Missouri Department of SOCIAL SERVICES

MoHealth Net

Medicare Part C ~ QMB claim filing

eMOMED Electronic Claim Filing

- Medicare Part C
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- Participant Eligibility
- Claim Management
  - Choosing the Correct Claim Form
  - Help Information
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- Adjusting Claims
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Source: https://www.emomed.com

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.

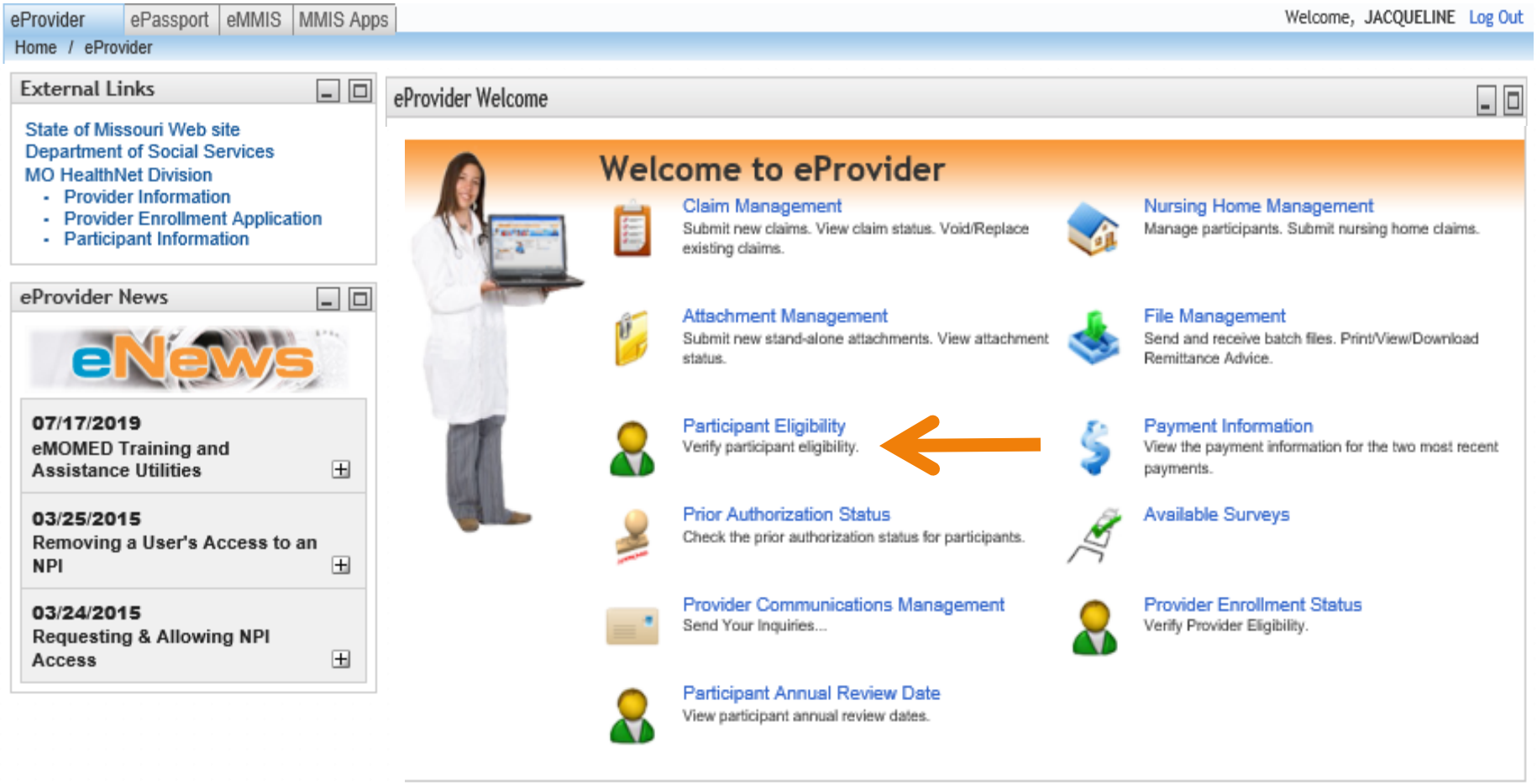
MHD guidelines and policies regarding attachments and prior authorization must be followed for participants, including Medicare Part C non-QMB participants. If the procedure billed requires an attachment (Certificate of Medical Necessity, Second Surgical Opinion, Sterilization Consent, etc.), you must 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 coins insurance and deducible 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 deducible 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.



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)

