Professional Billing Book

Published by the Provider Education Unit
MO HealthNet Division

PREFACE

The MO HealthNet *Professional Billing Book* contains information to help providers submit claims correctly to 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.

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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, Inc. help desk at 1-888-581-9797 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;
- 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

September 2, 2013 Labor Day

October 14, 2013 Columbus Day

November 11, 2013 Veteran's Day

November 28, 2013 Thanksgiving Day

December 25, 2013 Christmas Day

January 1, 2014 New Year's Day

January 20, 2014 Martin Luther King's Birthday

February 12, 2014 Lincoln's Birthday

February 17, 2014 Washington's Birthday

May 8, 2014 Truman's Birthday

May 26, 2014 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

Wipro Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. 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. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a.* Insured's I.D.	Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the patient's ID card.
2.* Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the patient's ID card.
3. Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.** Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5. Patient's Address	Enter address and telephone number if available.

Field number and name		Instructions for completion
6.**	Patient Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)]
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.**	Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.**	Insurance Plan Name or Program Name.	Enter the secondary policyholder's insurance plan or program name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
10a.-10c.**	Is Patient's Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. **If the services are not related to an accident, leave blank.** [See Note (1)]

Field number and name	**Instructions for completion**
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or FECA Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box for the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name or Program Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.

Field number and name	**Instructions for completion**
14.** Date of Current Illness, Injury or Pregnancy	*This field is required when billing global prenatal, global OB and delivery services.* The date should reflect the last menstrual period (LMP).
15. Date Same/Similar Illness	Leave blank.
16. Dates Patient Unable to Work	Leave blank.
17.** Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1) referring provider; 2) ordering provider; or, 3) supervising provider. If the physician is nonparticipating in the MO HealthNet program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups and providers with a specialty of “30” (radiology/radiation therapy).*
17a.** Other ID	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in 17b. *This field is required for independent laboratories and independent radiology groups and providers with a specialty of “30” (radiology/radiation therapy).*
17b.**NPI	Enter the NPI number of the referring, ordering or supervising provider *This field is required for independent laboratories and independent radiology groups and providers with a specialty of “30” (radiology/radiation therapy).*

Field number and name	Instructions for completion
18.** Hospitalization Dates	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required if services were provided in an inpatient hospital setting.
19. Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.** MO HealthNet Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank**.**
24a.* Date of Service	Enter the date of service under "from" in the month/day/year format using the six digit format in the unshaded area of the field. All line items must have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting supplemental information. It is **not** intended to allow the billing of 12 lines of service.

Field number and name	Instructions for completion
24b.* Place of Service	Enter the appropriate place of service code in the unshaded area of the field. See Section 15.8 of the MO HealthNet *Physician's Provider Manual* for the list of appropriate place of service codes.
24c. EMG-Emergency	Enter a Y in the unshaded area of the field. If this is not an emergency, leave this field blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.)
24e.* Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21 in the unshaded area of the field.
24f.* Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
24g.* Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank. Anesthesia—Enter the total number of minutes of anesthesia. Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B."

Field number and name	Instructions for completion
24i. ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering/performing provider is required to report a Provider Taxonomy Code to MO HealthNet.
24j.** Rendering Provider ID	If the Provider Taxonomy qualifier was reported in 24i, enter the 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering/performing the service in the unshaded area. Required for a clinic, FQHC, radiology group, teaching institution or a group practice only.
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on MO HealthNet claims.
28.* Total Charge	Enter the sum of the line item charges.
29.** Amount Paid	Enter the total amount received by all other insurance resources. **Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30. Balance Due	Enter the difference between the total charge (field 28) and any insurance amount paid (field 29).
31. Provider Signature	Leave blank.
32.** Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.

Field number and name	Instructions for completion
32a.** NPI Number	Enter the 10 digit NPI number of the service facility location reported in field 32.
32b.** Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. A provider taxonomy code must reported if the provider has a one to many provider NPI.
33.* Provider Name/ Number/Address	Enter the Provider's name, address, and telephone number
33a.* NPI Number	Enter the NPI number of the billing provider listed in field 33.
33b.** Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number.

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **leave blank**. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

SAMPLE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

SECTION 3
PHARMACY CLAIM
FILING INSTRUCTIONS

All pharmacy claims must be submitted electronically either through a clearinghouse, billing agent or the MO HealthNet Web site at emomed.com for billing and to maintain the business relationship with the MO HealthNet Division (MHD).

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 Pharmacy Program. Existing Fee-for-Service Pharmacy Program clinical editing parameters and Preferred Drug List criteria 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 physicians and private medical clinics (including FQHCs and provider based RHCs) includes all injections and birth control devices administered in the physician’s office or a private clinic setting. Note – injection administrations, including VFC vaccine administrations, must still be billed to the participant’s managed care health plan and not MO HealthNet.

MEDICATION BILLING

The quantity to be billed for pharmacy items (e.g. birth control devices and systems) 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.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- 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.

Reimbursement for pharmacy items and injectable medications is made on the basis of the lower of the following:

1. Applicable Federal Upper Limit;
2. Applicable Missouri Maximum Allowable Cost (MAC);
3. Applicable Wholesaler Acquisition Cost (WAC), plus 10%; or,
4. Usual and customary charge.

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

Pharmacy Claim

Billing NPI:

Claim Header Information

Participant Information

Participant DCN * | Participant Last Name * | Participant First Name *

Place of Service | Patient Residence

Code Details

Prior Authorization Type Code ** | Prior Authorization Number ** | National Drug Code *

Special Packaging Indicator | Compound Indicator ** | Other Coverage Code **

Service Information

Prescription Number * | Prescribing Provider Identifier Number * | Date Dispensed *

Fill Number * | Decimal Quantity (9999999.999) | Days Supply *

Billed Charges *

Save Claim Header | Reset

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 2 Manufacturer Unit Dose 3 Pharmacy Unit Dose

FIELD	INSTRUCTIONS FOR COMPLETION
Compound Indicator**	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 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
Other Coverage Amount**	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are **not** to be entered in this field. This field is required if the Other Coverage Code field has a value.
Patient Responsibility Amount**	Enter the total amount the other payer identified as patient's responsibility.
Prescription Number*	Enter the number assigned by the physician's office or the clinic. 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

FIELD	INSTRUCTIONS FOR COMPLETION
Decimal Quantity*	Enter the decimal quantity dispensed or used in Administration. Note: Use the guidelines outlined on page 3.1 of this billing booklet, titled Medication Billing.
Day's supply*	Enter the estimated duration of the prescription supply in days. **If billing for an administration in a physician's office/clinic, 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

Other Payers

Header Summary

Other Payer Coverage Type | Other Payer ID Qualifier | Other Payer ID | Other Payer Date | Other Payer Reject Code | Action

Add/Edit Details

Other Payer Coverage Type *

Other Payer ID Qualifier * | Other Payer ID | Other Payer Date

Other Payer Reject Code

Other Payer Amount Paid Summary

Other Payer Amount Paid Qualifier | Other Payer Amount Paid | Action

Add/Edit Other Payer Amount Paid

Other Payer Amount Paid Qualifier | Other Payer Amount Paid

Save Other payer Amount Paid | Reset

Other Payer-Patient Responsibility Summary

Other Payer-Patient Responsibility Amount Qualifier | Other Payer-Patient Responsibility Amount | Action

Add/Edit Other Payer-Patient Responsibility

Other Payer-Patient Responsibility Amount Qualifier | Other Payer-Patient Responsibility Amount

Blank - Not Specified

Save Other Payer-Patient Responsibility Amount | Reset

Save Other Payer To Claim | Reset

Invoice of Cost (click to manage)

Submit Claim | Printer Friendly | Reset | Cancel

FIELD	INSTRUCTIONS FOR COMPLETION
Other Payer Coverage Type*	Determines the order in which the claim was paid by other payers

FIELD	INSTRUCTIONS FOR COMPLETION
Other Payer ID Qualifier*	Choose from the options that best describes the Other Payer, options are: 01 National Payer ID 1C Medicare Number 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 3.8 and 3.9 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.

