MoHealth Net

Ambulance Billing Book

MO HealthNet Ambulance Billing Book

Preface

This Ambulance training booklet contains information to help you submit claims correctly. The information is only recommended for MO HealthNet providers and billers. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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SECTION 1
MO HEALTHNET PROGRAM RESOURCES

http://dss.mo.gov/mhd/providers/

CONTACTING MO HEALTHNET

PROVIDER COMMUNICATIONS

573-751-2896

MO HealthNet providers can contact the Provider Communications Unit with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

The IVR (Interactive Voice Response) system is accessed by calling the 573-751-2896 number. The IVR system can address participant eligibility, last two check amounts and claim status inquiries. At anytime during the IVR options, providers may select "0" to speak with the next available specialist. Calls are put into a queue and will be answered in the order received. Providers must use a touchtone phone to access the IVR.

Providers may send and receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk Staff. This application is available through the MO HealthNet Web portal at www.emomed.com. Once logged in and on the eProvider page, click on the 'Provider Communications Management' icon, this opens the 'Manage Provider Communications' page. From here, click on 'New Request' to open the 'Create New Request' form to enter and submit an inquiry. Providers are limited to one inquiry per E-mail. The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry.

The Provider Communications Unit also responds to written inquiries. Written inquiries should be sent to:

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

WIPRO INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK

573-635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Wipro Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers are required to notify Missouri Medicaid Audit Compliance, Provider Enrollment Section regarding changes to their Provider Master File. Changes include, but are not limited to, physical address, tax identification, ownership, individual's name or practice name, or NPI number.

Changes may be reported via E-mail at mmac.providerenrollment@dss.mo.gov or by mail to:

Missouri Medicaid Audit and Compliance
Provider Enrollment Section
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

573-751-2005

Call the Third Party Liability Unit to report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MO HealthNet participant.

PROVIDER EDUCATION

573-751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for MO HealthNet claims. Contact the unit for training information and scheduling. Providers may also send E-mails to the unit at mhd.provtrain@dss.mo.gov.

PARTICIPANT SERVICES

800-392-2161 or 573-751-6527

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MO HEALTHNET PHARMACY AND CALL CENTER

800-392-8030

Providers can call this toll free number to:

- Request pre-certification for specific DME items;
- Initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program;
- Request information on Medicare Part D,
- Request a drug prior authorization; or,
- Request medical pre-certification for a CT scan or MRI.

Providers are encouraged to sign up for the MO HealthNet Web tool – CyberAccess[SM] – which automates the pre-certification process. To become a CyberAccess[SM] user, contact the Xerox Care and Quality help desk at 888-581-9797 or 573-632-9797 or send an E-mail to CyberAccessHelpdesk@xerox.com. The CyberAccess[SM] tool allows each pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and procedure codes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the HIPAA-EDI Companion Guide online by going to the MO HealthNet Division Web page at http://dss.mo.gov/mhd/providers/ and click on the HIPAA-EDI Companion Guide link in the column on the right hand side of the page. This will take you directly to the EDI Companion Guide and ASC X12 Version 5010 Companion Guide links.

For information on the MO HealthNet Trading Partner Agreement, click on the link to Section 1- Getting Started; then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Wipro Infocrossing Healthcare Services Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)

573-751-2896

The Provider Communications Unit Interactive Voice Response (IVR) system, 573-751-2896, requires a touchtone phone. The ten-digit NPI (National Provider Identifier) number 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 listed below. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 <u>Participant Eligibility</u>

Participant eligibility must be verified each time a participant presents and should be verified prior to the service. Eligibility information can be obtained by a participant's MO HealthNet number (DCN), social security number and date of birth, or if a newborn, using the mother's MO HealthNet number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status
After entering the participant's MO HealthNet ID number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MO HEALTHNET PROVIDERS

The MO HealthNet Division (MHD), in cooperation with Wipro Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers. MO HealthNet providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify participant eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply online at http://dss.mo.gov/mhd/providers/. At this site choose the "Apply for Electronic/Internet system access" link in the left hand column. Each user is required to complete this 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 www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Wipro Infocrossing Healthcare Services Help Desk, 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.

