SECTION 12
FREQUENTLY ASKED QUESTIONS

INPATIENT HOSPITAL

What date is considered the date of admission for an inpatient hospital stay?
MO HealthNet follows Medicare policy on the date of admission. Medicare policy is: "A patient of a hospital is considered an inpatient upon issuance of written doctor orders to that effect".

How does a provider submit an inpatient claim that requires a two-page claim for all the services?
If at all possible, the provider should list all the services on a single claim form. If this is not possible, the provider may bill the services on two claim forms. In field 80 on the first page of the claim, put “page 1 of 2”. In field 80 of the second page, put “page 2 of 2”. Staple the claims together prior to submission.

Does a provider have to submit a claim to Medicare for a patient who has exhausted his/her Medicare inpatient benefits and get a denial from Medicare before filing a claim to MO HealthNet?

Yes. MO HealthNet requires that a claim be filed to Medicare first before filing a claim to MO HealthNet. Once the denial has been received, a paper claim can be filed to MO HealthNet and a copy of the Medicare denial or exhausted benefit letter attached to it. The claim can be filed also using the X12 837 institutional claims transaction or the direct data entry inpatient or outpatient claim through the MO HealthNet Internet billing Web site, emomed.com. The range of dates on the claim to be filed to MO HealthNet must fall within the range of dates on the claim filed to Medicare. The denial code description should be visible on the Medicare denial or entered in the appropriate field(s) on the electronic claim form.

Is a precertification required for a participant with QMB benefits enrolled in a Medicare Advantage/Part C Plan?
Inpatient hospital claims for deductible and coinsurance for MO HealthNet patients with Medicare Part C benefits are exempt from admission certification. However, if Medicare Part C benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. Pre-admission certification is required also for denied Medicare Part C inpatient hospital claims including exhausted benefits. Before requesting a pre-certification, the provider must exhaust all appeals through the Medicare Advantage/Part C plan appeals process and have a final denial that can be submitted to Xerox Care and Quality Solutions with the pre-certification request.

For non-QMB MO HealthNet participants enrolled in a Medicare Advantage/Part C Plan, admissions require certification. Additional information regarding inpatient hospital

certification reviews is covered in Section 13.31 of the MO HealthNet hospital provider manual available at http://dss.mo.gov/mhd/providers/.

Are hospitals required to keep paper copies of attachments related to physicians' inpatient services, e.g., Sterilization Consent form, etc.?
Yes. The hospital must maintain a paper copy of these forms in the patient's permanent file.

Is the inpatient hospital per diem rate based on the date of admission or the date of service when there is a rate change?
The per diem rate is based on the date of admission.

A hospital receives certification for a patient admission and admits the patient. Later in the admission day, the patient has to be transferred to another facility which also needs certification. How is this processed and how would the services be billed?
The MO HealthNet *Hospital Provider Manual*, Section 13.30.B - DAY OF DISCHARGE, DEATH, OR TRANSFER states: "MO HealthNet reimburses a facility for the day of admission. MO HealthNet does not cover the day of discharge, death or transfer **unless it also is the day of admission and then it is reimbursable**. The costs for the day of discharge, death or transfer cannot be billed to the recipient."

In the example above, both facilities must obtain certification from Xerox Care and Quality Solutions. Whichever facility submits a properly completed claim to MO HealthNet first should receive reimbursement. The facility that submits a claim to MO HealthNet second will have its claim denied as a duplicate unless a completed *Certificate of Medical Necessity* (CMN) is submitted with the claim to justify the care on the same date of service. It is advisable, however, for both facilities to submit a completed *Certificate of Medical Necessity* with their claims to avoid a duplicate service denial. The *Certificate of Medical Necessity* can be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com, as an attachment to the electronic claim.