FIELD INSTRUCTIONS FOR COMPLETION

FIELD	INSTRUCTIONS FOR COMPLETION
Save Other Payer Amount Paid (button)	Click to Save Other Payer Amount Paid
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 Responsibilit 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

Reject Code	Code Description
AD	Billing Provider Not Eligible To Bill This Claim Type
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 4
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 thirty (30) days from the date of Medicare's explanation of benefits (EOMB) showing payment before filing an electronic claim to 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 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 site at www.emomed.com:

- ➢ From Claim Management choose the Medicare CMS-1500 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 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. Do not check the 'Payer at Header Level' box on the Header Summary for Medicare crossover claims.

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 site, www.emomed.com. The following tips provide assistance in successfully filing Medicare Advantage/Part C crossover claims:

- From "Claim Management" choose the Medicare CMS-1500 Part C Professional under the 'New Xover Claim' drop down box.
- Select 16-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 as regular hospital claims 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 5
THE REMITTANCE ADVICE

MO HealthNet has discontinued printing and mailing paper Remittance Advices (RAs). The RAs both current and aged are available through the MO HealthNet web portal at www.emomed.com. Some providers utilize an electronic HIPAA 835 transaction to retrieve their 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.

More information on accessing and using the printable RA is found later in this section.

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, www.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 final processing 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.

15 – CMS 1500 paper claim
49 – Internet claim

50 – Individual Adjustment Request
55 – Mass 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 1513001000000 is read as a CMS-1500 paper medical claim entered in the processing system on January 1, 2013.

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 www.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 www.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://www.adobe.com/products/acrobat/readstep2.htm to download it to your computer.
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RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

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

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the “Aged RA Request” located under the File Management option on the eProvider 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.
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), recipient 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.
PERF PROV	The MO HealthNet ID number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
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 6

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 Care and Quality Solutions, Inc. 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://www.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)
- Ultrasound

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

IMPLEMENTATION RESOURCES

Links to the following resources are available at:
http://www.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://www.emomed.com.

SECTION 7
ADJUSTMENTS & RESUBMISSIONS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Wipro Infocrossing web portal at, www.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 8
HEALTHY CHILDREN AND YOUTH PROGRAM

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). MO HealthNet covers any physical or mental illness identified by the HCY screen regardless of whether the services are covered under the state MO HealthNet plan. Services that are beyond the scope of the MO HealthNet state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope and prognosis. A Prior Authorization (PA) may be required for some services.

When the initial application for public assistance is made, all qualified applicants (or his/her guardian) under age 21 are informed of the HCY program. However, it is advisable for providers to notify their patients when HCY screenings are due in accordance with the following periodicity schedule:

Newborn (2-3 days)	15-17 months	8-9 years
By 1 month	18-23 months	10-11 years
2-3 months	24 months	12-13 years
4-5 months	3 years	14-15 years
6-8 months	4 years	16-17 years
9-11 months	5 years	18-19 years
12-14 months	6-7 years	20 years

FULL SCREENING

A full screen must be performed by an enrolled MO HealthNet physician, nurse practitioner or nurse midwife *(only infants age 0-2 months and females age 15-20 years)* and must include all of the components listed below. If all of the components are not included, a provider cannot bill for a full screen and is to bill only for a partial screen.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment (Provider must use the *HCY Lead Risk Assessment* form)
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

It is mandatory that the age appropriate *HCY Screening Guide* be used to document that all components of a full or partial screen are met. The *HCY Screening Guide* is not all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener must sign and date the guide and retain it in the patient's medical record.** *HCY Screening Guides* can be obtained by downloading them from the Internet at http://dss.mo.gov/mhd/providers/

The paper copy of the *Healthy Children and Youth Screening Guide* and the *Lead Risk Assessment Guide* is not the only method a provider can use to document in the patient's medical record that a service was provided. The provider can also document the screenings in an electronic medical record.

If the provider uses an electronic medical record, the electronic version must contain all of the components listed on the *HCY Screening Guide* and the *Lead Risk Assessment Guide* for the patient's appropriate age group. The *HCY Screening Guide* and the *Lead Risk Assessment Guide* can also be scanned into a patient's electronic medical record. The components of the *HCY Screening Guide* must be available in an easily accessible format. The *Lead Risk Assessment Guide* must contain the questions included on the paper form as well as responses and the date and the results of the blood level test administered to the patient. Each component of each guide must be entered into the patient's electronic medical record, and must be made available to the MO HealthNet program upon request.

Note: A provider cannot bill for an office visit and an HCY screen on the same date of service for a patient unless documentation in the medical record indicates a medical need for the office visit. The department must include a "Certificate of Medical Necessity" with the claim when submitting it for payment.

DIAGNOSIS CODES FOR FULL, PARTIAL OR INTERPERIODIC SCREENS

Providers must use V20.2 as the primary diagnosis on claims for HCY screening services. There are two exceptions. CPT codes 99381EP and 99391EP **must** be billed with diagnosis code V20.2, V20.31 or V20.32. CPT codes 99385 and 99395 **must** be billed with diagnosis code V25.01-V25.9, V70.0 or V72.31.

FULL SCREENING PROCEDURE CODES (New Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 2	Fee
99381*	EP	$60.00
99382*	EP	$60.00
99383*	EP	$60.00
99384*	EP	$60.00
99385*	EP	$60.00

FULL SCREENING PROCEDURE CODES (Established Patient)

Procedure Code	Modifier 2	Fee

(Use Age Appropriate Code)		
99391*	EP	$60.00
99392*	EP	$60.00
99393*	EP	$60.00
99394*	EP	$60.00
99395*	EP	$60.00

Modifier "UC" must be used if child was referred for further care as a result of the screening.

PARTIAL SCREENING

Different providers may provide segments of the full medical screen. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial screening service to have a referral source to refer the child for the remaining components of a full screening service.

An unclothed physical and history screen (CPT codes 9938152EP-9938552EP and 9939152EP-9939552EP) includes the first five sections of the age appropriate screening guide including:

- Interval history;
- Unclothed physical exam;
- Anticipatory guidance;
- Laboratory/Immunizations; and
- Age appropriate lead screening. Federal regulations require a mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age. The provider must use the *HCY Lead Risk Assessment* form.

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (New Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99381*	52	EP	$20.00
99382*	52	EP	$20.00
99383*	52	EP	$20.00
99384*	52	EP	$20.00
99385*	52	EP	$20.00

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (Established Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99391*	52	EP	$20.00
99392*	52	EP	$20.00
99393*	52	EP	$20.00
99394*	52	EP	$20.00
99395*	52	EP	$20.00

Modifier "UC" must be used if child was referred for further care as a result of the screening

PARTIAL SCREENING CODES – DENTAL

Procedure Code	Modifier 1	Modifier 2	Fee
99429			$20.00
99429	UC		$20.00

PARTIAL SCREENING CODES – DEVELOPMENTAL/MENTAL HEALTH

Procedure Code	Modifier 1	Modifier 2	Fee
99429	59		$15.00
99429	59	UC	$15.00

PARTIAL SCREENING CODES – HEARING

Procedure Code	Modifier 1	Modifier 2	Fee
99429	EP		$5.00
99429	EP	UC	$5.00

PARTIAL SCREENING CODES – VISION

Procedure Code	Modifier 1	Modifier 2	Fee
99429	52		$5.00
99429	52	UC	$5.00

DESCRIPTION OF MODIFIERS USED FOR HCY SCREENINGS

- **EP -** Service provided as part of MO HealthNet early periodic, screening, diagnosis, and treatment (EPSDT).
- **52 -** Reduced services. Modifier 52 must be used when all the components for the unclothed physical and history procedure codes (99381-99395) have not been met according to CPT. Also used with procedure code 99429 to identify that the components of a partial HCY vision screen have been met.
- **59 -** Distinct Service. Modifier 59 must be used to identify the components of an HCY screen when only those components related to developmental and mental health are being screened.

- **UC-** EPSDT Referral for Follow-Up Care. The modifier UC must be used when the child is referred on for further care as a result of the screening.

NEWBORN EXAMINATIONS

Initial newborn examinations have been identified as HCY screenings and providers **must** use either procedure code 99460 or 99461. When billing for either of these codes, field 24h on the CMS-1500 form **must** be marked with an "E." This indicates an EPSDT/HCY exam. The newborn's medical record must document that the billing provider performed all components of a full HCY examination appropriate to the child's age and circumstances.