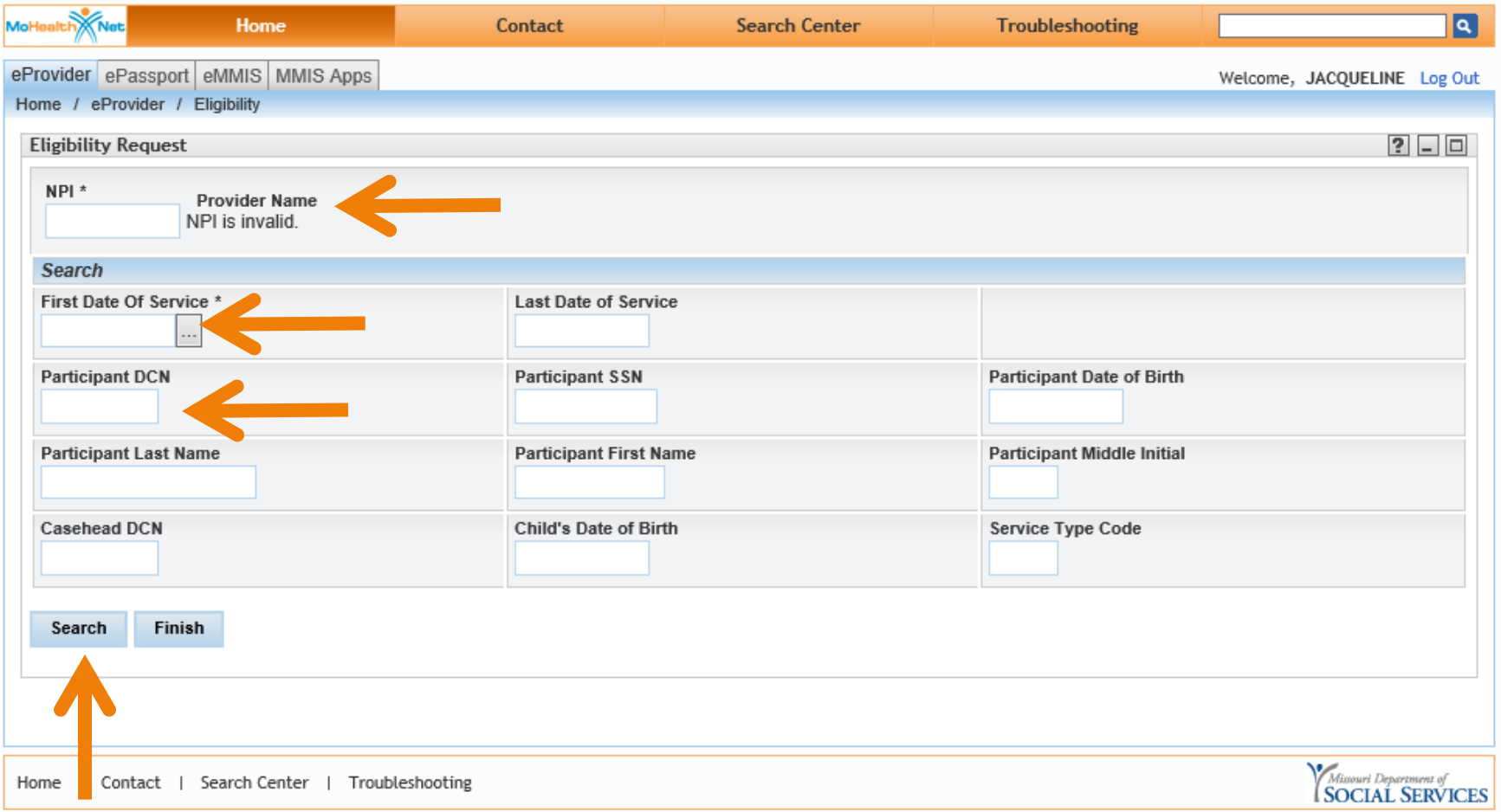
Participant Eligibility Screen

- 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

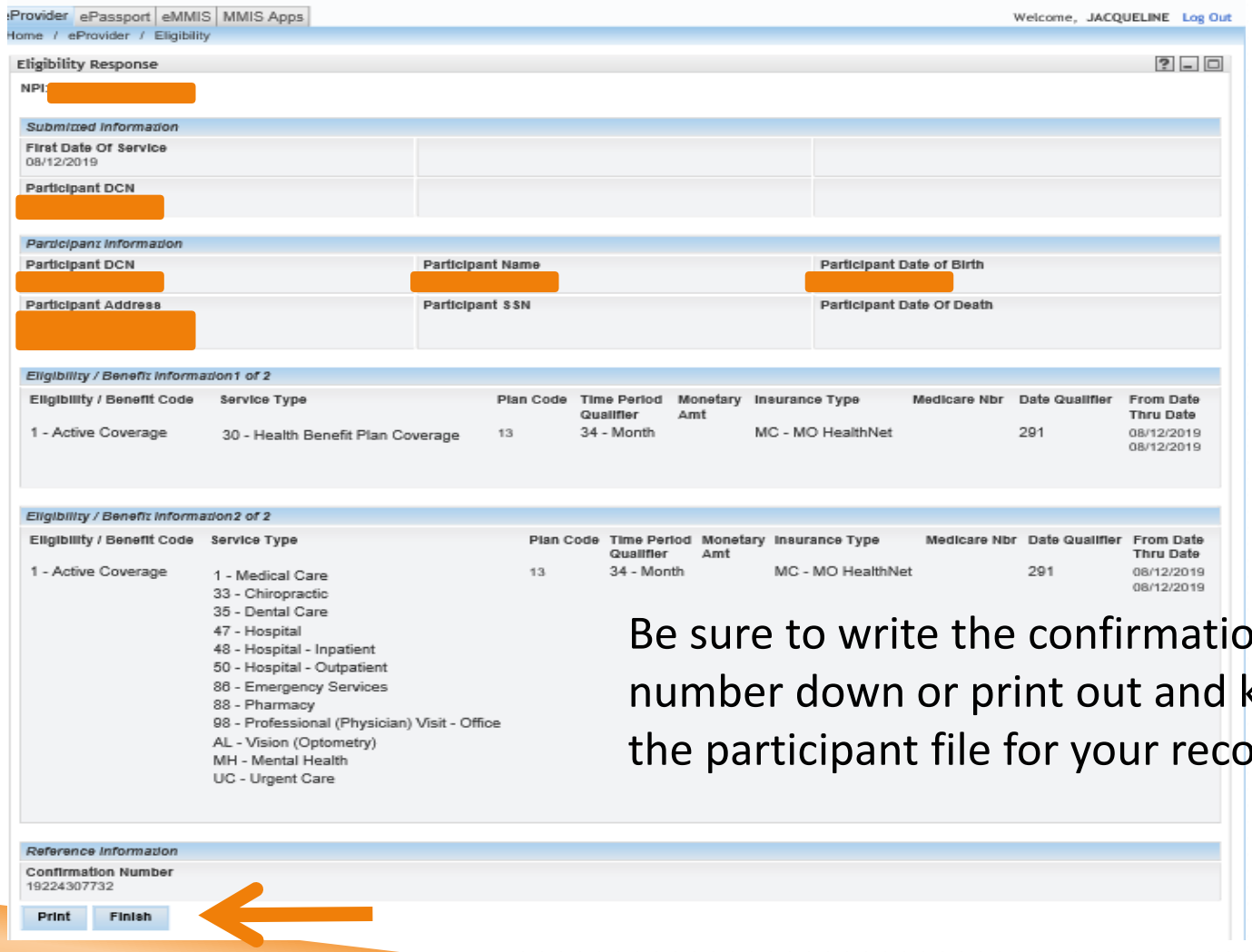
If you bill for more than one Provider, you ***MUST*** make sure you have the correct Provider NPI you are billing under. This way if a claim would deny, for an eligibility issue, Provider Communications will always check to see if the provider verified eligibility

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

Participant Eligibility Screen



Participant Eligibility Screen Cont'd



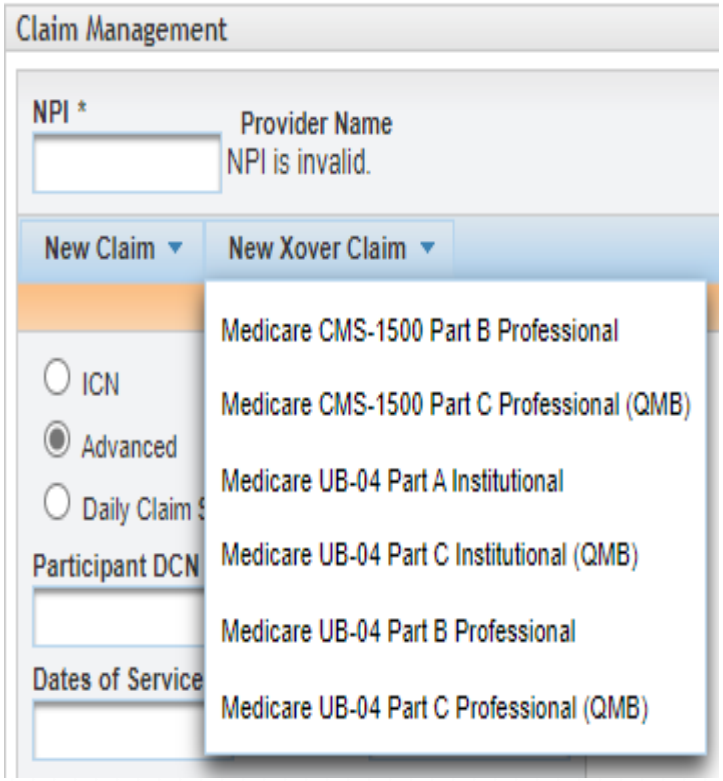
Be sure to write the confirmation number down or print out and keep in the participant file for your records.

