

# **Medicare Part C NON ~ QMB claim filing**

# eMOMED Electronic Claim Filing

- Medicare Part C
  - How do Medicare/Medicaid payments work
- Participant Eligibility
- Claim Management
  - Choosing the Correct Claim Form
  - Help Information
  - Medicare Part C~ Non QMB Claim Form
- Adjusting Claims
  - Void
  - Copy Claim Original/Advanced
  - Replacement
- Provider Communications Management
- File Management

# Medicare Part C

October 19, 2009

Confusion exists among providers in determining which MO HealthNet Division (MHD) claim form to complete to be reimbursed for co-insurance and deductible amounts for those Medicare/MO HealthNet participants with Part C coverage. Claims for participants with Part C coverage do not cross over automatically from the Medicare Part C Plans. As a result, providers must file claims through the **MO HealthNet Web portal**. Choose from the appropriate claim options shown below.

If the participant is enrolled in a Medicare Advantage/Part C Plan and **is not QMB eligible**, you must submit your claim on one of the following:

- The Inpatient UB-04 for room and board. You must show the Part C information on the header screen. Choose filing indicator '16' (Health Maint Org Medicare Risk). **Inpatient claims require pre-certification through Conduent;** or
- The Outpatient UB-04 for outpatient professional services. Show the Part C information on the header and line detail screens. Choose filing indicator '16' (Health Maint Org Medicare Risk); or
- The Medical (CMS-1500) claim form for professional services. Show the Part C information on the header and line detail. Choose filing indicator '16' (Health Maint Org Medicare Risk).

Reminder – For non QMB participants enrolled in a Medicare Advantage/Part C Plan, MHD will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the **MHD provider manuals**. In accordance with this policy, the amount paid by MHD is the difference between the MHD allowable amount and the amount paid by the third party resource.

MHD guidelines and policies regarding attachments and prior authorization must be followed for participants, including Medicare Part C non-QMB participants. If the procedure billed requires an attachment (Certificate of Medical Necessity, Second Surgical Opinion, Sterilization Consent, etc.), you must have a completed, approved form on file. If the procedure requires prior authorization, you must have an approved prior authorization from MHD on file.

# How do Medicare/Medicaid payments work?

## **MO HealthNet with Medicare Part B-**

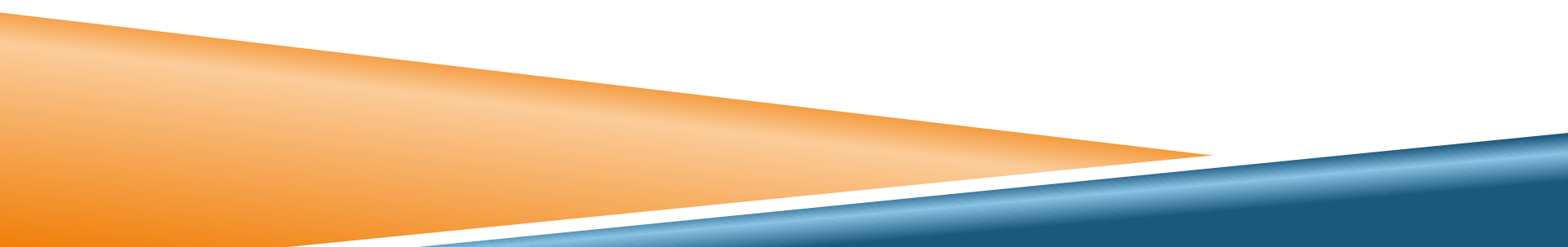
MO HealthNet will pay coins insurance and deductible for Medicare **covered** services.  
(Crossover claim Part B- claim should crossover to Medicaid automatically)  
If Medicare doesn't cover the service it can be billed on a CMS-1500 and paid up to the allowable. (Report Medicare RA/EOB information on the claim)

## **MO HealthNet with Medicare Part C with QMB-**

MO HealthNet will pay coins insurance and deductible for Medicare **covered** services.  
(Crossover claim Part C QMB -claim won't crossover automatically)  
If Medicare doesn't cover the service it can be billed on a CMS-1500 and paid up to the allowable. (Report Medicare/part C RA/EOB information on the claim)

## **MO HealthNet with Medicare Part C non-QMB-**

MO HealthNet won't pay coinsurance and deductible for Medicare covered services. (Bill on a Medical CMS-1500 and report Part C AR/EOB)  
MO HealthNet will pay up to the allowable on MO HealthNet covered codes.



