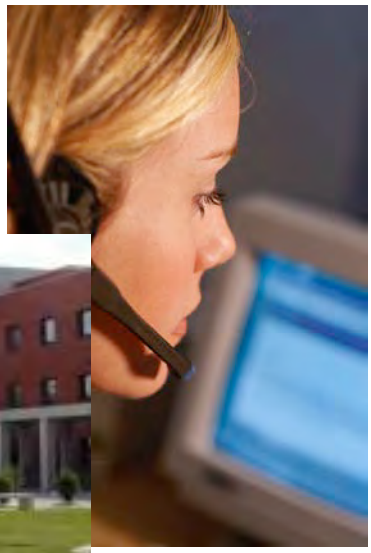
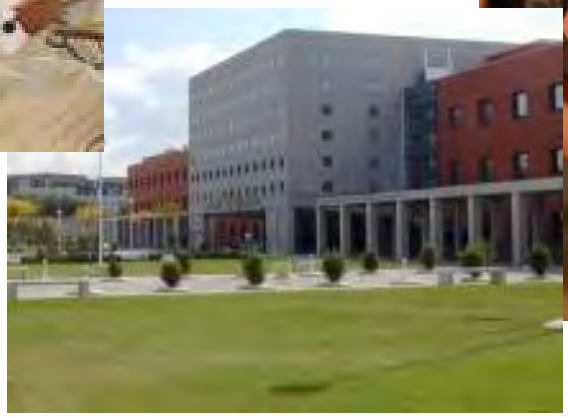
Hospital Billing Book





Published by the Provider Education Unit

MO HealthNet Division

PREFACE

The MO HealthNet *Hospital Billing Book* contains information to help providers submit claims correctly to the MO HealthNet program. The information in this book is only for persons who are submitting claims for hospitals that are enrolled providers in the MO HealthNet program. The book is not all inclusive of program benefits and limitations. Providers should refer to specific program manuals for complete information.

CONTENTS

SECTION 1
MO HealthNet PROGRAM RESOURCES

CONTACTING MO HealthNet

PROVIDER COMMUNICATIONS
(573) 751-2896

The following phone number is available for MO HealthNet providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

Provider Communications (573) 751-2896

When you call the (573) 751-2896 number, you are transferred automatically to the IVR (interactive voice response). Anytime during the IVR options, you may select "0" to speak to the next available specialist. Your call will be put into a queue and will be answered in the order it was received.

Providers may send and receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk staff. This application is available through the MO HealthNet Web portal page at emomed.com. Once logged in and on the eProvider/Welcome to eProvider page, click on “Provider Communications Management.” This opens the "Manage Provider Communications” page. Click on “New Request” to access the “Create New Request” form. Providers are limited to one inquiry per E-mail. The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry.

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

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

The interactive voice response (IVR) system also addresses participant eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR.

WIPRO INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK
(573) 635-3559

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

PROVIDER ENROLLMENT

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

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

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

THIRD PARTY LIABILITY

(573) 751-2005

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

PROVIDER EDUCATION

(573) 751-6683

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

PARTICIPANT SERVICES

(800) 392-2161 or (573) 751-6527

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

MO HEALTHNET PHARMACY AND MEDICAL PRE-CERTIFICATION HELP DESK

(800) 392-8030

Providers can call this toll free number to: request a pre-certification for a radiological procedure (MRI, MRA, CT, CTA, PET, ultrasound and cardiac imaging studies); to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program; to request information on Medicare Part D; or, to request a drug prior authorization. The MO HealthNet fax line for non-emergency service or equipment exception requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470. Do **not** use either of these numbers for requests for pre-certifications of MRI, MRA, CT, CTA, PET, ultrasound and cardiac imaging studies procedures.

MHD has implemented pre-certification for certain radiological procedures. In order for providers to be reimbursed for these services, the participant must meet certain medical criteria and the physician must obtain the pre-certification for the procedure unless performed in an inpatient hospital or emergency room setting.

The list of medical imaging procedures and durable medical equipment and supplies that currently require pre-certification along with the related medical criteria can be referenced at the MO HealthNet Web site dss.mo.gov/mhd/cs/medprecert/pages/medprecert.htm.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the *HIPAA-EDI Companion Guide* online by going to the MO HealthNet Division Web page at dss.mo.gov/mhd and clicking on the "Providers" link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the right hand side of the page. This will take you directly to the EDI Companion Guide.

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

INTERACTIVE VOICE RESPONSE (IVR) (573) 751-2896

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 751-2896 requires a touchtone phone. The ten-digit MO HealthNet National Provider Identifier **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 0 Provides access to a MO HealthNet phone specialist
If all the specialists are busy with other calls, the caller is put into a queue until the next specialist is available. Calls are taken in the order in which they are received. Callers selecting this option are limited to three inquiries per call. Limiting the number of inquiries to three allows communications specialists to respond to more provider calls.

Option 1 Participant Eligibility

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

Option 2 Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status

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

INTERNET SERVICES FOR MO HEALTHNET PROVIDERS

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

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

The Web site address for this service is emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply online at dss.mo.gov/mhd/providers/index.htm.

Each user is required to complete this online application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Wipro Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, emomed.com, allows for the submission of the following HIPAA compliant transactions.

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated.

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

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

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET

Providers can access MO HealthNet participant eligibility files via the Web site. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

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

MO HealthNet CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

837 - Health Care Claim
Professional
Dental
Institutional (hospital inpatient and outpatient, nursing home, and home health care)
Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

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

Note – Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Wipro Infocrossing Internet Web service: Sterilization Consent, Acknowledgement of Receipt of Hysterectomy Information, the PI-118 Referral (Lock-In) forms, Certificate of Medical Necessity or the Invoice of Cost.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

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

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

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

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

To sign up for this service, see the instructions at the beginning of this information on Internet services.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

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

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to MO HealthNet. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Wipro Infocrossing Internet service.

Sterilization Consent,
PI 118 Referral (administrative lock-in)
Acknowledgment of Receipt of Hysterectomy Information
Certificate of Medical Necessity
Invoice of Cost

MO HealthNet PROVIDER MANUALS AND BULLETINS ONLINE dss.mo.gov/mhd/providers

MO HealthNet provider manuals are available online at the MHD Web site, dss.mo.gov/mhd/providers. Scroll to the bottom of the Provider Participation page and click on the "Provider Manuals" link. The next page displays a State of Missouri MO HealthNet Web portal page with an alphabetical listing of the MO HealthNet provider manuals. Click on the appropriate manual link and when it opens, choose the section you want to view. The entire section, portions of a section or the current page displayed can be printed using the print feature on the computer toolbar.

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

CLAIM PROCESSING SCHEDULE FOR FISCAL YEAR 2014

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

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

State Holidays

July 4, 2013 Independence Day	January 1, 2014 New Year's Day
September 2, 2013 Labor Day	January 20, 2014 Martin Luther King's Birthday
October 14, 2013 Columbus Day	February 12, 2014 Lincoln's Birthday
November 11, 2013 Veteran's Day	February 17, 2014 Washington's Birthday
November 28, 2013 Thanksgiving Day	May 8, 2014 Truman's Birthday
December 25, 2013 Christmas Day	May 26, 2014 Memorial Day

SECTION 2
UB-04 CLAIM FILING INSTRUCTIONS
INPATIENT HOSPITAL

The following instructions pertain to inpatient hospital claims which are being filed to MO HealthNet on a paper UB-04 claim form. The requirements for filing an electronic version of the UB-04 claim form for inpatient services are slightly different. If filing claims electronically via the Wipro Infocrossing Internet service at emomed.com, refer to the help link (?) at the top of the electronic UB-04 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-04 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims for hospital inpatient care are mailed to:

Wipro Infocrossing Healthcare Services, Inc.
P.O. Box 5200
Jefferson City, MO 65102

MO HealthNet forms, for claims processing can be obtained at:
http://manuals.momed.com/manuals/presentation/forms.jsp

NOTE: An asterisk (*) beside field numbers indicates required fields on all inpatient UB-04 forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
1.*	Provider Name, Address, Telephone Number	Enter the provider name, address and telephone number.
2.	Unlabeled Field	Leave blank.
3.	Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
4.*	Type of Bill	The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
		The allowed values for each of the digits found in the type of bill are listed below: Type of Facility: 1st digit: (1) Hospital Bill Classification: 2nd digit: (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit: (1) Admit thru Discharge Claim (2) Interim Bill - First claim (3) Interim Bill - Continuing claim (4) Interim Bill - Last claim
5.	Federal Tax Number	Enter the provider's federal tax number.
6.*	Statement Covers Period ("From" and "Through" dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format. It **should** include the discharge date as the through date when billing for the entire stay. Unless noted below, it **should** include all days of the hospitalization. It **should not** include date(s) of participant ineligibility. It **should not** include inpatient days that were **not** certified by Xerox such as preoperative days or days beyond the cease payment date.
7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the participant's 8-digit MO HealthNet DCN identification number. **NOTE:** The MO HealthNet DCN identification number is **required** in field 60.
8b.*	Patient's Name	Enter the participant's name in the following format: last name, first name, middle initial

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
9.	Patient's Address	Enter the participant's full mailing address, including street number and name, post office box number, or RFD, city, state, and zip code.
10.	Patient's Birth Date	Enter the participant's date of birth in MMDDYY format.
11.	Patient's Sex	Enter the participant's sex, "M" (male) or "F" (female).
12.*	Admission Date	Enter in MMDDYY format the date that the patient was admitted for inpatient care. This should be the actual date of admission regardless of the participant's eligibility status on that date or Xerox certification/denial of the admission date.
13.	Admission Hour	Leave blank.
14.*	Admission Type	Enter the appropriate type of admission; the allowed values are: 1-Emergency 2-Urgent 3-Elective 4-Newborn
15. **	Source of Admission (SRC)	If this is a transfer admission, complete this field. The allowed values are: 4-Transfer from a hospital 5-Transfer from a skilled nursing facility 6-Transfer from another health care facility.
16.	Discharge Hour	Leave Blank.
17.*	Patient Status	Enter the 2-digit patient status code that best describes the patient's discharge status. Common values are: 01-Discharged to home or self-care 02-Discharged/transferred to another short-term general hospital for inpatient care 03-Discharged/transferred to skilled nursing facility

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
17.*Patient Status (continued)	04-Discharged/transferred to an intermediate care facility 05-Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06-Discharged/transferred to home under care of organized home health service 07-Left against medical advice, or discontinued care 08-Discharged/transferred to home under care of Home IV provider 20-Expired 30-Still a patient 63-Discharged/transferred to a Medicare certified long-term care hospital (LTCH)
18*-24*Condition Codes	Enter the appropriate two-character condition code(s). The values applicable to MO HealthNet are: C1-Approved as billed. Indicates the facility's Utilization Review authority has certified all days billed. C3- Partial Approval. The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. If C3 is entered, field 35 must be completed. **NOTE:** Code C1 or C3 is required.
18*-24*Condition Codes (continued)	A1-Healthy Children & Youth/EPSDT If this hospital stay is a result of an HCY referral or is an HCY related stay, this condition code must be entered on the claim A4-Family Planning. If family planning services occurred during the inpatient stay, this condition code must be entered