This Web site, www.emomed.com, 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

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

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET

Providers can access MO HealthNet participant eligibility files via the Web site. Functions include eligibility verification by participant ID, casehead 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 Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

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

MO HEALTHNET CLAIMS SUBMISSION THROUGH THE INTERNET

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 (NCPCD)

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.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The MO HealthNet program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive paper RAs. All providers and billers must have Internet access to obtain the printable electronic RA via the Wipro Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Wipro Infocrossing Help Desk, 573-635-3559, to learn how to obtain a paper remittance.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

MO HEALTHNET PROVIDER MANUALS AND BULLETINS ONLINE
http://dss.mo.gov/mhd/providers/

MO HealthNet provider manuals are available online at the MHD web site, http://dss.mo.gov/mhd/providers/. To access the provider manuals, click on the "Provider Manuals" link at the bottom of the page. This brings up the http://manuals.momed.com/manuals/ page where a search by manual and specific criteria can be done.

MO HealthNet provider bulletins are also available at the MHD web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear online at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIM PROCESSING SCHEDULE FOR FISCAL YEAR 2014

FINANCIAL CYCLE DATE**		PROVIDER CHECK DATE	
Friday	06/21/2013	Friday	07/05/2013
Friday	07/12/2013	Friday	07/19/2013
Friday	07/26/2013	Tuesday	08/06/2013
Friday	08/16/2013	Friday	08/23/2013
Friday	08/30/2013	Tuesday	09/10/2013
Friday	09/13/2013	Tuesday	09/24/2013
Friday	09/27/2013	Monday	10/07/2013
Friday	10/11/2013	Tuesday	10/22/2013
Friday	10/25/2013	Tuesday	11/05/2013
Friday	11/08/2013	Wednesday	11/20/2013
Friday	11/22/2013	Thursday	12/05/2013
Friday	12/13/2013	Friday	12/20/2013
Friday	12/27/2013	Tuesday	01/07/2014
Friday	01/10/2014	Thursday	01/23/2014
Friday	01/24/2014	Wednesday	02/05/2014
Friday	02/07/2014	Thursday	02/20/2014
Friday	02/21/2014	Wednesday	03/05/2014
Friday	03/07/2014	Thursday	03/20/2014
Friday	03/21/2014	Friday	04/04/2014
Friday	04/04/2014	Friday	04/18/2014
Friday	04/18/2014	Friday	05/02/2014
Friday	05/09/2014	Friday	05/16/2014
Friday	05/23/2014	Thursday	06/05/2014
Friday	06/06/2014	Friday	06/20/2014

****Closeout is 5:00 p.m. on the date shown**

State Holidays

July 4, 2013 Independence Day

September 2, 2013 Labor Day

October 14, 2013 Columbus Day

November 11, 2013 Veteran's Day

November 28, 2013 Thanksgiving Day

December 25, 2013 Christmas Day

January 1, 2014 New Year's Day

January 20, 2014 Martin Luther King's Birthday

February 12, 2014 Lincoln's Birthday

February 17, 2014 Washington's Birthday

May 8, 2014 Truman's Birthday

May 26, 2014 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 (08-05) claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

> Wipro Infocrossing Healthcare Services, Inc.
> PO 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 indicates 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 ID number (DCN) as shown on the participant's ID card.
2.*Patient's Name	Enter last name, first name, middle initial in that order as it appears on the 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.
5.Patient's Address	Enter address and telephone number if available.
6.Patient's Relationship To Insured	Mark appropriate box if there is other insurance.
7.Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available.
8.Patient Status	Not used.

9.**Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. See Note(1)
9a.**Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance Group Number policy number or group number, if the insurance is through a group such as an employer, union, etc. See Note(1)
9b.**Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. See Note(1)
9c.**Employer's Name	Enter the secondary policyholder's employer name. See Note(1)
9d.**Insurance Plan Or Program Name	Enter the other insured's insurance plan program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1)
10a.-10c. Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank.
10d. Reserved for Local Use	May be used for comments/descriptions.
11.**Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. See Note(1)
11a.** Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. See Note(1)
11b.**Employer's Name	Enter the primary policyholder's employer name. See Note(1)
11c.**Insurance Plan Name	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1)
11d.**Other Health Plan	Indicate whether the patient has a secondary health insurance plan; if so, complete fields #9-#9d with the secondary insurance information. See Note(1)

12.Participant's Signature	Leave blank.
13.Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.Date of Current Illness, Injury	Not required for Ambulance
15.Date Same/Similar Illness	Leave blank.
16.Dates Patient Unable To Work	Leave blank.
17.Name of Referring Physician	Not required for Ambulance
17a.Other I.D.	Not required for Ambulance
17b.NPI	Not required for Ambulance
18.Hospitalization Dates	Not required for Ambulance
19.Reserved for Local Use	Providers may use this field for additional remarks or descriptions.
20.Lab Work Performed Outside Office	Not required for Ambulance
21.*Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.**MO HealthNet Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.Prior Authorization Number	Leave blank.

