

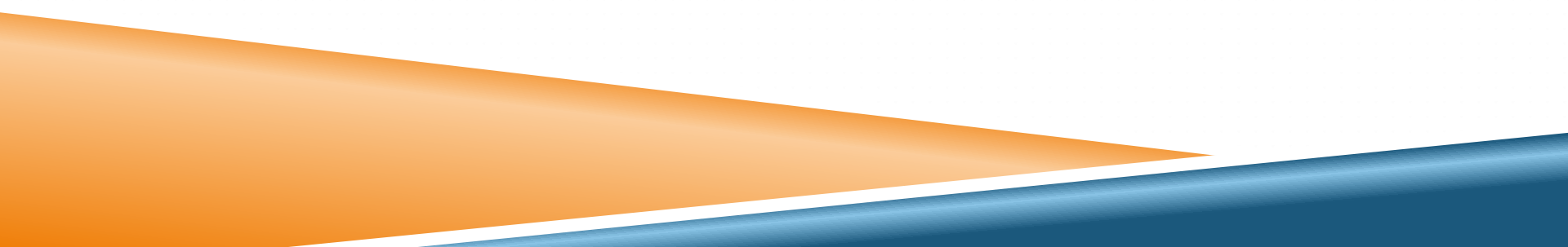
# Durable Medical Equipment

## Policy and Billing Resources

July 28, 2022

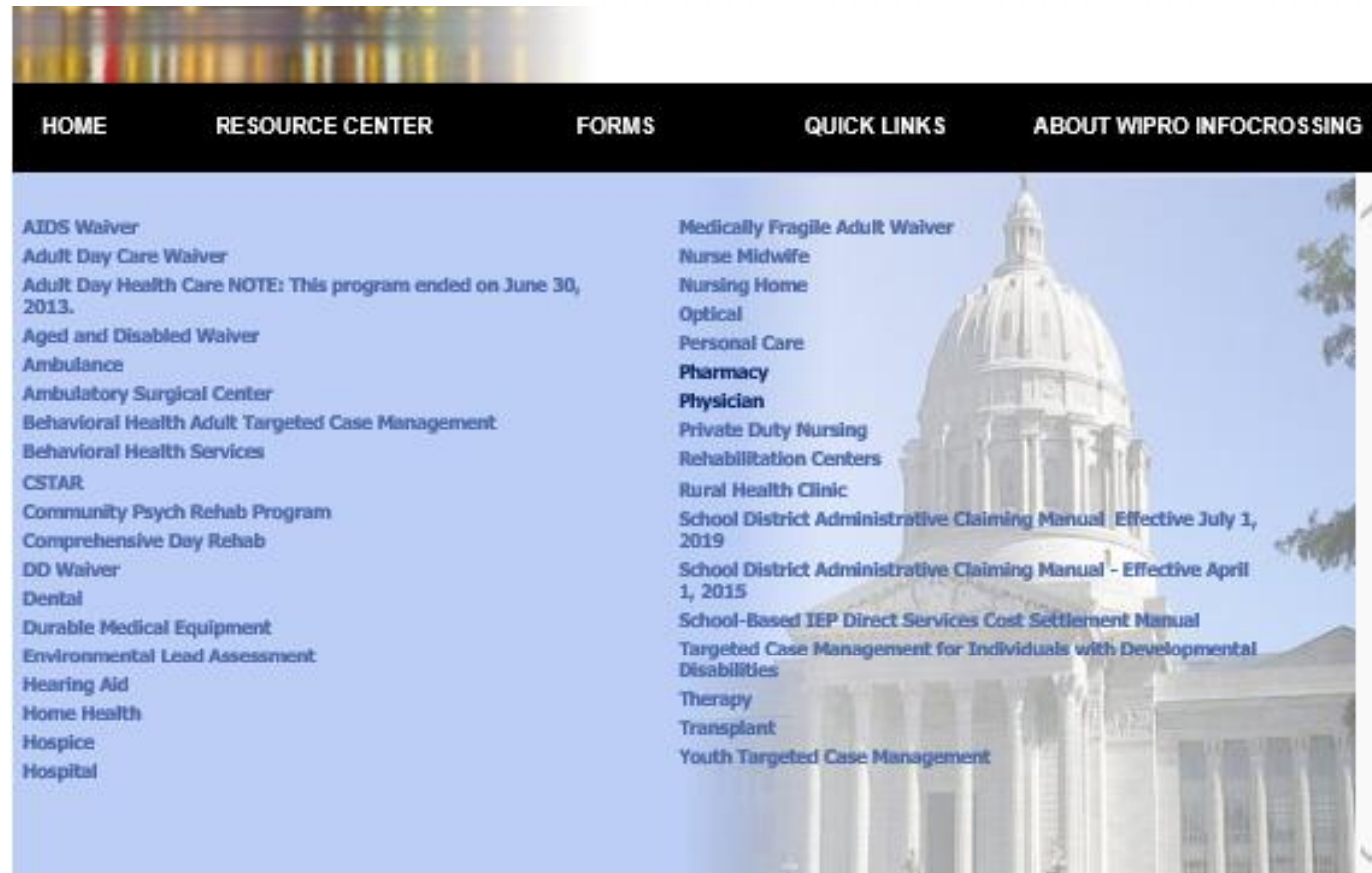
Amanda Fahrendorf

# PowerPoint Overview

- DME Provider Manual Overview
  - eMOMED Electronic Claim Filing
  - Resources
- 

# **Durable Medical Equipment Provider Manual**

# DME Provider Manual



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

# Provider Manuals

The table of contents is very detailed.

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# General vs. Program Specific Sections

## **General Sections:**

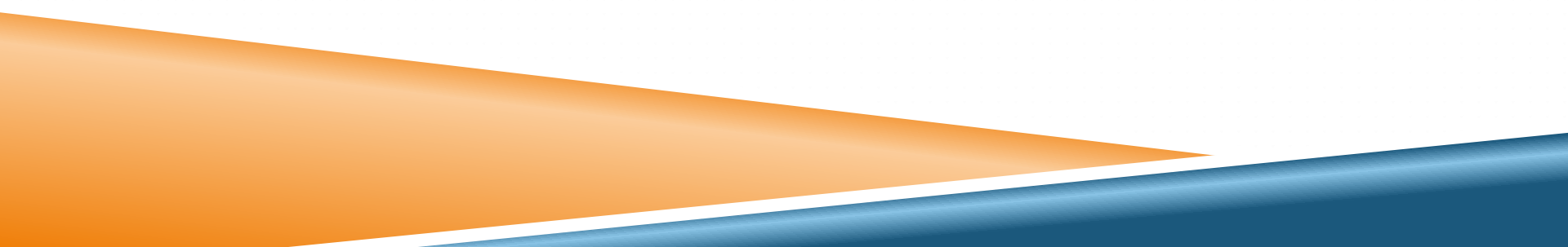
General sections published in each manual are written broadly to encompass all provider types.

(Sections: 1-10 and 16, 17, and 20-23)

## **Program Specific Sections:**

Program specific sections address the individual program.

(Sections: 12-15 and 18, and 19)



# Provider Manual Resource

| <b>Manual Sections</b> |  |
|------------------------|--|
| <b>Section Name</b>    | <b>Description</b>                               |
| Cover                  | Cover  |
| General Section 01     | Client Conditions of Participation               |
| General Section 02     | Provider Conditions of Participation             |
| General Section 03     | Provider and Participant Services                |
| General Section 04     | Timely Filing                                    |
| General Section 05     | Third Party Liability                            |
| General Section 06     | Adjustments                                      |
| General Section 07     | Medical Necessity                                |
| General Section 08     | Prior Authorization                              |
| General Section 09     | Healthy Children and Youth Program               |
| General Section 10NA   | Family Planning Not Applicable                   |
| General Section 11     | MO HealthNet Managed Health Care Delivery System |
| Section 12             | Reimbursement Methodology                        |
| Section 13             | Benefits and Limitations                         |
| Section 14             | Special Documentation Requirements               |
| Section 15             | Billing Instructions                             |
| General Section 16     | Medicare/Medicaid Crossover Claims               |
| General Section 17     | Claims Disposition                               |
| Section 18             | Diagnosis Codes                                  |
| Section 19             | Procedure Codes                                  |
| General Section 20     | Exception Process                                |
| General Section 21NA   | Advance Health Care Directives Not Applicable    |
| General Section 22     | Non-Emergency Medical Transportation (NEMT)      |
| General Section 23     | Claim Attachment Submission and Processing       |

# Searching the Provider Manual

## How to search the manual?

Use the **control “F”** search function to find information in the provider manual.

- Start with the section you think the information is in.  
*example “Section 13”*
- Then search by Key words.  
*examples: “Walker, Wheelchair, E1399...”*



# Provider Manual Overview

Section 1 – Client conditions of Participation

Section 2 – Adequate Documentation

Section 3 – Stakeholder Services

Section 4 – Timely Filing

Section 5 – Third Party Liability

Section 6 – Adjustments

Section 7 – Certificate of Medical Necessity

Section 8 – Prior Authorization

**\*\* Program Specific Section**

# Provider Manual Overview

Section 9 – Healthy Children and Youth Program

Section 10 – Family Planning

Section 11 – Stakeholder Services

Section 12 – Managed Care Delivery System \*\*

Section 13 – Benefits and Limitations \*\*

Section 14 – Special Documentation Requirements \*\*

Section 15 – Billing Instructions \*\*

Section 16 – Medicare Medicaid Crossover Claims

**\*\* Program Specific Section**

# Provider Manual Overview

Section 17 – Claims Disposition

Section 18 – Diagnosis Codes \*\*

Section 19 – Procedure Codes (CDT Codes) \*\*

Section 20 – Exception Process

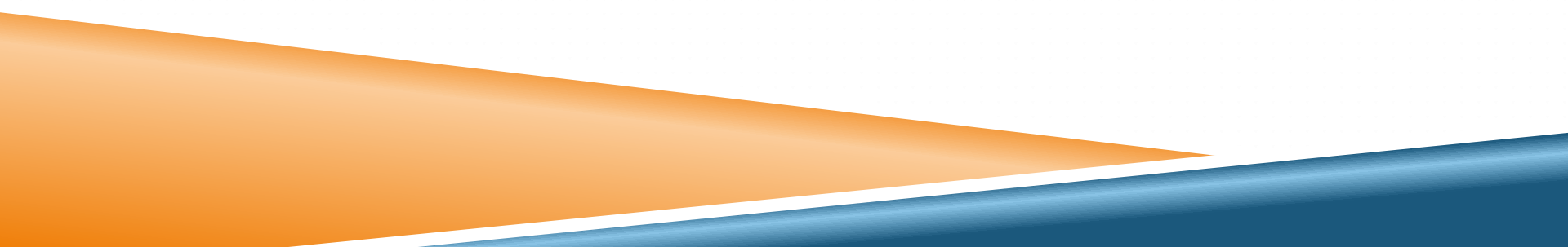
Section 21 – Advance Health Care Directives

Section 22 – Non-Emergency Transportation (NEMT)

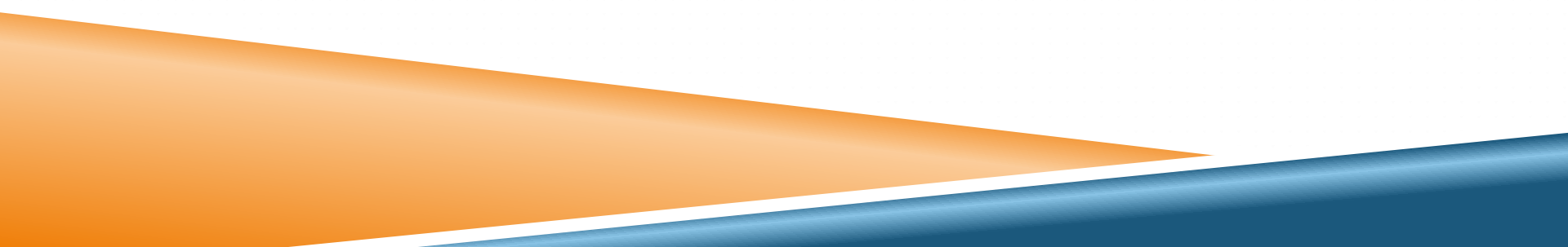
Section 23 – Claim Attachment and Processing

**\*\* Program Specific Section**

# Section 1- Client conditions of Participation

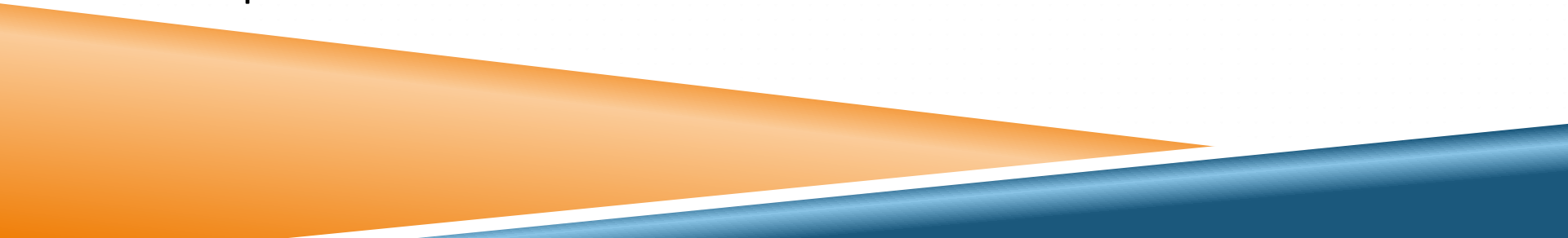
- Eligibility Categories-General eligibility information
  - Medical Eligibility (ME) Codes-Descriptions
  - Managed Care – General guidelines
  - Qualified Medicare Beneficiaries (QMB)
  - General Spend down information
- 

# Section 2- Provider Conditions of Participation

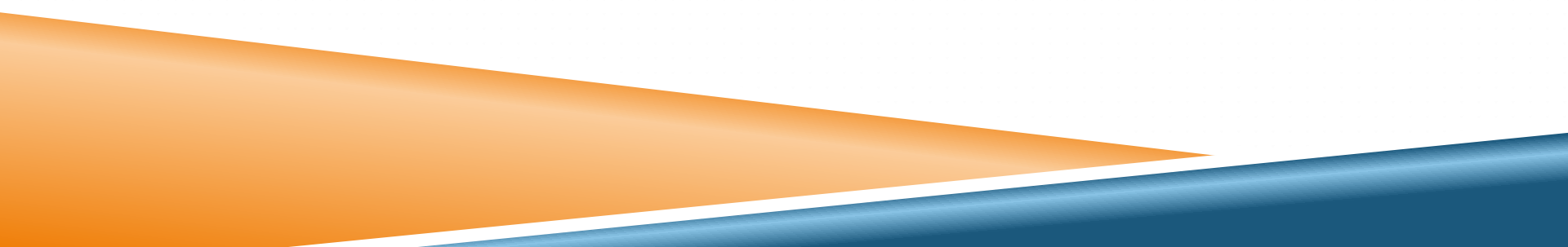
- Provider Eligibility- General Enrollment information
  - eMOMED- enrollment information
  - Notification of changes
  - Retention of Records- must retain records for 5 years from the date of services
  - Fraud and Abuse (Missouri Medicaid Audit and Compliance) General information about MMAC
- 

# Section 2.3.A - Adequate Documentation

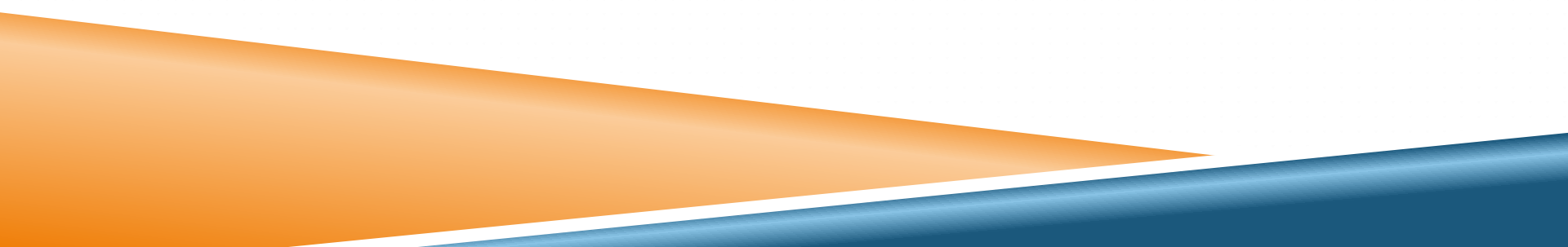
13 CSR 70-3.030, Section (2)(A) defines “adequate documentation” and “adequate medical records” as follows:

- Documentation of rendered services:  
Some procedure codes require certain services to be performed. Document what services were provided. Be sure they match the code being billed.
  - Ensure Received Reimbursement can be readily discerned.
  - Symptoms, conditions, diagnoses, treatments, prognosis. Identify the patient who was treated.
- 

# Section 3- Stakeholder Services

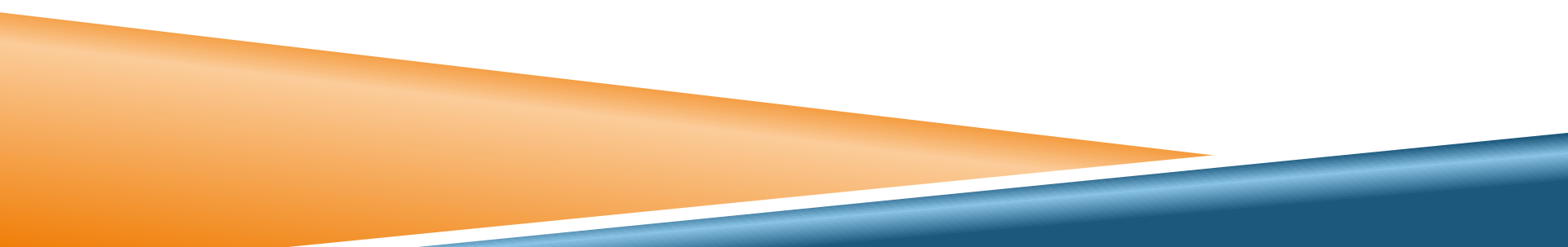
- MHD Technical Help Desk
  - MMAC contact information (provider enrollment)
  - Provider Communications Unit
  - Provider Education Unit
  - Participant Services
  - Forms ([link](#))
  - Third Party Liability (TPL)
- 