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled Field	Leave blank.
31-34.**Occurrence Codes Dates	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01 - Auto accident 02 - No Fault Insurance 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim 42 - To be entered when "Through" date in field 6 (Statement Covers Period) is **not** equal to the discharge date and the frequency code in field 4 indicates this is a final bill.
35. ** Occurrence Span Code & Dates	Required if C3 is entered in fields 18-24. Enter code "MO" and the first and last days that were approved by Utilization Review.
36. Occurrence Span Code & Date	Leave blank.
37. Unlabeled Field	Leave blank.
38. Responsible Party Name and Address	Leave blank.
39-41* Value Codes & Amounts	Enter the appropriate codes(s) and unit amount(s) to identify the information necessary for the processing of the claim. 80-Covered Days Enter the number of days shown in field 6, minus the date of discharge. The discharge date is not a covered day and should not be included in the calculation of this field.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
39-41* Value Codes & Amounts (continued)	The through date of service in field 6 is included in the covered days, if the patient status code in field 17 is equal to "30-still a patient." **NOTE:** The units entered in this field must be equal to the number of days in "Statement Covers Period", less day of discharge. If patient status is "still a patient," units entered include through day. 81-Non-covered Days If applicable, enter the number of non-covered days. Examples of non-covered days are those days for which the participant is ineligible. **NOTE:** The total units entered in this field must be equal to the total accommodation units listed in field 46.
42.* Revenue Code	List appropriate accommodation revenue codes first in chronological order. Ancillary codes should be shown in numerical order. Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to ICU to general. A private room must be medically necessary and the medical need must be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

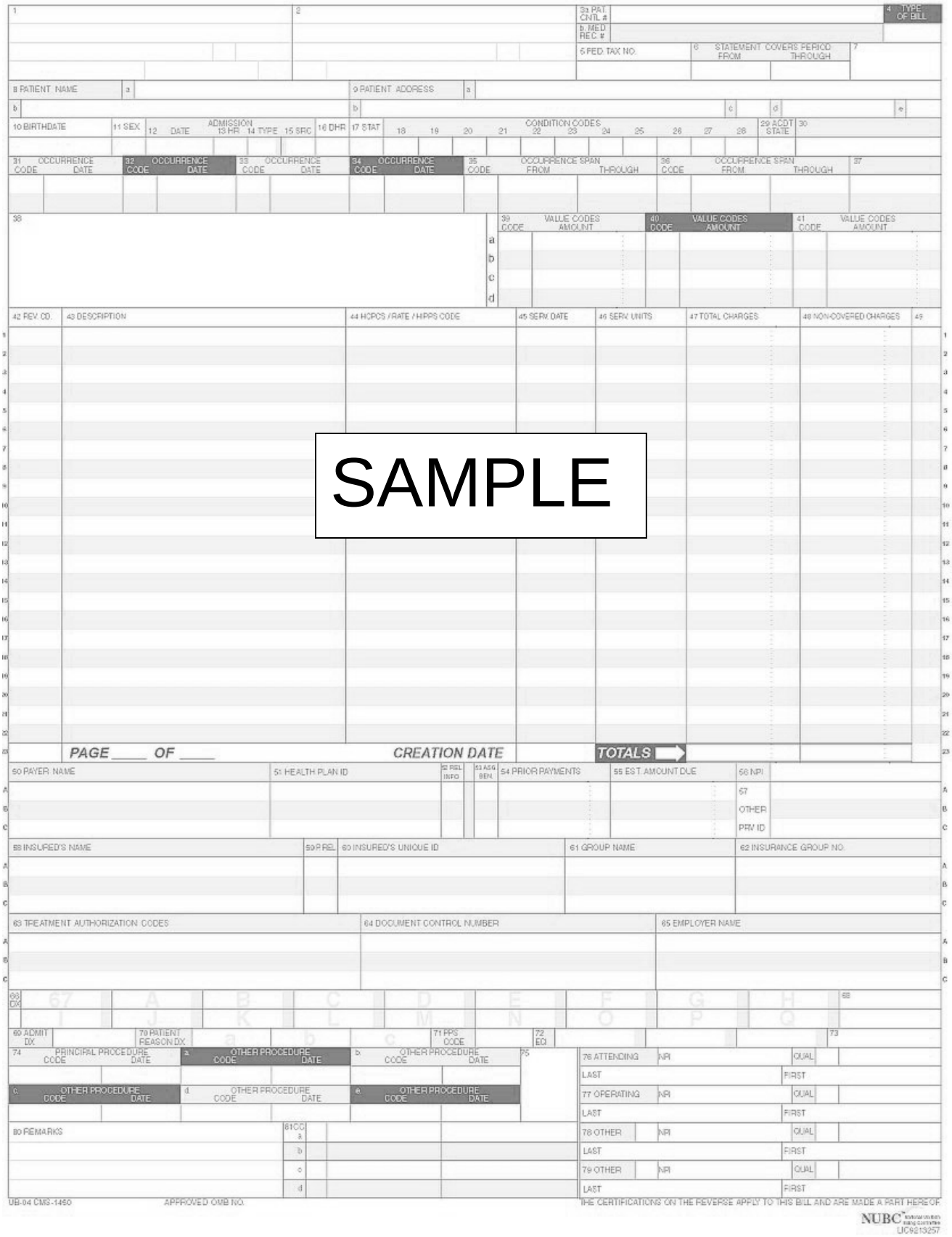
FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
42.*Revenue Code (Continued)		If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in field 47. Enter the difference between the private room total charge and the semi-private room total charge in field 48, "non-covered charges" After all revenue codes are shown, skip a line and list revenue code 001 which represents the total charges.
43.	Revenue Description	Leave blank.
44.*	HCPCS/Rates/ HIPPS Code	Enter the daily room and board rate to coincide with the accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use separate lines to report each rate.
45.	Service Date	Leave blank.
46.*	Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days. **NOTE:** The number of units in fields 39-41 must equal the number of units in this field.
47.*	Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 001. **NOTE:** The room rate multiplied by the number of units must equal the charge entered for room accommodation(s).

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
48. ** Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in fields 39-41. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was not medically necessary should be shown as non-covered in this field.
49. Unlabeled Field	Leave blank.
50.* Payer Name	The primary payer is always listed first. If the participant has insurance, the insurance plan is the primary payer and "MO HealthNet" is listed last.
51. Health Plan ID	Leave blank.
52. Release of Information Certification Indicator	Leave blank.
53. Assignment of Benefits Certification of Indicator	Leave blank.
54. ** Prior Payments	Enter the amount the hospital received toward payment of this bill from all other health insurance companies. Payments **must** correspond with the appropriate payer entered in field 50. *Do not enter a previous MO HealthNet payment, Medicare payment or co-pay amount received from the patient in this field.*
55. Estimated Amount Due	Leave blank.
56. National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number.
57.* Other Provider ID	Leave blank.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
59.	Patient's Relationship to the Insured	Leave blank.
60.*	Insured's Unique ID	Enter the participant's 8-digit MO HealthNet DCN identification number. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61. **	Insurance Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured.
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered.
63. **	Treatment Authorization Code	For claims requiring certification, enter the unique 7-digit certification number supplied by Xerox.
64. **	Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65.	Employer Name	If the participant is employed, the employer's name may be entered here.
66.	Diagnosis & Procedure Code Qualifier	Leave blank.
67.*	Principal Diagnosis Code	Enter the complete ICD-9-CM diagnosis code for the condition established after study to be chiefly responsible for the admission. Remember to code to the highest level of specificity shown in the current version of the ICD-9-CM diagnosis code book.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
67. ** A-D. Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received or the length of stay.
67. E-Q. Other Diagnosis Codes	Leave blank.
68. Unlabeled Field	Leave blank.
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment System (PPS) Code	Leave blank.
72. External Cause of Injury Code (E code)	Leave blank.
73. Unlabeled Field	Leave blank.
74. ** Principal Procedure Code & Date	Enter the full ICD-9-CM procedure code of the principal surgical procedure. The date on which the procedure was performed must be shown. Only the month and day are required.
74. ** A-E. Other Procedure Codes & Dates	Identify and date any other procedures that may have been performed.
75. Unlabeled Field	Leave blank.
76.* Attending Provider Name & Identifiers	Physician's NPI is required. Enter the attending physician's name, last name first.
77. ** Operating Provider Name & Identifiers	Physician's NPI number. Enter the operating physician's name, last name first.
78-79. ** Other Provider Name & Identifiers	Physician's NPI number. Enter the physician's name, last name first.
80. ** Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
81CC. Code-Code Field	Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy Code for the NPI number reported in field 56. The appropriate qualifier is: B3- Healthcare Provider Taxonomy Code.


SAMPLE
1
2
3a PAT. CNTL #
b MED REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28
CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC
a
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UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF
NUBC
UC9213257

SECTION 3
REVENUE CODES - INPATIENT

COVERED REVENUE CODES – INPATIENT SERVICES

A. ACCOMMODATIONS

Code	Description	Abbreviation
010X	**All Inclusive Rate**	
0101	All-Inclusive Room and Board	ALL INCL R&B
011X	**Room and Board - Private (Medical or General)**	
0110	General Classification	ROOM-BOARD/PVT
0111	Medical/Surgical/Gyn	MED-SUR-GY/PVT
0112	Obstetric	OB/PVT
0113	Pediatric	PEDS/PVT
0114	Psychiatric	PSYCH/PVT
0116	Detoxification	DETOX/PVT
0117	Oncology	ONCOLOGY/PVT
0118	Rehabilitation	REHAB/PVT
0119	Other	OTHER/PVT
012X	**Room and Board - Semi-Private Two Bed (Medical or General)**	
0120	General Classification	ROOM-BOARD/SEMI
0121	Medical/Surgical/Gyn	MED-SUR-GYN/2BED
0122	OB	OB/2BED
0123	Pediatric	PEDS/2BED
0124	Psychiatric	PSTAY/2BED
0126	Detoxification	DETOX/2BED
0127	Oncology	ONCOLOGY/2BED
0128	Rehabilitation	REHAB/2BED
0129	Other	OTHER/2BED
013X	**Room and Board - Semi-Private - Three and Four Beds**	
0130	General Classification	ROOM-BOARD/3&4BED
0131	Medical/Surgical/Gyn	MED-SUR-GY/3&4BED
0132	OB	OB/3&4BED
0133	Pediatric	PEDS/3&4BED
0134	Psychiatric	PSYCH/3&4BED
0136	Detoxification	DETOX/3&4BED
0137	Oncology	ONCOLOGY/3&4BED
0138	Rehabilitation	REHAB/3&4BED
0139	Other	OTHER/3&4BED

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

014X	**Room and Board - Private (Deluxe)**	
0140	General Classification	ROOM-BOARD/PVT/DLX
0141	Medical/Surgical/Gyn	MED-SUR-GY/DLX
0142	OB	OB/DLX
0143	Pediatric	PEDS/DLX
0144	Psychiatric	PSYCH/DLX
0146	Detoxification	DETOX/DLX
0147	Oncology	ONCOLOGY/DLX
0148	Rehabilitation	REHAB/DLX
0149	Other	OTHER/DLX

015X	**Room and Board – Ward (Medical or General)**	
0150	General Classification	ROOM-BOARD/WARD
0151	Medical/Surgical/Gyn	MED-SUR-GY/WARD
0152	OB	OB/WARD
0153	Pediatric	PEDS/WARD
0154	Psychiatric	PSYCH/ WARD
0156	Detoxification	DETOX/WARD
0157	Oncology	ONCOLOGY/WARD
0158	Rehabilitation	REHAB/WARD
0159	Other	OTHER/WARD

016X	**Room and Board - Other**	
0164	Sterile Environment	R&B/STERILE

017X	**Nursery**	
0170	General Classification	NURSERY
0171	Newborn - Level I	NURSERY/LEVELI
0172	Newborn - Level II	NURSERY/LEVELII
0173	Newborn - Level III	NURSERY/LEVELIII
0174	Newborn - Level IV	NURSERY/LEVELIV
0179	Other Nursery	NURSERY/OTHER