DENTAL EXAMINATIONS

When a child receives a full HCY medical screen, it includes an oral examination that is **not** a full dental exam. A referral to a dental provider must be made where medically indicated when the child is under the age of one year. When the child is one year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. Providers or participants can use the MO HealthNet Internet Web page, http://dss.mo.gov/mhd/participants/index.htm, to search for an enrolled dental provider in their area or other area of the state. On the Web page, the patient should click on the "MO HealthNet Provider Search" link and follow the instructions.

IMMUNIZATIONS

HCY screening providers are responsible for giving required immunizations. Immunizations are recommended in accordance with guidelines of the Advisory Committee on Immunization Practices (ACIP). Immunizations must be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is not provided, the patient's medical record must document why the appropriate immunization was not provided.

Providers must use the free vaccine provided by the Missouri Department of Health and Senior Services through the Vaccine for Children (VFC) program. To receive the free vaccine, providers must be enrolled with the Department of Health and Senior Services. Additional information on the VFC program appears later in this section.

LEAD SCREENING AND TREATMENT

All children ages six months to 72 months must be verbally assessed for lead poisoning using the questions contained in the *HCY Lead Risk Assessment Guide* (download the guide from the Internet at http://dss.mo.gov/mhd/providers/). The *HCY Lead Risk Assessment Guide* is designed to allow the same document to follow the child for all visits from 6 months to 72 months of age. The guide has space on the reverse side to identify the type of blood test, venous or capillary; and also has space to identify the dates and results of blood lead levels. When an answer to any verbal question is "yes", a blood lead test must be done at that time.

Risk is determined from the response to the questions on the *HCY Lead Risk Assessment Guide*. The verbal risk assessment determines whether the child is low risk or high risk.

- If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure.
- If the answer to any question is positive, a child is considered high risk for high doses of lead exposure and must receive a blood lead test.
- Blood level testing is mandatory at ages 12 and 24 months regardless to the response of the verbal assessment or where a child resides.

The Healthy Children and Youth Screening and Lead Risk Assessment Guides became available in an electronic format through MO HealthNet's Web tool, CyberAccess. Providers are strongly encouraged to complete the Assessment Guides electronically through the CyberAccess tool. As the CyberAccess tool becomes more widely used for various MO HealthNet Division (MHD) programs, the EPSDT feature will enhance the overall usefulness. This will allow the completed forms to be part of the participant's MO HealthNet electronic health record (EHR). The use of the EHR to enable better continuity of care for MHD participants is a State goal. The information provided in the assessment guides will be available to other health care providers and will provide helpful information when making treatment decisions.

For additional information on HCY/EPSDT, providers should reference Section 9 of the MO HealthNet *Provider Manual* at http://dss.mo.gov/mhd/providers/.

INTERPERIODIC SCREENS

Interperiodic Screens are medically necessary screens outside the periodicity schedule that do not require the completion of all components of a full screen and may be provided as an interperiodic screen or as a partial screen. An interperiodic screen has been defined by the Centers for Medicare & Medicaid Services (CMS) as any encounter with a health care professional acting within his or her scope of practice. This screen may be used to initiate expanded HCY services. Providers who perform interperiodic screens may use the appropriate level of Evaluation/Management visit procedure code, the appropriate partial HCY screening procedure code, or the procedure codes appropriate for the professional's discipline as defined in their provider manual. Office visits and full or partial screenings that occur on the same day by the same provider are not covered unless the medical necessity is clearly documented in the participant's record. The diagnosis for the medical condition necessitating the interperiodic screening must be entered in the primary diagnosis field, and the V20.2 diagnosis should be entered in the secondary diagnosis field.

Interperiodic Screens commonly are used for school and athletic physicals. A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis code V20.2 should be used as the primary diagnosis. This also applies for other school physicals when required as conditions for entry into or

continuance in the educational process. Use the age appropriate code from the following lists.

INTERPERIODIC SCREEN – REDUCED- (New Patient)

Procedure Code (Use Age Appropriate Code)	Fee
99381	$23.00
99382	$23.00
99383	$23.00
99384	$23.00
99385	$32.50

INTERPERIODIC SCREEN – REDUCED – (Established Patient)

Procedure Code (Use Age Appropriate Code)	Fee
99391	$15.00
99392	$15.00
99393	$15.00
99394	$15.00
99395	$24.00

WELL WOMAN EXAMINATION

A well woman exam for a female patient 18-20 years of age can be billed using the age appropriate preventive medicine code and modifiers with diagnosis code V72.31.

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services are covered by MO HealthNet. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis. Additional information on SAFE-CARE examinations can be referenced in Section 13.15 of the MO HealthNet physician manual located on the Internet at: http://dss.mo.gov/mhd.providers/.

SAFE/CARE EXAM PROCEDURE CODES

Procedure Code	Modifier 1	Modifier 2	Fee
99205	U7		$187.50
99205	U7	52	$106.38

VACCINES FOR CHILDREN (VFC) PROGRAM

Through the VFC Program, federally provided vaccine is available at no charge to public and private providers for MO HealthNet eligible children ages 0 through 18 years.

MO HealthNet requires providers who administer immunizations to qualified MO HealthNet eligible children to enroll in the VFC program. The VFC program is administered by the Department of Health and Senior Services. Providers should contact the DHSS as follows:

Missouri Department of Health and Senior Services
Section for Communicable Disease Prevention
Vaccines for Children Program
P.O. Box 570
Jefferson City, MO 65102
(800) 219-3224, (573) 526-5833

MO HealthNet will pay an administration fee per dose to providers to administer the free vaccine **except** to those providers enrolled as rural health clinics (RHCs) or Federally Qualified Health Centers (FQHCs). RHCs and FQHCs may bill an encounter code or appropriate level Evaluation and Management code if a medically necessary evaluation and management service is provided in addition to the VFC vaccine**.**

Immunizations for Managed Care Health Plan Participants

Managed care health plans and their providers must use the VFC vaccine for MO HealthNet Managed Care eligible participants. Plan providers must enroll in the program through the Department of Health and Senior Services. Providers should contact the appropriate managed care health plan for proper billing procedures.

Immunizations Given Outside the VFC Guidelines

If an immunization is given to a MO HealthNet participant who does not meet the VFC guidelines, use the standard procedure for billing injections. Physicians, clinics, and advanced practice nurse prescribers must bill injections on the Pharmacy Claim Form using the National Drug Code (NDC). The provider may bill either procedure code 90471 or 90472 for the administration of the immunization if that is the only service provided. If a significant, separately identifiable Evaluation and Management (E&M) service (codes 99201-99205; 99211-99215) is performed, the appropriate E&M code may be billed in addition to the administration code.

The administration procedure codes may not be billed by Federally Qualified Health Centers (FQHCs) or rural health clinics (RHCs) as outlined by federal guidelines. The administration of any medications, including immunizations, is included in the encounter rate and additional reimbursement is not allowed.

FQHCs can bill the immunization on the electronic CMS 1500 claim form. Provider based RHCs can bill the immunization on the electronic UB-04 claim form. Both FQHCs and

provider based RHCs can bill on a Pharmacy Claim form through emomed.com, or on the 837 claim transaction. Independent RHCs bill the encounter procedure code T1015 or T1015EP, which includes all services provided during the encounter.

VFC ADMINISTRATION CODES

Providers must use the SL modifier when billing for the VFC administration codes.