## Section 4- Timely Filing

- Claims must be initially filed within 12 months of the date of service (DOS).
  - Medicare crossover claims must be filed within 12 months of the DOS or 6 months of the date of the Medicare notice of an allowed claim, whichever date is later.
  - The final deadline to correct and re-file for all claims is 24 months from the DOS.
- 



# Section 5- Third Party Liability (TPL)

- MO HealthNet is the Payer of last resort
  - Participant's Liability when there is TPR
  - Providers May Not Refuse Service Due to TPL
  - TPL Information resources
  - Insurance Coverage Codes
  - Commercial Managed Health Care Plans
  - Provider Claim Documentation Requirements
  - Third Party Liability Bypass
  - MO HealthNet Insurance Resource Report (TPL-4)
- 

# Section 5- Third Party Liability (Cont.)

Hot Tip dated May 11, 2018

- When checking the participant's eligibility, you are given information about known possible insurance coverage. **The insurance information on file at the MO HealthNet Division (MHD) does not guarantee the insurance(s) listed is (are) the only resource(s) available nor does it guarantee the coverage is currently in effect.** If the participant has not informed the eligibility specialist of changes, the information on file may need to be updated.
- Complete the MO HealthNet Insurance Resource Report form, commonly known as the TPL-4 form. This form should be emailed to [MHD.CostRecovery@dss.mo.gov](mailto:MHD.CostRecovery@dss.mo.gov)

# Section 5- TPL-4 Form

| MISSOURI DEPARTMENT OF SOCIAL SERVICES<br>MO HEALTHNET DIVISION<br>MO HEALTHNET INSURANCE RESOURCE REPORT   |                                       | TPL-4   |
|---|---------------------------------------|---|
|   |                                       | <input type="button" value="Save"/> <input type="button" value="Print"/> <input type="button" value="Reset"/> |
| Submit this form to notify the MO HealthNet agency of insurance information that you have verified for a MO HealthNet participant. Please send the completed form to:<br>Department of Social Services<br>MO HealthNet Division<br>Attention: TPL Unit<br>P.O. Box 6500<br>Jefferson City, MO 65102-6500<br>MHD.CostRecovery@dss.mo.gov |                                       |   |
| DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.   |                                       |   |
| PROVIDER IDENTIFIER   | PROVIDER TAXONOMY CODE                | DATE (MM/DD/YY)   |
|   |                                       |   |
| PROVIDER NAME   |                                       |   |
|   |                                       |   |
| CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION  |                                       |   |
| <input type="checkbox"/> ADD NEW RESOURCE OR <input type="checkbox"/> CHANGE MO HEALTHNET RESOURCE FILES  |                                       |   |
| PARTICIPANT NAME  | MO HEALTHNET ID NUMBER                |   |
|   |                                       |   |
| INSURANCE COMPANY NAME  |                                       |   |
|   |                                       |   |
| POLICYHOLDER (IF OTHER THAN PARTICIPANT)  | POLICYHOLDER'S SOCIAL SECURITY NUMBER |   |
|   |                                       |   |
| POLICY NUMBER   | GROUP NAME OF NUMBER                  |   |
|   |                                       |   |
| VERIFIED INFORMATION  |                                       |   |
|   |                                       |   |
| SOURCE OF VERIFIED INFORMATION: <input type="checkbox"/> EMPLOYER <input type="checkbox"/> INSURANCE COMPANY  |                                       |   |
| TELEPHONE NUMBER OF CONTACT   |                                       | DATE CONTACTED (MM/DD/YY)   |
|   |                                       |   |

# Section 5- Medicare Suspect

- If the eligibility file shows patient has Medicare.
- Provider must file the claim to Medicare first.
- Wait 45 days from the date of the Medicare notice of an allowed claim before filing a crossover claim to MO HealthNet using [www.emomed.com](http://www.emomed.com) to prevent potential duplicate payments.
- You must use the patient's name that is on the MO HealthNet file when filing on [www.emomed.com](http://www.emomed.com).

**Provider Manual Section 15- Billing Procedures for Medicare/MHD**

**<http://manuals.momed.com/manuals/>**



# Section 6- Adjustments

Adjusting claims in eMOMED ([www.emomed.com](http://www.emomed.com))

- Void Claim - used when the claim *paid* and should never have been billed, i.e., wrong billing NPI or wrong DCN
- Choose “Void” tab to bring up paid claim, 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

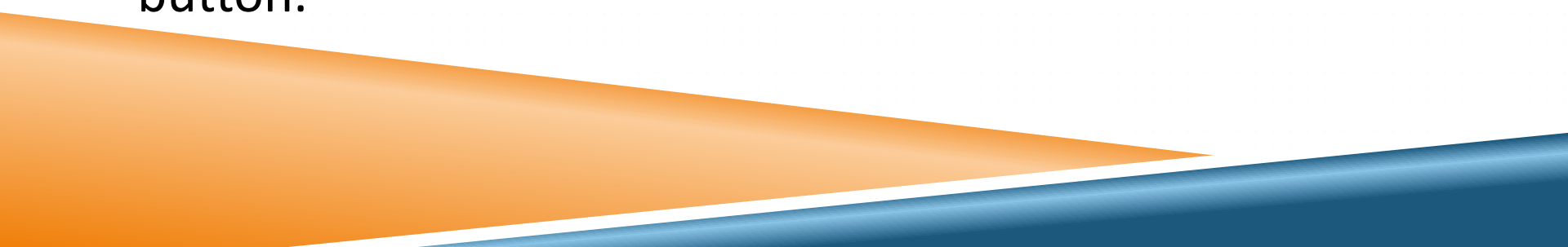
# Section 6- Adjustments

- Replacement Claim – used to modify a *paid* claim.
- Choose “Replacement” tab to bring up paid claim, select “edit” button to make changes, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button. The replacement claim has now been submitted

# Section 6- Adjustments

- **Copy Claim - Original**— used when a claim or any line of a claim *denied* needs to be corrected. This will copy a claim just as it was entered.
- Choose “Copy Claim” tab to bring up claim, choose “original,” select “edit” button to make changes, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button. The corrected claim has now been submitted.

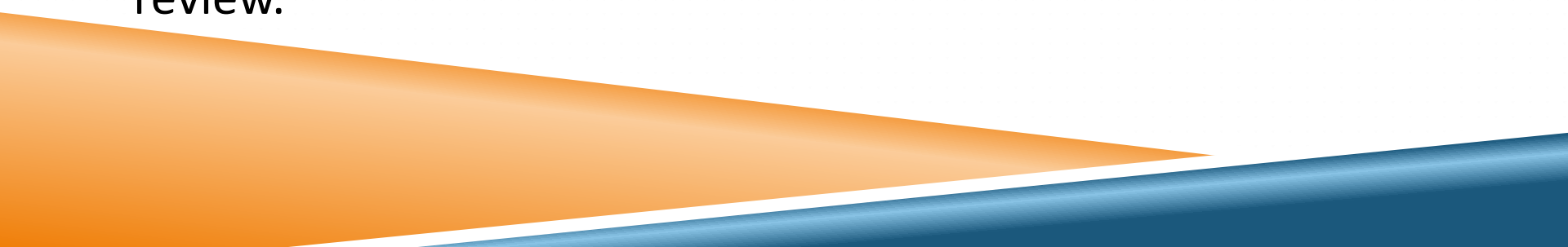
## Section 6- Adjustments

- **Copy Claim - Advanced**— used when a claim *denied* that had been filed using the wrong NPI or wrong claim form.
  - Choose “Copy Claim” tab to bring up claim, choose “advanced,” select “edit” button to edit NPI, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button.
  - If claim was filed on wrong form, only DCN and Name will transfer to correct form. Key in claim and click “submit” button.
- 



# Section 7- Certificate of Medical Necessity

See DME Provider Manual: Sections 7 and 14

- HCPC(s) identified
  - Description of the supply/equipment
  - Brand name or Model number
  - Accessories or components (*if applicable*)
  - Diagnosis
  - Prognosis
  - Reason why the equipment/item is needed
  - Anticipated length of need
  - All necessary fields and/or information must be submitted for review.
- 

# Certificate of Medical Necessity



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
MO HEALTHNET DIVISION  
CERTIFICATE OF MEDICAL NECESSITY

|                                   |                             |          |          |          |                    |                                       |  |
|-----------------------------------|-----------------------------|----------|----------|----------|--------------------|---------------------------------------|--|
| PATIENT NAME                      |                             |          |          |          |                    | PARTICIPANT MO HEALTHNET ID NUMBER    |  |
| PROCEDURE<br>CODES<br>(MAXIMUM 6) | DESCRIPTION OF ITEM/SERVICE |          |          |          | REASON FOR SERVICE | MONTHS EQUIP.<br>NEEDED<br>(DME ONLY) |  |
|                                   | MOD<br>1                    | MOD<br>2 | MOD<br>3 | MOD<br>4 |                    |                                       |  |
|                                   |                             |          |          |          |                    |                                       |  |
|                                   |                             |          |          |          |                    |                                       |  |
|                                   |                             |          |          |          |                    |                                       |  |

**DME Manual, Section 7.2 - Instructions for Completing the CMN**

**[http://manuals.momed.com/forms/Certificate\\_of\\_Medical\\_Necessity.pdf](http://manuals.momed.com/forms/Certificate_of_Medical_Necessity.pdf)**

# CMN for DME Providers

Two submission options:

- Submit through Attachment Management via eMOMED.
- Submit at the bottom of the claim on eMOMED.

**Note:** CMN's have a six (6) month approval period from the prescription date.

DME Manual, Section 7.1.A

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



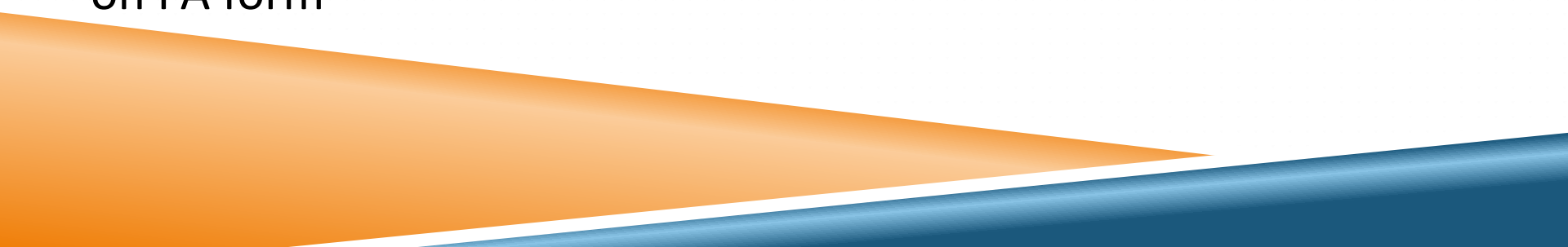
# Section 8 – Prior Authorization

- Prior Authorization Guidelines
- Procedure for obtaining Prior Auth
- Instructions for Completing the PA Form
- When to Submit a PA Request
- MO HealthNet Auth Determination
- Denial of PA Requests
- Auth Determination Explanation

NOTE: Section 8 is a General Section. See Section 14 for special documentation requirements related to PA's in the DME program.



# Prior Authorization (PA) Section 14.2.A

- Detailed description of the requested supply/equipment
  - Detailed description of the need for the supply/equipment
  - Duration of need (length of treatment, frequency, etc.)
  - Diagnosis
  - Prognosis (desired outcome from treatment)
  - Attending physician signature required
  - Specific documentation (evaluation or IOC, *if applicable*) must accompany the PA form
  - Additional documentation can be attached due to limited fields on PA form
- 

# Prior Authorization (PA)



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
MO HEALTHNET DIVISION  
**PRIOR AUTHORIZATION REQUEST**

Return to: Infocrossing Healthcare Services, Inc.  
PO Box 5700  
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The participant must be MO HealthNet Eligible on the date of service or date the equipment or prosthesis is received by the participant. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

## I. GENERAL INFORMATION

|  |                                   |                                |
|--|-----------------------------------|--------------------------------|
| 1. _____   | 2. NAME (LAST, FIRST, M.I.) _____ | 3. DATE OF BIRTH _____         |
| 4. ADDRESS (STREET, CITY, STATE, ZIP CODE) _____   |                                   | 5. MO HEALTHNET NUMBER _____   |
| 6. PROGNOSIS _____   | 7. DIAGNOSIS CODE _____           | 8. DIAGNOSIS DESCRIPTION _____ |
| 9. NAME AND ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE _____ |                                   |                                |

## II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

|                                   |  |                                      |
|-----------------------------------|--|--------------------------------------|
| 10. DATE OF HCY SCREEN _____      | 11. SCREENING<br><input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL | 12. TYPE OF PARTIAL HCY SCREEN _____ |
| 13. SCREENING PROVIDER NAME _____ | 14. PROVIDER IDENTIFIER _____  | 15. TELEPHONE NUMBER<br>( ) _____    |

## III. SERVICE INFORMATION

### FOR STATE USE ONLY


| 16. REF. NO. | 17. PROCEDURE CODE | 18. MODIFIERS | 19. FROM | 20. THROUGH | 21. DESCRIPTION OF SERVICE/ITEM | 22. QTY OR UNITS | 23. AMOUNT TO BE CHARGED | APPR. | DENIED | AMOUNT ALLOWED IF PRICED BY REPORT |
|--------------|--------------------|---------------|----------|-------------|---------------------------------|------------------|--------------------------|-------|--------|------------------------------------|
| (1)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (2)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (3)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (4)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (5)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (6)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (7)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (8)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |
| (9)          |                    |               |          |             |                                 |                  |                          |       |        |                                    |

Form [http://manuals.momed.com/collections/collection\\_dme/print.pdf](http://manuals.momed.com/collections/collection_dme/print.pdf)

# PA Helpful Hints

PA approves the medical necessity of the item/service but, does not guarantee payment.

PA's can be submitted two ways:

- Fax: (573) 659-0207 Dispositions will be sent via fax if submitted by fax.
  - Mail:  
Wipro Infocrossing  
P.O. Box 5700  
Jefferson City, MO 65102
- 

# PA Helpful Hints Continued...

## PA Determinations

- Responses are broken down by line number.
- Refer to your copy of the original PA submission for line detail information.
- “I” Incomplete- often means that the documentation was not sufficient to approve the requested item. Review your documentation and be sure your documentation is clear.
- Submit a NEW PA for procedures marked “I” (Incomplete) or “D” (Denied) with all supporting documentation if you want them reconsidered. (stand alone process)

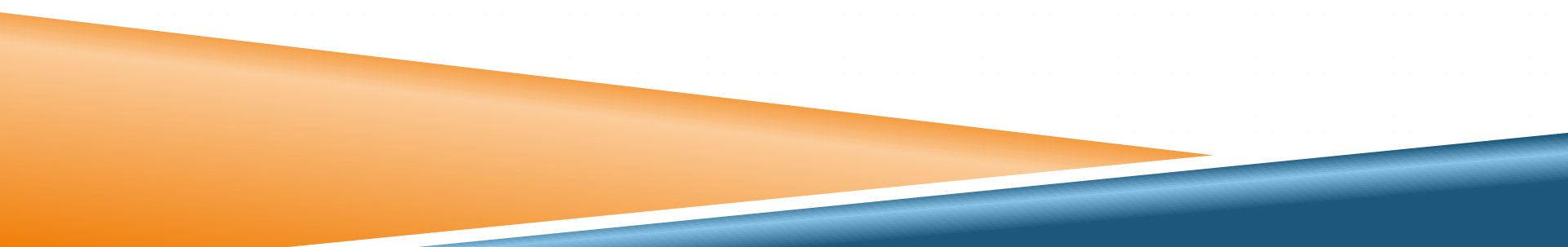
**NOTE: Don't resubmit lines that were approved.**





# Request for Change (RFC) to PA

## Key Notes:

- The PA must be **approved (A)** to request RFC.
  - Changes **must be** on the MHD Authorization Determination.
  - Attach additional documentation per program requirements, if the requested change is in frequency, amount, duration or scope, or if it documents an error on the original request.
  - The amended MHD Authorization Determination **must be signed and dated** and submitted with applicable documentation.
- 

# Not Eligible for RFC Request

- Requests for reconsideration of any detail lines that reflect a **Denied “D” or Incomplete “I”** status ***must not*** be included on an RFC.
- Providers ***must*** submit a new **PA Request form** for reconsideration of denied detail lines.

***NOTE:*** Unless otherwise stated in Section 13 or 14 of the applicable provider manual, PA Request forms and RFC's should be

mailed to:

**Mo HealthNet Division**

**P.O. Box 5700**

**Jefferson City, MO 65102**



# Manual and Power Wheelchair Accessories

## **K0108**

- Wheelchair accessories must be billed under the specific HCPC(s) if available.
- If there is no HCPC(s) for the supply, K0108 may be used.

