analysis\\_Precertification.pdf](http://manuals.momed.com/forms/Request_for_Applied_Behavior_Analysis_Precertification.pdf)

**The Request for Applied Behavior Analysis (ABA) Precertification form**



STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES  
**REQUEST FOR APPLIED BEHAVIOR ANALYSIS (ABA) PRECERTIFICATION**

PARTICIPANT NAME (LAST, FIRST, M.I.)	PARTICIPANT DCN NUMBER	DATE OF BIRTH
BILLING PROVIDER NAME	BILLING PROVIDER NPI	PROVIDER TAXONOMY CODE (IF REQUIRED)
PERFORMING PROVIDER NAME	PERFORMING PROVIDER NPI	PROVIDER PHONE NUMBER
PERFORMING PROVIDER SIGNATURE	DATE	PROVIDER FAX NUMBER

**SERVICE TYPE REQUESTED**

<input type="checkbox"/> Assessment for Intervention Planning	Total Hours: 0.00	Precertification Start Date:
<input type="checkbox"/> ABA Intervention	Total Hours (6 months): 0.00	Precertification Start Date:
<input type="checkbox"/> Continued ABA Intervention	Total Hours (6 months): 0.00	Precertification Start Date:

List relevant behavioral health diagnostic code(s):

USE WORKSHEET BELOW TO DETERMINE TOTAL HOURS REQUESTED. FOR ASSESSMENT, ENTER TOTAL HOURS REQUESTED TO COMPLETE ASSESSMENT. FOR INTERVENTION, ENTER TOTAL HOURS REQUESTED FOR SIX MONTH PERIOD.

**Assessment for Intervention Planning**

Code	Description	Units Requested	Unit Size	Number of Hours
0359T	Behavior identification assessment		Untimed (typically 60 min)	
0360T / 0361T	Observational behavioral follow-up assessment		30 min	
0362T / 0363T *	Exposure behavioral follow-up assessment		30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

**Intervention**

Code	Description	Units Requested	Unit Size	Number of Hours
0364T / 0365T	Adaptive behavior treatment by protocol		30 min	
0368T / 0369T	Adaptive behavior treatment with protocol modification		30 min	
0370T	Family adaptive behavior treatment guidance		Untimed (typically 60 min)	
0372T	Adaptive behavior treatment social skills group		Untimed (typically 90 min)	
0373T / 0374T *	Exposure adaptive behavior treatment with protocol modification		First unit that day = 60 min; each additional that day = 30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

**Continued ABA Intervention**

Code	Description	Units Requested	Unit Size	Number of Hours
0364T / 0365T	Adaptive behavior treatment by protocol		30 min	
0368T / 0369T	Adaptive behavior treatment with protocol modification		30 min	
0370T	Family adaptive behavior treatment guidance		Untimed (typically 60 min)	
0372T	Adaptive behavior treatment social skills group		Untimed (typically 90 min)	
0373T / 0374T *	Exposure adaptive behavior treatment with protocol modification		First unit that day = 60 min; each additional that day = 30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

## INSTRUCTIONS FOR COMPLETION

## HEADER INFORMATION

**Participant Name** – Enter the participant's name as it appears on the MO HealthNet ID card.

**Participant DCN Number** – Enter the participant's DCN number as it appears on the MO HealthNet ID card.

**Date of Birth** – Enter the participant's date of birth as it appears on the MO HealthNet ID card.

**Billing Provider Name** – Enter the billing provider name.

**Billing Provider NPI** – Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

**Provider Taxonomy Code** – Enter the provider taxonomy code (if required).

**Performing Provider Name** – Enter the performing provider name.

**Provider Phone Number** – Enter current phone number of the provider making the request.

**Provider Fax Number** – Enter the fax number of the provider making the request.

**Performing Provider Signature/Date** – The provider of services must sign the request and indicate the date the form was completed.

**Performing Provider NPI** – Enter the provider identifier (NPI) for the performing/rendering provider.

**Service Requested** – Select the service requested, enter total number of hours requested to complete assessment or total intervention hours for six month period.

**Precertification Start Date** – Please indicate the date you would like for your precertification to begin. NOTE: The authorized start is the date of receipt or noted subsequent date.

**Diagnostic Code** – List relevant behavioral health diagnostic code(s) per the current edition of the International Classification of Diseases (ICD).

## WORKSHEET TO DETERMINE TOTAL HOURS REQUESTED

Complete the worksheet to determine total hours requested (for assessment) or total hours requested for a 6 month precertification period (for intervention):

- Enter the number of units for each procedure code in the Units Requested column
- Use number of units requested and Unit Size to calculate the Number of Hours requested per procedure code
- Enter the number of hours requested in the Number of Hours column
- Add up the Number of Hours column to find the Total Hours for each type of service requested
- Enter the total hours per service type in the Service Requested section

## REQUIRED DOCUMENTATION

Documentation required varies by service type and must be submitted with the Request for Applied Behavior Analysis (ABA) Precertification form. Required documentation for each service type is listed below:

SERVICE TYPE REQUESTED:	REQUIRED DOCUMENTATION:
ABA Assessment for Intervention Planning	Diagnostic Evaluation
ABA Intervention (initial)	Assessment for Intervention Planning, Intervention Plan
ABA Intervention (continued)	Current Intervention Plan, Progress Data/Graphs

Precertification requests may be faxed or mailed to the call center:

Wipro InfoCrossing  
P.O. Box 4800  
Jefferson City, MO 65102  
Phone (toll free) 866-771-3350  
Fax 573-635-6516

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# NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS employees, applicants for employment, and contractors are treated equitably regardless of race, color, national origin, ancestry, genetic information, pregnancy, sex, sexual orientation, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain nondiscrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

DSS applicants for, or recipients of, services from DSS are treated equitably regardless of race, color, national origin, ancestry, sex, age, sexual orientation, disability, veteran status, or religion. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. **Anyone who requires an auxiliary aid or service for effective communication, or a modification of policies or procedures to participate in a program, service, or activity of the Department of Social Services should notify DSS as soon as possible, and no later than 48 hours before the scheduled event, by contacting either their DSS local office or Anna Wise, DSS ADA Coordinator and Manager of the DSS Office for Civil Rights at the address/phone number listed below.**

Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by contacting either their DSS local office or the Missouri DSS Office for Civil Rights at (800) 776-8014; or (866) 735-2460 (Voice); (800) 735-2966 (Text). Complaints may also be filed by writing to: Missouri DSS Office for Civil Rights, P. O. Box 1527, Jefferson City, MO 65102-1527.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability, or religion may also file a complaint by writing to: U.S. Department of Health and Human Services, Office for Civil Rights, 601 East 12<sup>th</sup> Street, Room 353, Kansas City, MO 64106, (800) 368-1019 (Voice); (800) 537-7697 (TDD).

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Rather than using the links in the above statements, for your convenience, the Family Support Division customer service number is 855-FSD-INFO (855-373-4636).

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.