## External Links


State of Missouri Web site  
Department of Social Services  
MO HealthNet Division

- [Provider Information](#)
- [Provider Enrollment Application](#)
- [Participant Information](#)












## eProvider News

**07/17/2019****eMOMED Training and Assistance Utilities****03/25/2015****Removing a User's Access to an NPI****03/24/2015****Requesting & Allowing NPI Access**

## eProvider Welcome

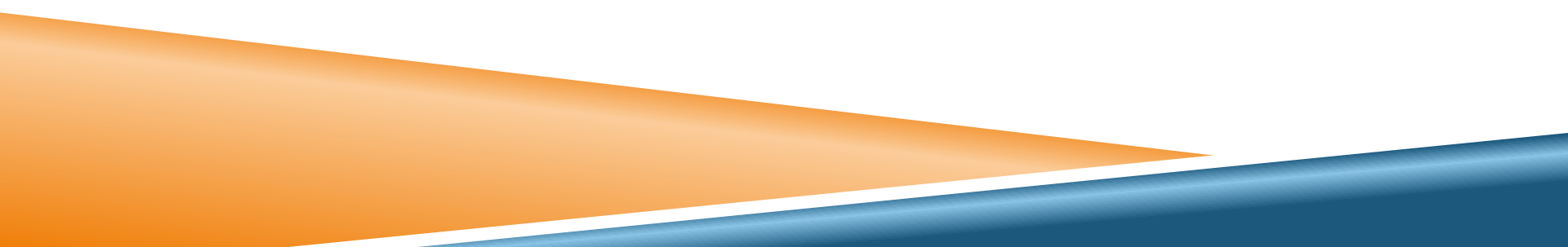


## Welcome to eProvider

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

**Click on Participant Eligibility** ~ This is the first thing you should do before rendering services on a participant. Here you will be able to view if participant has Medicaid eligibility, ME code, enrolled in Managed Care Plan (MCO)

# Participant Eligibility Screen


- It is the provider's responsibility to verify eligibility
  - Participant Eligibility should be checked/verified prior to appointment or shortly after.
  - Interactive Voice Response (IVR) (573) 751-2896
  - Determining Eligibility PowerPoint  
<http://dss.mo.gov/mhd/providers/education/avtrain.htm>
  - Provider responsibility to verify eligibility on the date services are rendered
- 



If you bill for more than one Provider, you ***MUST*** make sure you have the correct Provider NPI you are billing under. This way if a claim would deny, for an eligibility issue, Provider Communications will always check to see if the provider verified eligibility

This will benefit the provider in case we have to special handle a claim.


# Participant Eligibility Screen

MoHealth Net Home Contact Search Center Troubleshooting  


eProvider ePassport eMMIS MMIS Apps Welcome, JACQUELINE Log Out


Home / eProvider / Eligibility

### Eligibility Request

NPI \*  Provider Name  
NPI is invalid. 

#### Search

First Date Of Service * <input type="text"/> 	Last Date of Service <input type="text"/>	
Participant DCN <input type="text"/>	Participant SSN <input type="text"/>	Participant Date of Birth <input type="text"/>
Participant Last Name <input type="text"/>	Participant First Name <input type="text"/>	Participant Middle Initial <input type="text"/>
Casehead DCN <input type="text"/>	Child's Date of Birth <input type="text"/>	Service Type Code <input type="text"/>

Home Contact | Search Center | Troubleshooting 

# Participant Eligibility Screen Cont'd

Provider: ePassport | eMMIS | MMIS Apps | Welcome, JACQUELINE | Log Out

Home / eProvider / Eligibility

### Eligibility Response

NP: [REDACTED]

---

#### Submitted Information

First Date Of Service 08/12/2019		
Participant DCN [REDACTED]		

---

#### Participant Information

Participant DCN [REDACTED]	Participant Name [REDACTED]	Participant Date of Birth [REDACTED]
Participant Address [REDACTED]	Participant SSN [REDACTED]	Participant Date Of Death [REDACTED]

---

#### Eligibility / Benefit Information 1 of 2

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
1 - Active Coverage	30 - Health Benefit Plan Coverage	13	34 - Month		MC - MO HealthNet	291		08/12/2019 08/12/2019

---

#### Eligibility / Benefit Information 2 of 2

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
1 - Active Coverage	1 - Medical Care 33 - Chiropractic 35 - Dental Care 47 - Hospital 48 - Hospital - Inpatient 50 - Hospital - Outpatient 88 - Emergency Services 88 - Pharmacy 98 - Professional (Physician) Visit - Office AL - Vision (Optometry) MH - Mental Health UC - Urgent Care	13	34 - Month		MC - MO HealthNet	291		08/12/2019 08/12/2019

---

#### Reference Information

Confirmation Number 19224307732
------------------------------------

**Print** **Finish**

Be sure to write the confirmation number down or print out and keep in the participant file for your records.