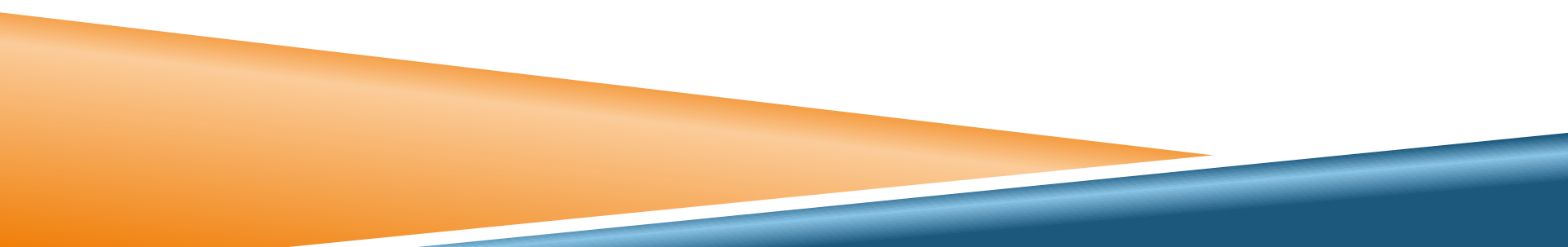
**Section 13.30.C Power Wheelchair Accessories**

**Section 13.30.F Wheelchair Accessories Not Otherwise Listed**



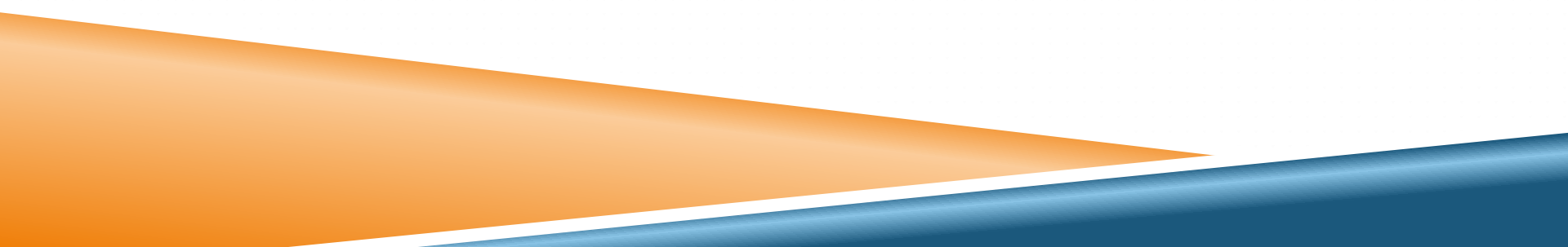
# K0108 PA Form - Special Requirements

## What is required?

- List K0108 one (1) time on the Prior Authorization Request form and combine all items/accessories that do not have an assigned HCPC(s) code into one line.
  - Combine requested amounts.
  - Description: Enter a general abbreviated description of each item in same description box.
- 

# K0108 PA Form - Special Requirements


## Additional Documentation

- Provide specific information about the item(s).
  - **Circle each K0108** item in supporting documents and write “**K0108**” next to specific item.
  - The pricing information in the supporting documents **must add up** to your requested amount.
  - Be cautious of items that are sold in pairs or sold individually.
- 


# Status of Prior Authorizations

PA Status Search

NPI



M012136305 - BPST



Search

Results

Participant DCN

Procedure Code

Modifiers

PA Status \*

☐ Approved

☐ Closed

☐ Denied

☐ Hold

☐ Incomplete

☐ Pending

☒ All

Search

Clear

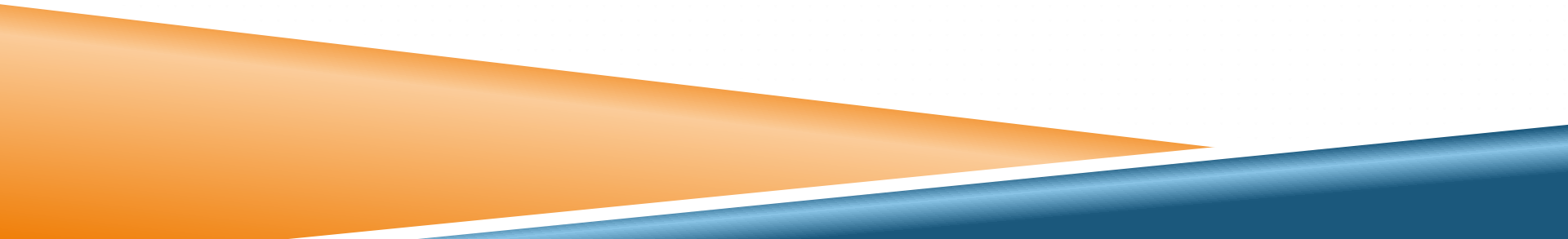
Finish

Check Status of PA's on eMOMED

Home | Contact | Search Center | Troubleshooting

# Section 9- Healthy Children and Youth Program

Not Applicable



# Section 10- Family Planning

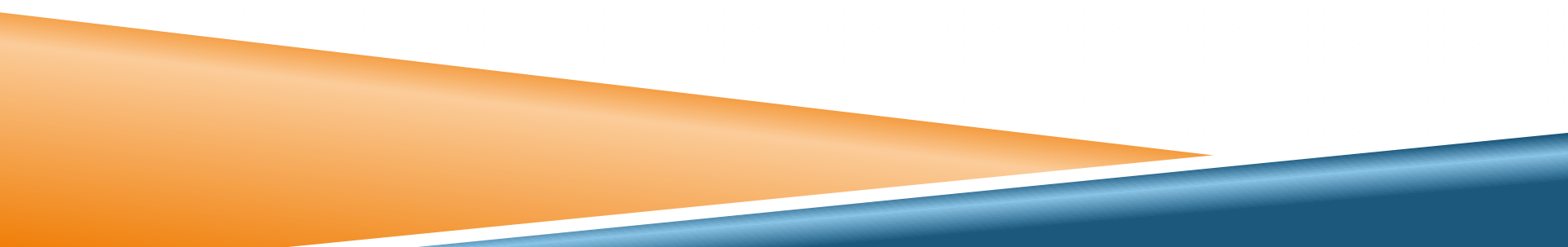
- Participants with Family Planning only coverage are not eligible for DME services:

ME Code 80 and 89

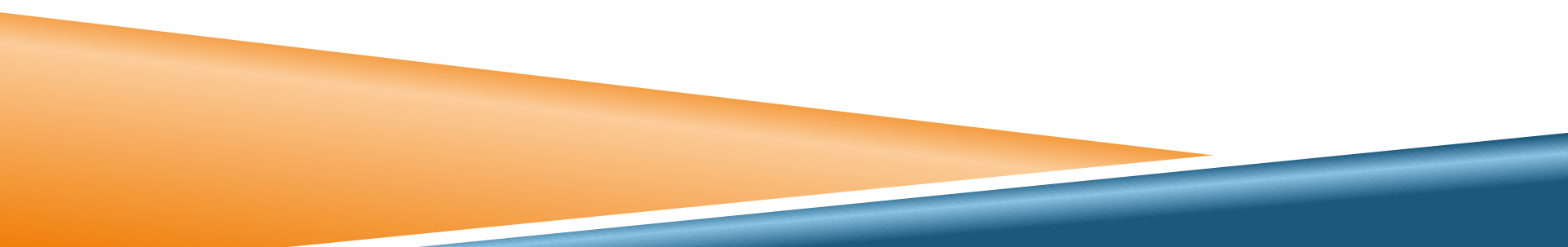
(other codes may apply see section 1 of the provider manual and the Provider Resource guide for more information)



# Section 11- MO HealthNet Managed Care Program Delivery System

- Managed Care Plan information. (State Wide)
  - MO HealthNet Managed Care Health Plan Enrollment
  - Included Individuals
  - Excluded Individuals
  - Managed Care Member Benefits
  - Standard Benefits under Managed Care plans
  - Benefits for children and pregnant woman
  - Services provided outside Managed Care Program
- 

# Section 12- Reimbursement Methodology

- Basis for Establishing a Rate of Payment
  - On-line Fee Schedule- general information
  - Medicare/Medicaid Reimbursement (crossover claims)
  - Participant Copay and Coinsurance
  - MO HealthNet Managed Health Care Delivery System  
Method of Reimbursement
  - MO HealthNet Managed Health Care
- 

# DME Section 13 - Benefits and Limitations

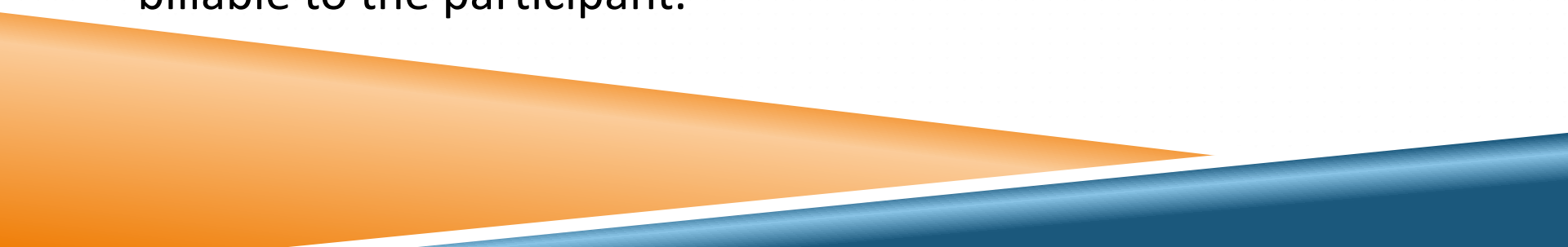
- Delivery Rules and Requirements
- Rental – Purchase – Repair
- Rules for Custom-Made Items
- DME Coverage for Nursing Home Participants
- DME for Participants in the Hospital
- Specific coverage information for several DME Items

**Section 13 of the DME Provider Manual**



# Delivery

## **13.9.B DELIVERY OF ITEMS COVERED UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM**

- Items that are covered under the DME Program must be dispensed to the participant before the provider bills MO HealthNet for the item. Holding equipment until MO HealthNet payment is received constitutes a payment for a service not provided and is in violation of State Regulation 13 CSR 70-3.030(3)(A)23.
  - All charges for delivery, pickup, shipping, freight, C.O.D. and handling are included in the MO HealthNet allowed reimbursement amount and are not paid for separately or billable to the participant.
- 

# Direct Delivery

## 13.15.B DIRECT DELIVERY

DME providers may deliver an item or supply directly to the participant or their designee. An example of proof of delivery made directly to a participant is a signed and dated delivery slip. It is recommended the delivery slip include the following:

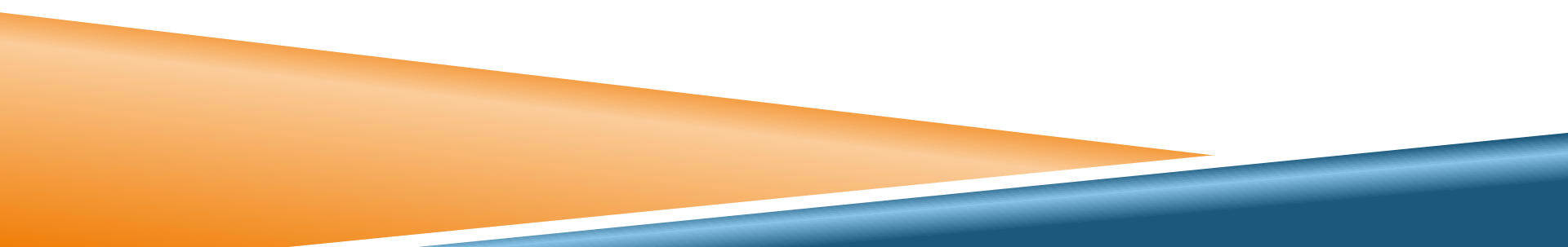
- Participant's name
- Quantity delivered
- Detailed description of the item being delivered
- Brand name of the item
- Serial number (if applicable)

The date of signature on the delivery slip *must* be the date that the item/supply was received by the participant or designee. In instances where the item/supply is delivered directly by the DME provider, the actual date the participant received the item/supply shall be the date of service on the claim.

# Mail Order/Shipping Service Delivery

## **13.15.C MAIL ORDER/SHIPPING SERVICE DELIVERY**

If a DME provider uses a shipping or mail order service, an example of proof of delivery should include the services tracking slip and the DME provider's own shipping invoice. If possible, the DME provider's record should also include the delivery service's package identification number for the package sent to the participant. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and, if possible, the date delivered. DME providers should use the shipping date as the date of service on the claim.



# Section 13.15.D

## Supply Refills- No Auto Refills

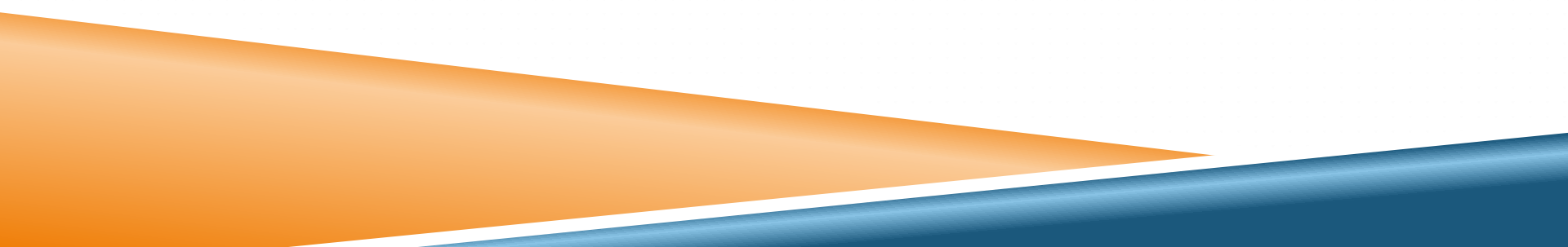
- The DME provider **MUST** contact the participant or caregiver prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the participant.
- This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modification to the order. Direct contact with the participant or designee is required.

**See Section 13.15.D for more requirements**



## 13.16 Custom-Made Items

MO HealthNet provider payment may be made for custom-made items, such as orthotics, prosthetics, custom wheelchairs, and custom Healthy Children and Youth HCY equipment.

- when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility *or*
  - change of assistance category to one in which the particular service is *not* covered) *or*
  - dies *after* the item is ordered or fabricated, and *prior* to the date of delivery or placement of the item.
- 



# Custom-made Items Continued

The following prerequisites apply to all such payments:

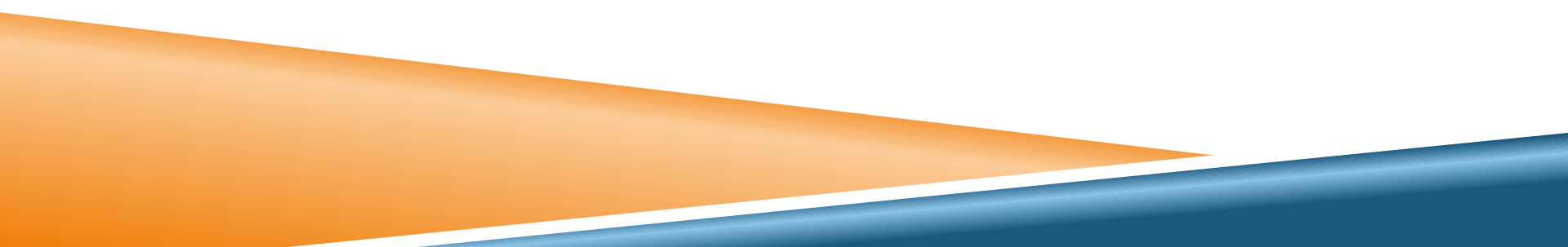
- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization Request form if required), and at the time of any subsequent service, including preparatory visits prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item *must* have been delivered or placed if the participant is living;

**NOTE: (Refer to section 13.16 for the full process)**



# 13.18 Coverage of DME in a Nursing Home

DME is *not* covered for those participants residing in a nursing home (place of service 31 or 99 with level of care 1 or 2). DME is included in the nursing home per diem rate and *not* paid for separately with the **exception** of the following items:

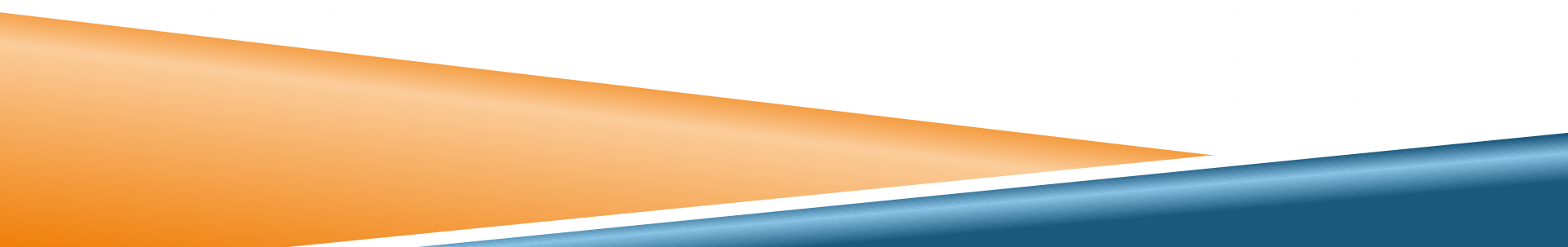
- Augmentative Communication Devices (ACDs) and accessories
  - Custom Wheelchairs;
  - Power Wheelchairs;
  - Orthotic and Prosthetic Devices;
  - Total Parenteral Nutrition; and
  - Volume Ventilators.
- 

# Section 14 - Special Documentation Requirements

- Certificate of Medical Necessity (CMN)
- Prior Authorization (PA)
- Pre-Certification (PC)

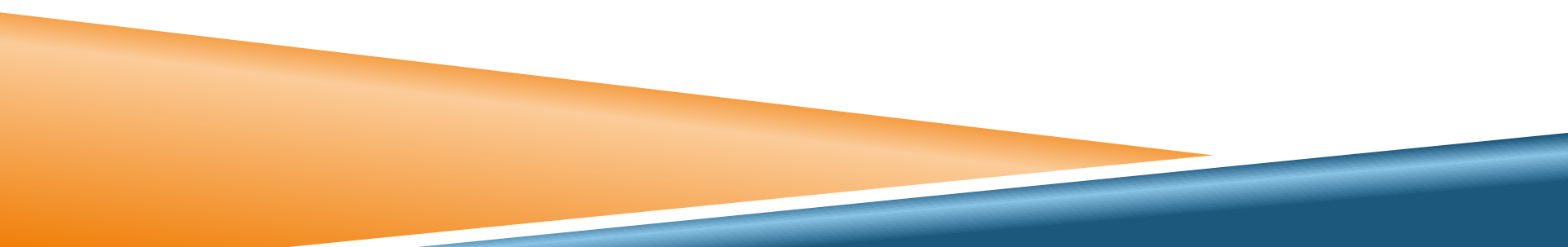
DME Manual, Section 14 – Special Documentation Requirements

# CyberAccess - Section 14.4

- The CyberAccess tool enables providers to obtain pre-certifications for specific items and services electronically.
  - CyberAccess can automatically reference the individual participant's claim history, including applicable ICD diagnosis codes and CPT procedure codes.
  - Requests for precertification must meet medical criteria established by the MHD in order to be approved.
- 

# CyberAccess

Pre-certification is available for the following services:

- Radiology
  - Durable Medical Equipment
  - Optical
  - Inpatient
  - Drug Prior Authorization (PA)
  - Clinical Edit Override (EO)
- 

# CyberAccess

Account setup or technical questions

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

[cyberaccesshelpdesk@xerox.com](mailto:cyberaccesshelpdesk@xerox.com)

CyberAccess web address:

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

CyberAccess helpful Tips:

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



# Quick link to CyberAccess

**CyberAccess**

**Protect your patients by following a few simple rules**

**Log In**  
User Name:   
Password:   
[Forget Your Password?](#)

- 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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Version: 10.7

[FREQUENTLY ASKED QUESTIONS](#) [SYSTEM REQUIREMENTS](#)  
**For technical support with CyberAccess please call 1-888-581-9797**







[CYBERACCESS FLYER](#)