Claim Management

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

Source: https://www.emomed.com

Choosing the correct claim form

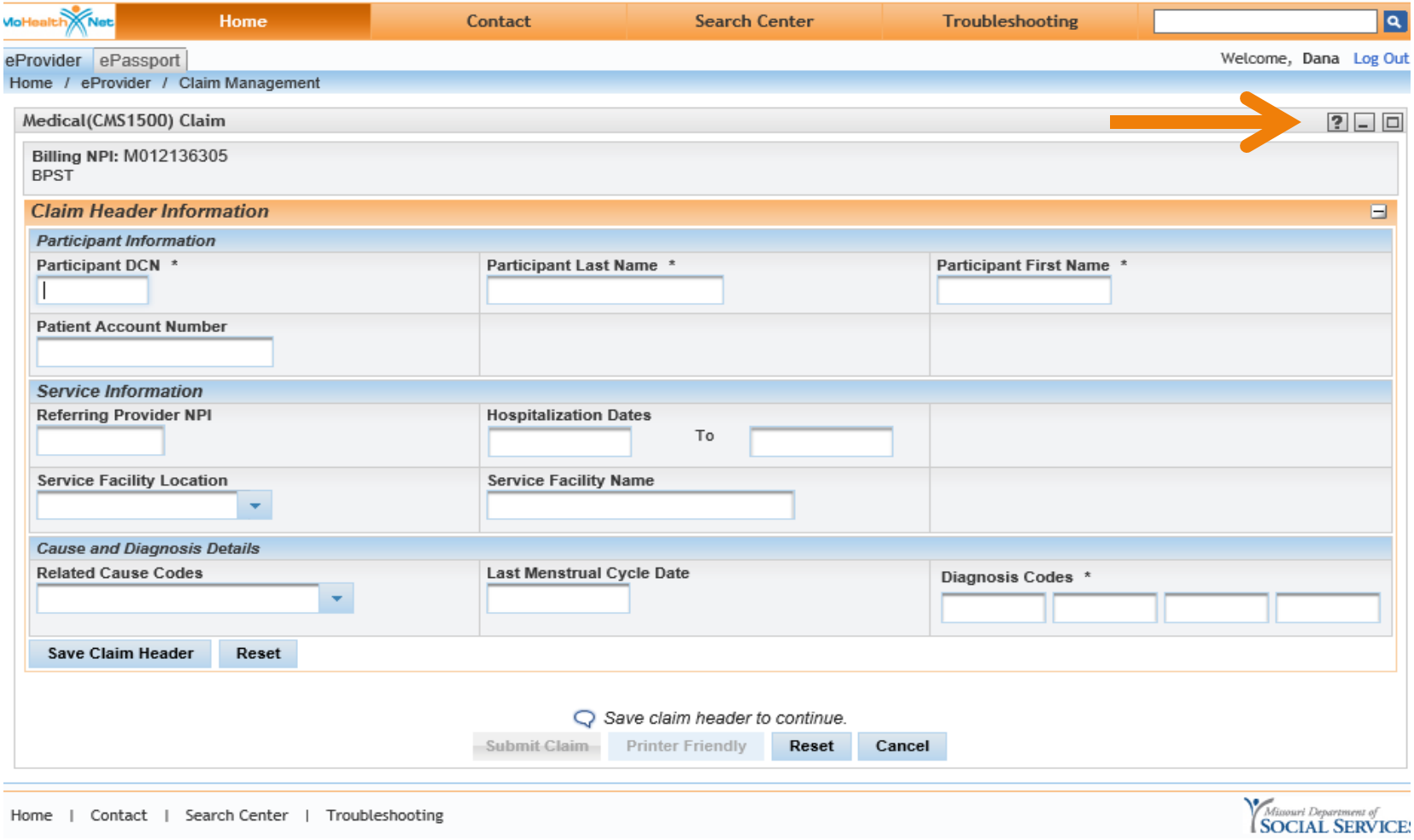


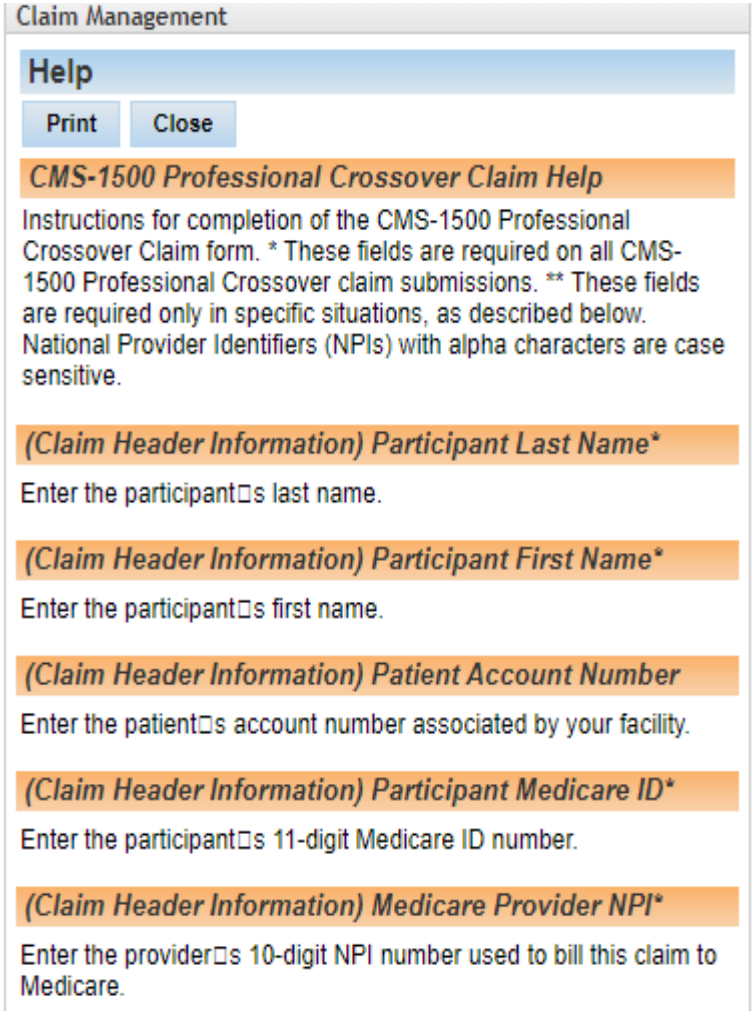
Click on New Claim and click on the appropriate claim form you want to use.