24a.*Date of Service	Enter the date of service under “from” in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a "from" date.
24b.*Place of Service	Enter the appropriate place of service code. Place of service is the destination of the ambulance trip.
24c.**EMG-Emergency	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency leave this field blank.
24d.*Procedure Code	Enter the appropriate HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.)
24e.*Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field #21 in the unshaded area of the field.
24f.*Charges	Enter the provider’s usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
24g.*Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a “1” if the field is left blank. Units shown must reflect the total “loaded” mileage one-way from point of pick-up to destination.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY transport, enter “E.”
24i.ID Qualifier	Leave blank.
24j.Rendering Provider ID	Not required for ambulance.
25.SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a Maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on MO HealthNet claims.
28.*Total Charge	Enter the sum of the line item charges.

29.Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.
30.Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).
31.Provider Signature	Leave blank.
32.**Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
32a.**NPI#	Enter the 10-digit NPI number of the service facility location in 32.
32b.Other ID#	Leave blank.
33.*Provider Name/ Number/Address	Write or type the information exactly as it appears in the Provider Master file.
33a.* NPI #	Enter the NPI number of the billing provider in 33.
33b. Other ID #	Leave blank.

SECTION 3
ADJUSTMENTS & RESUBMISSIONS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Wipro Infocrossing web portal at, www.emomed.com. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25 minimum limitation does not apply.

Providers receive real time notification of receipt for adjustments for claim credits submitted via the Internet. The status of the adjustment is provided.

Paid Claim Options on eMomed

Only claims in 'paid' or 'to be paid' status can be voided or replaced. Voiding and replacing claims are done through "Claim Management" on the emomed.com website. Providers may do claim search by the ICN (Internal Control Number), the participant's DCN (MO HealthNet ID number) or by the date the claim was originally submitted.

VOID - To void a claim from the claim status screen on eMomed, select 'Void' from the menu bar. When the claim is brought up, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The claim has now been submitted to be voided or credited in the system.

REPLACEMENT – To replace a claim from the claim status screen on eMomed, select 'Replacement' from the menu bar. When the claim is brought up, corrections can be made to the claim by selecting the appropriate edit button then saving the changes. Once all corrections have been made scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The replacement claim with corrections has now been submitted.

Resubmitting Denied Claims on eMomed

Providers can resubmit denied claims electronically on the eMomed website. Claims may be resubmitted by entering a new claim. Claims may also be resubmitted by selecting 'Timely Filing' or 'Copy Claim' from the menu bar.

Timely Filing – To reference timely filing, choose the 'Timely Filing' tab on the claim status screen on eMomed. This function automatically places the ICN of the claim chosen. Make certain the ICN chosen meets MO HealthNet's timely filing criteria. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button.

Copy Claim/Original – This option is used to copy a claim just as it was originally entered on eMomed. Corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim'.

Copy Claim/Advanced – This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual or performing provider NPI and should have been submitted under the

group NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and name information will transfer over to the new claim type. An example would be if the claim was submitted as a crossover claim and should have been submitted as a medical claim.

Claim Status Codes

Once a claim is submitted, 'Claim Received' is given in real time on the 'Claim Status' page. In addition, one of the following claim status codes is provided:

C – Claim has been **Captured** (*in suspense*) and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – Claim is to be **Paid.**

K – Claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

SECTION 4
MEDICARE 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 or through the 837 electronic claims transaction. It is advised providers wait sixty (60) days from the date of Medicare's explanation of benefits (EOMB) showing payment before filing an electronic claim. This will avoid possible duplicate payments from MO HealthNet.

Claims may not cross over from Medicare to MO HealthNet for various reasons. Two of the most common reasons 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 Eligibility Specialist.
- MO HealthNet enrolled providers who have not provided their National Provider Identifier (NPI) used to bill Medicare to the Missouri Medicaid Audit Compliance (MMAC), Provider Enrollment Section, also causes claims to not cross over electronically from Medicare. Providers in doubt as to what NPI is on file should contact Provider Enrollment by e-mail at mmac.providerenrollment@dss.mo.gov. Providers who have not submitted their Medicare NPI 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:

- From Claim Management choose the Medicare CMS-1500 Part B Professional format under the 'New Xover Claim' column.
- Providers must submit claims to MO HealthNet with the same NPI they used to bill Medicare.
- 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 EOB with the exception of the participant's name and HIC; these should be stated as they appear in the MO HealthNet eligibility file.