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

# Pre-Certification

## DME Pre-Certification Criteria Documents

[home](#) » [mo healthnet division](#) » [clinical services](#) » [dmeprecert](#) » [pages](#) » dmeprecert

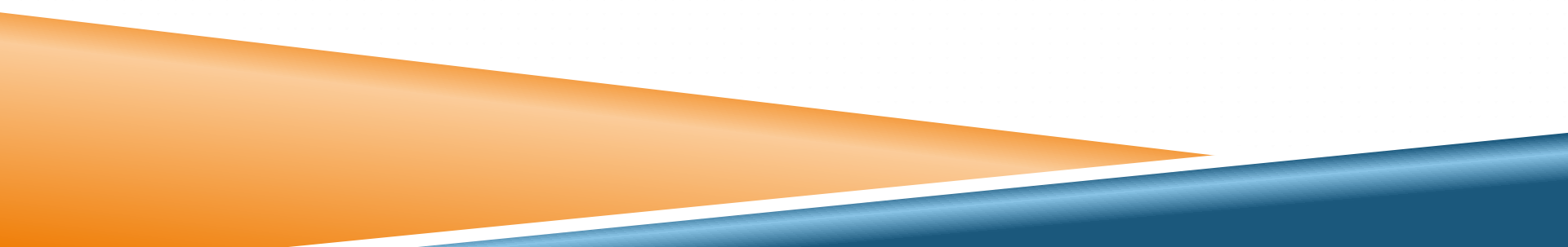
| Issue Date   | DME Pre-Certification Criteria Documents   |
|--------------|--|
| Nov 13, 2008 | <b>Apnea monitor, with recording feature, months 5-12, E0619 (RRKJ)</b>   |
| Nov 30, 2009 | <b>Augmentative Communication Devices</b>   |
| Nov 30, 2009 | <b>Augmentative Communication Devices, Subsequent Pre-Cert after rental</b>   |
| Oct 06, 2009 | <b>Breast Prostheses</b>    |
| Nov 13, 2008 | <b>Canes and Crutches</b>   |
| Dec 11, 2008 | <b>Commodes, bed pans, urinals; E0163NU, E0163RR, E0165NU, E0165RR, E0168NU, E0168RR, E0275NU, E0276NU, E0325NU, E0326NU</b>  |

<https://dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm>



# Pre-Certification Documents

## **Examples of Information provided:**

- Product information
  - Approval Criteria
  - Denial Criteria
  - Quantity Limitation
  - Approval Period
- 

# Section 15- Billing Instructions

Two options for CMS(Medical)-1500 claim submission

- **Electronic** : [www.emomed.com](http://www.emomed.com) (preferred)
- **Paper mailing:**

Wipro Infocrossing

P.O. Box 5600

Jefferson City, MO 65102

DME Provider Manual Section

15.1 CMS-1500 Claim Form

15.3 Resubmission of Claims

15.4 Billing Procedures for Medicare/MHD

15.5 CMS-1500 Claim Filing Instructions



# Section 16- Medicare/Medicaid Crossover Claims

## **Always bill Medicare prior to billing Medicaid**

- Medicare Part B paid claims *should* crossover automatically.

**Form:** Medicare CMS-1500 Part B Professional

## **Billing for Medicare Non-covered services (Part B)**

- Medicare Part B denied claims have to be keyed on eMOMED.

**Form:** Medical CMS-1500 report Medicare EOB information



# Section 16- Medicare/Medicaid Crossover Claims

- Medicare Part C paid claims **never** crossover and must be keyed on eMOMED.

**Form:** Medicare CMS-1500 Part C Professional *-with QMB*

**Form:** Medical CMS-1500 *-No QMB*

*Always use the 16 indicator on both claim forms.*

## **Billing for Medicare Non-covered services (Part C)**

- Medicare Part C denied claims **never** crossover and must be keyed on eMOMED.

**Form:** Medical CMS-1500 *—regardless if they have QMB or not*

*Always use the 16 indicator on both claim forms.*

**NOTE:** Paper crossover claims are no longer accepted



# Section 17 – Claims Disposition

17.1 Access to Remittance Advices

17.2 Internet Authorization

17.3 On-line Help

17.4 Remittance Advice

17.5 Claim status message codes

17.5.A Frequently reported reductions or cutbacks



# Section 18 – Diagnosis Codes

- ICD 10-CM Diagnosis Codes are required to bill MO HealthNet
- Refer to the most current ICD-10-CM manual

# Section 19- Procedure Codes (HCPC)

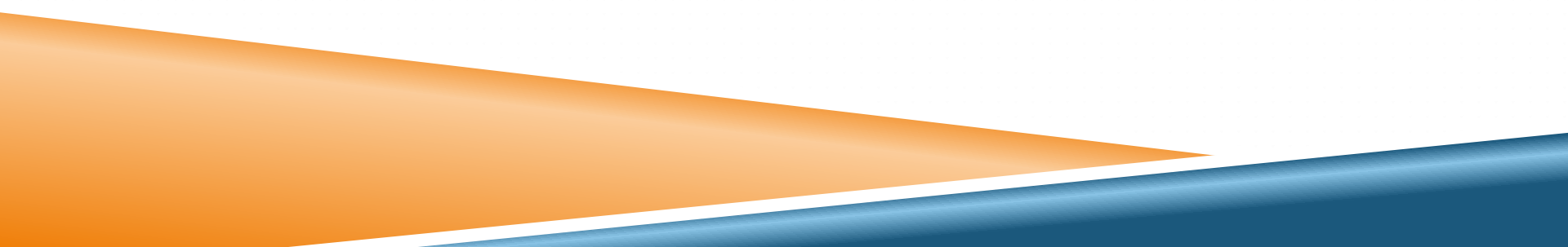
## SECTION 19 - PROCEDURE CODES

19.1 HEALTHY CHILDREN AND YOUTH (HCY) COVERED *ONLY* FOR PARTICIPANTS AGE 0 - 20

19.2 DURABLE MEDICAL EQUIPMENT (DME), INCLUDES ALL AGE PARTICIPANTS

- IOC = Invoice of Cost
- MN = Medical Necessity
- MNF = Medical Necessity on File – Keep in patients file don't submit.
- MP = Manually Priced
- PA = Prior Authorization- Think... PA for paper process submit via fax.
- PC = Pre-Certification- Think... PC computer process through CyberAccess.

# DME Section 19- Modifiers

- RB- Repair
  - EP- Children Under 21
  - NU- Purchase
  - UB- Exception Program (patients 21 and over)
  - RR- Rental
- 



# Section 19- Procedure Codes

SECTION 19 DME PROCEDURE CODES

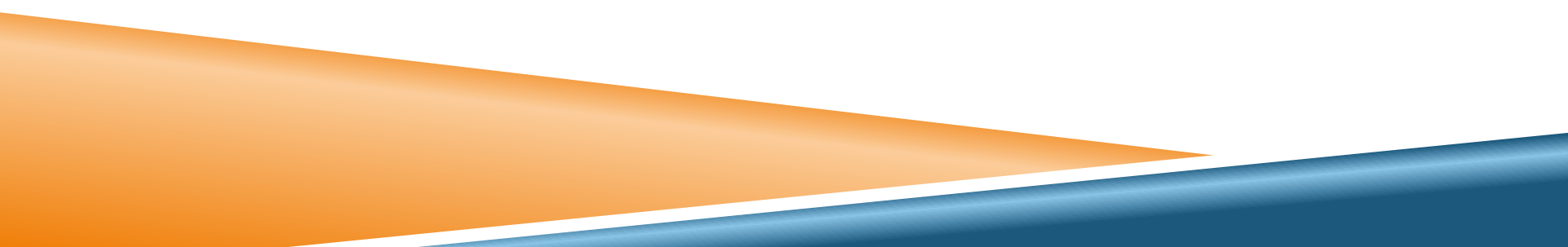
19.1 HEALTHY CHILDREN AND YOUTH (HCY) COVERED ONLY FOR PARTICIPANTS AGE 0-18

| Procedure Code | Modifiers |    |  | Description  | Reimbursement Guidelines |     | Limits qty/days and Comments |
|----------------|-----------|----|--|--|--------------------------|-----|------------------------------|
| A4206          | NU        | EP |  | 1 CC STERILE SYRINGE&NEEDLE  | MNF                      |     | 100/30                       |
| A4207          | NU        | EP |  | SYRINGE WITH NEEDLE, STERILE 2 CC EACH   | MNF                      |     | 30/30                        |
| A4208          | NU        | EP |  | SYRINGE WITH NEEDLE, STERILE 3 CC EACH   | MNF                      |     | 100/30                       |
| A4209          | NU        | EP |  | SYRINGE WITH NEEDLE, STERILE 5 CC OR GREATER, EACH                                 | MNF                      |     | 100/30                       |
| A4211          | NU        | EP |  | SUPPLIES FOR SELF-ADMIN INJECT.  | PA                       | IOC |                              |
| A4212          | NU        | EP |  | NON-CORING NEEDLE OR SYLET W/WO CATHETER   | MNF                      |     | 15/30                        |
| A4213          | NU        | EP |  | SYRINGE STERILE 20CC OR GREAT, EACH  | MNF                      |     | 100/30                       |
| A4215          | NU        | EP |  | NEEDLE, STERILE, ANY SIZE, EACH  | MNF                      |     | 100/30                       |
| A4216          | NU        | EP |  | STERILE WATER/SALINE, 10 ML  | MNF                      |     | 100/30                       |
| A4217          | NU        | EP |  | STERILE WATER/SALINE, 500 ML   | MNF                      |     | 30/30                        |
| A4221          | NU        | EP |  | SUPP NON-INSULIN INF CATH/WK   |                          |     | 1/7                          |
| A4222          | NU        | EP |  | SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG LIST DRUG SEPARATELY |                          |     |                              |

Section 19 outlines modifiers, item descriptions, required processes such as: CMN, PA, or IOC, and quantity limitations.

# Invoice of Cost (IOC)

## **Invoice of Cost typically includes:**

- Itemization of manufacturer's materials to produce a finished product.
  - Manufacturer's bulk discounts, cost reduction due to quick payment and other Manufacturer incentives.
  - Reporting of state sales tax  
(non- reimbursable by MHN)
  - Reporting of shipping fees  
(non-reimbursable by MHN)
- 

# Invoice of Cost (IOC)

**Some supplies or equipment require IOC.**

**IOC can be submitted:**

- Attached to the eMOMED electronic claim
- Submitted with the prior authorization

# Invoice of Cost Attachment

**Invoice of Cost**

**Invoice of Cost Details Summary**

| Line Item(s) | Vendor Name | Date of Invoice | Action |
|--------------|-------------|-----------------|--------|
|--------------|-------------|-----------------|--------|

**Add/Edit Invoice of Cost**

Claim Line Numbers Associated with Invoice \*

☐ 1

Vendor/Supplier Name \*

Date of Invoice \*

**Add/Edit Cost Details For This Invoice of Cost**

**Cost Details Summary**

| Item Description | Unit Cost | Total Cost | Cost Type | Action |
|------------------|-----------|------------|-----------|--------|
|------------------|-----------|------------|-----------|--------|

**Add/Edit Cost Details**

Item Description \*

Unit Cost \*

Total Cost \*

Cost Type \*

☐ MSRP ☐ Cost

Save IOC Details

Reset

Save IOC to Claim

Reset

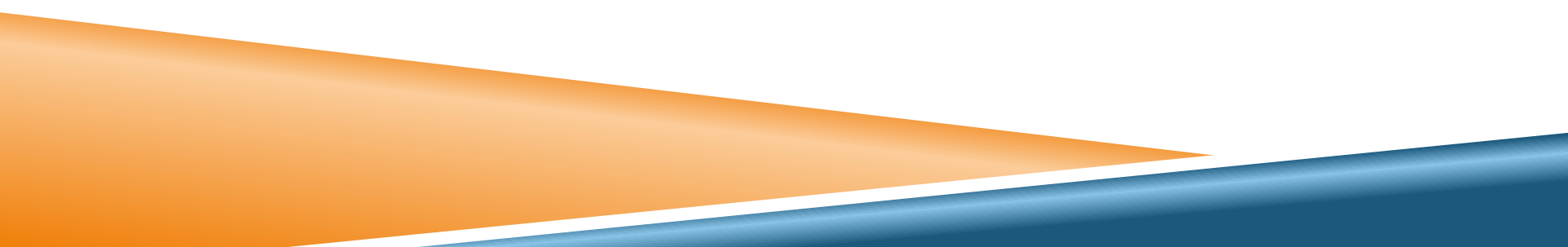
Submit Claim

Printer Friendly

Reset

Cancel

# Manufacturer's Suggested Retail Price

- The manufacturer's suggested retail price (**MSRP**), or list price of a product, is the price at which the manufacturer recommends that the retailer sell the product.
  - MSRP information is required for pricing certain manually-priced DME items.
  - MSRP should be submitted with PA's as supporting documentation.
- 

# When to Submit MSRP?

|       |       |   |    |    |  |
|-------|-------|---|----|----|--|
| K0108 | NU    | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |
| K0108 | NU SC | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |
| K0108 | RB    | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |
| K0108 | RB SC | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |
| K0108 | RR    | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |
| K0108 | RR SC | Wheelchair Component Or Accessory Not Otherwise Specified | PA | MP |  |

- Manually-Priced (MP) items could require MSRP or IOC.
- Refer to DME Manual Section 13 for additional direction.

# Section 20- Exceptions Process

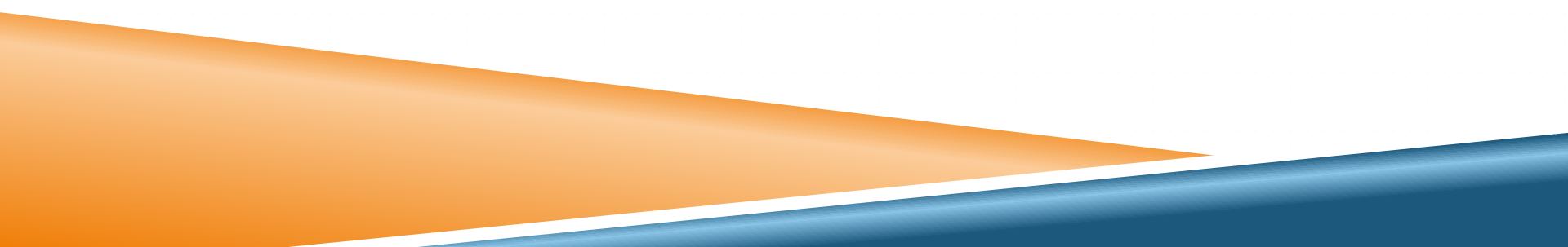
Under certain conditions of medical need, the MO HealthNet Division may authorize payment for a MO HealthNet eligible participant to receive an *essential* medical service or item of equipment that otherwise exceeds the benefits and limitations of any one of the various medical service programs administered by the Division. The Exceptions Process is for participants 21 and over.

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



# Section 20- Exceptions Process

Requests for exception consideration *must* support and demonstrate that one (1) or more of the following conditions is met:

- 1. The item or service is required to sustain the participant's life;*
  - 2. The item or service would substantially improve the quality of life for a terminally ill patient;*
  - 3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or*
  - 4. The item or service is necessary to prevent a higher level of care.*
- 



# Section 20- Exceptions Process

Non- Emergency Exception Requests-

## **Submission Methods:**

**Prescriber** can submit via fax (573)-522-3061

Or mail to:

MO HealthNet Division

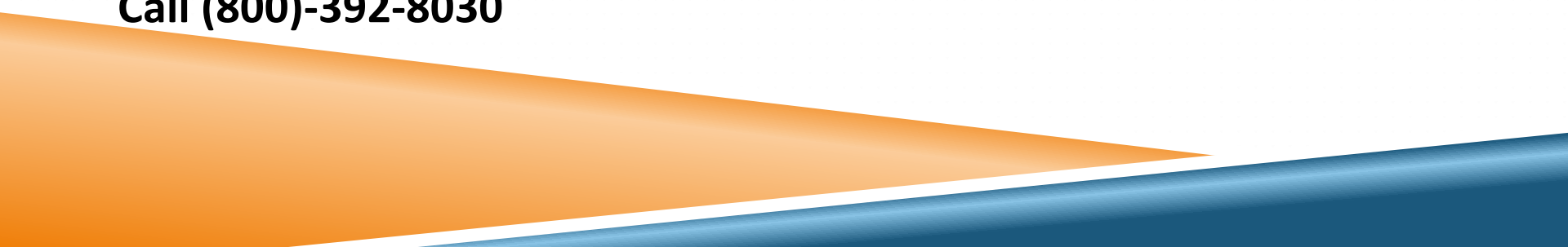
Exceptions Unit

PO Box 6500

Jefferson City MO 65102

**Life-Threatening Emergency Exceptions Requests**

**Call (800)-392-8030**



# Exceptions Process - Tips

In an effort to make the Exceptions process move smoothly for providers and MO HealthNet, we have identified some areas of concern.

A MO HealthNet enrolled treating prescriber must initiate all requests.

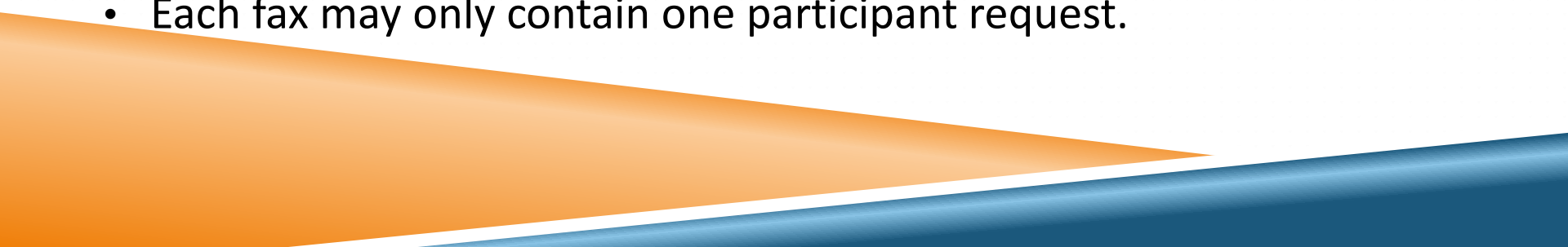
- The DME Company should not facilitate exception requests. It is to be completed by the prescribing provider.
- Provide correct prescriber contact information. Request for additional information will be sent to the prescriber's fax.

# Exceptions Process – Tips (cont.)

Multiple requests on the same patient for identical equipment or services.

- This creates duplicate requests and slows down the review process.
- Providers can call MO HealthNet at 800-382-8030 option 2 to check status and receipt of the request.