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

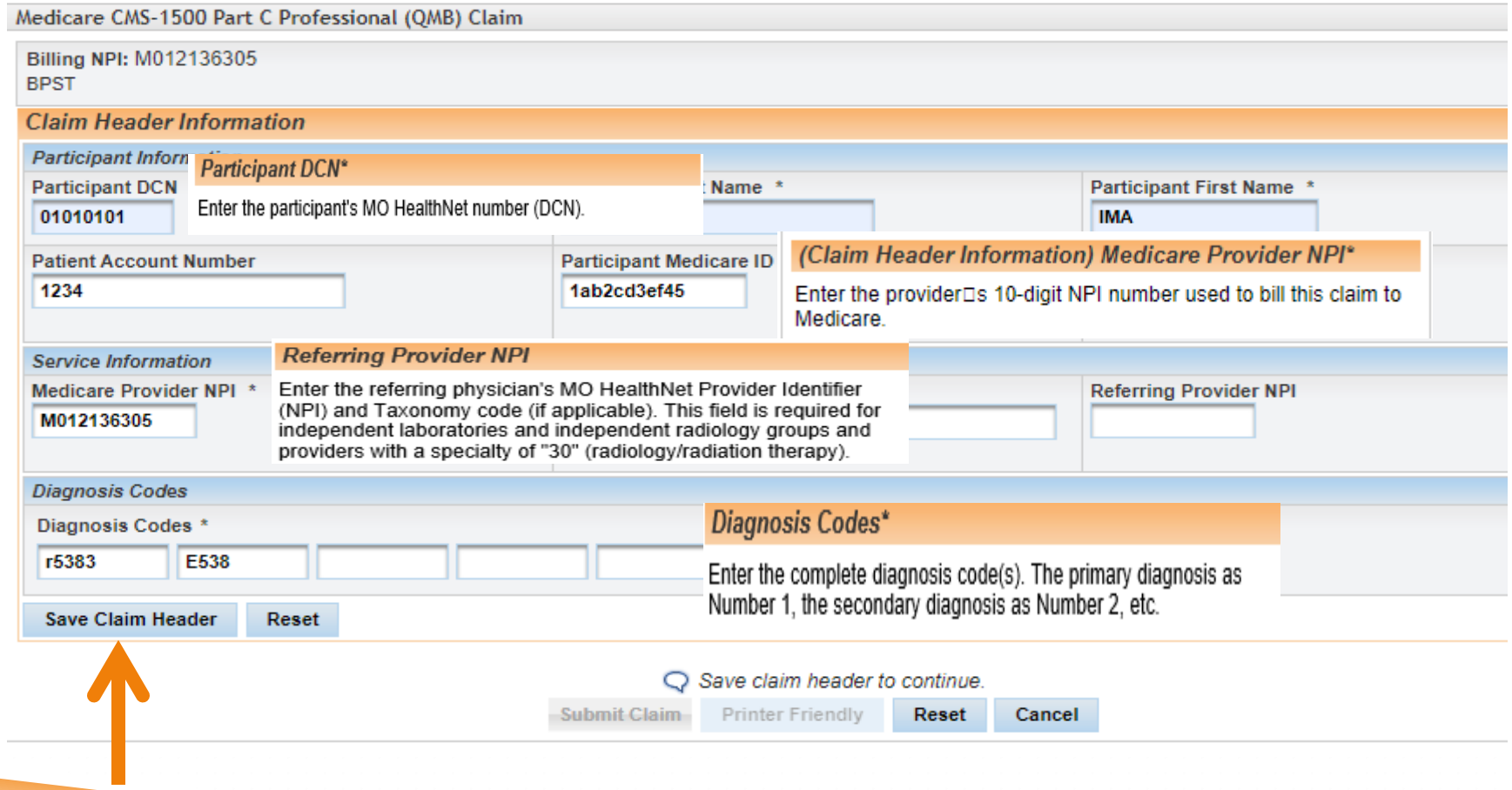
? = HELP

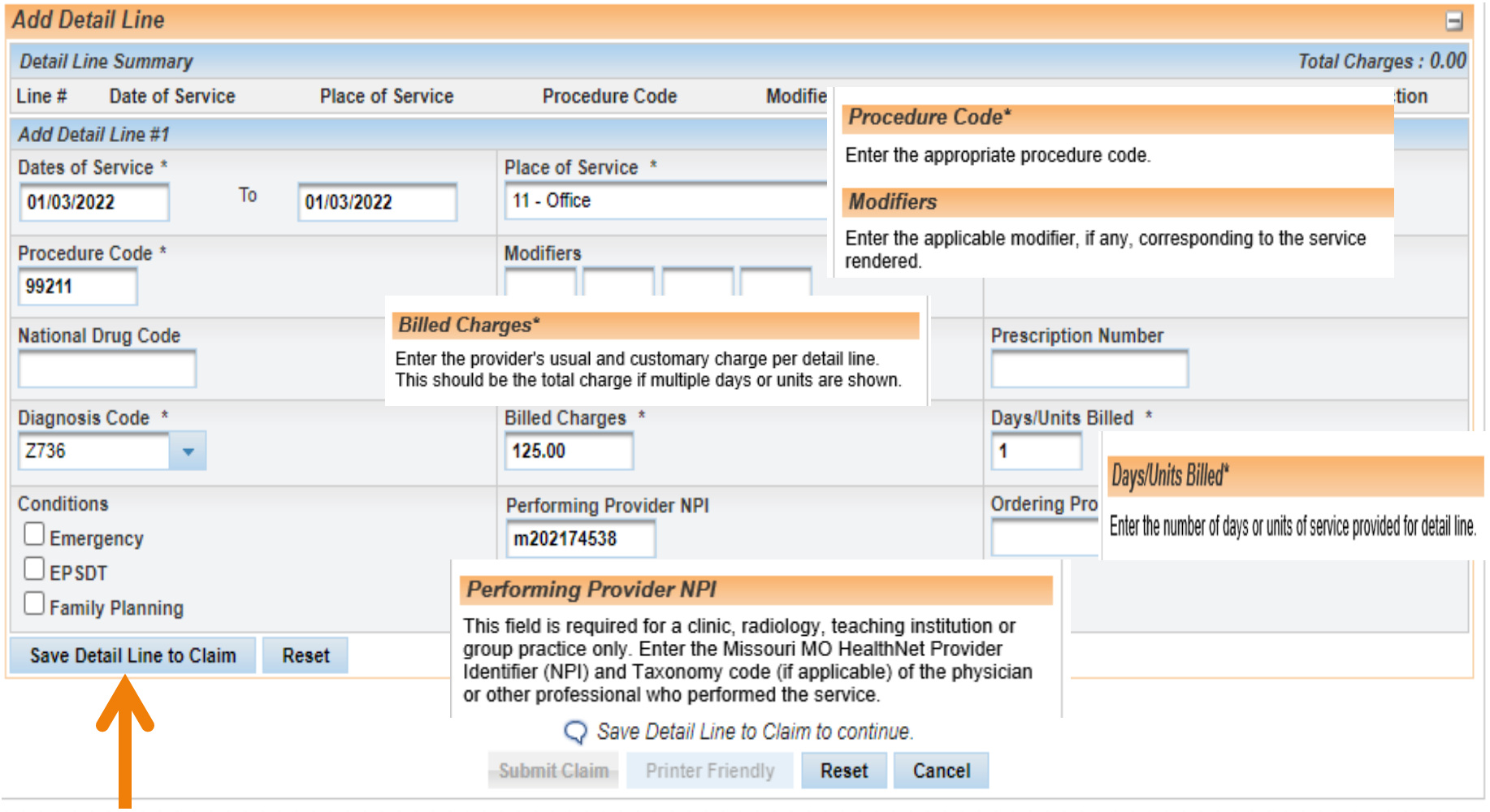

MoHealthNet
Home
Contact
Search Center
Troubleshooting
ePassport
Welcome, Dana Log Out
Home / eProvider / Claim Management
Medical(CMS1500) Claim
Billing NPI: M012136305
BPST
Claim Header Information
Participant Information
Participant DCN *
Participant Last Name *