020X	**Intensive Care**	
0200	General Classification	INTENSIVE CARE (or ICU)
0201	Surgical	ICU/SURGICAL
0202	Medical	ICU/MEDICAL
0203	Pediatric Intensive Care	ICU/PEDS
0204	Psychiatric	ICU/PSTAY
0206	Intermediate ICU	ICU/INTERMEDIATE
0207	Burn Care	ICU/BURN CARE
0208	Trauma	ICU/TRAMA
0209	Other Intensive Care	ICU/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

021X	**Coronary Care**	
0210	General Classification	CORONOARY CARE (or CCU)
0211	Myocardial Infarction	CCU/MYO INFARC
0212	Pulmonary Care	CCU/PULMONARY
0214	Intermediate CCU	CCU/INTERMEDIATE
0219	Other Coronary Care	CCU/OTHER

B. ANCILLARIES

Code	Description	Abbreviation
025X	**Pharmacy**	
0250	General Classification	PHARMACY
0251	Generic Drugs	DRUGS/GENERIC
0252	Non-generic Drugs	DRUGS/NONGENERIC
0254	Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT/ODX
0255	Drugs Incident to Radiology	DRUGS/ INCIDENT RAD
0257	Non-prescription Drugs	DRUGS/NONPSCRPT
0258	IV Solutions	IV SOLUTIONS
0259	Other Pharmacy	DRUGS/OTHER
026X	**I.V. Therapy**	
0260	General Classification	IV THERAPY
0261	Infusion Pump	IV THER/INFSN PUMP
0262	IV Therapy/Pharmacy Svcs	IV THER/PHARM/SVC
0263	IV Therapy/Drug/Supply Delivery	IV THER/DRUG/SUPPLY DELV
0264	IV Therapy/Supplies	IV THER/SUPPLIES
0269	Other IV Therapy	IV THER/OTHER
027X	**Medical/Surgical Supplies and Devices**	
0270	General Classification	MED-SUR SUPPLIES
0271	Non-Sterile Supply	NON-STER SUPPLY
0272	Sterile Supply	STERILE SUPPLY
0275	Pacemaker	PACE MAKER
0276	Intraocular Lens	INTRA OC LENS
0278	Other Implant	SUPPLY/IMPLANTS
0279	Other Supplies/Devices	SUPPLY/OTHER
028X	**Oncology**	
0280	General Classification	ONCOLOGY
0289	Other Oncology	ONCOLOGY/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

030X	**Laboratory**	
0300	General Classification	LABORATORY or (LAB)
0301	Chemistry	LAB/CHEMISTRY
0302	Immunology	LAB/IMMUNOLOGY
0304	Non-routine Dialysis	LAB/NR DIALYSIS
0305	Hematology	LAB/HEMATOLOGY
0306	Bacteriology & Microbiology	LAB/BACT-MICRO
0307	Urology	LAB/UROLOGY
0309	Other Laboratory	LAB/OTHER
031X	**Laboratory Pathological**	
0310	General Classification	PATHOLOGY LAB (PATH LAB)
0311	Cytology	PATHOL/CYTOLOGY
0312	Histology	PATHOL/HISTOL
0314	Biopsy	PATHOL/BIOPSY
0319	Other Laboratory Pathological	PATHOL/OTHER
032X	**Radiology - Diagnostic**	
0320	General Classification	DX X-RAY
0321	Angiocardiography	DX X-RAY/ANGIO
0322	Arthrography	DX X-RAY/ARTH
0323	Arteriography	DX X-RAY/ARTER
0324	Chest X-ray	DX X-RAY/CHEST
0329	Other Radiology - Diagnostic	DX X-RAY/OTHER
033x	**Radiology – Therapeutic and/or Chemotherapy Administration**	
0330	General Classification	RX X-RAY
0331	Chemotherapy Administration-Injected	CHEMOTHER/INJ
0332	Chemotherapy Administration-Oral	CHEMOTHER/ORAL
0333	Radiation Therapy	RADIATION RX
0335	Chemotherapy Administration - IV	CHEMOTHERP-IV
0339	Other Radiology - Therapeutic	RX X-RAY/OTHER
034X	**Nuclear Medicine**	
0340	General Classification	NUCLEAR MEDICINE or (NUC MED)
0341	Diagnostic Procedures	NUC MED/DX
0342	Therapeutic Procedures	NUC MED/RX
0343	Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM
0344	Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
0349	Other	NUC MED/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

035X	**CT Scan**	
0350	General Classification	CT Scan
0351	Head Scan	CT SCAN/HEAD
0352	Body Scan	CT SCAN/BODY
0359	Other CT Scan	CT SCAN/OTHER
036X	**Operating Room Service**	
0360	General Classification	OR SERVICES
0361	Minor Surgery	OR/MINOR
0369	Other Operating Room Services	OR/OTHER
037X	**Anesthesia**	
0370	General Classification	ANESTHESIA
0371	Anesthesia Incident to Radiology	ANESTHE/INCIDENT RAD
0372	Anesthesia Incident to Other Diagnostic Services	ANESTH/INCIDENT OTHER DX
0379	Other Anesthesia	ANESTHESIA/OTHER
038X	**Blood**	
0380	General Classification	BLOOD
0381	Packed Red Cells	BLOOD/PKD RED
0382	Whole Blood	BLOOD/WHOLE
0383	Plasma	BLOOD/PLASMA
0384	Platelets	BLOOD/PLATELETS
0385	Leucocytes	BLOOD/LEUCOCYTES
0386	Other Components	BLOOD/COMPONENTS
0387	Other Derivatives (Cryopricipitates)	BLOOD/DERIVATIVES
0389	Other Blood	BLOOD/OTHER
039X	**Blood and Blood Component Administration, Processing and Storage**	
0390	General Classification	BLOOD/STOR-PROC
0391	Administration (e.g. Transfusion)	BLOOD/ADMIN
0399	Other Processing and Storage	BLOOD/OTHER STOR
040X	**Other Imaging Services**	
0400	General Classification	IMAGE SERVICE
0401	Diagnostic Mammography	DIAG MAMMOGRAPHY
0402	Ultrasound	ULTRASOUND
0403	Screening Mammography	SCRN MAMMOGRAPHY
0404	Positron Emission Tomography	PET SCAN
0409	Other Imaging Services	OTHER IMAG SVS

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

041X	**Respiratory Services**	
0410	General Classification	RESPIRATORY SVC
0412	Inhalation Services	INHALATION SVC
0413	Hyperbaric Oxygen Therapy	HYPERBARIC O2
0419	Other Respiratory Services	OTHER RESPIR SVS
042X	**Physical Therapy**	
0420	General Classification	PHYSICAL THERAP
0422	Hourly Charge	PHYS THERP/HOUR
0423	Group Rate	PHYS THERP/GROUP
0424	Evaluation or Re-evaluation	PHYS THERP/EVAL
0429	Other Physical Therapy	OTHER PHYS THERP
043X	**Occupational Therapy**	
0430	General Classification	OCCUPATION THER
0432	Hourly Charge	OCCUP THERP/HOUR
0433	Group Rate	OCCUP THERP/GROUP
0434	Evaluation or Re-evaluation	OCCUP THERP/EVAL
0439	Other Occupational Therapy	OTHER OCCUP THER
044X	**Speech - Language Pathology**	
0440	General Classification	SPEECH PATHOL
0442	Hourly Charge	SPEECH PATH/HOUR
0443	Group Rate	SPEECH PATH/GROUP
0444	Evaluation or Re-evaluation	SPEECH PATH/EVAL
0449	Other Speech - Language Pathology	OTHER SPEECH PATH
046X	**Pulmonary Function**	
0460	General Classification	PULMONARY FUNC
0469	Other Pulmonary Function	OTHER PULMON FUNC
048X	**Cardiology**	
0480	General Classification	CARDIOLOGY
0481	Cardiac Cath Lab	CARDIAC CATH LAB
0482	Stress Test	STRESS TEST
0483	Echocardiology	ECHOCARDIOLOGY
0489	Other Cardiology	OTHER CARDIOL
061X	**Magnetic Resonance Technology (MRT)**	
0610	General Classification	MRT
0611	MRI-Brain (including Brainstem)	MRI-BRAIN
0612	MRI-Spinal Cord (including Spine)	MRI-SPINE
0614	MRI-Other	MRI-OTHER
0615	MRA-Head and Neck	MRA-HEAD AND NECK

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

061X	**Magnetic Resonance Technology (MRT) (continued)**	
0616	MRA-Lower Extremities	MRA-LOWER EXT
0618	MRA-Other	MRA-OTHER
0619	Other MRT	MRT-OTHER
062X	**Medical/Surgical Supplies – Extension of 027X**	
0621	Supplies Incident to Radiology	MED-SUR SUPP/INCIDENT RAD
0622	Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCIDENT ODX
0623	Surgical Dressings	SURG DRESSINGS
063X	**Pharmacy – Drugs Requiring Specific Identification**	
0631	Single Source Drug	DRUG/SNGLE
0632	Multiple Source Drug	DRUG/MULT
0633	Restrictive Prescription	DRUG/RSTR
0634	Erythropoietin (EPO) less than 10,000 Units	DRUG/EPO <10,000 UNITS
0635	Erythropoietin (EPO) 10,000 or more Units	DRUG/EPO > 10,000 UNITS
0636	Drugs Requiring Detailed Coding	DRUG/DETAIL CODE
0637	Self Administrable Drugs	DRUG/ SELF ADMIN
071X	**Recovery Room**	
0710	General Classification	RECOVERY ROOM
0719	Other Recovery Room	OTHER RECOVERY RM
072X	**Labor Room/Delivery**	
0720	General Classification	DELIVERROOM/LABOR
0721	Labor	LABOR
0722	Delivery	DELIVERY ROOM
0724	Birthing Center	BIRTHING CENTER
0729	Other Labor Room/Delivery	OTHER/DELIV-LABOR
073X	**EKG/ECG (Electrocardiogram)**	
0730	General Classification	EKG/ECG
0731	Holter Monitor	HOLTER MONT
0739	Other EKG/ECG	OTHER EKG-ECG
074x	**EEG (Electroencephalogram)**	
0740	General Classification	EEG
0749	Other EEG	OTHER EEG

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

075X	**Gastro-Intestinal Services**	
0750	General Classification	GASTR-INST SVS
0759	Other Gastro-Intestinal	OTHER GASTRO-INTS
079X	**Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)**	
0790	General Classification	ESWT
0799	Other ESWT	ESWT/OTHER
080X	**Inpatient Renal Dialysis**	
0800	General Classification	RENAL DIALYSIS
0801	Inpatient Hemodialysis	DIALY/INPT
0802	Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
0803	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
0804	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
0809	Other Inpatient Dialysis	DIALY/INPT/OTHER
088X	**Miscellaneous Dialysis**	
0880	General Classification	DIALY/MISC
0881	Ultrafiltration	DIALY/ULTRAFILT
0889	Other Miscellaneous Dialysis	DIALY/MISC/OTHER
090X	**Behavioral Health Treatments/Services**	
0901	Electroshock Treatment	BH/ELECTRO SHOCK
091X	**Behavioral Health Treatments/Services – Extension of 090X**	
0911	Rehabilitation	BH/REHAB
0914	Individual Therapy	BH/INDIV RX
0915	Group Therapy	BH/GROUP RX
0918	Testing	BH TESTING
0919	Other Behavioral Health Treatments/Services	BH/OTHER
092X	**Other Diagnostic Services**	
0920	General Classification	OTHER DX SVS
0921	Peripheral Vascular Lab	PERI VASCUL LAB
0922	Electromyelogram	EMG
0923	Pap Smear	PAP SMEAR
0924	Allergy Test	ALLERGY TEST
0925	Pregnancy Test	PREG TEST
0929	Other Diagnostic Service	ADDITIONAL DX SVS

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

094X	**Other Therapeutic Services**	
0940	General Classification	OTHER RX SVS
0941	Recreational Therapy	RECREATION RX
0943	Cardiac Rehabilitation	CARDIAC REHAB
0944	Drug Rehabilitation	DRUG REHAB
0945	Alcohol Rehabilitation	ALCOHOL REHAB
0946	Complex Medical Equipment-Routine	CMPLX MED EQUIP-ROUT
0947	Complex Medical Equipment-Ancillary	CMPLX MED EQUIP-ANC
0949	Other Therapeutic Service	ADDITIONAL RX SVS

NON-COVERED REVENUE CODES – INPATIENT SERVICES

001X-0100	0253	0450-0459	0882
0102-0109	0256	0470-0479	0890-0899
0115	0273-0274	0490-0609	0900
0125	0277	0613	0902-0909
0135	0290-0299	0617	0912-0913
0145	0303	0624	0916-0917
0155	0362	0630	0930-0939
0160	0367	0640-0709	0942
0167-0169	0374	0723	0950-0999X
0180-0199	0421	0732	
0213	0431	0760-0789	
0220-0249	0441	0810-0879	

NOTE: Any service for which there is no assigned revenue code is considered non-covered.