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

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. The following tips will assist you in successfully filing your Medicare Advantage/Part C crossover claims:

- From Claim Management choose the CMS-1500 Part C Professional format under the 'New Xover Claim' column.
- 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 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 needs to be checked for each date of service. The Part C format can only be used if the participant is QMB eligible on the date of service.

Providers are not to submit crossover claims for participants enrolled in a Medicare Advantage/Part C plan who are non-QMB. These services are to be filed as Medical claims.

Under no circumstances may providers submit crossover claims, Medicare Part B and Medicare Advantage/Part C QMB to Wipro Infocrossing Healthcare Services as paper claims.

SECTION 5
BENEFITS AND LIMITATIONS

Missouri Statute 208.152 authorizes MO HealthNet coverage of emergency ambulance services. Only those transports considered an emergency and made to the nearest appropriate hospital are covered and should be submitted to MO HealthNet for payment. This policy can be found in section 13.3.A of the MO HealthNet Ambulance manual located at http://manuals.momed.com/manuals/. Exceptions to this policy can be found in sections 13.3.P, Healthy Children and Youth (HCY) services; 13.3.O, transfer of participants to another hospital; and 13.3.L, transports for specialized testing.

> Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
>
> - placing the participant's health in serious jeopardy; or
> - serious impairment to bodily functions; or
> - serious dysfunction of any bodily organ or part.

"Nearest appropriate hospital" is the hospital equipped and staffed to provide the needed care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the service necessary to support the required medical care that determines whether it has appropriate facilities. The fact a more distant institution is better equipped, either qualitatively or quantitatively, to care for the participant does not in itself support a conclusion a closer institution does not have appropriate facilities. MO HealthNet does not allow transportation to a more distant facility solely to avail a participant of the services of a specific physician or family or personal preferences when considering the "nearest appropriate facility".

Services not considered emergent or within the exempted categories should not be submitted to MO HealthNet for processing. Non-emergent trips, as well as services provided to a participant not eligible for MO HealthNet benefits on the date of the transport, may be billed to the participant. MO HealthNet participants who dispute a bill from an ambulance provider may contact the MO HealthNet Participant Services Unit (PSU) at 1-800-392-2161. It is not the responsibility of the ambulance provider to submit a claim to MO HealthNet in order to receive a denial before billing the participant.

If the participant contacts PSU regarding a bill, the ambulance provider may be contacted by PSU staff requesting a copy of the trip ticket. This documentation must be sent to PSU by the requested date in their letter. A medical consultant reviews the trip ticket to determine if the trip was emergent in nature. After review both the ambulance provider and the participant will receive written notification. If the review determines the transport meets the emergency criteria, the provider will be instructed to submit the claim to MO HealthNet and the participant is not financially responsible. If the review determines the transport does not meet policy, the participant is notified they are responsible for payment of the bill. **If the ambulance provider does not comply with**

PSU's request for documentation, the participant is notified they are not responsible for payment of the bill.

A list of non-covered ground and air ambulance services can be found in section 13.3.U of the MO HealthNet Ambulance manual.

MILEAGE

When mileage charges are made they are considered as one way charges unless the ambulance service provides some documentation on the trip ticket. Charges for mileage must be based on loaded mileage, from the point of pickup of the participant to his or her arrival at destination. Loaded mileage, i.e., miles traveled while the participant is present in the ambulance, is covered; unloaded mileage is included in the reimbursement of the base rate.

HEALTHY CHILDREN AND YOUTH (HCY) SERVICES

MO HealthNet covers medically necessary ambulance services for participants under the age of 21 through the HCY program. Transport by ambulance is only covered if it is medically necessary and any other method of transportation would endanger the child's health. Examples include a child in a full body cast or having a tracheotomy requiring ventilatory assistance. A trip ticket documenting the ambulance trip was medically necessary must be attached to the claim form. HCY services are identified by the "EP" modifier. Any ambulance trip not meeting the emergency services definition according to MO HealthNet policy but is medically necessary for a participant under 21 must use the "EP" modifier with the appropriate ambulance procedure code. Transports for the under 21 population meeting the definition of emergency services must not use the "EP" modifier.

If a participant under 21 needs to be transported from one hospital to another for treatment or specialized testing and the transfer meets MO HealthNet policy (reference sections 13.3.L through 13.3.O of the MO HealthNet Ambulance provider manual), the trip is a covered service. In these cases, the "EP" modifier is not used.