Multiple participants in the same fax.

- Each fax is a request regardless if you submit multiple patient's information. If faxed together our system scans the documents in the same transaction causing a rejection.
  - MO HealthNet will fax a rejection back to the prescriber.
  - Each fax may only contain one participant request.
- 

# Exceptions Process- Tips

Incorrect or incomplete forms:

- Provide correct DME information: NPI or provider ID, location, fax, and phone numbers. It is important that contact information for the actual location of service is provided. Approval letters are faxed to the DME providing the equipment or service. (not corporate)
- HPCS must be present if the item has an assigned HCPC code. DME providers can help provide these codes to the prescriber completing the Exceptions Request.

Contact the Exception Hotline: 800-392-8030 option 2 or Constituent Services, Provider Education 573-751-6683 or email:

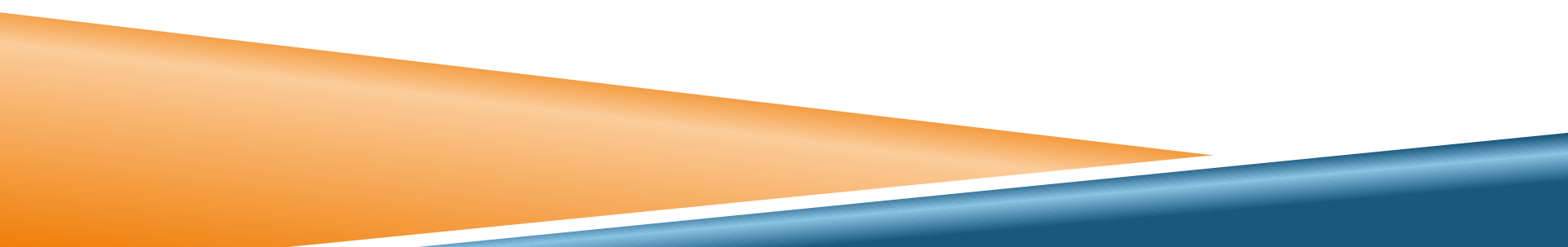
[MHD.PROVTRAIN@dss.mo.gov](mailto:MHD.PROVTRAIN@dss.mo.gov) for additional clarification.

Note: Refer to Section 20 to see the full Exceptions Process.

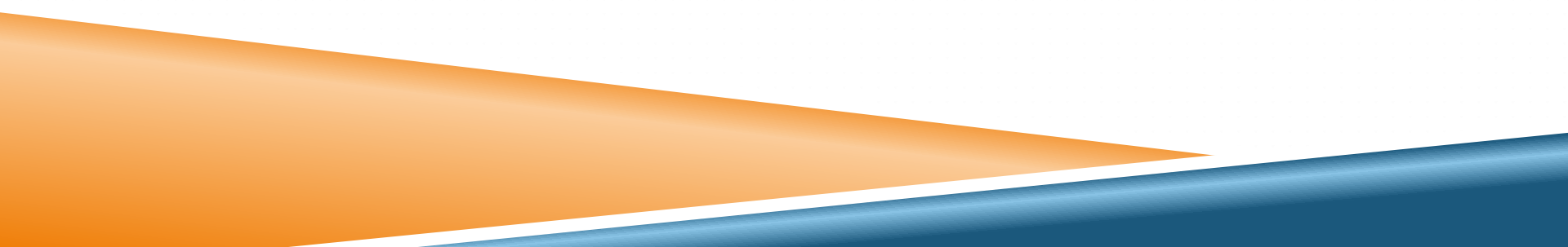


# Not Applicable

SECTION 21- ADVANCE HEALTH CARE DIRECTIVES-NA



# Section 22- Non-Emergency Medical Transportation (NEMT)

- The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.
  - For questions about Non-Emergency Medical Transportation (NEMT), participants may call the reservation line at **(866) 269-5927**.
- 

# Section 23 – Claim Attachment Submission and Processing

CMN- Certificates of Medical Necessity can be submitted via eMOMED through Attachment Management.

CMN- Can also be attached to the bottom of a claim on eMOMED.



# emomed.com electronic claim filing

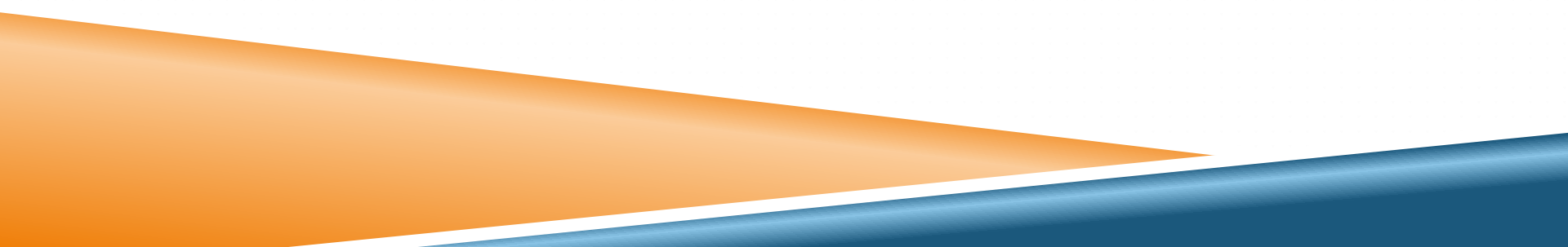
The screenshot displays the MoHealthNet eProvider portal. At the top, a navigation bar includes links for Home, Contact, Training, Search Center, and Troubleshooting, along with a search box. Below this is a banner featuring a group of healthcare professionals and the MoHealthNet logo. The main content area is divided into several sections:

- External Links:** A list of links including "State of Missouri Web site", "Department of Social Services", "MO HealthNet Division", "Provider Information", "Provider Enrollment Application", and "Participant Information".
- eProvider News:** A section titled "eNews" with a list of recent news items, each with a date and a brief description, such as "09/30/2015 ICD-10 MO HealthNet Provider Resources" and "08/31/2015 835 Posting Dates based on 370 EFT & ERA REASSOCIATION (CCD+/835) RULE".
- eProvider Welcome:** A central section titled "Welcome to eProvider" featuring a large image of a healthcare professional and a grid of service tiles. Each tile includes an icon, a title, and a brief description of the service, such as "Claim Management", "Attachment Management", "Participant Eligibility", "Prior Authorization Status", "Provider Communications Management", "Participant Annual Review Date", "Nursing Home Management", "File Management", "Payment Information", and "Available Surveys".

The interface is designed to be user-friendly, with clear navigation and a focus on providing essential services to healthcare providers.



# Claim Samples

- MO HealthNet Only
  - MO HealthNet and Commercial Insurance
  - MO HealthNet and Medicare Part B
  - MO HealthNet and Medicare Part C + QMB
- 

# eMOMED Electronic Claim Filing

## Welcome to eProvider



### Claim Management

Submit new claims. View claim status. Void/Replace existing claims.



### Nursing Home Management

Manage participants. Submit nursing home claims.



### Attachment Management

Submit new stand-alone attachments. View attachment status.



### File Management

Send and receive batch files. Print/View/Download Remittance Advice.



### Participant Eligibility

Verify participant eligibility.



### Payment Information

View the payment information for the two most recent payments.



### Prior Authorization Status

Check the prior authorization status for participants.



### Available Surveys



### Provider Communications Management

Send Your Inquiries...



### Provider Enrollment Status

Verify Provider Eligibility.

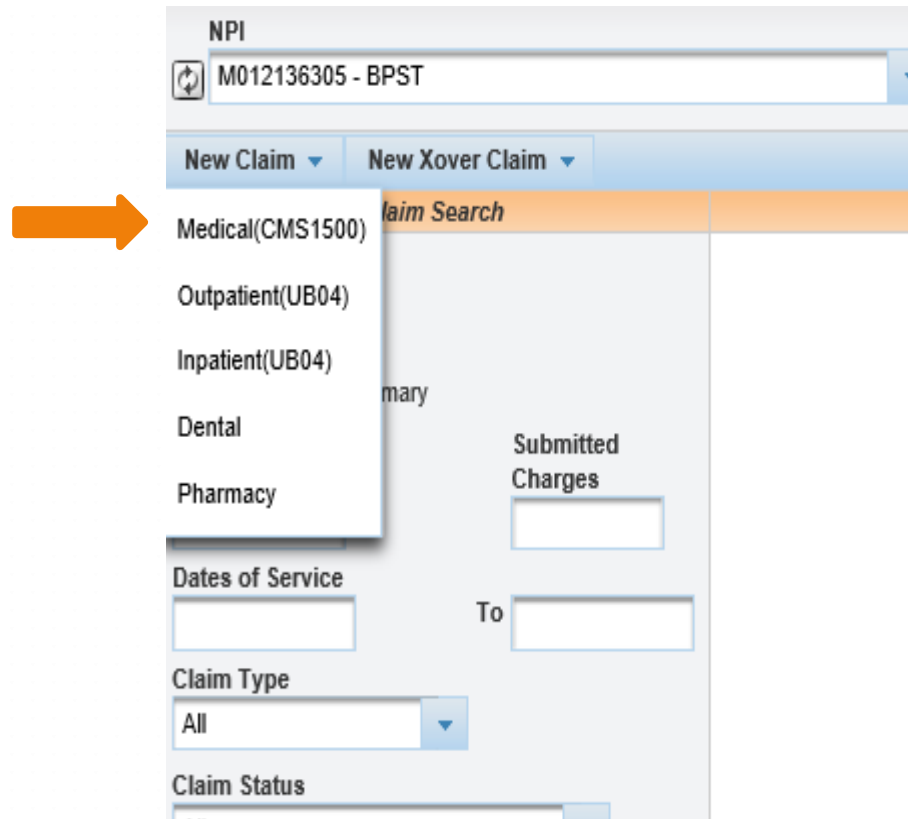


### Participant Annual Review Date

View participant annual review dates.

# Mo HealthNet Only

Select CMS 1500 (Medical) Claim Form



The screenshot shows a web-based claim form interface. At the top, there is a field for 'NPI' with a dropdown menu showing 'M012136305 - BPST'. Below this are two tabs: 'New Claim' and 'New Xover Claim'. An orange arrow points to the 'New Claim' tab, which has a dropdown menu open. The menu options are: 'Medical(CMS1500)', 'Outpatient(UB04)', 'Inpatient(UB04)', 'Dental', and 'Pharmacy'. The 'Medical(CMS1500)' option is highlighted. Below the dropdown menu, there are fields for 'Submitted Charges' and 'Dates of Service' (with 'To' and 'From' sub-labels). The 'Claim Type' dropdown is set to 'All'. The 'Claim Status' field is partially visible at the bottom.

# Claim Header

Medical(CMS1500) Claim

Billing NPI: M012136305  
BPST

**Claim Header Information** Enter information as it appears on MHD card

**Participant Information**

|                        |                         |                          |
|------------------------|-------------------------|--------------------------|
| Participant DCN *      | Participant Last Name * | Participant First Name * |
| 01010101               | patient                 | ima                      |
| Patient Account Number |                         |                          |
| 123                    |                         |                          |

Optional

**Service Information**

|                           |                       |                           |
|---------------------------|-----------------------|---------------------------|
| Referring Provider NPI    | Hospitalization Dates |                           |
| M012174504                |                       | To                        |
| Service Facility Location | Service Facility Name | PRTF Certification Number |
|                           |                       |                           |

Required

**Cause and Diagnosis Details**

|                     |                           |                   |
|---------------------|---------------------------|-------------------|
| Related Cause Codes | Last Menstrual Cycle Date | Diagnosis Codes * |
|                     |                           | Z111              |

Save Claim Header Reset

Save claim header

Enter ICD10 DX (No decimals)

# Detail Line Summary

**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 *             |                |                       |                    |                |        |
| 04/01/2022 To 04/01/2022   |                 | 12 - Home                      |                |                       |                    |                |        |
| Procedure Code *   |                 | Modifiers                      |                |                       |                    |                |        |
| L5673  |                 | NU                             |                |                       |                    |                |        |
| National Drug Code   |                 | Decimal Quantity (9999999.999) |                | Prescription Number   |                    |                |        |
|  |                 |                                |                |                       |                    |                |        |
| Diagnosis Code *   |                 | Billed Charges *               |                | Days/Units Billed *   |                    |                |        |
| Z111   |                 | 600.00                         |                | 1                     |                    |                |        |
| Conditions   |                 | Performing Provider NPI        |                | Ordering Provider NPI |                    |                |        |
| <input type="checkbox"/> Emergency<br><input type="checkbox"/> EPSDT<br><input type="checkbox"/> Family Planning |                 | M012136305                     |                | M012174504            |                    |                |        |
| Save Detail Line to Claim  |                 | Reset                          |                |                       |                    |                |        |

Click save detail line to claim

# Submit Claim

## Add Detail Line

| Detail Line Summary |                         |                  |                |           |                    |                | Total Charges : 600.00  |
|---------------------|-------------------------|------------------|----------------|-----------|--------------------|----------------|---|
| Line #              | Date of Service         | Place of Service | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action  |
| 1                   | 04/01/2022 - 04/01/2022 | 12 - Home        | L5673          | NU        |                    | 600.00         |   |

### Add Detail Line #2

|  |                         |   |                       |
|--|-------------------------|---|-----------------------|
| Dates of Service *   |                         | Place of Service *  |                       |
| <input type="text" value="#####"/>   | To <input type="text"/> | <input type="text"/>  |                       |
| Procedure Code *   |                         | Modifiers   |                       |
| <input type="text"/>   |                         | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |                       |
| National Drug Code   |                         | Decimal Quantity (9999999.999)  | Prescription Number   |
| <input type="text"/>   |                         | <input type="text"/>  | <input type="text"/>  |
| Diagnosis Code *   |                         | Billed Charges *  | Days/Units Billed *   |
| <input type="text" value="Z111"/>  |                         | <input type="text"/>  | <input type="text"/>  |
| Conditions   |                         | Performing Provider NPI   | Ordering Provider NPI |
| <input type="checkbox"/> Emergency<br><input type="checkbox"/> EPSDT<br><input type="checkbox"/> Family Planning |                         | <input type="text"/>  | <input type="text"/>  |

Save Detail Line to Claim

Reset

Other Payers (click to manage)

Invoice of Cost (click to manage)

Certificate of Medical Necessity (click to manage)

Submit Claim

Submit Claim

Printer Friendly

Reset

Cancel

# Claim Status

Void

Replacement

Copy claim

Printer friendly

Claim Details

|   |                         |                                     |                |           |                  |                                     |             |                        |               |                        |                       |
|---|-------------------------|-------------------------------------|----------------|-----------|------------------|-------------------------------------|-------------|------------------------|---------------|------------------------|-----------------------|
| Void Replacement Timely Filing Copy Claim View Claim Details Printer Friendly |                         |                                     |                |           |                  |                                     |             |                        |               |                        |                       |
| <b>Participant Details</b>  |                         | <b>Participant Data</b>             |                |           |                  |                                     |             | <b>Payment Details</b> |               |                        |                       |
| Participant Name<br>IMA PATIENT   |                         | 4922152063741                       |                |           |                  | Claim Submission Date<br>06/01/2022 |             | Total Paid<br>0.00     |               |                        |                       |
| Participant DCN<br>01010101   |                         | First Date Of Service<br>04/01/2022 |                |           |                  | Last Date of Service<br>04/01/2022  |             | RA Date                |               |                        |                       |
|   |                         | Claim Type<br>MEDICAL               |                |           |                  | Bill Type                           |             | Check Number           |               |                        |                       |
|   |                         | Total Charges<br>600.00             |                |           |                  |                                     |             |                        |               |                        |                       |
| <b>Provider Details</b>   |                         | <b>Claim Status Details</b>         |                |           |                  |                                     |             |                        |               |                        |                       |
| NPI<br>M012136305   |                         | Claim Status<br>21                  |                |           |                  | Category Code<br>F0                 |             | Entity Identifier Code |               |                        |                       |
| Taxonomy Code   |                         | Status Effective Date<br>06/01/2022 |                |           |                  | Adjudication Date<br>06/01/2022     |             |                        |               |                        |                       |
| <b>Service Line Details Summary</b>   |                         |                                     |                |           |                  |                                     |             |                        |               |                        |                       |
| Line Number   | From/To Dates           | Revenue Code                        | Procedure Code | Modifiers | Units Of Service | Submitted Charge                    | Paid Amount | Status                 | Category Code | Entity Identifier Code | Status Effective Date |
| 1   | 04/01/2022 - 04/01/2022 |                                     | L5673          | NU        | 1                | 600.00                              | 0.00        | 20                     | A2            |                        | 06/01/2022            |

Click on the button below to start a new claim of the last submitted claim type.

New Claim

Finish

NOTE: See Section 6 for additional information

# Why Did Claim Deny?

Home / eProvider / Claim Management

## Claim Status

Claim received.

### Claim Details

Void
 Replacement
 Timely Filing
 Copy Claim
 View Claim Details
 Printer Friendly

| Participant Details             | Claim Data                          | Payment Details                     |
|---------------------------------|-------------------------------------|-------------------------------------|
| Participant Name<br>IMA PATIENT | ICN<br>4922152063741                | Claim Submission Date<br>06/01/2022 |
| Participant DCN<br>01010101     | First Date Of Service<br>04/01/2022 | Last Date of Service<br>04/01/2022  |
|                                 | Claim Type<br>MEDICAL               | Bill Type                           |
|                                 | Total Charges<br>600.00             |                                     |
|                                 |                                     | Total Paid<br>0.00                  |
|                                 |                                     | RA Date                             |
|                                 |                                     | Check Number                        |

| Provider Details     | Claim Status Details                |
|----------------------|-------------------------------------|
| Claim status details | Claim Status<br>21                  |
|                      | Category Code<br>F0                 |
| Taxonomy Code        | Status Effective Date<br>06/01/2022 |
|                      | Adjudication Date<br>06/01/2022     |

### Service Line Details Summary

| Line Number | From/To Dates           | Revenue Code | Procedure Code | Modifiers | Units Of Service | Submitted Charge | Paid Amount | Status | Category Code | Entity Identifier Code | Status Effective Date |
|-------------|-------------------------|--------------|----------------|-----------|------------------|------------------|-------------|--------|---------------|------------------------|-----------------------|
| 1           | 04/01/2022 - 04/01/2022 |              | L5673          | NU        | 1                | 600.00           | 0.00        | 20     | A2            |                        | 06/01/2022            |

Click on the button below to start a new claim of the last submitted claim type.