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	M\HD FEE
DTaP	DTaP	Infanrix DAPTACEL Tripedia	90700SL	$15.00
DTaP, Hepatitis B, and Polio	DTaP/HB/IPV	Pediarix	90723SL	$25.00
DTaP, Hib, and Polio	DTaP/Hib/IPV	Pentacel	90698SL	$25.00
DTaP and Polio	DTaP/IPV	KINRIX	90696SL	$20.00
DT	DT		90702SL	$10.00
Td	Td, Preservative Free	DECAVAC	90714SL	$10.00
Tdap	Tdap	BOOSTRIX ADACEL	90715SL	$15.00
Polio	EIPV	IPOL	90713SL	$5.00
Hepatitis A	Hepatitis A	Havrix VAQTA	90633SL	$5.00
Hepatitis B	Hepatitis B	Engerix B Recombivax HB	90744SL	$5.00
Hepatitis B and Hib	Hepatitis B/Hib	COMVAX	90748SL	$10.00
Hib	Hib	PedvaxHIB ACTHib	90647SL 90648SL	$5.00 $5.00
HPV	HPV quadrivalent types 6,11,16,18	Gardasil	90649SL	$5.00
	HPV bivalent Types 16,18	Cervarix	90650SL	$5.00

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	M\HD FEE
Influenza	Influenza (injectable)	Influenza, Preservative Free	90655SL	$5.00
		Influenza, Preservative Free	90656SL	$5.00
		Influenza	90658SL	$5.00
	Influenza, live attenuated	FluMist	90660SL	$5.00
Meningococcal	Meningococcal	Menactra	90734SL	$5.00
MMR	MMR	MMRII	90707SL	$15.00
MMR and Varicella	MMRV	ProQuad	90710SL	$20.00
Pneumococcal	Pneumococcal 7-valent (conjugate)	Prevnar	90669SL	$5.00
	Pneumococcal 13-valent (conjugate	Prevnar 13-valent	90670SL	$5.00
	Pneumococcal 23-valent (polysaccharide)	Pneumovax 23 Pnu-Immune 23	90732SL	$5.00
Rotavirus	Rotavirus	RotaTeq	90680SL	$5.00
		Rotarix	90681SL	$5.00
Varicella	Varicella	Varivax	90716SL	$5.00

SECTION 9
MATERNITY CARE AND DELIVERY

GLOBAL POLICIES

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as a clinic or an obstetric clinic where there is one patient record and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic may elect to bill globally for all prenatal, delivery, and postpartum care services provided with the clinic, using the primary care physician's individual National Provider Identifier (NPI) as the performing provider.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis), and the completion of the *Risk Appraisal for Pregnant Women* form. Only one prenatal care code, 59425 (four-six visits) or 59426 (seven or more visits), may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the participant goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

Billing for global services cannot be done until the date of delivery.

EXEMPTED VISITS/CONSULTATIONS

A total of two visits may be reimbursed by MO HealthNet to the initial provider (who is not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. For example, many participants utilize the services of a local health agency to establish their pregnancy which then refers them elsewhere for continuing care for their pregnancy. Therefore, if the participant sees another provider for no more than two visits for her pregnancy, the provider of ongoing care is allowed to bill global.

In addition, two consultations may be reimbursed by MO HealthNet to another provider. The referring provider may still bill global.

RISK APPRAISAL - CASE MANAGEMENT

As part of the global prenatal/delivery requirements, providers must complete the *Risk Appraisal for Pregnant Women* form. No additional reimbursement will be paid for the completion of the form. Any eligible woman who meets any of the risk factors listed on the form is eligible for case management for pregnant women services and should be referred to a MO HealthNet enrolled participating case management provider.

NOTE - If you are not billing any of the global prenatal/delivery codes and you complete the *Risk Appraisal for Pregnant Women* form, you may bill for completion of the form using procedure code H1000.

The risk appraisal should be done during the initial prenatal visit or any time after the initial appraisal of a patient originally determined not to be at risk when changes in the patient's medical condition indicate the need.

GLOBAL OB CODES

Code	Description	MO HealthNet Allowable
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and or forceps), and postpartum care.	$1,182.50
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,237.50
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and postpartum care, after previous cesarean delivery	$1,182.50
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	$1,237.50
59425	Antepartum care only, 4-6 visits	$371.32
59426	Antepartum care only, 7 or more visits	$577.50

Billing Tip - To avoid a denial for global delivery code 59400, 59510, 59610, or 59618, if the participant has more than two visits, you can bill the antepartum code, 59425 or 59426, plus the appropriate delivery code. If the participant has more than two visits, only the global antepartum will be denied.

MO HealthNet providers have the option to bill OB services either globally or by individual dates of service. In order to bill globally, all MO HealthNet guidelines must be met.

OTHER DELIVERY CODES

Code	Description	MO HealthNet Allowable
59410	Vaginal delivery (with or without episiotomy, and/or forceps) including postpartum care	$605.00
59409	Vaginal delivery only (with or without episiotomy, and/or forceps), no post partum care	$484.00
59430	Postpartum care only (separate procedure), vaginal delivery	$121.00

Code	Description	MO HealthNet Allowable
59515	Cesarean delivery including postpartum care	$660.00
59514	Cesarean delivery only, no post partum care	$544.42
59430	Postpartum care only (separate procedure), cesarean delivery	$121.00
59514-80	Assistant Surgeon, cesarean delivery	$ 108.88
59612	Vaginal delivery only, after previous cesarean delivery, (with or without episiotomy and/or forceps)	$515.87
59614	Vaginal delivery only, after previous cesarean delivery, (with our without episiotomy and/or forceps), including postpartum care	$605.00
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.	$594.36
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care	$692.41

OTHER BILLING REQUIREMENTS

- All claims with global and delivery procedure codes must show the date of the last menstrual period (LMP) in Field 14 on the CMS-1500 claim form.
- If billing a global delivery code or other delivery code, use a delivery diagnosis on the claim, e.g., 650, 669.70, etc.
- If billing a global prenatal code, 59425 or 59426, or other prenatal services, a pregnancy diagnosis, e.g., V22.0, V22.1, etc. is required on the claim.

FREQUENTLY ASKED QUESTIONS

The following are frequently asked questions by providers concerning global services and directed to the MO HealthNet staff.

Can MO HealthNet be billed by the same provider for the initial visit in the office for the pregnancy in addition to billing global?

> No, all care related to the pregnancy is included in global. The only exception would be if the patient is under the age of 21 and a Healthy Children and Youth (HCY) screen was performed at the initial visit. If this is the case, the provider may bill the HCY screen using V20.2 for the primary diagnosis and a pregnancy diagnosis for the second diagnosis. Then as long as the provider meets all other global OB guidelines, the global OB codes may be billed as well.

Can the start up of a pitocin drip be billed separately?

No, MO HealthNet may not be billed for the start up of a pitocin drip. Not only is this procedure included in the global OB billing, it is also included in the delivery code if not billing global.

Can obstetrical ultrasounds be billed separately?

Yes, you may bill for ultrasounds when the ultrasounds are medically necessary. Obstetrical ultrasounds are limited to three per calendar year per participant. If more than three are performed in one calendar year, the additional ultrasounds must be reasonable and necessary based on the medical indication(s). The medical necessity must also be documented in the patient's medical record. Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedures.

If the MO HealthNet patient has received care for her pregnancy by a provider on three different occasions, can another provider still bill global if they have met all the global guidelines?

No, the participant is allowed two visits to a provider to establish the pregnancy and obtain a referral. If more than two visits to another provider have been reimbursed by MO HealthNet, the provider of ongoing care must bill out all services separately, i.e., office visits, each urinalysis, hospital visits, delivery, etc.

WILL YOUR PATIENT BE IN A MANAGED CARE HEALTH PLAN?

Depending on the area of the state, it is quite possible many of your patients may be required to enroll in a managed care health plan and choose a primary care provider. Once a patient is enrolled in a managed care health plan, payment for covered services becomes the responsibility of the health plan. Providers are encouraged to contact health plans to become enrolled as a managed care provider with the plans.

If a patient becomes enrolled in a managed care health plan in her third trimester of pregnancy, she may elect to continue to receive her obstetrical services from an out-of-plan provider. The out-of-plan provider must contact the appropriate health plan for instructions. If the out-of-plan provider only has admitting privileges in an out-of-plan hospital, the health plan is obligated to negotiate with the hospital on an agreeable reimbursement schedule.

When a patient receives more than two prenatal visits in a fee-for-service setting and transitions into a managed care health plan and changes providers, neither provider may bill for a global OB service. In this situation, both providers must bill for each date of service using the appropriate CPT code.

When the obstetrical care begins as fee-for-service and continues with the same provider into a managed care health plan, the provider must bill for date specific services for each program (MO HealthNet and the managed care health plan). The provider cannot submit a claim for global OB care to either program.

TEMPORARY MO HealthNet DURING PREGNANCY (TEMP), MEDICAL ELIGIBILITY (ME) CODE 58 OR 59

The purpose of the Temporary MO HealthNet During Pregnancy (TEMP) Program is to provide pregnant women with access to prenatal care while they await the formal determination of MO HealthNet eligibility.