TRIP TICKET REQUIREMENTS

A paper claim with the trip ticket attached is required under the following circumstances:

- providers on prepayment review; and
- transports for HCY services.

Providers are required to maintain all trip documentation, including the trip ticket, in the participant's file even when the trip ticket isn't a required attachment.

TRANSPORTS TO TWO DIFFERENT HOSPITALS

MO HealthNet covers transportation from the point of pickup to two different hospitals made on the same day by the same ambulance provider when it is medically necessary. This situation can occur when the ambulance transports the participant to the nearest hospital, but before the participant leaves the emergency room it is decided the first hospital is not appropriate and the participant is transported to a second hospital. When

it is medically necessary to transport a participant from one hospital to another on the same date of service, providers must bill the base rate procedure code with a quantity of "2". Mileage and any ancillary charges for both trips are to be combined.

TWO TRIPS ON THE SAME DATE OF SERVICE

Two emergency ambulance trips to a hospital in one day for the same participant may be covered when medically necessary. Proper trip documentation must be maintained in the participant's record. To bill for two trips on the same day, the same provider must show a quantity of "2" units for the base rate procedure code when appropriate. Mileage and any ancillary charges for both trips are to be combined. If the base rate procedure codes aren't the same for each trip, both trips must be billed on the same claim form as separate line items with the appropriate base rate procedure codes.

If two different ambulance services transport the same participant on the same date of service, both providers must maintain proper trip documentation in the participant's record to substantiate medical necessity.

HOSPITAL TO HOSPITAL TRANSFERS

Ground ambulance transfers of MO HealthNet participants from one hospital to another hospital to receive medically necessary inpatient services not available at the first facility are covered services. Hospital transfers shall be covered when the participant has been stabilized at the first hospital but needs a higher level of care available only at a second hospital. Examples of medically necessary transfers for services not available at the first facility include, but are not limited to:

- rehabilitation
- burn unit
- ventilator assistance
- other specialized care

The hospital to hospital transfer may not be considered emergent; however, hospital to hospital transfers that meet the transfer criteria listed in section 13.13.O(1) of the MO HealthNet Ambulance provider manual qualify for coverage under the ambulance program.

The documentation in the participant's record must support the procedure code billed. For accurate reporting purposes, the appropriate base code from the following list should be billed with the "HH" modifier.

- A0428HH – Ambulance service, BLS, non-emergency transport, hospital to hospital transfer
- A0426HH – Ambulance service, ALS 1, non-emergency transport, hospital to hospital transfer
- A0429HH – Ambulance service, BLS, emergency transport, hospital to hospital transfer
- A0427HH – Ambulance service, ALS 1, emergency transport, hospital to hospital transfer

- A0433HH – Ambulance service, ALS 2, emergency transport, hospital to hospital transfer

Transport from a hospital capable of treating the participant because the participant and/or the participant's family or the participant's physician prefer a specific hospital is not a covered service.

TRANSPORT FOR SPECIALIZED TESTING

Transporting from one hospital to another hospital and return for specialized testing and/or treatment is covered for ground ambulance. One base charge is payable even though two separate trips or waiting time may be involved. The appropriate place of service when billing for specialized testing and/or treatment is 21 (inpatient hospital) since the hospital is both the point of pickup and final destination after receiving services at the diagnostic or therapeutic site. Mileage may be billed if participant transport from point of pickup to the destination and back is more than five miles. Use procedure code A0428HD to bill for transportation for specialized testing and/or treatment.

Transport from one medical facility to another for specialized testing and/or treatment is non-covered for emergency air ambulance services.

DECEASED PARTICIPANTS

An individual is considered to have expired as of the time the individual is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician.

- If the participant was pronounced dead before the ambulance was called, no payment is made by MO HealthNet.
- If the participant was pronounced dead after the ambulance was called but prior to arrival at the scene, payment may only be made for mileage from the base to the point of pickup. Transport from point of pickup to destination is not payable; the base rate is not reimbursable.
- If the participant was pronounced after the ambulance arrived on the scene but prior to transport and life saving measures were performed at the scene, the base rate and mileage from base to point of pickup may be covered. ALS level 1 or 2 must be documented in the participant's trip documentation (reference section 13.3.D of the MO HealthNet Ambulance provider manual for ALS level 1 and 2 service definitions).
- If the participant was pronounced dead while enroute to or upon arrival at the destination, the base rate and mileage from point of pickup to the destination may be covered. ALS level 1 or 2 must be documented in the participant's trip documentation.