Participant First Name *
Patient Account Number
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 *
Save Claim Header
Reset
Save claim header to continue.
Submit Claim
Printer Friendly
Reset
Cancel
Home | Contact | Search Center | Troubleshooting
Missouri Department of SOCIAL SERVICES

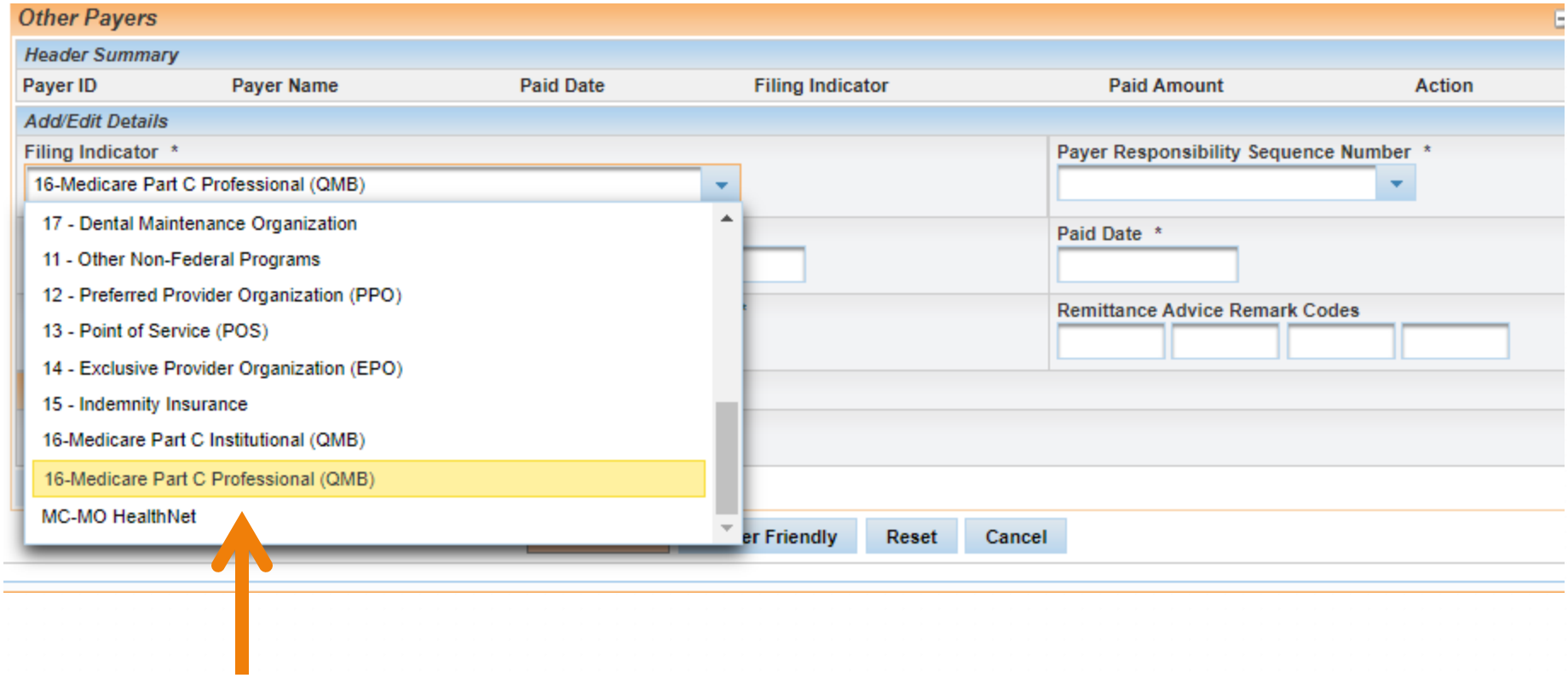


Provides information as to what is needed for each field on eMOMED.