New Claim
 Finish

Claim status detail and claim category code

Note: Refer to the Washington Publishing Company



# Refer to Washington Publishing Company



This includes most of the external code lists that were previously published on [www.wpc-edi.com/reference](http://www.wpc-edi.com/reference) and [www.x12.org/codes](http://www.x12.org/codes). To purchase code list subscriptions call WPC: (425) 562-2245 or email WPC: [admin@wpc-edi.com](mailto:admin@wpc-edi.com).

10

|                                     |
|-------------------------------------|
| Claim Adjustment Reason Codes       |
| Health Care Claim Status            |
| Health Care Claim Status Category   |
| Health Care Service Decision Reason |
| Provider Taxonomy Codes             |
| Remittance Advice Remark Codes      |

<https://nex12.org/index.php/codes>

# Printer Friendly

claimDetails.pdf1 / 1100%+

MO HealthNet

Medical(CMS1500) Claim Details - ICN: 4922152063741

Billing NPI: M012136305

Claim Header Information

| Participant Information       |                                  |                               |
|-------------------------------|----------------------------------|-------------------------------|
| Participant DCN<br>01010101   | Participant Last Name<br>PATIENT | Participant First Name<br>IMA |
| Patient Account Number<br>123 |                                  |                               |

| Service Information                  |                       |                           |
|--------------------------------------|-----------------------|---------------------------|
| Referring Provider NPI<br>M012174504 | Hospitalization Dates |                           |
| Service Facility Location<br>N       | Service Facility Name | PRTF Certification Number |

| Cause and Diagnosis Details |                           |                         |
|-----------------------------|---------------------------|-------------------------|
| Related Cause Codes<br>0    | Last Menstrual Cycle Date | Diagnosis Codes<br>Z111 |

Claim Service Lines

| Service Line 1  |                                       |                                     |
|---|---------------------------------------|-------------------------------------|
| Dates of Service<br>04/01/2022 To 04/01/2022                    | Place of Service<br>12 - Home         |                                     |
| Procedure Code<br>L5673   | Modifiers<br>NU                       |                                     |
| National Drug Code  | Decimal Quantity<br>0.000             | Prescription Number                 |
| Diagnosis Code<br>Z111  | Billed Charges<br>600.00              | Days/Units Billed<br>1              |
| Conditions<br>N - Emergency<br>N - EPSDT<br>N - Family Planning | Performing Provider NPI<br>M012136305 | Ordering Provider NPI<br>M012174504 |

# Claims Research

**Claim Management**

**NPI**  
M822627402 - MID-AMERICA HOSPICE

New Claim ▾ New Xover Claim ▾

**Claim Search**

☐ ICN **ICN Specific**  
☒ Advanced **Advanced Search: DCN, DOS, Claim type, or status.**  
☐ Daily Claim Summary

Participant DCN  Submitted Charges

Dates of Service  To

Claim Type  
All ▾

Claim Status  
All ▾

Submission Date

☐ Show My Claims Only

Search Clear

Finish

# Claim Status

Claim Status

Void

Replacement

Copy claim

Timely filing

Participant Details

Participant Name  
IMA PATIENT

Participant DCN  
01010101

Claim Submission Date  
12/12/2016

First Date Of Service  
11/01/2016

Last Date of Service  
11/01/2016

Claim Type  
OUTPATIENT

Bill Type  
1

Total Charges  
4,802.40

Payment Details

Total Paid  
0.00

RA Date

Check Number

Provider Details

NPI  
M012136305

Taxonomy Code

Claim Status Details

Claim Status  
33

Status Effective Date  
12/12/2016

Category Code  
F0

Adjudication Date  
12/12/2016

Entity Identifier Code

Service Line Details Summary

| Line Number | From/To Dates           | Revenue Code | Procedure Code | Modifiers | Units Of Service | Submitted Charge | Paid Amount | Status | Category Code | Entity Identifier Code | Status Effective Date |
|-------------|-------------------------|--------------|----------------|-----------|------------------|------------------|-------------|--------|---------------|------------------------|-----------------------|
| 1           | 11/01/2016 - 11/01/2016 | 0651         |                |           | 30               | 4,802.40         | 0.00        | 21     | F2            |                        | 12/12/2016            |

Click on the button below to start a new claim of the last submitted claim type.

New Claim

Finish

Home | Contact | Training | Search Center | Troubleshooting

Missouri Department of  
SOCIAL SERVICES

VERIFY

NOTE: Select appropriate option. See Section 6 for additional information.

# Editing Claim

**Medical(CMS1500) Claim**?-□

**Billing NPI:** M012136305  
BPST

**Claim Header Information**-

**Participant Information**

**Participant DCN \***  
01010101

**Participant Last Name \***  
PATIENT

**Participant First Name \***  
IMA

**Patient Account Number**  
1234

**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 \***  
R112 G43909

Edit Claim Header

Edit claim header

**Add Detail Line**10

**Detail Line Summary**

| Line # | Date of Service         | Place of Service             | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action  |
|--------|-------------------------|------------------------------|----------------|-----------|--------------------|----------------|---|
| 1      | 04/01/2017 - 04/01/2017 | 23 - Emergency Room-Hospital | A0425          |           |                    | 231.00         |   |

**Add Detail Line #2**

**Dates of Service \***  
To

**Place of Service \***

**Procedure Code \***

**Modifiers**

Trash can – delete line detail

# New Claim Status

## Claim Status



✓ Claim received.

i 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

Participant Name  
IMA PATIENT

Participant DCN  
01010101

#### Claim Data

ICN  
4917129056608

New ICN with updated information

First Date Of Service  
04/01/2017

Last Date of Service  
04/01/2017

Claim Type  
MEDICAL

Bill Type

Total Charges  
231.00

#### Payment Details

Total Paid  
0.00

RA Date

Check Number

#### Provider Details

NPI  
M012136305

Taxonomy Code

#### Claim Status Details

Claim Status  
21

Category Code  
F0

Entity Identifier Code

Status Effective Date  
05/09/2017

Adjudication Date  
05/09/2017

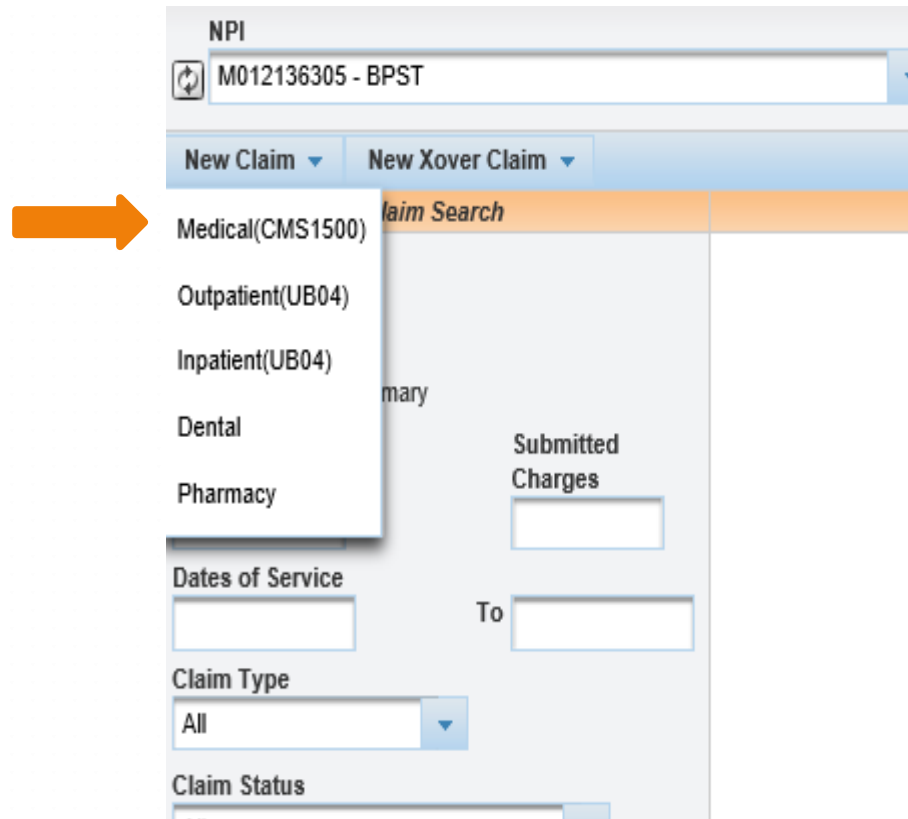
#### Service Line Details Summary

| Line Number | From/To Dates           | Revenue Code | Procedure Code | Modifiers | Units Of Service | Submitted Charge | Paid Amount | Status | Category Code | Entity Identifier Code | Status Effective Date |
|-------------|-------------------------|--------------|----------------|-----------|------------------|------------------|-------------|--------|---------------|------------------------|-----------------------|
| 1           | 04/01/2017 - 04/01/2017 |              | A0425          |           | 22               | 231.00           | 0.00        | 20     | A2            |                        | 05/09/2017            |

Click on the button below to start a new claim of the last submitted claim type

# MO HealthNet + Commercial Insurance

Select CMS-(Medical)1500



The screenshot shows a web interface for submitting claims. At the top, there is a field for 'NPI' with the value 'M012136305 - BPST'. Below this are two tabs: 'New Claim' and 'New Xover Claim'. The 'New Claim' tab is selected, and its dropdown menu is open, showing several options: 'Medical(CMS1500)', 'Outpatient(UB04)', 'Inpatient(UB04)', 'Dental', and 'Pharmacy'. An orange arrow points to the 'Medical(CMS1500)' option. To the right of the dropdown menu, there is a 'Claim Search' section with a 'Submitted Charges' field. Below this is a 'Dates of Service' section with 'From' and 'To' fields. At the bottom, there is a 'Claim Type' dropdown menu with 'All' selected, and a 'Claim Status' section.

# Claim Header

Medical(CMS1500) Claim

Billing NPI: M012136305  
BPST

**Claim Header Information** Enter information as it appears on MHD card

**Participant Information**

|                   |                         |                          |
|-------------------|-------------------------|--------------------------|
| Participant DCN * | Participant Last Name * | Participant First Name * |
| 01010101          | patient                 | ima                      |

Patient Account Number

123 Optional

**Service Information**

|                        |                       |    |
|------------------------|-----------------------|----|
| Referring Provider NPI | Hospitalization Dates |    |
| M012174504 Required    |                       | To |

|                           |                       |                           |
|---------------------------|-----------------------|---------------------------|
| Service Facility Location | Service Facility Name | PRTF Certification Number |
|                           |                       |                           |

**Cause and Diagnosis Details**

|                     |                           |                   |
|---------------------|---------------------------|-------------------|
| Related Cause Codes | Last Menstrual Cycle Date | Diagnosis Codes * |
|                     |                           | Z111              |

Save Claim Header Reset Save claim header Enter ICD10 DX (No decimals)



# Detail Line Summary

**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 * |                                |           |                             |                |        |
| 04/01/2022 To 04/01/2022   |                 | 12 - Home          |                                |           |                             |                |        |
| Procedure Code *   |                 |                    | Modifiers                      |           |                             |                |        |
| L5673  |                 |                    | NU                             |           |                             |                |        |
| National Drug Code   |                 |                    | Decimal Quantity (9999999.999) |           | Prescription Number         |                |        |
|  |                 |                    |                                |           |                             |                |        |
| Diagnosis Code *   |                 |                    | Billed Charges *               |           | Days/Units Billed *         |                |        |
| Z111   |                 |                    | 600.00                         |           | 1                           |                |        |
| Conditions   |                 |                    | Performing Provider NPI        |           | Ordering Provider NPI       |                |        |
| <input type="checkbox"/> Emergency<br><input type="checkbox"/> EPSDT<br><input type="checkbox"/> Family Planning |                 |                    | M012136305                     |           | M012174504                  |                |        |
|  |                 |                    | Enter performing provider NPI  |           | Enter ordering provider NPI |                |        |
| Save Detail Line to Claim  |                 |                    | Reset                          |           |                             |                |        |

Click save detail line to claim

# Add other Payer Information

**Add Detail Line**

| Detail Line Summary |                         |                  |                |           |                    |                | Total Charges : 600.00  |
|---------------------|-------------------------|------------------|----------------|-----------|--------------------|----------------|---|
| Line #              | Date of Service         | Place of Service | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action  |
| 1                   | 04/01/2022 - 04/01/2022 | 12 - Home        | L5673          | NU        |                    | 600.00         |   |

**Add Detail Line #2**

|  |                         |   |                       |
|--|-------------------------|---|-----------------------|
| Dates of Service *   |                         | Place of Service *  |                       |
| <input type="text" value="#####"/>   | To <input type="text"/> | <input type="text"/>  |                       |
| Procedure Code *   |                         | Modifiers   |                       |
| <input type="text"/>   |                         | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |                       |
| National Drug Code   |                         | Decimal Quantity (9999999.999)  | Prescription Number   |
| <input type="text"/>   |                         | <input type="text"/>  | <input type="text"/>  |
| Diagnosis Code *   |                         | Billed Charges *  | Days/Units Billed *   |
| <input type="text" value="Z111"/>  |                         | <input type="text"/>  | <input type="text"/>  |
| Conditions   |                         | Performing Provider NPI   | Ordering Provider NPI |
| <input type="checkbox"/> Emergency<br><input type="checkbox"/> EPSDT<br><input type="checkbox"/> Family Planning |                         | <input type="text"/>  | <input type="text"/>  |

Save Detail Line to Claim

Reset

Other Payers (click to manage)

Click on Other Payers

Invoice of Cost (click to manage)

Certificate of Medical Necessity (click to manage)

Submit Claim

Printer Friendly

Reset

Cancel

# Add EOB Information

Other Payers

Header Summary

| Payer ID | Payer Name | Paid Date | Filing Indicator | Paid Amount | Action |
|----------|------------|-----------|------------------|-------------|--------|
|----------|------------|-----------|------------------|-------------|--------|

Add/Edit Details

Filing Indicator \*

CI - Commercial Insurance Co.

Select filing indicator

Payer Responsibility Sequence Number

P - Primary

Payer responsibility

Other Payer ID \*

1234

Other payer ID

Other Payer Name \*

UMR

Other payer name

Paid Date \*

05/01/2022

Paid date

Paid Amount \*

400.00

Paid amount

Total Denied Amount \*

0.00

Leave blank

Remittance Advice Remark Codes

Leave blank

☐ Payer at Header Level

Save Other Payer Data and Manage Codes

Save other payer data & manage codes

Save Other Payer To Claim

Reset

Invoice of Cost (click to manage)

Certificate of Medical Necessity (click to manage)

Submit Claim

Printer Friendly

Reset

Cancel

**Note:** The Other Payer ID is not a specific number. The provider can put anything in the field. The number must be different if there are multiple other payers.

# Add/Edit Group Code, Reason Code & Adjustment Amount

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

Other Payer Detail Summary

| Select each associated line Item      | Claim Adjustment Reason Code              | Adjustment Amount          | Action                          |
|---------------------------------------|---|----------------------------|---------------------------------|
| <b>Associated Line Items *</b>        |   |                            |                                 |
| <input checked="" type="checkbox"/> 1 | <b>Enter claim adjustment reason Code</b> |                            |                                 |
| <b>Claim Group Code *</b>             | <b>Claim Adjustment Reason Code *</b>     | <b>Adjustment Amount *</b> |                                 |
| CO - Contractual Obligations          | 45  | 150.00                     | <b>Enter adjustment amounts</b> |
| PR - Patient Responsibility           | 1   | 50.00                      |                                 |
|                                       |   |                            |                                 |
|                                       |   |                            |                                 |
|                                       |   |                            |                                 |

Save Codes to Other Payer Reset

Save Other Payer To Claim **Click save codes to other payer**

Invoice of Cost (click to manage) +





Certificate of Medical Necessity (click to manage) +

# Save Other Payer to Claim

Edit Other Payer Info

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  |
|--------------|------------------------------|------------------------------|-------------------|---|
| 1            | CO - Contractual Obligations | 45                           | 150.00            |   |
| 1            | PR - Patient Responsibility  | 1                            | 50.00             |   |

Add / Edit Other Payer Detail Information

Associated Line Items \*

☐ 1

| Claim Group Code *        | Claim Adjustment Reason Code * | Adjustment Amount *  |
|---------------------------|--------------------------------|----------------------|
| <div>- Select One -</div> | <input type="text"/>           | <input type="text"/> |
| <div>- Select One -</div> | <input type="text"/>           | <input type="text"/> |
| <div>- Select One -</div> | <input type="text"/>           | <input type="text"/> |
| <div>- Select One -</div> | <input type="text"/>           | <input type="text"/> |

Save Codes to Other Payer

Reset

Save Other Payer To Claim

Click: save other payer To claim

Invoice of Cost (click to manage)

Certificate of Medical Necessity (click to manage)

Save the Other Payer to Claim to continue.