# Claim Management

- Choosing the Correct Claim Form
- Help Information
- Medicare Part C Non ~ QMB Crossover Claim



# Choosing the correct claim form

The screenshot shows a web interface titled "Claim Management". At the top, there is a section for "NPI \*" and "Provider Name" with a message "NPI is invalid." Below this, there are two tabs: "New Claim" (selected) and "New Xover Claim". A dropdown menu is open under "New Claim", listing several claim types: "Medical(CMS1500)", "Outpatient(UB04)", "Inpatient(UB04)", "Dental", "Pharmacy", and "Nurse Assistant Training". Below the dropdown, there is a "Dates of Service" section with two input fields labeled "From" and "To".

Click on New Claim and click on the appropriate claim form.




This claim is for a **Medicare Part C Non-QMB** claim that does not crossover from Medicare. This is the provider's responsibility to submit through eMOMED.

? = HELP


 [Home](#) [Contact](#) [Search Center](#) [Troubleshooting](#)  

[eProvider](#) [ePassport](#) Welcome, Dana [Log Out](#)

[Home](#) / [eProvider](#) / [Claim Management](#)

**Medical(CMS1500) Claim**   

Billing NPI: M012136305  
BPST

**Claim Header Information** 

**Participant Information**

Participant DCN *	Participant Last Name *	Participant First Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient Account Number		
<input type="text"/>		


**Service Information**

Referring Provider NPI	Hospitalization Dates	
<input type="text"/>	<input type="text"/> To <input type="text"/>	
Service Facility Location	Service Facility Name	
<input type="text"/>	<input type="text"/>	

**Cause and Diagnosis Details**

Related Cause Codes	Last Menstrual Cycle Date	Diagnosis Codes *
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

[Save Claim Header](#) [Reset](#)

 Save claim header to continue.

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

Claim Management

Help

PrintClose

**Medical Claim (CMS-1500) Help**

Instructions for the completion of a Medical Claim (CMS-1500). \* These fields are required on all CMS-1500 claim submissions. \*\* These fields are required only in specific situations, as described below. NPIs with alpha characters are case sensitive.

**Participant DCN\***

Enter the participant's MO HealthNet number (DCN).

**Participant Last Name\***

Enter the participant's last name.

**Participant First Name\***

Enter the participant's first name.

**Patient Account Number**

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

**Referring Provider NPI**

Enter the referring physician's MO HealthNet Provider Identifier (NPI) and Taxonomy code (if applicable). This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).

**Hospitalization Dates**

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

Provides information as to what is needed for each field on eMOMED.

Billing NPI: M012136305  
BPST

**Claim Header Information**

Enter information as it appears on MHD card

**Participant Information**

Participant DCN \*

01010101

Participant Last Name \*

patient

Participant First Name \*

ima

Patient Account Number

123

Optional

**Service Information**

Referring Provider NPI

M202174538

Required

Hospitalization Dates

To

Service Facility Location

Service Facility Name

**Cause and Diagnosis Details**

Related Cause Codes

Last Menstrual Cycle Date

Diagnosis Codes \*

Z89511

Save Claim Header

Reset

Enter ICD10 DX (No decimals)

Save claim header

Enter all REQUIRED \* information and click **Save Claim to Header**  
\* - asterisk means something must be entered in this field.

You can always click on the question mark to see what needs to be entered in that field





**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 *		
<div> <div>16 - Health Maint Org Medicare Risk</div> <div> 17 - Dental Maintenance Organization  11 - Other Non-Federal Programs  12 - Preferred Provider Organization (PPO)  13 - Point of Service (POS)  14 - Exclusive Provider Organization (EPO)  15 - Indemnity Insurance  16 - Health Maint Org Medicare Risk  MA-Medicare  MB-Medicare </div> </div>			<div> <div></div> <div></div> </div>		
Name *			Paid Date *		
<div></div>			<div></div>		
Amount *			Remittance Advice Remark Codes		
<div></div>			<div></div> <div></div> <div></div> <div></div>		

**Filing Indicator\*** 16 – Health Maint Org Medicare Risk

**Other Payers**

**Header Summary**

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

**Add/Edit Details**

Filing Indicator * 16 - Health Maint Org Medicare Risk		Payer Responsibility Sequence Number * P - Primary			
Other Payer ID * xxxx	Other Payer Name * BCBS	Paid Date * 03/15/2022			
Paid Amount * 57.21	Total Denied Amount * 0.00	Remittance Advice Remark Codes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

☐ Payer at Header Level

**Save Other Payer Data and Manage Codes**

Save Other Payer Data to Claim    **Reset**

Click on Save Other Payer Data and Manage Codes

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

Other Payer Detail Summary				
Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount	Action
<b>Add / Edit Other Payer Detail Information</b>				
Associated Line Items *				
<input checked="" type="checkbox"/> 1				
Claim Group Code *	Claim Adjustment Reason Code *	Adjustment Amount *		
CO - Contractual Obligations	45	51.38		
PR - Patient Responsibility	3	41.41		
- Select One -				
- Select One -				
Save Codes to Other Payer				

Save Other Payer To Claim    Reset

**Associated Line Items:** If you have entered more than 1 Detail Line summary, you ***must*** check each box number separately when entering information from the Medicare EOB.