SECTION 4
INPATIENT HOSPITAL CERTIFICATION REVIEWS

Inpatient hospital admissions must be certified as medically necessary and appropriate as inpatient services before MO HealthNet reimburses for inpatient services. All hospitals enrolled with MO HealthNet as a provider are subject to this admission certification requirement. The review authority is assigned to Xerox Care and Quality Solutions. The responsibilities of Xerox include validation review services, admission certification for most admissions, and continued stay reviews for admissions subject to admission certification. Inpatient hospital certification reviews are covered in Section 13.31 of the MO HealthNet hospital provider manual available at:
http://manuals.momed.com/manuals/

SERVICES EXEMPT FROM ADMISSION CERTIFICATION

The following services do not require admission certification. Claims with a principal diagnosis that is one of the exempt diagnosis codes do not require a certification number in field 63 on the UB-04 claim form. Xerox does not need to be contacted under these circumstances.

Certain Pregnancy-Related Diagnosis Codes

630
631
633 range
640-649 range with a fifth digit of 0, 1, 2 or 3
651-676 range with a fifth digit of 0, 1, 2 or 3
677

NOTE: Diagnoses for missed abortion, pregnancy with abortive outcome, and postpartum care continue to require certification.

Admissions for Deliveries

Delivery diagnosis codes are:

640-649 range with a fifth digit of 0, 1, 2 or 3
650
651-676 range with a fifth digit of 0, 1, 2 or 3
V24.0
V27.0-V27.9

NOTE: Providers are cautioned to refer to the ICD-9-CM diagnosis coding book because a fifth digit of 0, 1, 2 or 3 is *not* valid with every diagnosis within the ranges listed above.

Admissions for Newborns

Newborn diagnosis codes are:

V30.00-V39.1 (If the fourth digit is 0, a fifth digit of 0 or 1 is required)
760-779.9

Admissions of Patients Enrolled in MO HealthNet Managed Care Health Plans

The health plan is responsible for certifying the hospital admission for MO HealthNet managed care plan enrollees. A transplant candidate may choose the MO HealthNet approved transplant facility and may choose a MO HealthNet approved transplant facility outside of the health plan's network and MO HealthNet will prior authorize the transplant. The health plan is responsible for pre-transplant and post-transplant follow-up at both the in-network and the out-of-network transplant facilities.

Admissions Covered By Medicare Part A

Claims for deductible and coinsurance for MO HealthNet patients with Medicare Part A benefits are exempt from admission certification. However, if Medicare Part A benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. Pre-admission certification is required also for denied Medicare Part A inpatient hospital claims including exhausted benefits. Before requesting a pre-certification, the provider must exhaust all appeals through the Medicare appeals process and have a final denial that can be submitted to Xerox with the pre-certification request.

Admissions for MO HealthNet patients with only Medicare Part B require certification.

Inpatient Hospital Certification Reviews for Medicare Part C Participants

Inpatient hospital claims for deductible and coinsurance for MO HealthNet patients with Medicare Part C benefits who also are QMB eligible are exempt from admission certification. However, if Medicare Part C benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. Pre-admission certification is required also for denied Medicare Part C inpatient hospital claims including exhausted benefits. Before requesting a pre-certification, the provider must exhaust all appeals through the Medicare Advantage/Part C plan appeals process and have a final denial that can be submitted to Xerox with the pre-certification request.

Admissions for non-QMB MO HealthNet participants enrolled in a Medicare Advantage/Part C Plan require certification.

Criteria Used in Review

Xerox utilizes the *Milliman Care Guidelines*® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations including those for adult and child psychiatric care, alcohol and drug abuse detoxification and physical

rehabilitation. It is important to remember that screening criteria are *not* standards of care. Failure to meet any particular screen does *not* mean that the patient does *not* require acute hospital level of care but rather that the case requires review by a physician.

CONTACTING XEROX

Providers may contact Xerox at:

Xerox Care and Quality Solutions
3425 West Truman Blvd
P.O. Box 105110
Jefferson City, MO 65110-5110

Internet: cyberaccessonline.net/CyberAccess/Login.aspx -- for admission certification prior to admission, on the day of admission, within twenty-four (24) hours after admission and prior to discharge or within fourteen (14) days after discharge for continued stay reviews. CyberAccess requests may be submitted twenty-four (24) hours a day seven (7) days a week.

Phone: (800) 766-0686—for admission certification prior to admission, on the day of admission, within twenty-four (24) hours after admission and for continued stay review.

Fax: (866) 629-0737— Other requests for certification of an inpatient stay may be made via fax. Faxes may be submitted twenty-four (24) hours a day seven (7) days a week.

Requests for retrospective review require all medical records related to the inpatient stay. This type of request must be faxed or mailed to the above P.O. Box. The medical records must only be mailed to the physical address when using Fed Ex or UPS or any other mode of delivery outside the US Postal Service.

The Xerox office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except for established DSS approved holidays. Telephone calls made before or after working hours receive a recorded message about the working hours.

PROVIDER RESPONSIBILITIES

Xerox must be contacted by the physician or the hospital to provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in Missouri state regulation 13 CSR 70-15.020.

CONTINUED STAY REQUESTS

The provider is responsible for contacting Xerox to request an extended stay beyond what was previously certified.

SECTION 5
UB-04 CLAIM FILING INSTRUCTIONS
OUTPATIENT HOSPITAL

The following instructions pertain to outpatient hospital claims which are being filed to MO HealthNet on a paper UB-04 claim form. The requirements for filing an electronic version of the UB-04 claim form for outpatient services are slightly different. If filing claims electronically via the Wipro Infocrossing Internet service, emomed.com, refer to the help link (?) at the top of the electronic UB-04 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-04 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims for hospital outpatient care are to be mailed to:

Wipro Infocrossing Healthcare Services, Inc.
P.O. Box 5200
Jefferson City, MO 65102

MO HealthNet forms, for claims processing can be obtained at:
http://manuals.momed.com/manuals/presentation/forms.jsp .

NOTE: An asterisk (*****) beside field numbers indicates required fields on all outpatient UB-04 claim forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (******) beside the field number indicate a field is required in specific situations.

FIELD NUMBER and NAME		INSTRUCTIONS FOR COMPLETION
1.*	Provider Name, Address Telephone Number	Enter the provider name, address, and telephone number.
2.	Unlabeled Field	Leave blank.
3.	Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
4.*	Type of Bill	For an outpatient claim, the only allowed type of bill is “131”.
5.	Federal Tax Number	Enter the provider's federal tax number or leave blank.
6.	Statement Covers Period	Indicate the beginning and ending dates being being billed on this claim form. Enter in the MMDDYY or MMDDYYYY numeric format or leave blank.
7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the participant's 8-digit MO HealthNet DCN identification number. **NOTE:** The MO HealthNet DCN identification number is required in field 60.
8b.*	Patient's Name	Enter the participant's name in the following format: last name, first name, middle initial.
9.	Patient's Address	Enter the participant's full mailing address, including street number and name, post office box number or RFD, city, state, and zip code.
10.	Patient's Birth Date	Enter the participant's date of birth in MMDDYY format.
11.	Patient's Sex	Enter the participant's sex, "M" (male) or "F" (female).
12.	Admission Date	Leave blank.
13.	Admission Hour	Leave blank.
14.**	Admission Type	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type 1. Condition code AJ also must be listed in field 24 to exempt the patient from the $3 cost sharing amount for the service.
15.	Source of Admission (SRC)	Leave blank.
16.	Discharge Hour	Leave blank.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
18-24.** Condition Codes.	Enter the applicable two-character condition code. The values are: A1 - HCY/EPSDT. If this service is the result of an HCY referral or is an HCY related visit, enter this condition code. A4 - Family Planning If the family planning service occurred during the visit, enter this condition code. Do *not* bill family planning services on the same claim with non-family planning services. AJ - Payer not Responsible for Co-payment If the visit is the result of an emergency or therapy services are provided, then this condition code must be entered to exempt the patient from the $3 cost sharing amount.
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled Field	Leave blank.
31-34.** Occurrence Codes	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. 01 - Auto Accident 02 - No Fault 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim
35-36. Occurrence Span Code and Dates	Leave blank.
37 Unlabeled Field	Leave blank.
38. Responsible Party Name and Address	Leave blank.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
39-41.	Value Codes and Amounts	Leave blank
42.**	Revenue Codes	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies, and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s). If reporting a surgical procedure enter the appropriate 4-digit surgical revenue code for the surgery.
43.	Revenue Description	Leave blank.
44.*	HCPCS/Rates/HIPPS	Only enter the CPT or HCPCS procedure code(s) if for services *other* than outpatient facility codes listed in field 42. If reporting a surgical procedure enter the appropriate surgical CPT code for the surgery.
45.*	Service Date	Enter the date of service on each line in the MMDDYY format.
46.*	Service Units	Enter the number of units for each procedure, code or revenue code. Facility revenue codes 0450, 0459, 0490, 0510 and supply codes 0260, 0270 and 0274 should always be billed with a unit of "1". The outpatient observation code 0762 should be billed with the appropriate number of hours the participant was in observation status. If reporting a surgical procedure enter a unit of “1”.
47.*	Total Charges	Enter the total charge for each line item. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001. If reporting a surgical procedure the charged amount must be zero ($0.00).
48.	Non-covered Charges	Leave blank.
49.	Unlabeled Field	Leave blank.
50.*	Payer Name	The primary payer is always listed first. If the participant has insurance, the insurance plan is the primary payer and MO HealthNet is listed last.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
51.	Health Plan ID	Leave blank.
52.	Release of Information Certification Ind.	Leave Blank.
53.	Assignment of Benefits Certification Ind.	Leave Blank.
54.**	Prior Payments	Enter the amount the provider received toward payment of this bill from all other health insurance companies. Payments must correspond with the appropriate payer entered in field 50. *Do not enter a previous MO HealthNet payment, Medicare payment or a co-pay amount from the patient in this field.*
55.	Estimated Amount Due From Patient	Leave blank.
56.	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number.
57.*	Other Payer ID	Leave blank.
58.**	Insured's Name	Complete if the insured's name is different from the participant's name.
59.	Patient's Relationship to the Insured	Leave blank.
60.*	Insured's Unique ID	Enter the participant's 8-digit MO HealthNet DCN identification number. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61.**	Insurance Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured.
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered.
63.	Treatment Authorization Code	Leave blank.

