

Medicare Part C ~ QMB claim filing

eMOMED Electronic Claim Filing

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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 **Qualified Medicare Beneficiary (QMB)** eligible, use one of the following:

- The Medicare UB-04 Part C Institutional Crossover to file for inpatient room and board. The header screen must be completed. Choose filing indicator '16' (Medicare Part C Institutional); or
- The Medicare UB-04 Part C Professional Crossover to file for outpatient professional services. The header screen and line detail screens must be completed. Choose filing indicator '16' (Medicare Part C Professional) on the header screen; or
- The Medicare CMS-1500 Part C Professional Crossover to file for professional services. The header and line detail screens must be completed. Choose filing indicator '16' (Medicare Part C Professional) on the header screen.

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 coinsurance 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 coinsurance 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

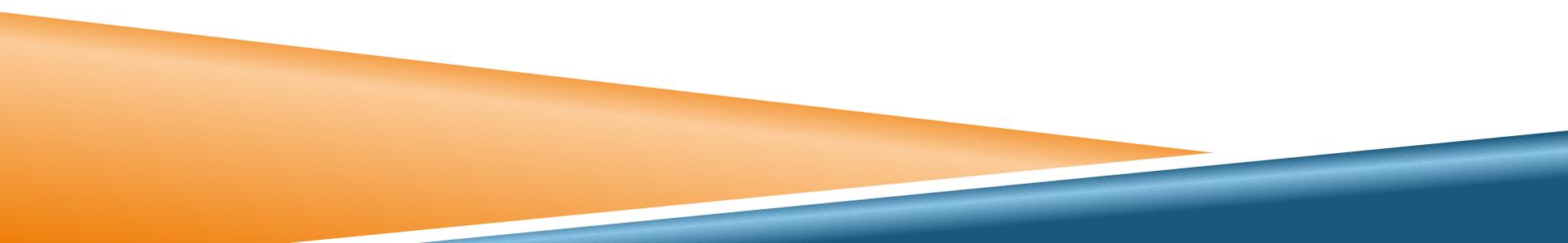
Welcome to eProvider



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

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

Missouri Department of SOCIAL SERVICES

Participant Eligibility Screen Cont'd

Provider ePassport eMMIS MMIS Apps Welcome, JACQUELINE Log Out

Home / eProvider / Eligibility

Eligibility Response

NPI: [REDACTED]

Submitted Information

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

Participant Information

Participant DCN	Participant Name	Participant Date of Birth
[REDACTED]	[REDACTED]	[REDACTED]
Participant Address	Participant SSN	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 86 - 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



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 ~ QMB Crossover Claim

Choosing the correct claim form

The screenshot shows a web interface titled "Claim Management". At the top, there are input fields for "NPI *" and "Provider Name". The "NPI *" field contains an error message: "NPI is invalid.". Below these fields are two dropdown menus: "New Claim" and "New Xover Claim". The "New Claim" dropdown is open, showing a list of claim form options with radio buttons next to them. The options are: "ICN", "Advanced" (which is selected), "Daily Claim S", "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)". Below the dropdown menu, there are input fields for "Participant DCN" and "Dates of Service".

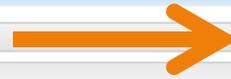
Click on New Claim and click on the appropriate claim form you want to use.

New Crossover Claim is a Medicare Part C QMB claim that does not crossover from Medicare. This is the provider's responsibility to submit through eMOMED.

Source: <https://www.emomed.com>

? = HELP

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

Help

Print

Close

CMS-1500 Professional Crossover Claim Help

Instructions for completion of the CMS-1500 Professional Crossover Claim form. * These fields are required on all CMS-1500 Professional Crossover claim submissions. ** These fields are required only in specific situations, as described below. National Provider Identifiers (NPIs) with alpha characters are case sensitive.

*(Claim Header Information) Participant Last Name**

Enter the participant's last name.

*(Claim Header Information) Participant First Name**

Enter the participant's first name.

(Claim Header Information) Patient Account Number

Enter the patient's account number associated by your facility.

*(Claim Header Information) Participant Medicare ID**

Enter the participant's 11-digit Medicare ID number.

*(Claim Header Information) Medicare Provider NPI**

Enter the provider's 10-digit NPI number used to bill this claim to Medicare.

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

Medicare CMS-1500 Part C Professional (QMB) Claim

Medicare CMS-1500 Part C Professional (QMB) Claim

Billing NPI: M012136305
BPST

Claim Header Information

Participant Information

Participant DCN * Enter the participant's MO HealthNet number (DCN).
Participant Name *
Participant First Name *

Patient Account Number
Participant Medicare ID
(Claim Header Information) Medicare Provider NPI*
Enter the provider's 10-digit NPI number used to bill this claim to Medicare.

Service Information

Referring Provider NPI

Medicare 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).
Referring Provider NPI

Diagnosis Codes

Diagnosis Codes *
Diagnosis Codes*
Enter the complete diagnosis code(s). The primary diagnosis as Number 1, the secondary diagnosis as Number 2, etc.