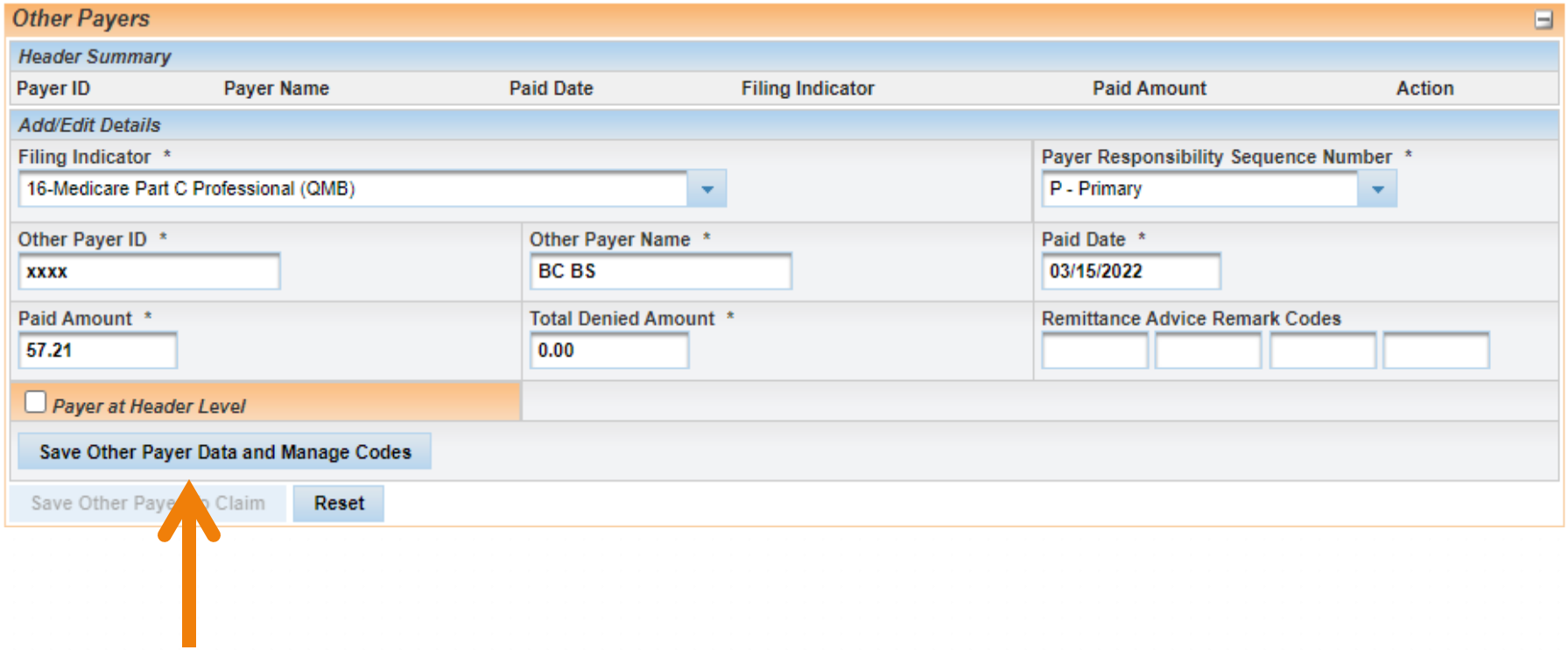
Medicare CMS-1500 Part C Professional (QMB) Claim



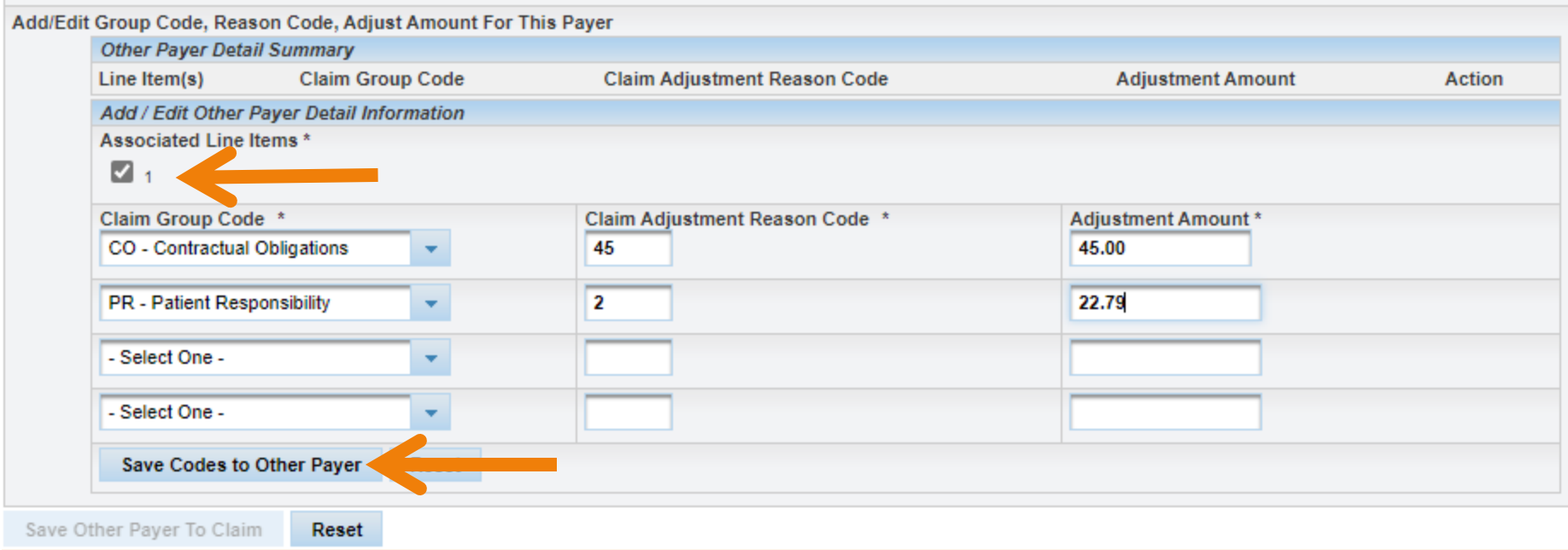

Add Detail Line
Detail Line Summary
Total Charges : 0.00
Line #
Date of Service
Place of Service
Procedure Code
Modifie
tion
Add Detail Line #1
Dates of Service *
01/03/2022
To
01/03/2022
Place of Service *
11 - Office
Procedure Code *
99211
Modifiers
National Drug Code
Prescription Number
Diagnosis Code *
Z736
Billed Charges *
125.00
Days/Units Billed *
1
Conditions
Emergency
EPSDT
Family Planning
Performing Provider NPI
m202174538
Ordering Pro
Save Detail Line to Claim
Reset
Procedure Code*
Enter the appropriate procedure code.
Modifiers
Enter the applicable modifier, if any, corresponding to the service rendered.
Billed Charges*
Enter the provider's usual and customary charge per detail line. This should be the total charge if multiple days or units are shown.
Days/Units Billed*
Enter the number of days or units of service provided for detail line.
Performing Provider NPI
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.
Save Detail Line to Claim to continue.
Submit Claim
Printer Friendly
Reset
Cancel