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
64.** Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65. Employer Name	If the participant is employed, the employer's name may be entered here.
66. Diagnosis & Procedure Code Qualifier	Leave blank.
67.* Principal Diagnosis Code	Enter the complete ICD-9-CM diagnosis code for the condition for which the services were provided. Remember to code to the highest level of specificity shown in the current version of the ICD-9 diagnosis code book.
67. A-D** Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received.
67. E-Q Other Diagnosis Codes	Leave blank.
68. Unlabeled field	Leave blank.
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment System (PPS) Code	Leave blank.
72. External Cause of Injury Code (E-code)	Leave blank.
73. Unlabeled Field	Leave blank.
74.** Principal Procedure Code and Date	Leave blank. [Now reported at the detail line with the appropriate surgical revenue code, surgical CPT code, quantity of “1”, and charged amount of zero ($0.00)].

FILED NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
74. A-E ** Other Procedure Codes and Dates	Leave blank. [Now reported at the detail line of the claim with the appropriate surgical revenue code, surgical CPT code, quantity of “1”, and charged amount of zero ($0.00)].
75. Unlabeled Field	Leave blank.
76. ** Attending Provider Name and Identifiers	Physician's NPI is required. Enter the attending physician’s name, last name first.
77.** Operating Provider Name and Identifiers	Physician's NPI number. Enter the operating physician's name, last name first.
78-79. ** Other Provider Name and Identifiers	Physician's NPI number. Enter the physician's name, last name first.
80. Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
81. CC Code-Code Field	Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy Code for the NPI number reported in field 56. The appropriate qualifier is: B3-Healthcare Provider Taxonomy Code.


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE ADMISSION
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57
OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d
UB-04 CMS-1450 APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF
NUBC
UC9213257

SECTION 6
REVENUE CODES – OUTPATIENT
HOSPITAL FACILITY

Only the revenue codes listed below are recognized on the outpatient hospital claim as facility revenue codes. Do not list both a facility code and a CPT/HCPCS code.

FACILITY CODE DESCRIPTION	REVENUE CODE
Outpatient Clinical: Non-surgical	0510
Outpatient Clinical: Surgical	0490
Emergency Room: Non-surgical	0450
Emergency Room: Surgical	0459
General – Pharmacy	0250
Medical/Surgical Supplies	0270*
IV Supplies	0260
Blood	0390
Orthopedic Supplies	0274
Cardiac Rehabilitation	0943

* Revenue code 270 should be reported only **once** on the outpatient claim. It is to be reported for medical or surgical supplies or both combined.

Observation room services

Procedure code G0378 **must** be billed with revenue code 0762 and the appropriate number of hours the participant was in observation status in the Units field of the claims. Only one observation code per stay may be billed. If the stay spans beyond midnight, only one date of service is billed, which is the date the participant was placed in observation status. If the hospital has a participant in an observation room more than 24 hours, the charges beyond that time **must** be absorbed as an expense to the hospital. Those charges **cannot** be billed to MO HealthNet or to the participant.

Hospital Based Dialysis Clinics

MO HealthNet accepts the following revenue codes for dialysis services provided in hospital based dialysis clinics.

Revenue Code	Description
0821	Hemodialysis
0831	Peritoneal Dialysis
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD)
0851	Continuous Cycling Peritoneal Dialysis (CCPD)

SECTION 7
OUTPATIENT THERAPY PROCEDURES

PHYSICAL THERAPY

Physical therapy (PT) is a MO HealthNet covered service for participants under age 21 or in the categories of assistance for pregnant women, blind participants or nursing facility residents. Use CPT procedure codes in the 97000 range for PT evaluation. If physical therapy is provided for a participant under 21 years of age as a result of a screening, enter code "A1" in fields 18-24 of the UB-04 claim form or the appropriate field(s) on the electronic claim form to indicate that it is an EPSDT/HCY service.

NOTE: Reimbursement made to hospitals for HCY therapy services is based on that hospital's interim outpatient reimbursement percentage; however, the final outpatient settlement does not include HCY costs or charges, nor are occupational and speech therapy cost centers allowed in computing the final outpatient cost settlement.

OCCUPATIONAL THERAPY

Occupational therapy is covered in the outpatient hospital setting for participants under age 21 or in the categories of assistance for pregnant women, blind participants or nursing facility residents.

Under the EPSDT/HCY Program, OT is covered for participants under 21 years of age when:

- the need is identified by an EPSDT/HCY screen; or
- there is a physician referral; or,
- the service regimen is incorporated into a plan of care.

Codes in the EPSDT/HCY OT Program are in fifteen-minute units only. Use the following procedure codes for the EPSDT/HCY Program.

97703EP	Occupational Therapy Evaluation - 15 minutes
97535EP	Occupational Therapy Treatment - 15 minutes

SPEECH/LANGUAGE THERAPY

Speech therapy is covered in the outpatient hospital setting for participants under age 21 or in the categories of assistance for pregnant women, blind participants or nursing facility residents.

Under the EPSDT/HCY Program, speech/language is covered for participants under 21 years of age when:

- the need is identified by an EPSDT/HCY screen; or
- there is a physician referral; or,
- the service regimen is incorporated into a plan of care.

Codes in the EPSDT/HCY Speech/Language Program are in 15-minute units only. Use the following procedure codes for the EPSDT/HCY Program.

92506EP	Speech/Language Evaluation - 15 minutes
92507EP	Individual Speech/Language Treatment - 15 minutes
92508EP	Group Speech/Language Treatment -15 minutes

LIMITATIONS OF EPSDT/HCY THERAPY

Evaluations are limited to four hours per discipline per provider in a 12-month period. Therapy treatment services that exceed one hour and fifteen minutes (five units) in one day must have documentation attached to the claim that justifies the need for intensive therapy treatment. Claims with six or more units for occupational or speech/language therapy suspend in the claims processing system for a consultant to review the documentation. If documentation is not attached or the consultant does not approve the additional units, the total number of units is reduced to those considered medically necessary; however, the total units are not reduced to less than five units per day. Documentation includes the evaluation, the treatment plan and the physician's orders or referral.

OUTPATIENT THERAPY SERVICES EXEMPT FROM COST SHARING

Condition code "AJ" must be used on the outpatient claim in field(s) 18-24 on the UB-04 in order to properly identify therapy services that are exempt from the cost sharing requirement.

When billing MO HealthNet, indicate the usual and customary charge for the service as the billed amount in the charge column. Do not deduct the participant's cost sharing amount from the billed charge and do not show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the cost sharing amount, thus determining the correct payable amount.

SECTION 8
THE REMITTANCE ADVICE

MO HealthNet discontinued printing and mailing paper Remittance Advices (RAs) to providers. The remittance advices are available via the Internet through the MO HealthNet Web portal, emomed.com. There are three versions available, the 837 format, a proprietary version and the Printable RA.

Using emomed.com, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run;
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the MO HealthNet Division Web site, dss.mo.gov/mhd/providers/index.htm, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the financial cycle runs. Reimbursement will be made through direct bank deposit approximately two weeks after the cycle run date. (See the Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

16 – UB-04 CMS 1450 paper claim
49 – Internet claim (Amount will have a negative sign behind a Credit/Adjustment)

50 – Individual Adjustment Request
55 – Mass Adjustment (Amount will have a negative sign behind a Credit/Adjustment)

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1612031000000 is read as a UB-04 paper hospital claim entered in the processing system on January 31, 2012.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at emomed.com. A provider must be enrolled with emomed.com in order to access the web portal and the printable RA. To apply online go to the MO HealthNet web portal emomed.com and click on Register Now.

On the Welcome to eProvider page, click on File Management, then select Printable RAs and the date you wish to view, you may print or upload files to your system. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://adobe.com/products/acrobat/readstep2.htm to download it to your computer.

Note: When printing an RA, it is set to page break after 70 lines per page.

In general, the Printable Remittance Advice is displayed as follows.

FIELD	DESCRIPTION
PARTICIPANT'S NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MO HEALTHNET ID	The participant's 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.

FIELD	DESCRIPTION
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant co-pay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PER PROV	The National Provider Identifier (NPI) for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.

FIELD	DESCRIPTION
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

SECTION 9
MEDICARE/MO HEALTHNET CROSSOVER CLAIMS

Medicare/MO HealthNet (crossover) claims that do not automatically cross from Medicare to MO HealthNet must be filed through the MO HealthNet billing Web site, www.emomed.com, or through the 837 electronic claims transaction. Providers should wait sixty (60) days from the date of Medicare's explanation of benefits (EOMB) showing payment before filing an electronic claim. This will avoid possible duplicate payments from MO HealthNet.

Claims do not cross over from Medicare to MO HealthNet for various reasons. Two of the most common are as follows:

- Invalid participant information on file causes many claims to not cross over electronically from Medicare. Participants not going by the same name with Medicare as they do with MO HealthNet will not cross over electronically. Additionally, the participant's Medicare Health Insurance Claim number (HIC) in the MO HealthNet eligibility file must match the HIC number used by the provider to submit to Medicare. It is the responsibility of the participant to keep this information updated with their Family Support Division Eligibility Specialist.
- MO HealthNet enrolled providers who have not provided the Provider Enrollment Unit with their National Provider Identifier (NPI) used to bill Medicare. Providers in doubt as to what NPI number is on file should contact the Provider Enrollment Unit by e-mail at mmac.providerenrollment@dss.mo.gov. Providers who have not submitted their Medicare NPI number may fax a copy of their Medicare approval letter showing their NPI, provider name and address, to Provider Enrollment at 573-526-2054.

Following are tips to assist you in successfully filing crossover claims on the MO HealthNet billing Web Portal, emomed.com.

- From 'Claim Management' choose either the 'Medicare UB-04 Part A – Institutional' or the 'Medicare UB-04 Part B Professional' format under the 'New Xover Claim' column.
- Providers must submit claims to MO HealthNet with the same NPI they used to bill Medicare.
- There is a 'Help' feature available by clicking on the question mark in the upper right hand corner of the screen.
- Select 'MA-Medicare' or 'MB-Medicare' as the 'Filing Indicator' from the drop down box.
- On the Header Summary screen, the 'Other Payer ID' is a unique identifier on the other payer remittance advice. If not provided, it is suggested using a simple, easy to remember ID. This field may contain numeric and/or alpha-numeric data up to 20 characters.

- All fields with an asterisk are required and should be completed with the same information submitted to Medicare. Data entered should be taken directly from your Medicare EOMB with the exception of the participant's name and HIC; these must be entered as they appear in the MO HealthNet participant eligibility file.
- The Other Payer Detail Summary must contain the same number of line items as the number of detail lines entered.
- The "Payer at Header Level" box should only be checked if the claim is for an Inpatient Medicare Part A hospital stay.