A hospital wants a pre-certification for a pregnant woman for a medical condition unrelated to the pregnancy, e.g. mental health services. Should a pregnancy diagnosis code be reported?
Xerox does not review most pre-certifications if the admitting or primary diagnosis code is related to pregnancy. Therefore, a diagnosis code relating to pregnancy should **not** be used as the admitting/primary diagnosis code. If the hospital stay is not related to pregnancy, it must be clear that the pregnancy is incidental to the admitting/primary diagnosis.

Are there special documentation requirements for billing for inpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with ICD-9 surgical code 69.93.

ICD-9 surgical codes 69.01, 69.51, 69.93, 69.99, 74.91, 75.99, and 96.49 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

OUTPATIENT HOSPITAL

Is a pre-certification required from Xerox Care and Quality Solutions for outpatient services and/or surgical procedures?
No, a pre-certification from Xerox is not required for outpatient services and/or surgeries.

If a hospital has an outpatient claim that requires the submission of a second page for services provided on the same date, should two separate claims be filed or can a two-page claim be submitted with the total appearing on the second page?
In this instance, the provider should submit two separate claims and total each individual claim page.

When billing for an outpatient facility charge, should a CPT/HCPCS code be entered in addition to the outpatient facility revenue code?
No. Enter only the appropriate outpatient facility revenue code. Do **not** list a CPT or HCPCS code along with the facility revenue code.

Can a provider bill for two emergency room visits on the same day for the same patient?
If the second ER visit is essentially for the same reason as the first, the hospital cannot bill for it. If the second visit is for a different reason, the hospital can bill for the visit. The two visits must be billed on the same paper claim and the ER notes for each visit attached to it.

If the patient has two ER visits on the same day at two different hospitals, whichever hospital submits a claim first will be paid. The provider that bills second will have its claim denied and will have to refile a paper claim with the ER notes attached to it.

How are emergency room services billed that continue from the initial day into the following day?
For ER services that continue past midnight, the date the patient was initially seen in the ER is the date of service for the facility charge. Diagnostic and procedural services performed into the following day (past midnight) should be billed on a separate outpatient claim form with the date of service that the diagnostic or procedural service was performed on.

How are observation services billed that continue from the initial day into the following day?
Only one observation code per stay may be billed. If the stay spans beyond midnight, only one date of service is billed, which is the date the participant was placed in observation status. For example: A MO HealthNet eligible participant is admitted for observation care on Tuesday at 10:00 am and then discharged Wednesday at 8:00am, the units billed would be 22 and the date of service billed would be Tuesday's date.

Can a hospital bill for multiple dates of service on the same claim for either emergency room services or therapy services and use the AJ condition code to exempt the patient from the $3.00 cost sharing amount for each date of service reported on the claim?
No. Only one date of service can be reported on an outpatient hospital claim on which the AJ condition code is reported. The AJ condition code is used on the outpatient hospital claim to exempt the patient from the $3.00 cost sharing for emergency room services or outpatient therapy services (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis).

A MO HealthNet patient presents to the hospital emergency department for non-emergent care. Eligibility is checked and it is determined the patient is administratively locked-in to a provider. The ER department tries to contact the designated lock-in provider who either is not available or will not authorize the services through the PI-118 lock-in form. Since the ER department cannot get a referral from the lock-in provider, can these services be billed to the patient or does the hospital have to write them off?
The patient can be billed for the care. Patients who have been administratively locked-in to a designated provider know this and know who their lock-in provider is. Further, they know that if they try to obtain non-emergent services from another provider, the patient can be held responsible for the costs of the service if the treating provider is unable to obtain a referral from the lock-in provider.

How are outpatient medications to be billed under revenue code 250?
There are several ways revenue code 250 can be used for billing outpatient medications. The first pertains to billing for a covered medication which does not have a valid HCPCS or CPT code. In this instance, revenue code 250 may be billed without a corresponding code. Note the following:

Quantity billed for revenue code 250 must be one (1) when a HCPCS or CPT code is not available. The charges for the medications must be totaled together for that line charge.