TEMP services for pregnant women are limited to ambulatory physician, clinic, nurse-midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services. Services other than those listed above may be reimbursed if a *Certificate of Medical Necessity* is submitted with the claim and it testifies that the pregnancy would have been adversely affected without the service.

The diagnosis on the claim form **must** be a pregnancy/prenatal diagnosis (V22.0 through V23.9 or V28 through V28.9). Nurse midwives must use diagnosis codes V22.0 through V22.2 or V28 through V28.9.

Inpatient hospital services and deliveries performed either inpatient or outpatient are *not* covered under the TEMP program. Other non-covered services include postpartum care; contraceptive management; D&C; treatment of spontaneous, missed abortions or other abortions.

Infants born to mothers who are eligible under the TEMP Program are **not** automatically eligible under this program.

ABORTIONS AND MISCARRIAGES

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, 636.00-636.92, 638.0-638.9 and 639.00-639.9, must be submitted on a paper CMS-1500 claim form with all appropriate documentation attached. **The documentation must include, at the minimum, the operative report, an ultrasound, the pathology report and the admit and discharge summary, 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 *Certificate of Medical Necessity for Abortion* form in addition to the previously noted documents.

SECTION 10
FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, providers must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter “F” in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A provider may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
  Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- A breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

Billing for Birth Control Devices and Systems

A provider must submit a claim for a birth control device or system on an electronic Professional or Institutional ASC X12N 837 Health Care claim transaction or by entering an electronic claim on MO HealthNet's billing website, emomed.com. The system will automatically generate a separate claim for the NDC to process as a pharmacy claim and will appear as a separate claim on the provider's Remittance Advice.

Physicians, nurse practitioners, nurse midwives, clinics, public health agencies, FQHCs and provider based rural health clinics also have the option to submit a separate claim to report only the device or system information by using the Pharmacy Form claim option at the MO HealthNet billing Web site, emomed.com. This is the same option currently used by physicians when billing for injectables dispensed in the office or clinic.

COPPER INTRAUTERINE DEVICE (IUD), LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, VAGINAL RING, AND DEPO-PROVERA INJECTION

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments must bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing web site, emomed.com, or using the Pharmacy Claim form on emomed.com.

Provider Based RHCs can bill for these items using the product's NDC on the electronic Institutional ASC X12N 837 Health Care claim transaction, by entering an electronic UB-04 claim on MO HealthNet's billing website, emomed.com., or using the Pharmacy Claim form on emomed.com.

The fee for procedure code 58300 (insertion of IUD) covers insertion of the IUD. The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be submitted with claims for these services for manual pricing.

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments can bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing website, emomed.com, or using the Pharmacy Claim form on emomed.com. An invoice of cost is not required if billed using the NDC.

Provider Based RHCs can bill for these items using the product's NDC on the electronic Institutional ASC X12N 837 Health Care claim transaction, by entering an electronic UB-04 claim on MO HealthNet's billing website, emomed.com., or using the Pharmacy Claim form on emomed.com. An invoice of cost is not required if billed using the NDC.

IMPLANTABLE CONTRACEPTIVE CAPSULE SYSTEM

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments must bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing web site, emomed.com, or using the Pharmacy Claim form on emomed.com.

Provider Based RHCs can bill for these items using the product's NDC on the electronic Institutional ASC X12N 837 Health Care claim transaction, by entering an electronic UB-04 claim on MO HealthNet's billing website, emomed.com., or using the Pharmacy Claim form on emomed.com.

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the system.

11976 - removal, implantable contraceptive capsules
11981 – insertion, non-biodegradable drug delivery implant
11982 – removal, non-biodegradable drug delivery implant
11983 – removal with reinsertion, non-biodegradable drug delivery implant

An office visit code may not be billed in addition to any of the above procedure codes.

STERILIZATIONS

A *Sterilization Consent* form is a required attachment for all claims containing the following procedure codes: 55250, 58565, 58600, 58605, 58611, 58615, 58670, and 58671. **The MO HealthNet participant must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The participant must have given informed consent voluntarily in accordance with Federal and State requirements.

The *Sterilization Consent* form must be completed and signed by the participant at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E (1) of the *MO HealthNet Provider Manual* available on the Internet at www.dss.mo.gov/mhd/providers/index.htm).

The *Sterilization Consent Form* can be submitted also through the emomed Internet Web site. The provider must still maintain a properly completed paper form in the patient's files and must provide a copy of the paper form to the hospital if the service was performed in the hospital.

Essure - The Essure procedure is a permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

MO HealthNet covers the Essure procedure (CPT code 58565). If the service is provided in the office setting (POS11) or FQHC setting (POS 50), bill CPT 58565 without a modifier. If the service is provided in the hospital outpatient (POS 22) or inpatient (POS 21) setting, bill CPT 58565 52.

The *Sterilization Consent Form* must be completed and signed at least 31 days prior to the sterilization.

MISSOURI'S WOMEN'S HEALTH SERVICES (ME CODES 80 and 89)

MO HealthNet offers Women's Health Services to uninsured women who lose MO HealthNet eligibility 60 days after the birth of their child for up to one year. Services include family planning and limited testing and treatment of Sexually Transmitted Diseases. The treatment of medical complications occurring from the STD is **not** covered by this program. Eligible participants are enrolled under Medicaid Eligibility (ME) code 80.

The Centers for Medicare and Medicaid Services (CMS) has approved the Missouri Department of Social Services' request to extend Women's Health Services effective January 1, 2009 to additional women. Eligible participants for the expanded Women's Health Services program will be enrolled under ME code 89.

Services for ME codes 80 and 89 are provided on a fee-for-service basis only.

ELIGIBILITY CRITERIA

To qualify for the expanded Women's Health Services Program, a woman must be:

- Uninsured, defined as not having creditable coverage for family planning services;
- 18 to 55 years of age;
- have a net family income of at or below 185% of the Federal Poverty Level (FPL); and
- have assets totaling no more than $250,000.

These women are not limited to one year of coverage and remain eligible for the program as long as they continue to meet eligibility requirements and require family planning services.

Benefit Package

The Women’s Health Services program benefits package and limitations are the same for both ME codes 80 and 89 and include:

- Department of Health and Human Services approved methods of contraception;
- family planning counseling/education on various methods of birth control:
- diagnosis, testing and treatment of a sexually transmitted disease found during a family planning visit, including pap tests and pelvic exams; and,
- drugs, supplies, or devices related to women's health services described above

that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements).

All services must be billed with a primary diagnosis code of V25-V25.9 or payment for the services will be denied.

Covered Services

Procedure Code	Description
00851	ANESTHESIA FOR TUBAL LIGATION/ TRANSACTION
00952	ANESTHESIA FOR HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY
11976	REMOVABLE, IMPLANTABLE CONTRACEPTIVE CAPSULES
11981	INERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
56820	COLPOSCOPY OF THE VULVA
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY
57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX, IF PRESESNT
57421	COLPOSCOPY OF THE ENTIRE VAGINA
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA
57454	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX AND ENDOCERVICAL CURETTAGE
57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX
57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH ENDOCERVICAL CURETTAGE
57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH LOOP ELECTRODE BIOPSY OF THE CERVIX
57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA, WITH LOOP ELECTRODE COLONIZATION OF THE CERVIX
57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)
57510	CAUTERY OF CERVIX, ELECTRO OR THERMAL
57511	CAUTERY OF CERVIX, CRYOCAUTERY, INITIAL OR REPEAT
57513	CAUTERY OF CERVIX; LASER ABLATION.
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY

58565	HYSTEROSCOPY, WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS
58600	LIGATION OR TRANSECTION OF FALLOPIAN TUBES
58611	LIGATION OR TRANSECTION OF FALLOPIAN TUBES
58615	OCCLUSION OF FALLOPIAN TUBES BY DEVICE
58670	LAPAROSCOPY, SURGICAL; W/ FULGURATION OF OVIDUCTS BY DEVICE (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (E.G., BAND, CLIP, ETC.)
74740	HYSTEROSALPINGOGRAPHY RADIOLGOICAL SUPERVISION AND INTERPRETATION
74742	TRANSCERVICAL CATHETERIZATION OF FALLOPIAN TUBE RADIOLOGICAL SUPERVISION AND INTERPRETATION
76830	ULTRASOUND TRANSVAGINAL
76831	ECHO EXAM UTERUS
76856	US EXAM PELVIC COMPLETE
76857	ULTRASOUND PELVIC (NONOBSTETRIC) B-CAN &/OR REAL TIME W/ IMAGE DOCUMENTATION
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZE)
80048	BASIC METABOLIC PANEL (CLIA PANEL PROC)
80050	GENERAL HEALTH PANEL
80051	ELECTROLYTE PANEL (CLIA PANEL PROC)
80055	OBSTETRIC PANEL
80074	ACUTE HEPATITIS PANEL
81000	URINALYSIS BY DIPSTICK/TABLET REAGENT; NON- AUTOMATED W/MICROSCOPY
81001	URINALYSIS ETC. AUTOMATED WITH MICROSCOPY
81002	URINALYSIS BY DIP STICK/TABLET REAGENT;NON-AUTOMATED W/OUT MICROSCOPY(CLIA WAIVER LIST)
81003	URINALYSIS BY DIP/TABLET;AUTOMATED W/O MICROSCOPY
81005	URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE EXCEPT IMMUNOASSAYS
81015	URINALYSIS MICROSCOPIC ONLY (PPMP CLIA LIST)
81020	URINALYSIS; 2 OR 3 GLASS TEST (PPMP CLIA LIST)
81025	URINE PREGNANCY TEST BY VISUAL COLOR COMPARISON METHODS (CLIA WAIVER LIST)
82105	ALPHA-FETOPROTEIN; SERUM
82120	AMINES VAGINAL FLUID QUALITATIVE
82670	ESTRADIOL
82671	ESTROGENS FRACTIONATED
82672	ESTROGENS TOTAL

82677	ESTRIOL
82679	ESTRONE
82947	GLUCOSE; QUANTITATIVE (CLIA WAIVER LIST)
82948	GLUCOSE; BLOOD REAGENT STRIP
82962	GLUCOSE BLOOD BY GLUCOSE MONITORING DEVICE(S) CLEARED/ FDA SPECIFICALLY/HOME USE
83001	GONADOTROPIN FOLLICLE STIMULATING HORMONE (FSH)
83002	GONADOTROPIN LUTEINIZING HORMONE (LH)
84144	PROGESTERONE
84146	PROLACTIN
84702	GONADOTROPIN CHORIONIC (HCG); QUANTITATIVE
84703	GONADOTROPIN CHORIONIC QUALITATIVE (CLIA WAIVER LIST)
85004	AUTOMATED DIFF WBC COUNT
85007	BL SMEAR W/DIFF WBC COUNT
85008	BL SMEAR W/O DIFF WBC COUNT
85009	MANUAL DIFF WBC COUNT B-COAT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT(CLIA WAIVER LIST)
85014	HEMATOCRIT
85018	HEMOGLOBIN
85025	COMPLETE CBC W/AUTO DIFF WBC
85027	COMPLETE CBC AUTOMATED
85032	MANUAL CELL COUNT EACH
85610	PROTHROMBIN TIME (CLIA WAIVER LIST)
85652	SEDIMENTATION RATE ERYTHROCYTE; AUTOMATED
85730	THROMBOPLASTIN TIME PARTIAL (PTT) PLASMA OR WHOLE BLOOD
86318	IMMUNOASSAY/INFECTI AGENT ANTIBODY QUALI/SEMIQUANTSINGLE STEP METHOD
86382	NEUTRALIZATION TEST VIRAL
86386	NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE
86403	PARTICLE AGGLUTINATION; SCREEN EACH ANTIBODY
86580	SKIN TEST TUBERCULOSIS INTRADERMAL (EXEMPT FROM CLIA EDITING)
86592	SYPHILIS TEST QUALITATIVE (EG VDRL RPR ART)
86593	SYPHILIS TEST QUANTITATIVE
86628	ANTIBODY; CANDIDA
86631	ANTIBODY; CHLAMYDIA
86632	ANTIBODY ; CHLAMYDIA IGM
86687	ANTIBODY; HTLV I
86688	ANTIBODY; HTLV-II
86689	ANTIBODY; HTLV OR HIV ANTIBODY CONFIRMATORY TEST (EG WESTERN BLOT)
86694	ANTIBODY; HERPES SIMPLEX NON-SPECIFIC TYPE TEST
86695	ANTIBODY; HERPES SIMPLEX TYPE I
86696	HERPES SIMPLEX TYPE 2
86701	ANTIBODY HIV 1

86702	ANTIBODY; HIV 2
86703	ANTIBODY; HIV-1 AND HIV-2 SINGLE RESULT
86706	HEPATITIS B SURFACE ANTIBODY (HBSAB)
86707	HEPATITIS BE ANTIBODY (HBEAB)
86762	ANTIBODY; RUBELLA
86787	ANTIBODY; VARICELLA-ZOSTER
86803	HEPATITIS C ANTIBODY
86900	BLOOD TYPING; ABO
86901	BLOOD TYPING; RH(D)
87015	CONCENTRATION (ANY TYPE) FOR PARASITES OVA OR TUBERCLE BACILLUS (TB AFB)
87040	BLOOD CULTURE FOR BACTERIA
87070	CULTURE BACTERIA OTHER
87071	CULTURE BACTERIA; QUANTITATIVE AEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87073	CULTURE BACTERIAL; QUANTITATIVE ANEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87075	CULTURE BACTERIA EXCEPT BLOOD
87076	CULTURE BACTERIAL ANY SOURCE DEFINITIVE IDENTIFICATION EACH ANAEROBIC ORGANISM
87077	CULTURE BACTERIAL;AEROBIC ISOLATE ADDITONAL METHODS REQUIRED FOR DEFINITIVE IDENTIFICATION
87081	CULTURE BACTERIAL SCREENING ONLY FOR SINGLE ORGANISMS
87086	CULTURE BACTERIAL URINE QUANTITATIVE COLONY COUNT
87088	URINE BACTERIA CULTURE
87102	CULTURE FUNGI ISOLATION OTHER SOURCE (EXCEPT BLOOD)
87110	CULTURE CHLAMYDIA
87147	CULTURE TYPING SEROLOGIC METHOD AGGLUTINATION GROUPING PER ANTISERUM
87164	DARK FIELD EXAMINATION ANY SOURCE (EG PENILE VAGINAL ORAL SKIN)
87184	SENSITIVITY STUDIES ANTIBIOTIC DISK METHOD PER PLATE (12 OR LESS DISKS)
87186	SENSITIVITY STUDIES ANTIBIOTIC MICROTITER MINIMUM INHIBITORY CONCENTRATION (MIC)
87205	SMEAR PRIMARY SOURCE WITH INTERPRETATION ROUTINE STAIN
87206	SMEAR PRIMARY SOURCE WITH INTERPRETATION FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA FUNGI
87207	SMEAR SPECIAL STAIN
87210	SMEAR PRIMARY SOURCE WITH INTERPRETATION WET MOUNT WITH SIMPLE STAIN
87220	TISSUE EXAMINATION FOR FUNGI (EG KOH SLIDE)
87252	VIRUS IDENTIFICATION; TISSUE CULTURE INOCULATION AND OBSERVATION