MEDICARE ADVANTAGE/PART C CROSSOVER CLAIMS FOR QMB OR QMB PLUS PARTICIPANTS

Medicare Advantage/Part C plans do not forward electronic crossover claims to MO HealthNet. Therefore providers must submit these claims through the MO HealthNet billing Web portal, emomed.com. The following tips provide assistance in successfully filing Medicare Advantage/Part C crossover claims:

- From "Claim Management" choose the 'Medicare UB-04 Part C Institutional' or the 'Medicare UB-04 Part C Professional' under the 'New Xover Claim' drop down box.
- Depending on the claim type, select '16-Medicare Part C Institutional' or 'Medicare Part C Professional' as the 'Filing Indicator' from the drop down box on the Header Summary screen.
- Always verify eligibility either through the 'Participant Eligibility' link on emomed.com or access the Interactive Voice Response (IVR) at 573-751-2896 to see if the participant is a Qualified Medicare Beneficiary (QMB) on the date of service. Eligibility must be checked prior to each date of service. The Part C format can only be used if the participant is QMB eligible on the date of service.

Providers must not use the crossover claim forms to submit claims for non-QMB participants enrolled in a Medicare Advantage/Part C plan. These services are to be filed on an Outpatient or Inpatient UB-04 depending on the claim type with the Part C information shown as though it is commercial insurance information. Under "Other Payers" filing Indicator, select
'16 -Health Maint Org Medicare Risk' from the drop down box.

Under no circumstances are providers to submit crossover claims, Medicare or Medicare Advantage/Part C QMB, as paper claims to Infocrossing Healthcare Services.

SECTION 10

PRE-CERTIFICATION FOR RADIOLOGICAL SERVICES

RADIOLOGY BENEFIT MANAGEMENT PROGRAM (RBM)

Effective for dates of services on and after July 19, 2010, the MO HealthNet Division, in conjunction with Xerox and MedSolutions (MSI), implemented a new quality-based Radiology Benefit Management Program (RBM). The RBM is an expansion of the existing precertification process previously used for MRIs and CTs of the brain, head, chest and spine. As of July 19, 2010, certain radiologic procedures require precertification and are processed using clinical guidelines that are available at http://medsolutions.com/documents/guidelines/guidelines.php. The guidelines are not intended to supersede or replace sound medical judgment, but instead should facilitate the identification of the most appropriate imaging procedure based upon the participant's clinical condition.

The RBM program is for the following outpatient, diagnostic, non-emergency procedures.

- High-Tech (MRI, MRA, CT, CTA, and PET scans)
- Cardiac Imaging (including Nuclear Cardiac (SPECT), EBCT/Calcium Scoring, Transthoracic ECHO, Cardiac PET and PET/CT, Transesophageal ECHO, diagnostic heart catheterization and Stress ECHO)

Detailed information on the RBM program is found in the MO HealthNet Radiology Bulletin, Volume 33, Number 32, dated February 8, 2011, available at:

http://dss.mo.gov/mhd/providers/pdf/bulletin33-32_2011feb08.pdf

RESOURCES

Links to the following resources are available at:
http://medsolutions.com/implementation/mo_health/

- 2012 CPT Code List
- Quick Reference Guide
- Provider Orientation Presentation
- Grouping Logic

DENIALS

MedSolutions notifies the referring physician and requested facility in writing of a denial and provides a rationale for the determination within one working day of decision. This communication sets forth the appeal options per current MO HealthNet policy. MedSolutions also offers the ordering physician a consultation with a MedSolutions Medical Director on a peer-to-peer basis. In certain instances, additional information provided during the peer-to-peer consultation is sufficient to satisfy medical necessity criteria. To request a peer-to-peer consultation, the physician must call (800) 392-8030, option 5.

PLEASE NOTE: An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at 573-751-2896 or by logging on to the MO HealthNet billing Web portal at http://emomed.com.

SECTION 11
PHARMACY CLAIM
FILING INSTRUCTIONS

Hospital outpatient medication claims may be submitted electronically either through a clearinghouse, billing agent or the MO HealthNet Web portal at emomed.com.

MANAGED CARE HEALTH PLAN PHARMACY "CARVE OUT"
Effective October 1, 2009, the MO HealthNet Managed Care health plans no longer provide pharmacy services for their members. Pharmacy claims for all MO HealthNet Managed Care members are processed by the MO HealthNet Fee-for-Service (FFS) Pharmacy Program. The MO HealthNet FFS Pharmacy Program will pay for all hospital outpatient pharmacy services and diabetic testing supplies. Existing FFS Pharmacy Program clinical editing parameters and Preferred Drug List criteria still apply for coverage of pharmacy claims, and can be found at the following link.

http://dss.mo.gov/mhd/cs/pharmacy/pages/clinedit.htm.

The carve out of pharmacy services in relation to hospitals includes all medications and pharmaceuticals administered in a hospital outpatient or emergency department setting including physician-administered drugs. **Note – any medications administered to a MO HealthNet participant officially admitted to observation status must be billed to the participant's managed care health plan.**

DRUG COVERAGE UNDER THE MO HEALTHNET PHARMACY PROGRAM

All drug products produced by manufacturers that have entered into a rebate agreement with the Federal Government are reimbursable under the MO HealthNet Pharmacy Program, with the exception of Drug Efficacy Study Implementation (DESI) drugs and drugs specified in Section 13, Benefits and Limitations, of the pharmacy manual.

To comply with the Deficit Reduction Act of 2005 (DRA) states must now collect the 11-digit National Drug Codes (NDC) on all outpatient drug claims submitted to the MO HealthNet program for rebate purposes. Providers are required to submit their claims for all medications administered in the clinic or outpatient hospital setting, with the exact NDC that appears on the product dispensed or administered. Should a dispute arise between MO HealthNet utilization data and a manufacturer's estimation of product sold, data is supplied to the manufacturer to resolve the dispute. If necessary, zip code or provider-specific utilization data is provided. Should data indicate that a provider is billing fraudulently by using NDCs other than those identifying the actual product dispensed, the information is referred to the Missouri Medicaid Audit & Compliance (MMAC) Unit and may result in legal action, provider sanctions and possible termination from the program.

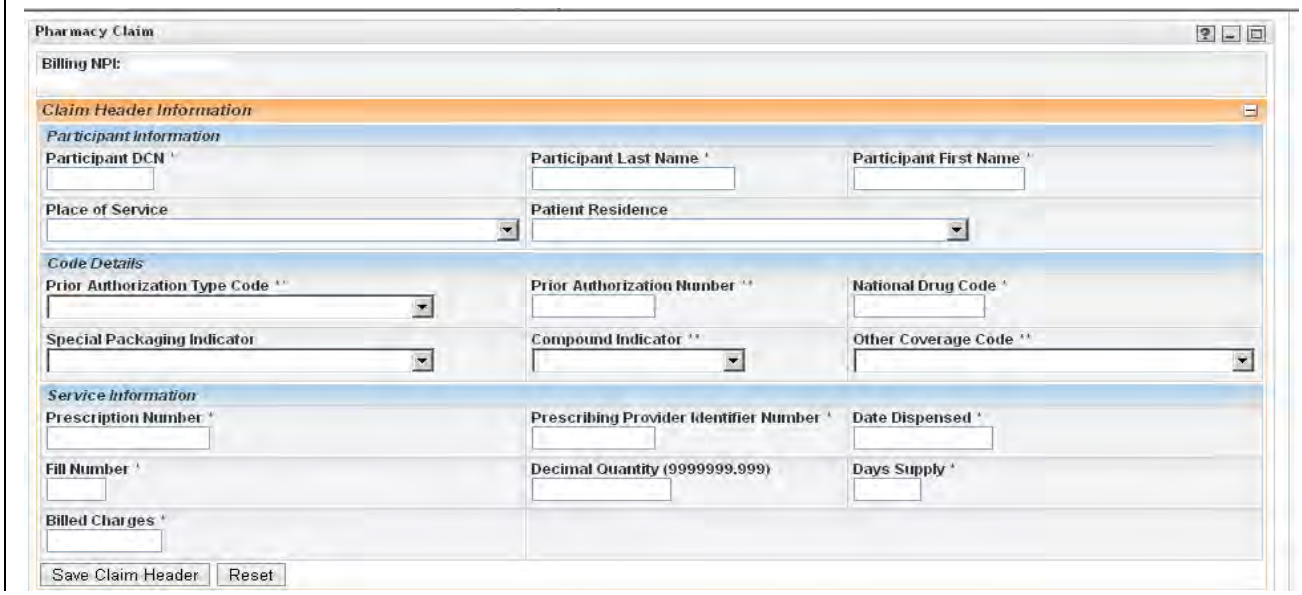
MEDICATION BILLING

The quantity to be billed for pharmacy items (e.g. creams, salves) and injectable medications dispensed to MHD patients must be calculated as follows:

- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) must be billed by the exact cubic centimeters or milliliters (cc or ml), even if the quantity includes a decimal (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Ointments, salves, or creams *must* be billed per number of grams even if the quantity includes a decimal.
- Eye drops *must* be billed per number of cubic centimeters or milliliters (cc or ml) in each bottle even if the quantity includes a decimal.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit for example Copaxone, Pegasys).
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- Bill the number of tablets dispensed.
- Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Claims billed incorrectly are identified through a dispute resolution process. When these claims are identified, providers are notified and required to file adjustments to accurately reflect the quantity dispensed.

For specific questions concerning pharmacy items and injectable medication billing, contact the Pharmacy and Clinical Services Administration Unit at (573) 751-6963.



Electronic Pharmacy Claim Form Filing Instructions

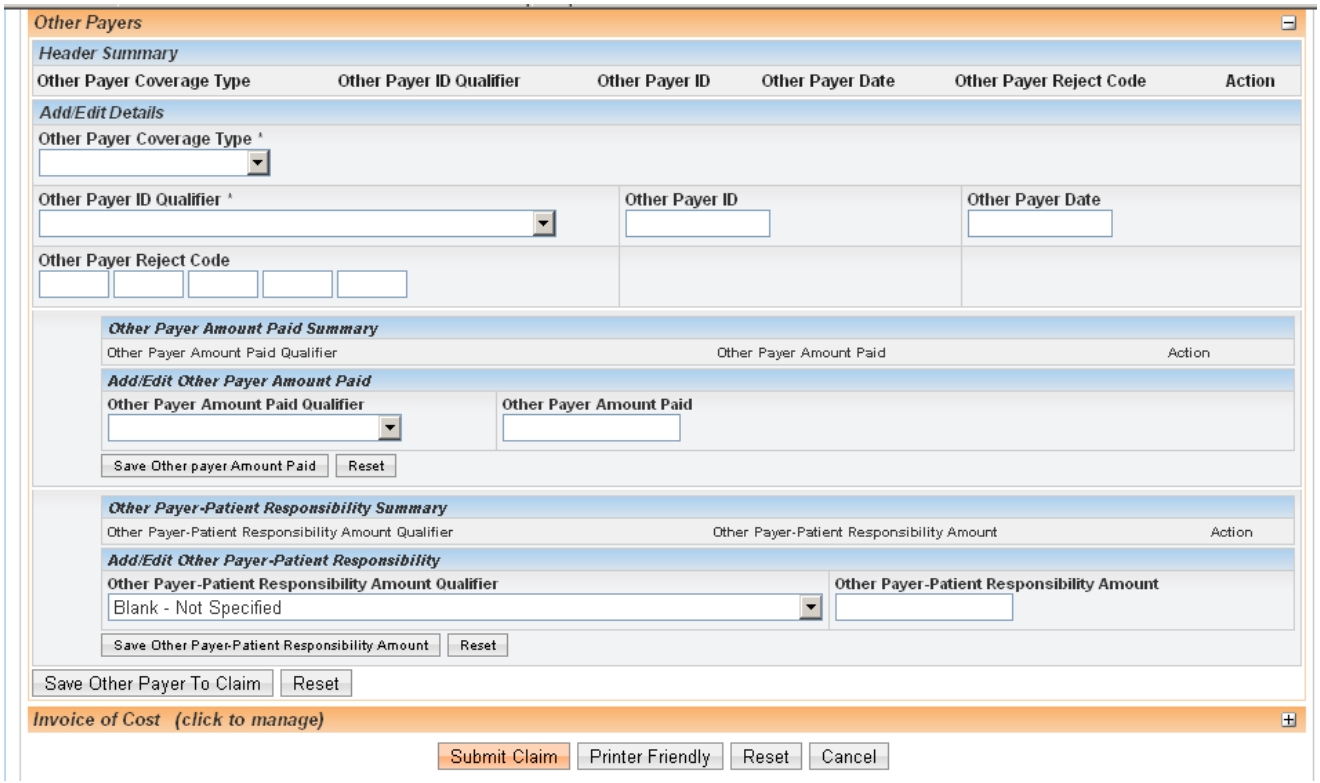
NOTE: *These fields are required on all Pharmacy claim submissions.
**These fields are required only in specific situations, as described below.
NPIs with alpha characters are case sensitive.