Submit Claim

Printer Friendly

Reset

Cancel

# Claim Status/Printer Friendly

| Claim Status  |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |
|---|-------------------------|--------------|-------------------------------------|-----------|------------------|-------------------------------------|-------------|--------|------------------------|------------------------|-----------------------|
| <p> Claim received.</p> <p> This claim has a status of K - To Be Denied, therefore some functions are not available.</p>  |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |
| <div style="text-align: center;"><b>Claim Details</b></div> <div style="float: right; background-color: orange; color: white; padding: 5px;">Click: printer friendly</div> <div style="clear: both;"></div>                             |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |
| <div style="display: flex; justify-content: space-between;"> <span> Void</span> <span> Replacement</span> <span> Timely Filing</span> <span> Copy Claim ▾</span> <span> View Claim Details</span> <span> Printer Friendly</span> </div> |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |
| <b>Participant Details</b>  |                         |              | <b>Claim Data</b>                   |           |                  |                                     |             |        | <b>Payment Details</b> |                        |                       |
| Participant Name<br>IMA PATIENT   |                         |              | ICN<br>4917153262184                |           |                  | Claim Submission Date<br>06/02/2017 |             |        | Total Paid<br>0.00     |                        |                       |
| Participant DCN<br>01010101   |                         |              | First Date Of Service<br>05/01/2017 |           |                  | Last Date of Service<br>05/01/2017  |             |        | RA Date                |                        |                       |
|   |                         |              | Claim Type<br>MEDICAL               |           |                  | Bill Type                           |             |        | Check Number           |                        |                       |
|   |                         |              | Total Charges<br>600.00             |           |                  |                                     |             |        |                        |                        |                       |
| <b>Provider Details</b>   |                         |              | <b>Claim Status Details</b>         |           |                  |                                     |             |        |                        |                        |                       |
| NPI<br>M012136305   |                         |              | Claim Status<br>21                  |           |                  | Category Code<br>F0                 |             |        | Entity Identifier Code |                        |                       |
| Taxonomy Code   |                         |              | Status Effective Date<br>06/02/2017 |           |                  | Adjudication Date<br>06/02/2017     |             |        |                        |                        |                       |
| <b>Service Line Details Summary</b>   |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |
| Line Number   | From/To Dates           | Revenue Code | Procedure Code                      | Modifiers | Units Of Service | Submitted Charge                    | Paid Amount | Status | Category Code          | Entity Identifier Code | Status Effective Date |
| 1   | 05/01/2017 - 05/01/2017 |              | L5673                               | NU        | 1                | 600.00                              | 0.00        | 20     | A2                     |                        | 06/02/2017            |
| <p> Click on the button below to start a new claim of the last submitted claim type.</p> <div style="display: flex; gap: 10px;"> <input type="button" value="New Claim"/> <input type="button" value="Finish"/> </div>                  |                         |              |                                     |           |                  |                                     |             |        |                        |                        |                       |

# Printer Friendly EOB Info

MO HealthNet

Medical(CMS1500) Claim Details - ICN: 4917153262184

Billing NPI: M012136305

Shows specific info

## Claim Header Information

| Participant Information               |                                  |                               |
|---------------------------------------|----------------------------------|-------------------------------|
| Participant DCN<br>01010101           | Participant Last Name<br>PATIENT | Participant First Name<br>IMA |
| Patient Account Number<br>123         |                                  |                               |
| Service Information                   |                                  |                               |
| Referring Provider NPI<br>M0202174538 | Hospitalization Dates            |                               |
| Service Facility Location<br>N        | Service Facility Name            |                               |
| Cause and Diagnosis Details           |                                  |                               |
| Related Cause Codes<br>0              | Last Menstrual Cycle Date        | Diagnosis Codes<br>289511     |

## Claim Service Lines

| Service Line 1  |                                       |                        |
|---|---------------------------------------|------------------------|
| Dates of Service<br>05/01/2017 To 05/01/2017                    | Place of Service<br>12 - Home         |                        |
| Procedure Code<br>L5673   | Modifiers<br>NU                       |                        |
| National Drug Code  | Decimal Quantity<br>0.000             | Prescription Number    |
| Diagnosis Code<br>289511  | Billed Charges<br>600.00              | Days/Units Billed<br>1 |
| Conditions<br>N - Emergency<br>N - EPSDT<br>N - Family Planning | Performing Provider NPI<br>M012136305 |                        |

## Service Line Other Payers

| Service Line1 Payer 1 Details                         |   |                                |
|---|---|--------------------------------|
| Filing Indicator<br>Commercial Insurance Co.          | Payer Responsibility Sequence Number<br>Primary |                                |
| Other Payer ID<br>123                                 | Other Payer Name<br>UMR                         | Paid Date<br>05/15/2017        |
| Paid Amount<br>400.00                                 | Total Denied Amount<br>0.00                     | Remittance Advice Remark Codes |
| Group Code, Reason Code, Adjust Amount For This Payer |   |                                |
| Other Payer Codes 1                                   |   |                                |
| Claim Group Code<br>CO - Contractual Obligations      | Claim Adjustment Reason Code<br>45              | Adjustment Amount<br>150.00    |
| Other Payer Codes 2                                   |   |                                |
| Claim Group Code<br>PR - Patient Responsibility       | Claim Adjustment Reason Code<br>1               | Adjustment Amount<br>50.00     |

# MO HealthNet + Medicare B

Select- Medicare CMS-1500 Part B Professional Claim

The screenshot displays the 'Claim Management' web application. At the top, the 'NPI' field is populated with 'M012136305 - BPST'. Below this, there are two tabs: 'New Claim' and 'New Xover Claim'. An orange arrow points to the 'New Claim' tab. A dropdown menu is open from the 'New Claim' tab, listing several claim types: 'Medicare CMS-1500 Part B Professional', 'Medicare CMS-1500 Part C Professional (QMB)', 'Medicare UB-04 Part A Institutional', 'Medicare UB-04 Part C Institutional (QMB)', 'Medicare UB-04 Part B Professional', and 'Medicare UB-04 Part C Professional (QMB)'. The 'Medicare CMS-1500 Part B Professional' option is highlighted. On the left side of the form, there are radio buttons for 'ICN', 'Advanced' (which is selected), and 'Daily Claim S'. Below these are fields for 'Participant DCN', 'Dates of Service' (with '04/01/2022' entered), 'Claim Type' (set to 'All'), 'Claim Status' (set to 'All'), and 'Submission Date'. At the bottom of the form are 'Search' and 'Clear' buttons. A 'Finish' button is located at the very bottom of the interface.

Claim Management

NPI  
M012136305 - BPST

New Claim ▼ New Xover Claim ▼

Medicare CMS-1500 Part B Professional  
Medicare CMS-1500 Part C Professional (QMB)  
Medicare UB-04 Part A Institutional  
Medicare UB-04 Part C Institutional (QMB)  
Medicare UB-04 Part B Professional  
Medicare UB-04 Part C Professional (QMB)

☐ ICN  
☒ Advanced  
☐ Daily Claim S

Participant DCN

Dates of Service  
04/01/2022

Claim Type  
All ▼

Claim Status  
All ▼

Submission Date

☐ Show My Claims Only

Search Clear


Finish



# Claim Header

|                                 |  |  |   |  |  |                          |  |  |
|---------------------------------|--|--|---|--|--|--------------------------|--|--|
| <b>Claim Header Information</b> |  |  | Enter information as it appears on MHD card |  |  |                          |  |  |
| <b>Participant Information</b>  |  |  |   |  |  |                          |  |  |
| Participant DCN *               |  |  | Participant Last Name *                     |  |  | Participant First Name * |  |  |
| 01010101                        |  |  | patient                                     |  |  | ima                      |  |  |
| Patient Account Number          |  |  | Participant Medicare ID (HIC) *             |  |  |                          |  |  |
| 1234                            |  |  | 400000000A                                  |  |  | Enter the Medicare HIC # |  |  |
| <b>Service Information</b>      |  |  |   |  |  |                          |  |  |
| Medicare Provider NPI *         |  |  | Hospitalization Dates                       |  |  |                          |  |  |
| M012136305                      |  |  |   |  |  | To                       |  |  |
| <b>Diagnosis Codes</b>          |  |  |   |  |  |                          |  |  |
| Diagnosis Codes *               |  |  | Enter ICD10 DX (no decimals)                |  |  |                          |  |  |
| M05441                          |  |  |   |  |  |                          |  |  |
| Save Claim Header               |  |  | Reset                                       |  |  |                          |  |  |

Save claim header

 Save claim header to continue.

Submit Claim

Printer Friendly

Reset

Cancel

# Claim Detail Line

**Add Detail Line**

**Detail Line Summary**

| Line # | Date of Service | Place of Service | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action |
|--------|-----------------|------------------|----------------|-----------|--------------------|----------------|--------|
|--------|-----------------|------------------|----------------|-----------|--------------------|----------------|--------|

**Add Detail Line**

**Dates of Service**  
05/01/2017 To 05/01/2017 Enter date of service

**Place of Service \***  
12 - Home Enter place of service

**Procedure Code \***  
L0631 Enter procedure code

**Modifiers**  
    Enter modifier(s)

**National Drug Code**

**Decimal Quantity (9999999.999)**

**Diagnosis Code \***  
M05441 Enter diagnosis code(s)

**Billed Charges \***  
125.00 Enter usual & customary charges

**Days/Units Billed \***  
1 Enter days/units

**Paid Amount**  
100.00 Enter paid amount

**Performing Provider NPI**  
M012136305 Enter performing provider NPI

**Save Detail Line to Claim to continue.**

**Click save detail line to claim**

**Submit Claim** **Printer Friendly** **Reset** **Cancel**

# Add EOB Info

**Other Payers**

**Header Summary**

| Payer ID | Payer Name | Paid Date | Filing Indicator | Paid Amount | Action |
|----------|------------|-----------|------------------|-------------|--------|
|----------|------------|-----------|------------------|-------------|--------|

**Add/Edit Details**

Filing Indicator \*  
MB-Medicare

Select filing indicator

Payer Responsibility Sequence Number \*  
P - Primary

Payer responsibility

Other Payer ID \*  
1234

\*Other payer ID

Other Payer Name \*  
Medicare B

Other payer name

Paid Date \*  
05/15/2017

Paid date

Paid Amount \*  
100.00

Paid amount

Total Denied Amount \*  
0.00

Leave blank

Remittance Advice Remark Codes

Leave blank

☐ Payer at Header Level

Save Other Payer Data and Manage Codes

Save other payer data & manage codes

Save Other Payer To Claim

Reset

Submit Claim

Printer Friendly

Reset

Cancel

**Note:** The Other Payer ID is not a specific number. The provider can put anything in the field. The number must be different if there are multiple other payers.

# Add/Edit Group Code, Reason Code & Adjust Amount

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 |
|--------------|------------------|------------------------------|-------------------|
|--------------|------------------|------------------------------|-------------------|

**Add / Edit Other Payer Detail Information**


Associated Line Items \*

☒ 1 Select each associated line Item Enter adjustment amounts

| Claim Group Code *           | Claim Adjustment Reason Code *                  | Adjustment Amount * |
|------------------------------|---|---------------------|
| CO - Contractual Obligations | 45  | 10.00               |
| PR - Patient Responsibility  | <span>Enter claim adjustment reason Code</span> | 15.00               |
| - Select One -               |   |                     |
|                              |   |                     |



Select each claim group code

Click save codes to other payer

 Save Codes to Other Payer to continue.

# Submit Claim

**Add Detail Line**

| Detail Line Summary |                         |                  |                |           |                    |                | Total Charges : 100.00  |
|---------------------|-------------------------|------------------|----------------|-----------|--------------------|----------------|---|
| Line #              | Date of Service         | Place of Service | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action  |
| 1                   | 03/01/2020 - 03/01/2020 | 12 - Home        | L5673          | NU        |                    | 100.00         |   |

**Add Detail Line #2**

Dates of Service \*  
##### x To

Place of Service \*

Procedure Code \*

Modifiers

National Drug Code

Decimal Quantity (9999999.999)

Prescription Number

Diagnosis Code \*  
Z891

Billed Charges \*

Days/Units Billed \*


Conditions  
☐ Emergency  
☐ EPSDT  
☐ Family Planning


Performing Provider NPI


Ordering Provider NPI

Save Detail Line to Claim

Reset

**Other Payers** (click to manage) 

**Invoice of Cost** (click to manage) 

**Certificate of Medical Necessity** (click to manage) 

Submit Claim

Printer Friendly

Reset

Cancel

Click: Submit Claim

# Claim Status

## Claim Status



✓ Claim received.

### Claim Details

Void Replacement Timely Filing Copy Claim View Claim Details Printer Friendly

| Participant Details             |                         | Claim Data                          |                |                                     |                  | Payment Details        |             |        |               |                        |                       |
|---------------------------------|-------------------------|-------------------------------------|----------------|-------------------------------------|------------------|------------------------|-------------|--------|---------------|------------------------|-----------------------|
| Participant Name<br>IMA PATIENT |                         | ICN<br>4920140045839                |                | Claim Submission Date<br>05/19/2020 |                  | Total Paid<br>0.00     |             |        |               |                        |                       |
| Participant DCN<br>01010101     |                         | First Date Of Service<br>03/01/2020 |                | Last Date of Service<br>03/01/2020  |                  | RA Date                |             |        |               |                        |                       |
|                                 |                         | Claim Type<br>MEDICAL               |                | Bill Type                           |                  | Check Number           |             |        |               |                        |                       |
|                                 |                         | Total Charges<br>100.00             |                |                                     |                  |                        |             |        |               |                        |                       |
| Provider Details                |                         | Claim Status Details                |                |                                     |                  |                        |             |        |               |                        |                       |
| NPI<br>M012136305               |                         | Claim Status<br>21                  |                | Category Code<br>F0                 |                  | Entity Identifier Code |             |        |               |                        |                       |
| Taxonomy Code                   |                         | Status Effective Date<br>05/19/2020 |                | Adjudication Date<br>05/19/2020     |                  |                        |             |        |               |                        |                       |
| Service Line Details Summary    |                         |                                     |                |                                     |                  |                        |             |        |               |                        |                       |
| Line Number                     | From/To Dates           | Revenue Code                        | Procedure Code | Modifiers                           | Units Of Service | Submitted Charge       | Paid Amount | Status | Category Code | Entity Identifier Code | Status Effective Date |
| 1                               | 03/01/2020 - 03/01/2020 |                                     | L5673          | NU                                  | 1                | 100.00                 | 0.00        | 20     | A2            |                        | 05/19/2020            |

Click on the button below to start a new claim of the last submitted claim type.

New Claim

Finish

# Medicare Part C + QMB vs. Non-QMB

## Helpful Hints:

- Medicare Advantage/Part C plans do NOT forward electronic crossover claims to MHD
- Part C + QMB= Crossover CMS-1500 Part C Professional Claim

(Filing Indicator 16 Health Maintenance Org Medicare Risk)

- Part C Non-QMB= CMS-1500 (Not a Crossover form )

(Filing Indicator (16) Health Maintenance Org Medicare Risk)



# Medicare Part C + QMB

Select- Medicare CMS-1500 Part C Professional (**QMB**) Claim

The screenshot displays the 'Claim Management' window. At the top, the NPI is listed as 'M012136305 - BPST'. Below this, there are two tabs: 'New Claim' and 'New Xover Claim'. The 'New Claim' tab is active, and a dropdown menu is open, showing a list of claim types. An orange arrow points to the 'Medicare CMS-1500 Part C Professional (QMB)' option. Other options in the list include 'Medicare CMS-1500 Part B Professional', 'Medicare UB-04 Part A Institutional', 'Medicare UB-04 Part C Institutional (QMB)', 'Medicare UB-04 Part B Professional', and 'Medicare UB-04 Part C Professional (QMB)'. Below the dropdown, there are fields for 'Participant DCN', 'Dates of Service' (with '04/01/2022' entered), 'Claim Type' (set to 'All'), 'Claim Status' (set to 'All'), and 'Submission Date'. There is also a checkbox for 'Show My Claims Only' and 'Search' and 'Clear' buttons at the bottom. A 'Finish' button is located at the very bottom of the window.

Claim Management

NPI  
M012136305 - BPST

New Claim ▼ New Xover Claim ▼

☐ Medicare CMS-1500 Part B Professional  
☒ Medicare CMS-1500 Part C Professional (QMB)  
☐ Medicare UB-04 Part A Institutional  
☐ Medicare UB-04 Part C Institutional (QMB)  
☐ Medicare UB-04 Part B Professional  
☐ Medicare UB-04 Part C Professional (QMB)

Participant DCN

Dates of Service  
04/01/2022

Claim Type  
All ▼

Claim Status  
All ▼

Submission Date

☐ Show My Claims Only

Search Clear

Finish



# Claim Header

| Claim Header Information                    |                                 |                              |
|---|---------------------------------|------------------------------|
| Enter information as it appears on MHD card |                                 |                              |
| Participant Information                     |                                 |                              |
| Participant DCN *                           | Participant Last Name *         | Participant First Name *     |
| 01010101                                    | patient                         | ima                          |
| Patient Account Number                      | Participant Medicare ID (HIC) * |                              |
| 1234  | 400000000A                      | Enter the Medicare HIC #     |
| Optional                                    |                                 |                              |
| Service Information                         |                                 |                              |
| Medicare Provider NPI *                     | Hospitalization Dates           |                              |
| M012136305                                  | To                              |                              |
| Required                                    |                                 |                              |
| Diagnosis Codes                             |                                 |                              |
| Diagnosis Codes *                           |                                 |                              |
| M05441                                      |                                 | Enter ICD10 DX (no decimals) |
| Save Claim Header                           |                                 |                              |
| Reset                                       |                                 |                              |

Save claim header

Save claim header to continue.