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



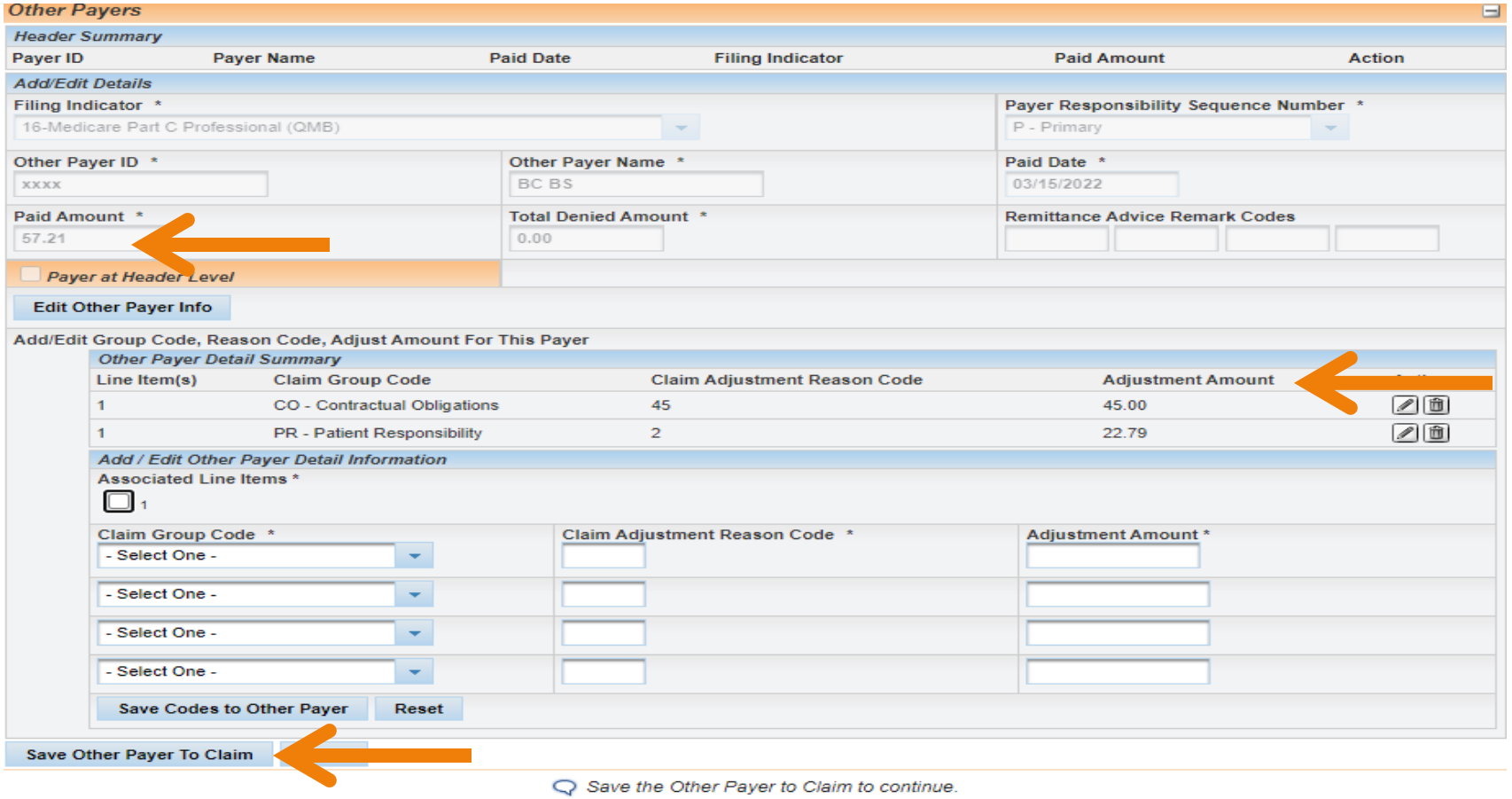
Click on Other Payer Data and Manage Codes



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.

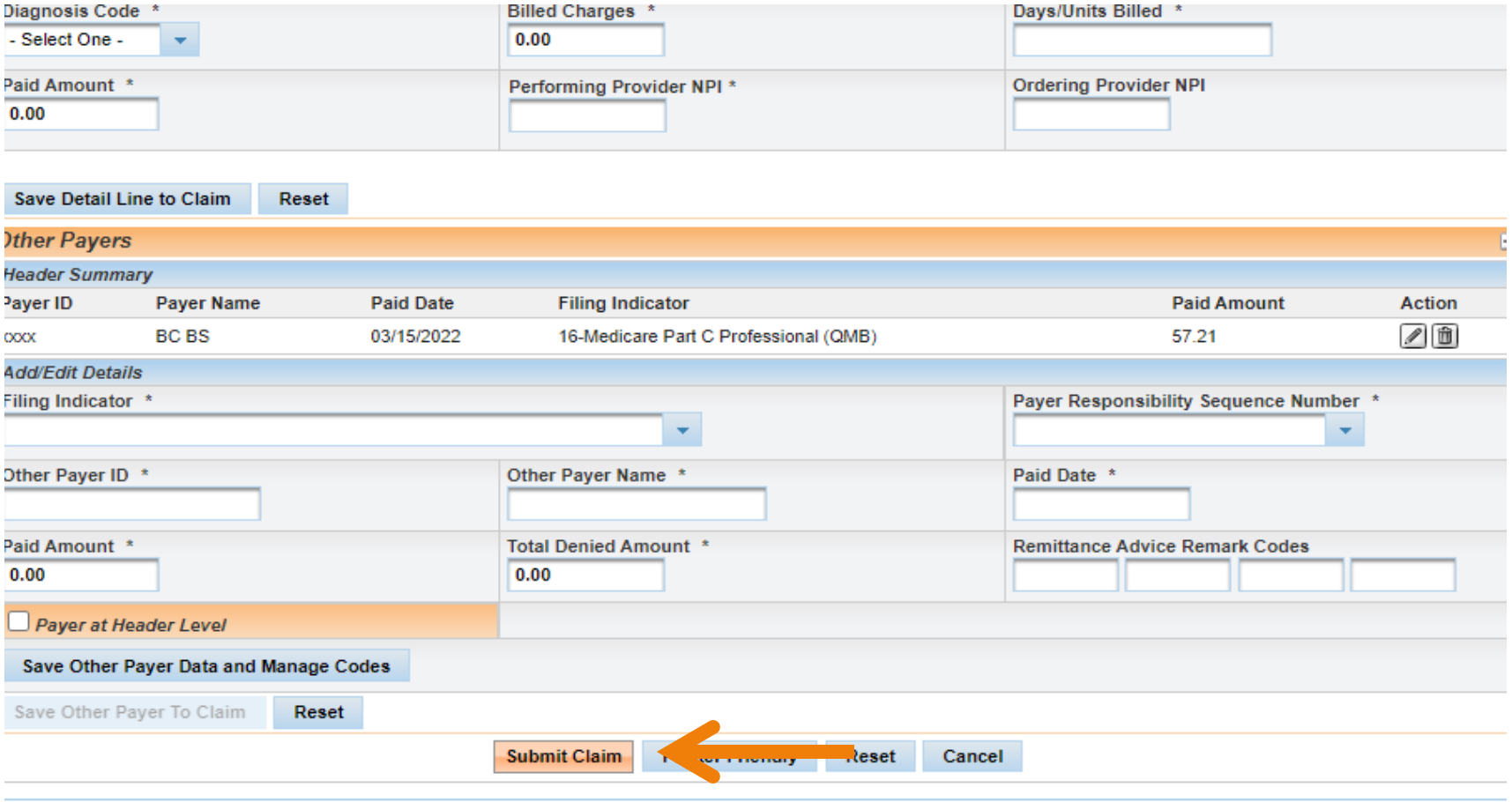
Claim Group Code: Enter information as what is on the EOB for that particular Line Item