FIELD	INSTRUCTIONS FOR COMPLETION
Participant's DCN*	Enter the participant's eight digit MO HealthNet identification number (DCN).
Participant's Last Name*	Enter the participant's last name.
Participant's First Name*	Enter the participant's first name.
Place of Service	Required only for pharmacy providers
Patient Residence	Required only for pharmacy providers
Prior Authorization Type Code**	The valid values are: 0 Not Specified 1 Prior Authorization 2 Medical Certification 3 EPSDT 4 Exemption from Co-pay 5 Exemption from Prescription 6 Family Plan 7 AFDC 8 Payer Defined Exemption
Prior Authorization Number	Enter the Prior Authorization number, if applicable. Otherwise, leave blank.
National Drug Code*	Enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
Special Packaging Indicator	Indicate the type of unit dose dispensing. The valid values are: 0 Not Specified 1 Not Unit Dose

FIELD	INSTRUCTIONS FOR COMPLETION
	2 Manufacturer Unit Dose 3 Pharmacy Unit Dose
Compound Indicator**	If billing for a compound drug, the first ingredient of a compound must be billed with a compound indicator of 0-First Ingredient. All other ingredients must be billed with a compound indicator of 1-Additional Ingredient... Otherwise, leave blank.
Other Coverage Code**	Indicate whether the patient has a secondary health insurance plan. If so, choose the appropriate value. The valid values for MO HealthNet are: 0 Not Specified 1 No Other Coverage identified 2 Other Coverage Exists – Payment Collected 3 Other Coverage Exists – This Claim Not Covered 4 Other Coverage Exists – Payment Not Collected
Prescription Number*	Enter the number assigned by the physician's office, the clinic, or outpatient hospital. Enter a sequential identification number in this field. If the billing provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injection administered on the same date of service. NOTE – This number is used to sort claims submitted electronically on the pharmacy remittance pages.
Prescribing Provider Identifier Number*	Enter the prescribing provider's NPI
Date Dispensed*	Enter the date the drug was dispensed or administered.
Fill Number*	The code indicating whether the prescription is an original or a refill. Enter a two-digit value. 00 = Original dispensing, 01-99 = Refill number
Decimal Quantity*	Enter the decimal quantity dispensed or used in administration. Note – Use the guidelines outlined on page 11.2 of this billing booklet, titled Medication Billing.

FIELD	INSTRUCTIONS FOR COMPLETION
Day's supply*	Enter the estimated duration of the prescription supply in days. **If billing for an administration in a physician's office/clinic or outpatient, the value must always be 1.**
Billed Charges*	Enter the charge for this medication.
Save Claim Header (button)	Click Save Claim Header to save the Pharmacy Claim Header information.

Pharmacy Other Payer Attachment



FIELD	INSTRUCTIONS FOR COMPLETION
Other Payer Coverage Type*	Determines the order in which the claim was paid by other payers
Other Payer ID Qualifier*	Choose from the options that best describes the Other Payer, options are: 01 National Payer ID 1C Medicare Number

FIELD	INSTRUCTIONS FOR COMPLETION
	1D Medicare Number 02 Health Industry Number (HIN) 03 Bank Information Number (BIN) 04 National Association of Insurance Commissioners (NAIC) 05 Medicare Carrier Number 99 Other Other Payer ID Determines the ID of prior payers, not a required field
Other Payer Date	The date prior payer processed the claim, not a required field
Other Payer Reject code	Indicate the reason the prior payer did not pay the claim. Up to 5 reject codes can be entered. This field will be required if the Other Coverage Code is populated with 3 Other Coverage Exists- This Claim Not Covered. A list of NCPDP reject codes can be located on pages 11.8 and 11.9 of this training booklet.
Other Payer Amount Paid Qualifier	Indicates the type of payment made by a prior payer. This is a required field if other payer amount paid is populated for the corresponding occurrence. The options are: 01 Delivery 02 Shipping 03 Postage 04 Administrative 05 Incentive 06 Cognitive Service 07 Drug Benefit 09 Compound Preparation Cost **Note: Only the Other Payer Amount Paid Qualifier value of 07- Drug Benefit will be used to determine the Third Party Liability amount that will be considered for payment.**
Other Payer Amount Paid	Indicated the amount paid by a prior payer. This is a required field if the Other Coverage Code is populated with 2 or 4.
Save Other Payer Amount Paid (button)	Click to Save Other Payer Amount Paid

FIELD	INSTRUCTIONS FOR COMPLETION
Patient Responsibility Amount Qualifier	The type of patient responsibility amount returned by prior payer. This is required if Other Payer Patient Responsibility Amount is populated. The options are: 01 Amount Applied to Periodic Deductible 02 Amount Attributed to Product Selection/Brand Drug 03 Amount Attributed to Sales Tax 04 Amount Exceeding Periodic Benefit Maximum 05 Amount of Copay 06 Patient Pay Amount 07 Amount of Coinsurance 08 Amount Attributed to Product Selections/Non-Preferred Formulary Selection 09 Amount Attributed to Health Plan Assistance Amount 10 Amount Attributed to Provider Network Selection 11 Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12 Amount Attributed to Coverage Gap 13 Amount Attributed to Processor Fee **Note: Only the Patient Responsibility Amount Qualifier value of 06- Patient Pay Amount will be considered for payment.**
Patient Responsibility Amount**	Indicates the patient responsibility amount returned by prior payer. This will be required when there is a 2 or 4 in the Other Coverage Code field.
Save Other Payer-Patient Responsibility Amount (button)	Click to Save Other Payer-Patient Responsibility Amount
Save Other Payer To Claim (button)	Click to Save Other Payer to claim
Reset/Cancel (button)	Click on reset or cancel to remove any data entered and revert to the previous values or blank form.
Submit Claim (button)	Click Submit Claim to submit the claim.
Printer Friendly (button)	Click Printer Friendly to open the claim in a printer friendly PDF format.

FIELD	INSTRUCTIONS FOR COMPLETION
Reset (button)	Click Reset to discard all claim information entered.
Cancel (button)	Click Cancel to discard all claim information entered and return to Claim Management

NCPDP Valid Other Payer Reject Codes

Reject Code	Code Description
40	Pharmacy Not Contracted With Plan On Date Of Service
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
65	Patient is not covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
76	Plan Limitations Exceeded
78	Cost Exceeds Maximum
80	Drug-Diagnosis Mismatch
81	Claim Too Old
88	DUR Reject Error
569	Provide Beneficiary with CMs Notice of Appeal Rights
3Y	Prior Authorization Denied
4Y	Patient Residence not supported by plan
4Z	Place of Service Not Support By Plan
6Z	Provider Not Eligible To Perform Service/Dispense Product
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
9G	Quantity Dispensed Exceeds Maximum Allowed,
9K	Compound Ingredient Component Count Exceeds Number Of ingredients Supported
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
A5	Not Covered Under Part D Law
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
Reject Code	**Code Description**
AG	Days Supply Limitation For Product/Service

AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
E7	M/I Quantity Dispensed
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network
G8	Pharmacy Not Contracted in Long Term Care Network
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MR	Drug Not on Formulary
N1	No patient match found.
PA	PA Exhausted/Not Renewable
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations

SECTION 12
FREQUENTLY ASKED QUESTIONS

INPATIENT HOSPITAL

What date is considered the date of admission for an inpatient hospital stay?
MO HealthNet follows Medicare policy on the date of admission. Medicare policy is: "A patient of a hospital is considered an inpatient upon issuance of written doctor orders to that effect".

How does a provider submit an inpatient claim that requires a two-page claim for all the services?
If at all possible, the provider should list all the services on a single claim form. If this is not possible, the provider may bill the services on two claim forms. In field 80 on the first page of the claim, put “page 1 of 2”. In field 80 of the second page, put “page 2 of 2”. Staple the claims together prior to submission.

Does a provider have to submit a claim to Medicare for a patient who has exhausted his/her Medicare inpatient benefits and get a denial from Medicare before filing a claim to MO HealthNet?

Yes. MO HealthNet requires that a claim be filed to Medicare first before filing a claim to MO HealthNet. Once the denial has been received, a paper claim can be filed to MO HealthNet and a copy of the Medicare denial or exhausted benefit letter attached to it. The claim can be filed also using the X12 837 institutional claims transaction or the direct data entry inpatient or outpatient claim through the MO HealthNet Internet billing Web site, emomed.com. The range of dates on the claim to be filed to MO HealthNet must fall within the range of dates on the claim filed to Medicare. The denial code description should be visible on the Medicare denial or entered in the appropriate field(s) on the electronic claim form.

Is a precertification required for a participant with QMB benefits enrolled in a Medicare Advantage/Part C Plan?
Inpatient hospital claims for deductible and coinsurance for MO HealthNet patients with Medicare Part C benefits are exempt from admission certification. However, if Medicare Part C benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. Pre-admission certification is required also for denied Medicare Part C inpatient hospital claims including exhausted benefits. Before requesting a pre-certification, the provider must exhaust all appeals through the Medicare Advantage/Part C plan appeals process and have a final denial that can be submitted to Xerox Care and Quality Solutions with the pre-certification request.

For non-QMB MO HealthNet participants enrolled in a Medicare Advantage/Part C Plan, admissions require certification. Additional information regarding inpatient hospital

certification reviews is covered in Section 13.31 of the MO HealthNet hospital provider manual available at http://dss.mo.gov/mhd/providers/.

Are hospitals required to keep paper copies of attachments related to physicians' inpatient services, e.g., Sterilization Consent form, etc.?
Yes. The hospital must maintain a paper copy of these forms in the patient's permanent file.

Is the inpatient hospital per diem rate based on the date of admission or the date of service when there is a rate change?
The per diem rate is based on the date of admission.

A hospital receives certification for a patient admission and admits the patient. Later in the admission day, the patient has to be transferred to another facility which also needs certification. How is this processed and how would the services be billed?
The MO HealthNet *Hospital Provider Manual*, Section 13.30.B - DAY OF DISCHARGE, DEATH, OR TRANSFER states: "MO HealthNet reimburses a facility for the day of admission. MO HealthNet does not cover the day of discharge, death or transfer **unless it also is the day of admission and then it is reimbursable**. The costs for the day of discharge, death or transfer cannot be billed to the recipient."