Save claim header to continue.



Add Detail Line

Detail Line Summary					Total Charges : 0.00
Line #	Date of Service	Place of Service	Procedure Code	Modifier	
Add Detail Line #1					
Dates of Service *		Place of Service *			
01/03/2022 To 01/03/2022		11 - Office			
Procedure Code *		Modifiers			
99211					
National Drug Code		Billed Charges*		Prescription Number	
		Enter the provider's usual and customary charge per detail line. This should be the total charge if multiple days or units are shown.			
Diagnosis Code *		Billed Charges *		Days/Units Billed *	
2736		125.00		1	
Conditions		Performing Provider NPI		Ordering Pro	
<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Family Planning		m202174538			
Save Detail Line to Claim Reset		Performing Provider NPI		Days/Units Billed*	
		This field is required for a clinic, radiology, teaching institution or group practice only. Enter the Missouri MO HealthNet Provider Identifier (NPI) and Taxonomy code (if applicable) of the physician or other professional who performed the service.		Enter the number of days or units of service provided for detail line.	
		Save Detail Line to Claim to continue.			
		Submit Claim		Printer Friendly	
		Reset		Cancel	



Other Payers

Header Summary

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

Add/Edit Details

Filing Indicator *
16-Medicare Part C Professional (QMB) [v]
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-Medicare Part C Institutional (QMB)
16-Medicare Part C Professional (QMB) [h]
MC-MO HealthNet

Payer Responsibility Sequence Number *
[] [v]

Paid Date *
[]

Remittance Advice Remark Codes
[] [] [] []

er Friendly Reset Cancel



Filing Indicator* 16-Medicare Part C Professional (QMB)

Other Payers

Header Summary

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

Add/Edit Details

Filing Indicator *		Payer Responsibility Sequence Number *			
16-Medicare Part C Professional (QMB)		P - Primary			
Other Payer ID *	Other Payer Name *	Paid Date *			
xxxx	BC BS	03/15/2022			
Paid Amount *	Total Denied Amount *	Remittance Advice Remark Codes			
57.21	0.00	<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 to Claim **Reset**



Click on 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
Add / Edit Other Payer Detail Information				
Associated Line Items *				
<input checked="" type="checkbox"/> 1				
Claim Group Code *	Claim Adjustment Reason Code *	Adjustment Amount *		
CO - Contractual Obligations	45	45.00		
PR - Patient Responsibility	2	22.79		
- 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 Part C 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-Medicare Part C Professional (QMB)	Payer Responsibility Sequence Number *	P - Primary
Other Payer ID *	XXXX	Other Payer Name *	BC BS
Paid Amount *	57.21	Total Denied Amount *	0.00
<input type="checkbox"/> Payer at Header Level		Remittance Advice Remark Codes	

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

Line Item(s)	Claim Group Code	Claim Adjustment Reason Code	Adjustment Amount
1	CO - Contractual Obligations	45	45.00
1	PR - Patient Responsibility	2	22.79

Add / Edit Other Payer Detail Information

Associated Line Items *

1

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

Save the Other Payer to Claim to continue.

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

Diagnosis Code * - Select One -	Billed Charges * 0.00	Days/Units Billed *
Paid Amount * 0.00	Performing Provider NPI *	Ordering Provider NPI

Save Detail Line to Claim Reset

Other Payers

Header Summary

Payer ID	Payer Name	Paid Date	Filing Indicator	Paid Amount	Action
0000	BC BS	03/15/2022	16-Medicare Part C Professional (QMB)	57.21	

Add/Edit Details

Filing Indicator *	Payer Responsibility Sequence Number *	
Other Payer ID *	Other Payer Name *	Paid Date *
Paid Amount *	Total Denied Amount *	Remittance Advice Remark Codes

Payer at Header Level

Save Other Payer Data and Manage Codes

Save Other Payer To Claim Reset

Submit Claim Reset Cancel

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 4922124014594	Claim Submission Date 05/04/2022	Total Paid 0.00		RA Date	
Participant DCN 01010101	First Date Of Service 02/01/2022	Last Date of Service 02/01/2022	Check Number			
	Claim Type CROSSOVER	Bill Type 5				
	Total Charges 22.79					

Provider Details		Claim Status Details			
NPI M012136305	Claim Status 33	Category Code F0	Entity Identifier Code		
Taxonomy Code	Status Effective Date 05/04/2022	Adjudication Date 05/04/2022			

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		99213	25	1	22.79	0.00	20	A2		05/04/2022

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

New Claim **Finish**

This will let you know the claim has been received.

If you have more Part C 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	Claim Submission Date 02/16/2016
Participant DCN 01010101	First Date Of Service 10/01/2015	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



The screenshot shows a web application window titled "eProvider Welcome". On the left, a female doctor in a white lab coat holds a laptop. The main content area is titled "Welcome to eProvider" and contains ten menu items arranged in two columns. An orange arrow points to the "Provider Communications Management" option at the bottom left.

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

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
Constituent Education Unit
573-751-6683
MHD.Provtrain@dss.mo.gov