**Claim Group Code:** Enter information as what is on the EOB for that particular Line Item

Click on Save Codes to Other Payer

**Other Payers**

**Header Summary**

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

**Add/Edit Details**

Filing Indicator \*  
16 - Health Maint Org Medicare Risk

Payer Responsibility Sequence Number \*  
P - Primary

Other Payer ID \*  
XXXX

Other Payer Name \*  
BCBS

Paid Date \*  
03/15/2022

Paid Amount \*  
57.21

Total Denied Amount \*  
0.00





Remittance Advice Remark Codes

☐ Payer at Header Level

**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	51.38	 
1	PR - Patient Responsibility	3	41.41	 

**Add / Edit Other Payer Detail Information**

Associated Line Items \*  
☐ 1





Claim Group Code *	Claim Adjustment Reason Code *	Adjustment Amount *
- Select One -		
- Select One -		
- Select One -		
- Select One -		

**Save Codes to Other Payer** **Reset**

**Save Other Payer To Claim**

Be sure to add the **Adjustment amount column** and the **Paid amount column** together. This should **ALWAYS** equal the total billed charges


If ready, click on Save other payer to claim

XXXX		BCBS	03/15/2022	MB-Medicare	57.21	 	
<b>Add/Edit Details</b>							
Filing Indicator *				Payer Responsibility Sequence Number *			
<input type="text"/>				<input type="text"/>			
Other Payer ID *		Other Payer Name *		Paid Date *			
<input type="text"/>		<input type="text"/>		<input type="text"/>			
Paid Amount *		Total Denied Amount *		Remittance Advice Remark Codes			
<input type="text" value="0.00"/>		<input type="text" value="0.00"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
<input type="checkbox"/> Payer at Header Level							
<a href="#">Save Other Payer Data and Manage Codes</a>							
<a href="#">Save Other Payer To Claim</a>		<a href="#">Reset</a>					
<b>Invoice of Cost</b> (click to manage) 							
<b>Certificate of Medical Necessity</b> (click to manage) 							
<a href="#">Submit Claim</a>		<a href="#">Printer Friendly</a>		<a href="#">Reset</a>		<a href="#">Cancel</a>	



Now you are ready to submit the claim. You can also click on Printer friendly button to print out claim before submitting.

**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 IMA PATIENT	ICN 4922157008247	Claim Submission Date 06/06/2022	Total Paid 0.00
Participant DCN 01010101	First Date Of Service 02/01/2022	Last Date of Service 02/01/2022	RA Date
	Claim Type MEDICAL	Bill Type	Check Number
	Total Charges 150.00		

Provider Details	Claim Status Details		
NPI M012136305	Claim Status 21	Category Code F0	Entity Identifier Code
Taxonomy Code	Status Effective Date 06/06/2022	Adjudication Date 06/06/2022	

**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	02/01/2022 - 02/01/2022		99203		1	150.00	0.00	20	A2		06/06/2022

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

This will let you know the claim has been received.

If you have more Medicare Part C Non-QMB claims to enter click on New Claim and if you are done entering claims, click Finish

# Adjusting Claims

**Claim Status**

**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		Claim Data	
Participant Name	IMA PATIENT	ICN	4916047049548
Participant DCN	01010101	First Date Of Service	10/01/2015
		Claim Submission Date	02/16/2016
		Last Date of Service	10/01/2015
		Claim Type	Bill Type

- Void
- Copy Claim Original or Advanced
- Replacement



# Claim Adjustments & Resubmissions

## Provider Manual

### Section 6

- **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

# Adjustments & Resubmissions

- **Replacement Claim** – used when a claim *paid* that has been billed incorrectly
- 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

# Adjustments & Resubmissions (cont.)

- **Copy Claim - Original**— used when a claim or any line of a claim **denied** that 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

# Adjustments & Resubmissions (cont.)

- **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

# Provider Communications Management



**Provider Communication Management portal** – Direct email to Provider Communications. Provider Communications answers questions re: claims and eligibility issues.

**NOTE: Only one question per submission. Phone (573-751-2896)**

WIPRO  
Provider Communications Unit  
573-751-2896

Mo HealthNet Division  
Education & Training Unit  
573-751-6683  
**MHD.Provtrain@dss.mo.gov**