Submit Claim

Printer Friendly

Reset

Cancel

# Claim Detail Line 1

| Editing Detail Line #1             |  |  |  |
|------------------------------------|--|--|--|
| Dates of Service *                 |  | Place of Service *                     |  |
| 01/01/2020 x Enter date of service |  | 12 - Home Enter place of service       |  |
| Procedure Code *                   |  | Modifiers                              |  |
| E0130 Enter procedure code         |  | NU Enter modifier(s)                   |  |
| National Drug Code                 |  | Decimal Quantity (9999999.999)         |  |
|                                    |  |  |  |
| Diagnosis Code *                   |  | Billed Charges *                       |  |
| Z334 Enter diagnosis code(s)       |  | 100.00 Enter usual & customary charges |  |
| Paid Amount *                      |  | Days/Units Billed *                    |  |
| 75.00 Enter paid amount            |  | 1 Enter days/units                     |  |
| Performing Provider                |  | Ordering Provider NPI                  |  |
| M012136305                         |  | M202174538                             |  |
| Save Detail Line to Claim Cancel   |  |  |  |

Click save detail line to claim

# Claim Detail Line 2

| Editing Detail Line #2                                     |                                       |                       |
|--|---------------------------------------|-----------------------|
| Dates of Service *   | Place of Service *                    |                       |
| 01/01/2020 x Enter date of service                         | 12 - Home Enter place of service      |                       |
| Procedure Code *   | Modifiers                             |                       |
| E0163 Enter procedure code                                 | NU Enter modifier(s)                  |                       |
| National Drug Code   | Decimal Quantity (9999999.999)        |                       |
|  |                                       |                       |
| Diagnosis Code *   | Billed Charges *                      | Days/Units Billed *   |
| Z334 Enter diagnosis code(s)                               | 50.00 Enter usual & customary charges | 1 Enter days/units    |
| Paid Amount *  | Performing Prov                       | Ordering Provider NPI |
| 30.00 Enter paid amount                                    | M012136305                            | M202174538            |
| Save Detail Line to Claim Cancel Save detail line to claim |                                       |                       |





Other Reverses

# Detail Lines

Edit Claim Header

## Add Detail Line

### Detail Line Summary

| Line # | Date of Service         | Place of Service | Procedure Code | Modifiers | National Drug Code | Billed Charges | Action  |
|--------|-------------------------|------------------|----------------|-----------|--------------------|----------------|---|
| 1      | 01/01/2020 - 01/01/2020 | 12 - Home        | E0130          | NU        |                    | 100.00         |   |
| 2      | 01/01/2020 - 01/01/2020 | 12 - Home        | E0163          | NU        |                    | 50.00          |   |

### Add Detail Line #3

Dates of Service \*

To

Place of Service \*

Procedure Code \*

Modifiers

# Other Payer

| 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 *  |        |  |
| 16-Medicare Part C Professional (QMB)          |            |                       |                  | P - Primary   |        |  |
| Other Payer ID *                               |            | Other Payer Name *    |                  | Paid Date *   |        |  |
| 1  |            | United health Care    |                  | 01/20/2020  |        |  |
| Paid Amount *                                  |            | Total Denied Amount * |                  | Remittance Advice Remark Codes  |        |  |
| 105.00 ×                                       |            | 0.00                  |                  | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |        |  |
| <input type="checkbox"/> PAYER AT HEADER LEVEL |            |                       |                  |   |        |  |
| Save Other Payer Data and Manage Codes         |            |                       |                  |   |        |  |
| Save other payer data and manage codes         |            |                       |                  |   |        |  |
| Save Other Payer To Claim    Reset             |            |                       |                  |   |        |  |

# Add/Edit Group Code, Reason Code & Adjust Amount

**Edit Other Payer Info**

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 |
| Add / Edit Other Payer Detail Information  |                                |                              |                   |        |
| Associated Line Items *  |                                |                              |                   |        |
| <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <div>Select each associated line Item</div> |                                |                              |                   |        |
| Claim Group Code   | Claim Adjustment Reason Code * | Adjustment Amount *          |                   |        |
| CO - Contractual Obligations   | 45                             | 15.00                        |                   |        |
| PR - Patient Responsibility  | 2                              | 10.00 x                      |                   |        |
| - Select One -   |                                |                              |                   |        |
| - Select One -   |                                |                              |                   |        |
| <div>Save Codes to Other Payer</div> <div>Save Codes to Other Payer</div>                                    |                                |                              |                   |        |

Save Other Payer To Claim

Reset

# Add/Edit Group Code, Reason Code & Adjust Amount

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  |
|--------------|------------------------------|------------------------------|-------------------|---|
| 1            | CO - Contractual Obligations | 45                           | 15.00             |   |
| 1            | PR - Patient Responsibility  | 2                            | 10.00             |   |

## Add / Edit Other Payer Detail Information

Associated Line Items \*

☐ 1 ☒ 2

Select each associated line Item

| Claim Group Code             | Claim Adjustment Reason Code * | Adjustment Amount *  |
|------------------------------|--------------------------------|--|
| CO - Contractual Obligations | 45                             | 15.00  |
| PR - Patient Responsibility  | 2                              | 5.00  |
| - Select One -               |                                |  |
| - Select One -               |                                |  |

Save Codes to Other Payer

Res

Save Codes to Other Payer

# Other Payer Info

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  |
|--------------|------------------------------|------------------------------|-------------------|---|
| 1            | CO - Contractual Obligations | 45                           | 15.00             |   |
| 1            | PR - Patient Responsibility  | 2                            | 10.00             |   |
| 2            | CO - Contractual Obligations | 45                           | 15.00             |   |
| 2            | PR - Patient Responsibility  | 2                            | 5.00              |   |

## Add / Edit Other Payer Detail Information

Associated Line Items \*

☐ 1 ☐ 2

Claim Group Code \*

- Select One -

Claim Adjustment Reason Code \*

Adjustment Amount \*

- Select One -

- Select One -

- Select One -

Save Codes to Other Payer

Reset

Save Other Payer To Claim

Cancel

Save Other Payer to Claim





# Other Payer Info

[Save Detail Line to Claim](#) [Reset](#)

**Other Payers**

**Header Summary**

| Payer ID | Payer Name         | Paid Date  | Filing Indicator                      | Paid Amount | Action  |
|----------|--------------------|------------|---------------------------------------|-------------|---|
| 1        | United health Care | 01/20/2020 | 16-Medicare Part C Professional (QMB) | 105.00      |   |

**Add/Edit Details**

Filing Indicator \*

Payer Responsibility Sequence Number \*

Other Payer ID \*

Other Payer Name \*

Paid Date \*

Paid Amount \*  
0.00

Total Denied Amount \*  
0.00

Remittance Advice Remark Codes

☐ **PAYER AT HEADER LEVEL**

[Save Other Payer Data and Manage Codes](#)

[Save Other Payer To Claim](#) [Reset](#)

[Submit Claim](#)

[Submit Claim](#) [Printer Friendly](#) [Reset](#) [Cancel](#)

# Claim Status Screen

✔ Claim received.

| Claim Details   |                         |                                     |                |           |                                     |                  |             |                        |               |                        |                       |
|---|-------------------------|-------------------------------------|----------------|-----------|-------------------------------------|------------------|-------------|------------------------|---------------|------------------------|-----------------------|
| <a href="#">Void</a> <a href="#">Replacement</a> <a href="#">Timely Filing</a> <a href="#">Copy Claim</a> <a href="#">View Claim Details</a> <a href="#">Printer Friendly</a> |                         |                                     |                |           |                                     |                  |             |                        |               |                        |                       |
| <b>Participant Details</b>  |                         | <b>Claim Data</b>                   |                |           |                                     |                  |             | <b>Payment Details</b> |               |                        |                       |
| Participant Name<br>IMA PATIENT   |                         | ICN<br>4920121059431                |                |           | Claim Submission Date<br>04/30/2020 |                  |             | Total Paid<br>0.00     |               |                        |                       |
| Participant DCN<br>01010101   |                         | First Date Of Service<br>01/01/2020 |                |           | Last Date of Service<br>01/01/2020  |                  |             | RA Date                |               |                        |                       |
|   |                         | Claim Type<br>CROSSOVER             |                |           | Bill Type<br>5                      |                  |             | Check Number           |               |                        |                       |
|   |                         | Total Charges<br>15.00              |                |           |                                     |                  |             |                        |               |                        |                       |
| <b>Provider Details</b>   |                         | <b>Claim Status Details</b>         |                |           |                                     |                  |             |                        |               |                        |                       |
| NPI<br>M012136305   |                         | Claim Status<br>33                  |                |           | Category Code<br>F0                 |                  |             | Entity Identifier Code |               |                        |                       |
| Taxonomy Code   |                         | Status Effective Date<br>04/30/2020 |                |           | Adjudication Date<br>04/30/2020     |                  |             |                        |               |                        |                       |
| <b>Service Line Details Summary</b>   |                         |                                     |                |           |                                     |                  |             |                        |               |                        |                       |
| Line Number   | From/To Dates           | Revenue Code                        | Procedure Code | Modifiers | Units Of Service                    | Submitted Charge | Paid Amount | Status                 | Category Code | Entity Identifier Code | Status Effective Date |
| 1   | 01/01/2020 - 01/01/2020 |                                     | E0130          | NU        | 1                                   | 10.00            | 0.00        | 255                    | F2            |                        | 04/30/2020            |
| 2   | 01/01/2020 - 01/01/2020 |                                     | E0163          | NU        | 1                                   | 5.00             | 0.00        | 255                    | F2            |                        | 04/30/2020            |

[Click on the button below to start a new claim of the last submitted claim type.](#)

# Printer Friendly

MO HealthNet

## Medicare CMS-1500 Part C Professional (QMB) Claim Details - ICN: 4920121059431

Billing NPI: M012136305

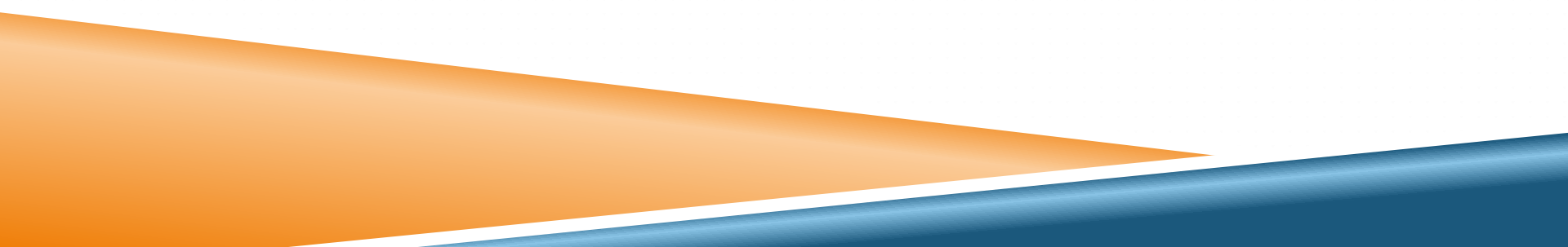
### Claim Header Information

| Participant Information             |   |                                      |
|-------------------------------------|---|--------------------------------------|
| Participant DCN<br>01010101         | Participant Last Name<br>PATIENT        | Participant First Name<br>IMA        |
| Patient Account Number              | Participant Medicare ID<br>40000000000A |                                      |
| Service Information                 |   |                                      |
| Medicare Provider NPI<br>M012136305 | Hospitalization Dates                   | Referring Provider NPI<br>M202174538 |
| Diagnosis Codes                     |   |                                      |
| Diagnosis Codes<br>Z334             |   |                                      |

### Claim Service Lines

| Service Line 1                              |  |                                     |
|---|--|-------------------------------------|
| Date of Service<br>01/01/2020 To 01/01/2020 | Place of Service<br>12 - Home          |                                     |
| Procedure Code<br>E0130                     | Modifiers<br>NU                        |                                     |
| National Drug Code                          | Decimal Quantity (999999.999)<br>0.000 |                                     |
| Diagnosis Code<br>Z334                      | Billed Charges<br>100.00               | Days/Units Billed<br>1              |
| Paid Amount<br>75.00                        | Performing Provider NPI<br>M012136305  | Ordering Provider NPI<br>M202174538 |
| Service Line 2                              |  |                                     |
| Date of Service<br>01/01/2020 To 01/01/2020 | Place of Service<br>12 - Home          |                                     |
| Procedure Code<br>E0163                     | Modifiers<br>NU                        |                                     |
| National Drug Code                          | Decimal Quantity (999999.999)<br>0.000 |                                     |
| Diagnosis Code<br>Z334                      | Billed Charges<br>50.00                | Days/Units Billed<br>1              |
| Paid Amount<br>30.00                        | Performing Provider NPI<br>M012136305  | Ordering Provider NPI<br>M202174538 |

# Resources and Contact Information

- Technical Help Desk
  - Provider Communication Unit
  - Participant Resources
  - Constituent Education
  - Pharmacy and Clinical Services
  - Pharmacy & Medical Pre-cert Help Desk
  - MHD Services and Programs
  - CyberAccess
  - MMAC
  - Provider Enrollment
- 

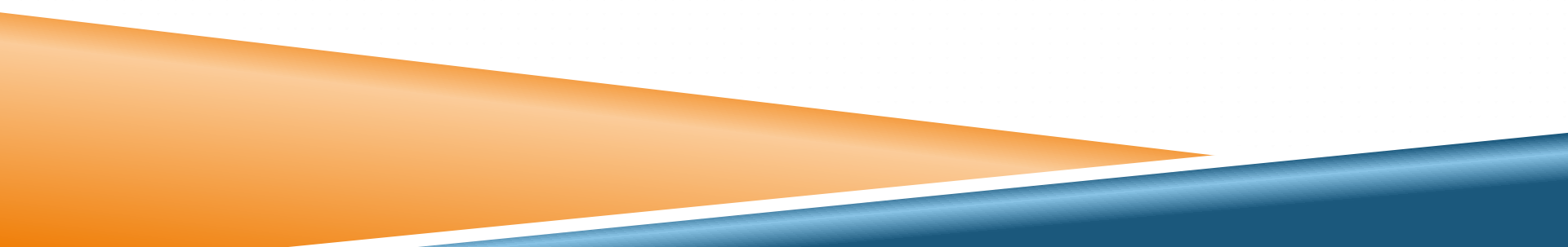
# Technical Help Desk

Technical support and assistance for issues with eMOMED.com

Establish required electronic claims and RA formats, network communication, HIPAA trading partner agreements

MHD Help Desk, (573) 635-3559

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

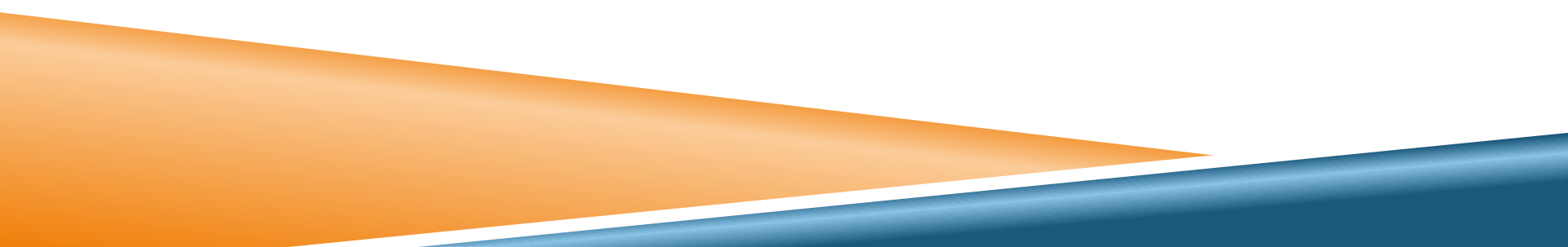


# Provider Communications Unit

## Providers' Initial Contact

Contact with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

Provider Communications Unit  
PO Box 5500  
Jefferson City, MO 65102-2500  
(573) 751-2896



# Participant Resources

Questions regarding MHD eligibility benefits and application process

Website address: [www.mydss.mo.gov](http://www.mydss.mo.gov)

Contact by phone: (855) 373-9994

Family Support Division Info Center 1-855-FSD-INFO. (855-600-4412)



# Education and Training Unit

Education and Training Unit

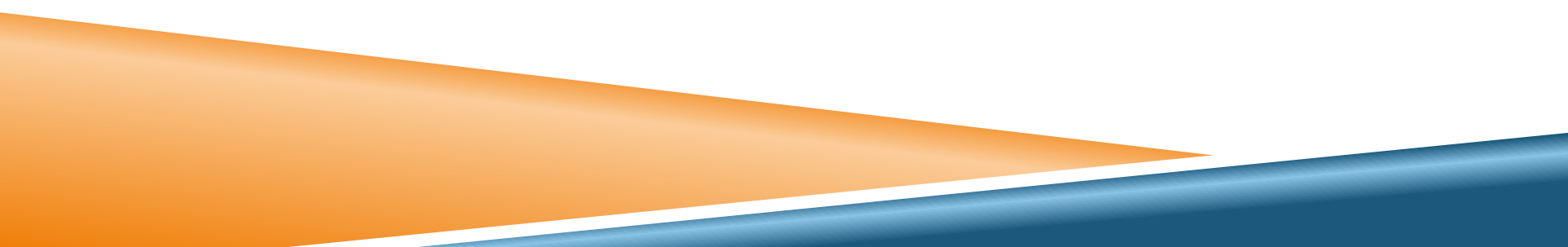
(573) 751-6683 or

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

Inquiries regarding education and training.

Register for Training Today

<http://dss.mo.gov/mhd/providers/education>



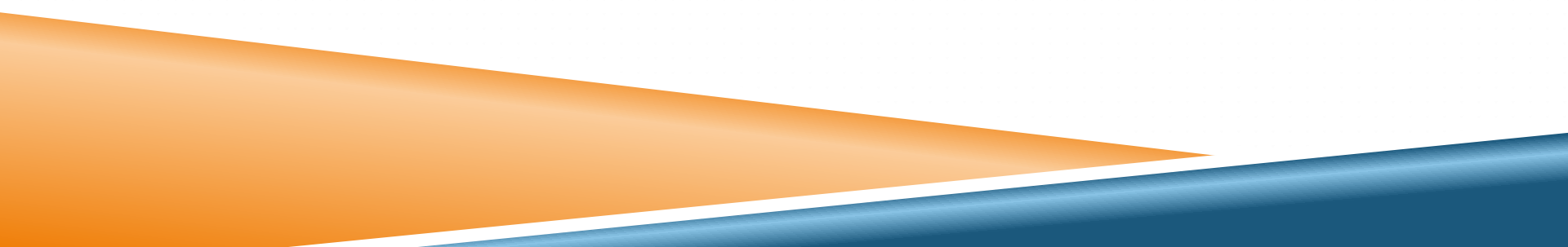


# Clinical Services

(573) 751-6963 or

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

Policy development, benefit design, coverage decisions,  
provider and program policy inquiries



# Pharmacy & Medical Pre-Certification Help Desk

Call: 800-392-8030

Pharmacy Clinical Authorizations, Edit Overrides, medical Pre-Certifications (outpatient, diagnostic, non-emergency MRI, MRA, CT, CTA, PET scans and cardiac imaging)

Pre-Certification for certain radiological procedures listed at:

<https://portal.healthhelp.com/mohealthnet>

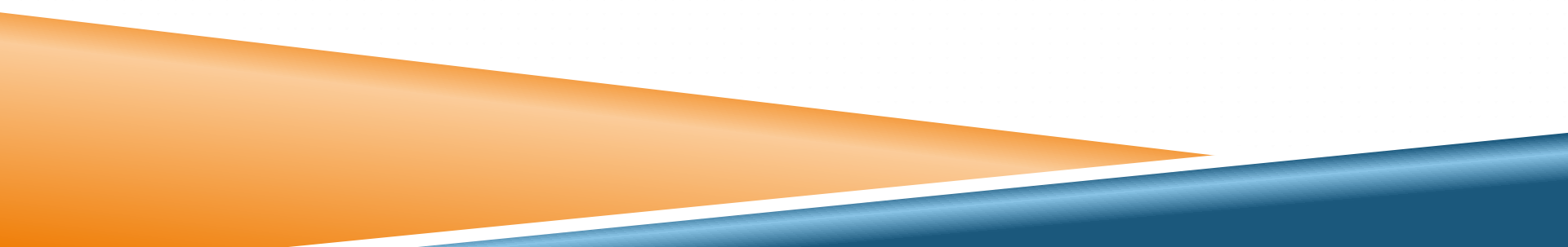


# MHD Services & Programs

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

Inquiries regarding programs and policies that cannot be answered by any other contact information.

Please provide NPI, name and contact information, and complete details regarding inquiry.



# Provider Manuals

Provider Manual Webpage:

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

Physician Manual:

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

Hospital Manual:

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



# Provider Bulletins and Hot Tips

Provider Bulletin Webpage:

<http://dss.mo.gov/mhd/providers/pages/bulletins.htm>

Hot Tips Webpage:

<http://dss.mo.gov/mhd/providers/pages/provtips.htm>