Click on Save Codes to Other Payer

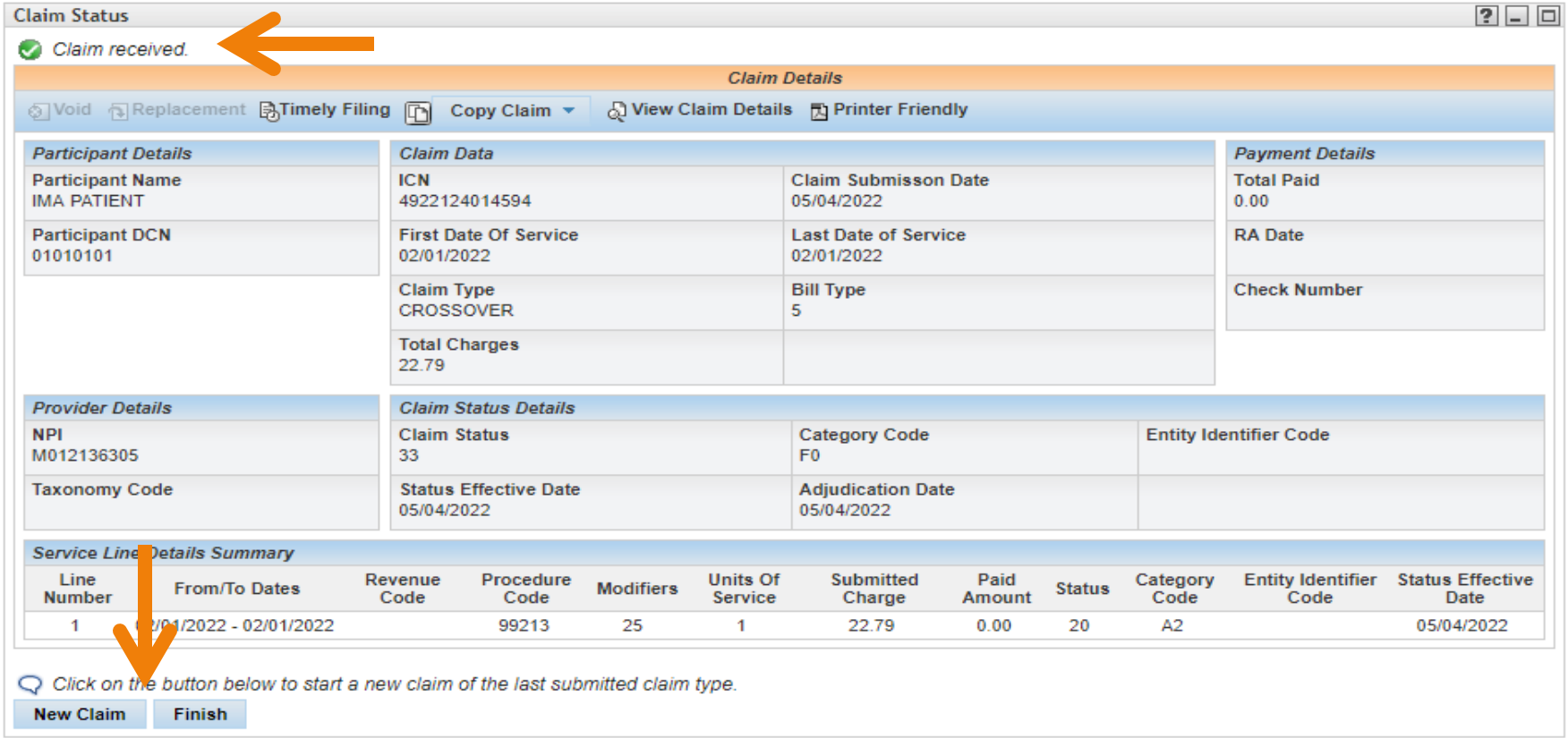


Be sure to add the ***Adjustment amount column*** and the ***Paid amount column*** together. This should **ALWAYS** equal the total billed charges

If ready, click on Save other payer to claim



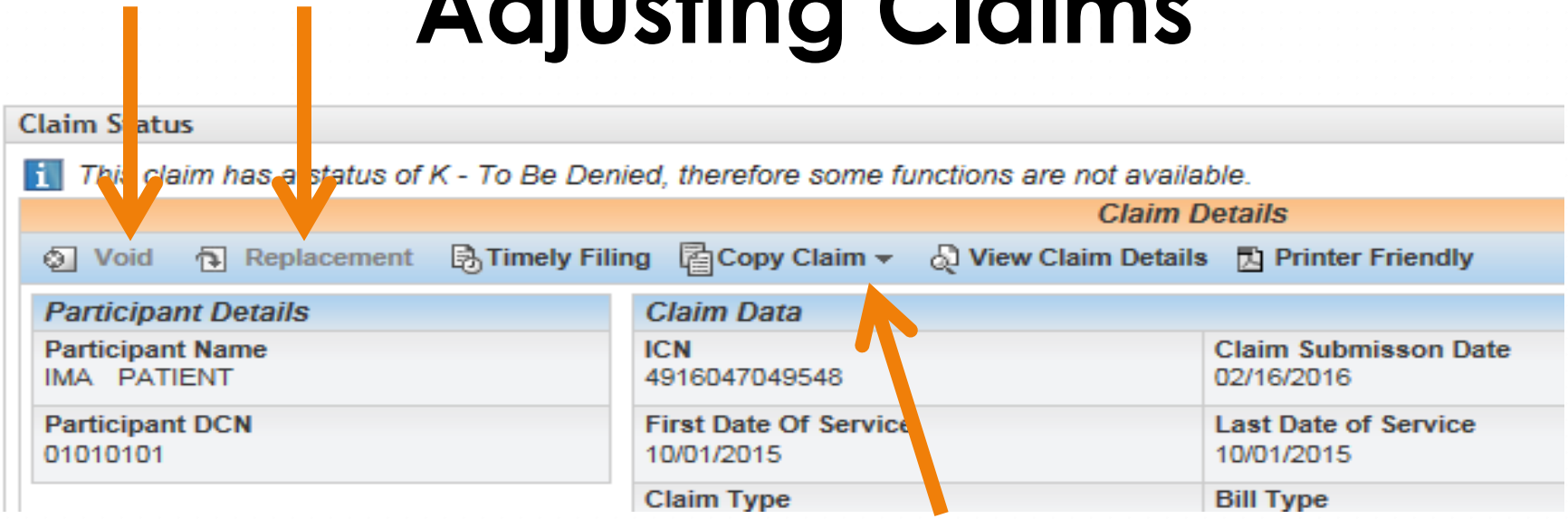
Now you are ready to submit the claim. You can also click on Printer friendly button to print out claim before submitting.



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



- Void
- Copy Claim Original or Advanced
- Replacement

Source: https://www.emomed.com

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

Source: Provider Manual Section 6-Adjustments
https://manuals.momed.com/manuals/

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

Source: Provider Manual Section 6-Adjustments
https://manuals.momed.com/manuals/

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

Source: Provider Manual Section 6-Adjustments
https://manuals.momed.com/manuals/

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

Source: Provider Manual Section 6-Adjustments
https://manuals.momed.com/manuals/

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