EMERGENCY AMBULANCE vs. NEMT TRANSPORTS

When participants are transported by ambulance to an emergency room for treatment and then released without admission to the hospital, the return trip is not covered under the MO HealthNet Emergency Ambulance program. Return trips to the nursing home when the participant has been discharged from a hospital stay are also not covered under the Emergency Ambulance program, 13 CSR 70-6.010(6).

Additional transports not covered in the Emergency Ambulance program include:

- transportation to a physician or dentist's office or a participant's home;
- ambulance services to a hospital for the first stage of labor; or,
- transport of a participant pronounced dead before the ambulance is called.

Transport by ambulance may be covered under the Non-Emergency Medical Transportation (NEMT) program for eligible participants if it is the most appropriate mode of transportation based on the participant's medical needs. Hospital staff, nursing home staff, social workers, case managers, family members and other related parties may call the NEMT broker for MO HealthNet toll free at 1-866-269-5927 to arrange non-emergency medical transportation to and from medical providers for eligible participants. NEMT services are available 24 hours per day, 7 days per week. To provide adequate time for NEMT services to be arranged, a participant or someone calling on their behalf should call at least five (5) calendar days in advance. For hospital discharges it may require up to three (3) hours to arrange the appropriate mode of transportation.

Neither the participant nor MO HealthNet is responsible for payment if physicians, hospital staff, or others arrange ambulance transports for non-emergency trips that are covered under the NEMT program without authorization from the NEMT broker. Missouri Code of State Regulations 13 CSR 70-4.030 (2) states a "service will not be the liability of the participant if the service would have been otherwise payable by the MO HealthNet agency at the MO HealthNet allowable amount had the provider followed all of the policies, procedures and rules applicable to the service as of the date provided."

The NEMT broker provides the most appropriate mode of transportation based on the patient's medical needs. If a patient is confined to a bed but does not require any medical equipment or medical attention en route, a stretcher van may be authorized. If the patient required medical attention or equipment en route, an ambulance will be authorized. When arranging non-emergency medical transportation, notify the NEMT broker if the patient is bed confined and whether or not medical attention or equipment is needed. For more information on the NEMT program and all modes of transportation under NEMT, please refer to section 22 of any MO HealthNet provider manual located on the MHD web site.

PLACE OF SERVICE (POS) CODES

The POS code must be one of the following:
21 – Inpatient hospital
23 – Emergency room – hospital

26 – Military treatment facility
51 – Inpatient psychiatric facility
55 – Residential substance abuse treatment facility
56 – Psychiatric residential treatment center
61 – Comprehensive inpatient rehabilitation hospital

Please keep the following in mind when submitting claims:

- HCY services are not limited to the above places of service
- POS codes 55, 56, and 61 are not valid for air transport
- POS codes 41 (land) and 42 (air/water) are Medicare codes and not valid MO HealthNet POS codes

VALID AMBULANCE MODIFIERS
EP – HCY services for participants under 21 years of age
GM – Ground transport for multiple participants
HH – Hospital to hospital transfer
HD – Specialized testing and treatment
SC – Medically necessary service or supply

A complete list of covered procedure codes can be found in section 19 of the MO HealthNet Ambulance provider manual.

SECTION 6
RESOURCE PUBLICATIONS FOR PROVIDERS

ICD-9-CM & Health Care Procedure Coding System (HCPCS)

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on claim forms and attachments. The accuracy of the code that describes the participant's condition is important.

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.

Both of the above publications can be ordered from the following:

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800-633-7467
http://pmiconline.com

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800-464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

SECTION 7
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

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

If there is no evidence of this written agreement, the provider cannot bill the participant 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, Second Surgical Opinion, etc.), the participant 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 RECIPIENT REIMBURSEMENT (MRR)

The Medicaid Recipient Reimbursement program (MRR) 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 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. The participant is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call (800) 392-2161.

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 to be 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 to be 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. Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); or Relay Missouri for hearing and speech impaired at (800) 735-2466 (Voice); (800) 735-2966 (Text). Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
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 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 (Voice); (816) 426-7065 (TDD)

Additionally, any person who believes they have been discriminated against because of race, color, national origin, age, sex, disability, religion, or political belief in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the:

U.S. Department of Agriculture
Office of Adjudication and Noncompliance
1400 Independence Avenue, SW
Washington, DC 20250-9410
(866) 632-9992 (Voice); (800) 877-8339 (TDD); (800) 845-6136 (Spanish)

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.

April 2013