- Non-covered medications cannot be billed under the 250 revenue code. They are not billable to the agency and can be billed to the participant.
- Questions regarding whether or not a medication is covered by MO HealthNet should be directed to the agency's Pharmacy and Clinical Services Administration Unit by phone at 573/751-6963 or by E-mail at clinical.services@dss.mo.gov.

Another choice when a valid HCPCS or CPT code is not available is to bill under revenue code 250 or 636 with one of the following J-codes.

J3490 – unclassified medication
J7599 - Immunosupppressive, not otherwise classified
J8499 - prescription drug, oral, non-chemotherapeutic, NOS
J8999 - oral prescription, chemotherapeutic, NOS

These codes can be filed on a paper UB-04 claim form and an invoice must be submitted with the claim which shows the medication's name, the NDC and its cost. When the claim is filed through emomed.com, after completing the header detail and line detail segments, click on "Invoice of Cost". This opens a new segment titled "Invoice of Cost Details Summary". Complete and save this segment before submitting the claim.

NOTE: The National Drug Code (NDC) should be submitted for all medication administered in the outpatient hospital setting along with a valid HCPCS or CPT code. However, the NDC is required when a "Top 20" drug is administered. The "Top 20" drugs are defined by CMS, and can be found on their Web site at http://ms.gov/Reimbursement/15_PhysicianAdministeredDrugs.asp.

Another use of the 250 revenue code pertains to billing a medication which has a valid HCPCS or CPT code and NDC. In this instance, the medication must be billed with a revenue code, either 250 or 636, along with a valid NDC. If the medication does not have a valid NDC but does have a CPT or HCPCS code, such as contrast media, the charges are to be billed without the NDC.

Can the hospital bill for a non-payable medication under medical supplies (revenue code 270) or medications (revenue code 250)?
No. An injection or medication that is not payable under MO HealthNet **cannot** be billed under revenue code 270 (medical supplies) or under revenue code 250 (medications).

Are hospitals required to keep paper copies of attachments used for physicians' outpatient services, e.g. Sterilization Consent form, etc.?
Yes. The hospital must maintain a copy of these forms in the patient's permanent file.

Can HCPCS "Q" codes be used to bill for MO HealthNet services?
HCPCS "Q" codes are national codes given by the Center for Medicare Services (CMS) on a temporary basis. In general, "Q" codes are not to be used to bill for MO HealthNet services and are considered non-covered.

Does MO HealthNet have allowable quantities that can be billed for outpatient services?
Yes. Each procedure code has an allowable quantity that can be billed to MO HealthNet without additional documentation. A provider can access the MO HealthNet fee schedules, which include allowable quantities, through the MO HealthNet Division Web site, http://dss.mo.gov/mhd/providers/. Note – The fee schedule for the technical component of laboratory procedures does not include hospitals. Contact Provider Communications, 573/751-2896, for information relating to the allowable quantity and reimbursement for outpatient laboratory procedures.

How is a claim billed when more than the allowable quantity of a procedure was performed?
A provider cannot bill for more than the MO HealthNet allowable quantity on a single line on the claim. The additional quantities have to be billed on subsequent lines and the hospital's notes sent with the claim for manual review and processing. Example - the MO HealthNet allowable for a procedure is two but the hospital wants to bill for five. The hospital would bill one line with the procedure code and a quantity of two, a second line with the procedure code and a quantity of two, and a third line with the procedure code and a quantity of 1, and the hospital notes submitted with the claim.

What is the proper way to bill for a comprehensive metabolic panel, procedure code 80053?
If only CPT code 80053 was performed, bill the code without any modifiers. Providers should be aware that 80053 might be included in CPT code 80050 (general health panel) if certain other lab services are being billed for the same date of service.

CPT code 80050 includes 80053 in addition to:

Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)

or,

Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)

Thyroid stimulating hormone (TSH) (84443)

What is the correct way to bill for outpatient cardiac rehabilitation services?
Providers should bill using the appropriate revenue code, 0943 - cardiac rehabilitation. Do **not** list a CPT procedure code with this revenue code.

Are there special documentation requirements for billing for outpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, or 59830.

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.