In the example above, both facilities must obtain certification from Xerox Care and Quality Solutions. Whichever facility submits a properly completed claim to MO HealthNet first should receive reimbursement. The facility that submits a claim to MO HealthNet second will have its claim denied as a duplicate unless a completed *Certificate of Medical Necessity* (CMN) is submitted with the claim to justify the care on the same date of service. It is advisable, however, for both facilities to submit a completed *Certificate of Medical Necessity* with their claims to avoid a duplicate service denial. The *Certificate of Medical Necessity* can be submitted electronically through the MO HealthNet Internet billing Web site, emomed.com, as an attachment to the electronic claim.

A hospital wants a pre-certification for a pregnant woman for a medical condition unrelated to the pregnancy, e.g. mental health services. Should a pregnancy diagnosis code be reported?
Xerox does not review most pre-certifications if the admitting or primary diagnosis code is related to pregnancy. Therefore, a diagnosis code relating to pregnancy should **not** be used as the admitting/primary diagnosis code. If the hospital stay is not related to pregnancy, it must be clear that the pregnancy is incidental to the admitting/primary diagnosis.

Are there special documentation requirements for billing for inpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with ICD-9 surgical code 69.93.

ICD-9 surgical codes 69.01, 69.51, 69.93, 69.99, 74.91, 75.99, and 96.49 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

OUTPATIENT HOSPITAL

Is a pre-certification required from Xerox Care and Quality Solutions for outpatient services and/or surgical procedures?
No, a pre-certification from Xerox is not required for outpatient services and/or surgeries.

If a hospital has an outpatient claim that requires the submission of a second page for services provided on the same date, should two separate claims be filed or can a two-page claim be submitted with the total appearing on the second page?
In this instance, the provider should submit two separate claims and total each individual claim page.

When billing for an outpatient facility charge, should a CPT/HCPCS code be entered in addition to the outpatient facility revenue code?
No. Enter only the appropriate outpatient facility revenue code. Do **not** list a CPT or HCPCS code along with the facility revenue code.

Can a provider bill for two emergency room visits on the same day for the same patient?
If the second ER visit is essentially for the same reason as the first, the hospital cannot bill for it. If the second visit is for a different reason, the hospital can bill for the visit. The two visits must be billed on the same paper claim and the ER notes for each visit attached to it.

If the patient has two ER visits on the same day at two different hospitals, whichever hospital submits a claim first will be paid. The provider that bills second will have its claim denied and will have to refile a paper claim with the ER notes attached to it.

How are emergency room services billed that continue from the initial day into the following day?
For ER services that continue past midnight, the date the patient was initially seen in the ER is the date of service for the facility charge. Diagnostic and procedural services performed into the following day (past midnight) should be billed on a separate outpatient claim form with the date of service that the diagnostic or procedural service was performed on.

How are observation services billed that continue from the initial day into the following day?
Only one observation code per stay may be billed. If the stay spans beyond midnight, only one date of service is billed, which is the date the participant was placed in observation status. For example: A MO HealthNet eligible participant is admitted for observation care on Tuesday at 10:00 am and then discharged Wednesday at 8:00am, the units billed would be 22 and the date of service billed would be Tuesday's date.

Can a hospital bill for multiple dates of service on the same claim for either emergency room services or therapy services and use the AJ condition code to exempt the patient from the $3.00 cost sharing amount for each date of service reported on the claim?
No. Only one date of service can be reported on an outpatient hospital claim on which the AJ condition code is reported. The AJ condition code is used on the outpatient hospital claim to exempt the patient from the $3.00 cost sharing for emergency room services or outpatient therapy services (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis).

A MO HealthNet patient presents to the hospital emergency department for non-emergent care. Eligibility is checked and it is determined the patient is administratively locked-in to a provider. The ER department tries to contact the designated lock-in provider who either is not available or will not authorize the services through the PI-118 lock-in form. Since the ER department cannot get a referral from the lock-in provider, can these services be billed to the patient or does the hospital have to write them off?
The patient can be billed for the care. Patients who have been administratively locked-in to a designated provider know this and know who their lock-in provider is. Further, they know that if they try to obtain non-emergent services from another provider, the patient can be held responsible for the costs of the service if the treating provider is unable to obtain a referral from the lock-in provider.

How are outpatient medications to be billed under revenue code 250?
There are several ways revenue code 250 can be used for billing outpatient medications. The first pertains to billing for a covered medication which does not have a valid HCPCS or CPT code. In this instance, revenue code 250 may be billed without a corresponding code. Note the following:

Quantity billed for revenue code 250 must be one (1) when a HCPCS or CPT code is not available. The charges for the medications must be totaled together for that line charge.

- Non-covered medications cannot be billed under the 250 revenue code. They are not billable to the agency and can be billed to the participant.
- Questions regarding whether or not a medication is covered by MO HealthNet should be directed to the agency's Pharmacy and Clinical Services Administration Unit by phone at 573/751-6963 or by E-mail at clinical.services@dss.mo.gov.

Another choice when a valid HCPCS or CPT code is not available is to bill under revenue code 250 or 636 with one of the following J-codes.

J3490 – unclassified medication
J7599 - Immunosupppressive, not otherwise classified
J8499 - prescription drug, oral, non-chemotherapeutic, NOS
J8999 - oral prescription, chemotherapeutic, NOS

These codes can be filed on a paper UB-04 claim form and an invoice must be submitted with the claim which shows the medication's name, the NDC and its cost. When the claim is filed through emomed.com, after completing the header detail and line detail segments, click on "Invoice of Cost". This opens a new segment titled "Invoice of Cost Details Summary". Complete and save this segment before submitting the claim.

NOTE: The National Drug Code (NDC) should be submitted for all medication administered in the outpatient hospital setting along with a valid HCPCS or CPT code. However, the NDC is required when a "Top 20" drug is administered. The "Top 20" drugs are defined by CMS, and can be found on their Web site at http://ms.gov/Reimbursement/15_PhysicianAdministeredDrugs.asp.

Another use of the 250 revenue code pertains to billing a medication which has a valid HCPCS or CPT code and NDC. In this instance, the medication must be billed with a revenue code, either 250 or 636, along with a valid NDC. If the medication does not have a valid NDC but does have a CPT or HCPCS code, such as contrast media, the charges are to be billed without the NDC.

Can the hospital bill for a non-payable medication under medical supplies (revenue code 270) or medications (revenue code 250)?
No. An injection or medication that is not payable under MO HealthNet **cannot** be billed under revenue code 270 (medical supplies) or under revenue code 250 (medications).

Are hospitals required to keep paper copies of attachments used for physicians' outpatient services, e.g. Sterilization Consent form, etc.?
Yes. The hospital must maintain a copy of these forms in the patient's permanent file.

Can HCPCS "Q" codes be used to bill for MO HealthNet services?
HCPCS "Q" codes are national codes given by the Center for Medicare Services (CMS) on a temporary basis. In general, "Q" codes are not to be used to bill for MO HealthNet services and are considered non-covered.

Does MO HealthNet have allowable quantities that can be billed for outpatient services?
Yes. Each procedure code has an allowable quantity that can be billed to MO HealthNet without additional documentation. A provider can access the MO HealthNet fee schedules, which include allowable quantities, through the MO HealthNet Division Web site, http://dss.mo.gov/mhd/providers/. Note – The fee schedule for the technical component of laboratory procedures does not include hospitals. Contact Provider Communications, 573/751-2896, for information relating to the allowable quantity and reimbursement for outpatient laboratory procedures.

How is a claim billed when more than the allowable quantity of a procedure was performed?
A provider cannot bill for more than the MO HealthNet allowable quantity on a single line on the claim. The additional quantities have to be billed on subsequent lines and the hospital's notes sent with the claim for manual review and processing. Example - the MO HealthNet allowable for a procedure is two but the hospital wants to bill for five. The hospital would bill one line with the procedure code and a quantity of two, a second line with the procedure code and a quantity of two, and a third line with the procedure code and a quantity of 1, and the hospital notes submitted with the claim.

What is the proper way to bill for a comprehensive metabolic panel, procedure code 80053?
If only CPT code 80053 was performed, bill the code without any modifiers. Providers should be aware that 80053 might be included in CPT code 80050 (general health panel) if certain other lab services are being billed for the same date of service.

CPT code 80050 includes 80053 in addition to:

Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)

or,

Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)

Thyroid stimulating hormone (TSH) (84443)

What is the correct way to bill for outpatient cardiac rehabilitation services?
Providers should bill using the appropriate revenue code, 0943 - cardiac rehabilitation. Do **not** list a CPT procedure code with this revenue code.

Are there special documentation requirements for billing for outpatient missed abortions/miscarriage services?
MO HealthNet does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-04 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, or 59830.

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

SECTION 13
ADJUSTMENTS & RESUBMISSIONS

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

Adjustments for claim credits submitted via the Internet receive an immediate confirmation after submission to confirm the acceptance and indicate the status of the adjustment.

See Section 4 of the MO HealthNet *Provider Manual* for timely filing requirements for adjustments and claim resubmissions.

PAID CLAIM OPTIONS on emomed.com

If there is a paid claim in the MO HealthNet emomed system, then the claim can be voided or replaced.

VOID - To void a claim from the claim status screen on emomed, choose the void tab. This will bring up the paid claim in the system; scroll to the bottom of the claim and click on the highlighted 'submit claim' button. The claim now has been submitted to be voided or credited in the system.

REPLACEMENT – To replace a claim from the claim status screen on emomed, choose the replacement tab. This will bring up the paid claim in the system; here corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Now scroll to the bottom of the claim and click on the highlighted 'submit claim' button. The replacement claim with corrections has now been submitted.

DENIED CLAIM OPTIONS on emomed.com

If there is a denied claim in the MO HealthNet emomed system, then the claim can be resubmitted as a New Claim. A denied claim can also be resubmitted by choosing Timely Filing, Copy Claim-original, or Copy Claim-advanced.

TIMELY FILING – To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the Internal Control Number (ICN) of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and click on the highlighted 'submit claim' button. The claim has now been submitted for payment.

COPY CLAIM- Original- This option is used to copy a claim just as it was entered originally on emomed. Corrections can be made to the claim by selecting the appropriate edit button, and then saving the changes. Now scroll to the bottom of the

claim and click on the highlighted submit claim button. The claim has now been submitted with the corrections made.

COPY CLAIM – Advanced- This option is used when the claim was filed using the wrong NPI number or wrong claim form. Example would be if the claim was entered under the individual provider NPI and should have been submitted under the group provider NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and Name information will transfer over to the new claim type. Example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

CLAIM STATUS OF THE CLAIM IS GIVEN AFTER THE CLAIM IS SUBMITTED

C – This status indicates that the claim has been **Captured** and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – This status indicates that the claim is to be **Paid.**

K – This status indicates that the claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

SECTION 14
PARTICIPANT LIABILITY
State Regulation 13CSR 70-4.030

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

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Precertification, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

MO HealthNet PARTICIPANT REIMBURSEMENT

The MO HealthNet Participant Reimbursement program is devised to make payment to those participants whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Participants are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The participant is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call (800) 392-2161.

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS employees, applicants for employment, and contractors are to be treated equitably regardless of race, color, national origin, ancestry, genetic information, pregnancy, sex, sexual orientation, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain nondiscrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

DSS applicants for, or recipients of, services from DSS are to be treated equitably regardless of race, color, national origin, ancestry, sex, age, sexual orientation, disability, veteran status, or religion. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); or Relay Missouri for hearing and speech impaired at (800) 735-2466 (Voice); (800) 735-2966 (Text). Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability, or religion may also file a complaint by writing to:

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 (Voice); (816) 426-7065 (TDD)

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

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

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

April 2013