87270	INFECT AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; CHLAMYDIA TRACHOMATIS
87273	INFECTIOUS AGENT ANTIGEN DETECTION BY FLOURESCENT ANTIBODY; HERPES SIMPLEX VIRUS TYPE 2
87274	INFECTIOUS AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; HERPES SIMPLEX VIRUS
87320	INFECT AGT ANTIGEN DETECTION BY ENZYME IMMUNOASSY METHOD; ADENOVIRUS ENTERIC TYPES 40/41 CHLAMYD
87340	HEPATITIS B SURFACE ANTIGEN
87350	HERPES SIMPLEX TYPE 2
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE
87390	HIV-1
87391	HIV-2
87470	INFECT AGT DETECT BY NUCLEIC ACID (DNA OR RNA); BARTONELLA HENSELAE AND BARTONELLA QUINTANA DIRECT
87480	CANDIDA SPECIES DIRECT PROBE TECHNIQUE
87481	CANDIDA SPECIES AMPLIFIED PROBE TECHNIQUE
87482	CANDIDA SPECIES QUANTIFICATION
87485	CHLAMYDIA PNEUMONIAE DIRECT PROBE TECHNIQUE
87486	CHLAMYDIA PNEUMONIAE AMPLIFIED PROBE TECHNIQUE
87487	CHLAMYDIA PNEUMONIAE QUANTIFICATION
87490	CHLAMYDIA TRACHOMATIS DIRECT PROBE TECHNIQUE
87491	CHLAMYDIA TRACHOMATIS AMPLIFIELD PROBE TECHNIQUE
87492	CHLAMYDIA TRACHOMATIS QUANTIFICATION
87495	CYTOMEGALOVIRUS DIRECT PROBE TECHNIQUE
87496	CYTOMEGALOVIRUS AMPLIFIED PROBE TECHNIQUE
87497	CYTOMEGALOVIRUS QUANTIFICATION
87510	GARDNERELLA VAGINALIS DIRECT PROBE TECHNIQUE
87511	GARDNERELLA VAGINALIS AMPLIFIED PROBE TECHNI
87512	GARDNERELLA VAGINALIS QUANTIFICATION
87528	HERPES SIMPLEX VIRUS DIRECT PROBE TECHNIQUE
87529	HERPES SIMPLEX VIRUS AMPLIFIED PROBE TECHNIQUE
87530	HERPES SIMPLEX VIRUS QUANTIFICATION
87531	HERPES VIRUS-6 DIRECT PROBE TECHNIQUE
87532	HERPES VIRUS-6 AMPLIFIED PROBE TECHNIQUE
87533	HERPES VIRUS-6 QUANTIFICATION
87534	HIV-1 DIRECT PROBE TECHNIQUE
87535	HIV-1 AMPLIFIED PROBE TECHNIQUE
87536	HIV-1 QUANTIFICATION
87537	HIV-2 DIRECT PROBE TECHNIQUE
87538	HIV-2 AMPLIFIED PROBE TECHNIQUE
87539	HIV-2 QUANTIFICATION

87590	NEISSERIA GONORRHOEAE DIRECT PROBE TECHNIQUE
87591	NEISSERIA GONORRHOEAE AMPLIFIED PROBE TECHNIQUE
87592	NEISSERIA GONORRHOEAE QUANTIFICATION
87620	PAPILLOMAVIRUS HUMAN DIRECT PROBE TECHNIQUE
87621	PAPILLOMAVIRUS HUMAN AMPLIFIED PROBE TECHNIQUE
87622	PAPILLOMAVIRUS HUMAN QUANTIFICATION
87660	TRICHOMONAS VAGIN DIR PROBE
87797	NOT OTHERWISE SPECIFIED DIRECT PROBE TECHNIQUE
87800	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; DIRECT PROBE TECHIQUE
87801	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; AMPLIFIED PROBE TECHNIQUE
87810	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; CHLAMYDIA TRACHOMATIS
87850	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; NEISSERIA GONORRHOEAE
88108	CYTOPATHOLOGY CONCENTRATION TECHNIQUE SMEARS AND INTERPRETATION (EG SACCOMANNO TECHNIQUE)
88141	CYTOPATHOLOGY CERVICAL OR VAGINAL
88142	CYTOPATHOLOGY CERVICAL OR VAGINAL, THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYS SUPERVISION
88143	CYTOPATHOLOGY CERVICAL OR VAGINAL, WITH MANUAL SCREENING AND RESCREENING
88147	CYTOPATHOLGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION
88148	CYTOPATHOLOGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING
88150	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION
88152	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL; W/ MANUAL & COMPUTER-ASSISTED RESCREENING UNDER PHYS SUPERVISION
88153	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88154	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENINGS AND COMPUTER-ASSISTED RESCREENING
88155	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL DEFINITIVE HORMONAL EVALUATION
88160	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; SCREENING AND INTERPRETATION
88161	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; PREPARATION SCREENING AND INTERPRETATION
88162	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS
88164	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL(THE BETHESDA SYSTEM)

88165	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); UNDER PHYSICIAN'S SUPERVISION
88166	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING
88167	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING USING CELL SELECTION
88172	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; IMMEDIATE CYTOHISTOLOGIC STUDY
88173	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; INTERPRETATION AND REPORT
88174	CYTOPATH C/V AUTO IN FLUID
88175	CYTOPATH C/V AUTOMATED THIN LAYER PREPARATION, WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION
99070	SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED
99201-99205	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER OUTPATIENT VISIT
99211-99215	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER OUTPATIENT VISIT
99383-99386	PREVENTATIVE MEDICINE SERVICES/NEW PATIENT
99393-99396	PREVENTATIVE MEDICINE SERVICES/ESTABLISHED PATIENT
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE
A4266	DIAPHRAGM
J7300*	INTRAUTERINE COPPER CONTRACEPTIVE
J7302*	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7303*	CONTRACEPTIVE VAGINAL RING
J7304*	CONTRACEPTIVE HORMONE RING
J7306*	LEVONORGESTREL IMPLANT
Q0111	WET MOUNTS, INCLUDING PREPARATIONS OF VAGINAL, CERVICAL, OR SKIN SPECIMENS
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE

*These items must be billed electronically with a National Drug Code (NDC) and a decimal quantity.

Drug Class	Description
G2A	PROGESTATIONAL AGENTS (Used for Contraception)
G8A	CONTRACEPTIVES, ORAL
G8B	CONTRACEPTIVES, IMPLANTABLE
G8C	CONTRACEPTIVES, INJECTABLE
G8F	CONTRACEPTIVES, TRANSDERMAL
G9B	CONTRACEPTIVES, INTRAVAGINAL
L5A	KERATOLYTICS
Q4F	VAGINAL ANTIFUNGALS
Q4W	VAGINAL ANTIBIOTICS
Q5R	TOPICAL ANTIPAPASITICS
Q5V	TOPICAL ANTIVIRALS
W1A	PENICILLINS
W1B	CEPHALOSPORINS
W1C	TETRACYCLINES
W1D	MACROLIDES
W1F	AMINOGLYCOSIDES
W1K	LINCOSAMIDES
W1P	BETALACTAMS
W1Q	QUINOLONES
W1Y	CEPHALOSPORINS 3RD GENERATION
W2A	ABSORBABLE SULFONAMIDES
W3B	ANTIFUNGAL AGENTS
W3C	ANTIFUNGAL AGENTS (CONTINUED)
W4E	ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS
W5A	ANTIVIRAL, GENERAL
WG4	2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL
X1B	DIAPHRAMS/CERVICAL CAP
X1C	INTRA-UTERINE DEVICES
Z2G	IMMUNOMODULATORS (Aldera)

SECTION 11
SURGERY

PROCEDURE CODES

MO HealthNet recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a MO HealthNet reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, rural health clinic (RHC) or an office setting; and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, RHC, office, home, nursing home, etc.).

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 13 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery "incidentally" performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the MO HealthNet *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same participant on the same date of service by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in

coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

100% of the allowable fee for the major procedure
50% of the allowable fee for the secondary procedure
25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same participant on the same date of service.

ASSISTANT SURGEON

MO HealthNet adheres to the guidelines set by Medicare Services for assistants at surgery. The services of an assistant surgeon are billed with modifier 80. Reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the assistant surgeon column of the database instruct carriers how to reimburse for services. The fee schedule can be found at http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp.

NOTE: Not all codes in the listing are covered by MO HealthNet, refer to the MO HealthNet fee schedule at http://dssapp2.dss.mo.gov/pricelistx/main_disclaimer.shtml.

An assistant surgeon's fee is payable at 20% of the surgeon's fee for the surgical procedure. Only one assistant surgeon can be paid for those procedures that warrant an assistant. If the surgeon's claim is systematically priced, the assistant surgeon's claim is also systematically priced. If the surgeon's claim is manually priced, the assistant surgeon's claim is also manually priced, and an operative record *must* be attached to the claim for payment.

Follow-up care provided by the assistant surgeon is subject to the 30-day postoperative policy as described in the MO HealthNet *Physician Provider Manual*, Section 13.41.

Registered nurses and other non-physician personnel are ancillary staff and *not* considered “assistant surgeons” and services performed by them are, therefore, *not* billable to MO HealthNet as a separate service.

The surgeon and assistant surgeon *must* each submit separate professional claims for services provided, using his/her individual NPI.

MO HealthNet does *not* reimburse for the services of an assistant surgeon when a co-surgeon is used.

A clinic may submit a single professional claim for the surgeon and assistant surgeon, using the clinic's NPI and *must* also include each individual provider's NPPI as the performing/rendering provider.

NOTE: For assisting at cesarean deliveries, the appropriate procedure code for the delivery only *must* be billed, regardless of whether or not the surgeon billed the global procedure. A "global" delivery indicates that the prenatal care, delivery and postpartum care are provided by a single physician; therefore global delivery procedure codes may *not* be billed by the assistant surgeon.

CO-SURGEONS

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic NPI number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician, and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes	In-patient Consult Codes
99241	99251
99242	99252
99243	99253
99244	99254
99245 (requires a copy of the consult report with the claim)	99255 (requires a copy of the consult report with the claim)

SECTION 12
ANESTHESIA

PROCEDURE CODES

MO HealthNet recognizes CPT anesthesia codes 00100 - 01999. The surgical procedure, for which anesthesia services are being provided, must be a covered MO HealthNet service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same participant on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes and are subject to National Correct Coding Initiative (NCCI) editing.

20550	36420	36625	64400	64418	64449	64520
31500	36425	36660	64402	64420	64450	64530
36000	36510	36680	64405	64421	64479	93503
36010	36555	62273	64408	64425	64480	99100
36011	36556	62281	64410	64430	64483	99116
36014	36568	62282	64412	64435	64484	99135
36400	36569	62310	64413	64445	64505	99140
36405	36584	62311	64415	64446	64508	99148
36406	36600	62318	64416	64447	64510	99149
36410	36620	62319	64417	64448	64517	99150

CPT Code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is billed with a quantity of 1 and without any modifier.

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

AA - Anesthesia services performed personally by anesthesiologist
QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
QX – CRNA/AA service, with medical direction by physician
QZ - CRNA service, without medical direction by physician

ANESTHESIA BILLING TIPS

- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- An AA and a CRNA are not allowed to bill for the same anesthesia services.
- Anesthesiologist and CRNA/AA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

  99100 - Anesthesia for patient of extreme age, under one year and over seventy.
  99116 - Anesthesia complicated by utilization of total body hypothermia.
  99135 - Anesthesia complicated by utilization of controlled hypotension.
  99140 - Anesthesia complicated by emergency conditions (specify).

When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.

SECTION 13
OFFICE MEDICAL SUPPLY CODES

Supplies and materials provided by the physician above those usually included with an office visit may be billed using the appropriate supply code.

PROC. CODE	DESCRIPTION
A4261	Cervical Cap for Contraceptive use (invoice required for pricing)
A4266	Diaphragm (invoice required for pricing)
A4300	Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal)
A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
A4565	Slings
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)
99070	Supplies and material (except eyeglasses, hearing aids) provided by the physician over and above those usually included with the office visit or other services rendered. (In Field 24D of the CMS-1500 claim form, list drugs, trays, supplies or materials provided.) (Invoice required for pricing)

SECTION 14
PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request **must** be completed and mailed to: Wipro Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, M0 65102. Providers should keep a copy of the original PA Request form, as the form is not returned to the provider.
- The provider performing the service **must** submit the PA Request form. Sufficient documentation or information **must** be included with the request to determine the medical necessity of the service.
- The service **must** be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do **not** request prior authorization for services to be provided to an ineligible person. Authorization considers medical necessity only and does not examine eligibility.
- Expanded HCY (EPSDT) services are limited to recipients 20 years of age and under and are **not** reimbursed for recipients 21 and over even if prior authorized.
- Prior authorization does **not** guarantee payment if the recipient is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is **not** made for services initiated before the approval date on the PA Request form or after the authorization deadline. For services to continue after the expiration date of an existing PA Request, a new PA Request **must** be completed and mailed.

Whether the prior authorization is approved or denied, a disposition letter will be returned to the provider containing all of the detail information related to the prior authorization request. Any other documentation submitted with the prior authorization request will not be returned with the exception of x-rays and dental molds. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request.

Instructions for completing the PA Request form are found in Section 8 of the MO HealthNet *Provider's Manual* available on the Internet at www.dss.mo.gov/mhd/providers/index.htm.

PROCEDURES REQUIRING A PRIOR AUTHORIZATION

The following procedure codes require a *Prior Authorization Request* form.

11920	15839	19364-50	21188	50547-50	67903-50
11920-EP	15847	19366	21194	50547-62	67903-62
11921	15847-62	19366-50	21230	50547-6250	67903-6250
11921-EP	17999-EP	19367	21235	54152	67904
11922-EP	19316	19367-50	21260	54161	67904-50
11960	19316-50	19368	21260-62	54162	67904-62
11970	19318	19368-50	21261	54163	67904-6250
11971	19318-50	19369	21261-62	54164	67906
15780	19324	19369-50	21720	56805	67906-50
15781	19324-50	19370	21725	56805-62	67908
15782	19325	19370-50	21725-62	57335	67908-50
15786	19325-50	19371	26580	57335-62	67909
15787	19328	19371-50	26590	58345	67909-50
15820	19328-50	19380	43644	58345-50	67923
15820-50	19330	19380-50	43645	58345-62	67923-50
15821	19330-50	20974	43659	58345-6250	67924
15821-50	19340	21086	43659-50	65767	67924-50
15822	19340-50	21086-50	43842	65780	69300
15822-50	19342	21087	43842-62	65780-50	69300-50
15823	19342-50	21088	43843	67782	69949-EP
15823-50	19350	21120	43843-62	65782-50	
15831	19350-50	21120-62	43845	67900	
15832	19355	21121	43846	67901	
15833	19355-50	21122	43846-62	67901-50	
15834	19357	21123	43847	67902	
15835	19357-50	21123-62	43847-62	67902-50	
15836	19361	21125	43848	67902-62	
15837	19361-50	21127	43848-62	67902-6250	
15838	19364	21127-62	50547	67903	

SECTION 15
LABORATORY SERVICES

Missouri MO HealthNet follows Medicare guidelines for billing of professional and technical and total components of laboratory tests. Providers should reference Medicare's Newsletter for Indicators/Global Surgery/Percentages/Endoscopies at http://wpsmedicare.com/.

Professional component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 80500 and 85097.

Technical component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 81002 and 82270.

Total component codes – These codes have a professional, technical, and total component. When billing for the professional component, use the 26 modifier. When billing for the technical component, use the TC modifier. When billing for the total component, do not use any modifiers. Examples - 88104, 88300.

Clinical Laboratory Improvement Act (CLIA)

CLIA WAIVER PROCEDURES

MO HealthNet providers possessing a "Certificate of Waiver" are allowed to perform the following procedures.

G0328	82042	82465	83026	84450	96618	87999
80047	82043	82550	83036	84460	86701	89300
80048	82044	82565	83037	84478	86703	89321
80051	82055	82570	83518	84520	87077	
80053	82120	82679	83605	84550	87210	
80061	82150	82947	83655	84703	87210U7	
80069	82247	82950	83718	85013	87449	
80178	82270	82951	83721	85014	87804	
81002	82271	82952	83861	85018	87807	
81003	82272	82962	83880	85576	87808	
81025	82274	82977	83986	85610	87809	
81025U7	82310	82985	84075	85651	87880	
82010	82330	83001	84132	86294	87899	
82040	82374	83002	84443	86318	87905	

PHYSICIAN PERFORMED MICROSCOPY PROCEDURES (PPMP)
MO HealthNet providers possessing a PPMP certificate are allowed to perform all the waiver procedures as well as the following additional procedures.

Q0111	Q0113	Q0115	81001	81020	89190
Q0112	Q0114	81000	81015	89055	

Questions regarding CLIA registration or accreditation should be directed to:

Bureau of Health Facility Regulation
Department of Health and Senior Services
P.O. Box 570
Jefferson City, Missouri 65102-0570
(573) 751-6318

SECTION 16
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

MO HealthNet uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600
www.amabookstore.com

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Optum
P.O. Box 88050
Chicago, IL 60680-9920
800/464-3649
Fax Orders: 801/982-4033
www.optumcoding.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

MO HealthNet also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

PMIC
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
Fax Orders: 800/633-6556
http://pmiconline.com

SECTION 17
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