

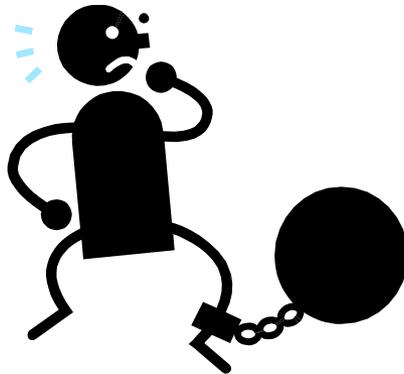
**2015 LPHA
Public Health Conference
Session 2
MO HealthNet Division (MHD)
Proper Billing Methods**

Gina Overmann and Kim Morgan
Provider Education Representatives

Session 2 Agenda

- Spenddown & Eligibility
- Electronic Claim Filing Overview
- Major Reasons for Claim Denials

Spenddown & Eligibility



What is Spenddown?



- Participant's income exceeds allowable amount to qualify for MHD coverage
- Spenddown is amount of medical expenses that are participant's financial responsibility
 - similar to insurance deductible
- Spenddown must be met or paid before MHD reimburses claims

Spenddown Amounts

- Family Support Division (FSD) determines spenddown amounts based on income
- Any income changes need to be reported to FSD
- Participants should contact FSD with questions or concerns about their spenddown amounts
- Questions should be directed to FSD at 1-855-FSD-INFO



Inactive Coverage



- If participant does not pay-in or submit bills, coverage shows “inactive”

- Coverage may show inactive during the month
 - spenddown option chosen by participant
 - whether payment received

Pay Spenddown to MHD

Participant can mail spenddown payment to MHD:

MO HealthNet Division

P.O. Box 808001

Kansas City, MO 64180-8001



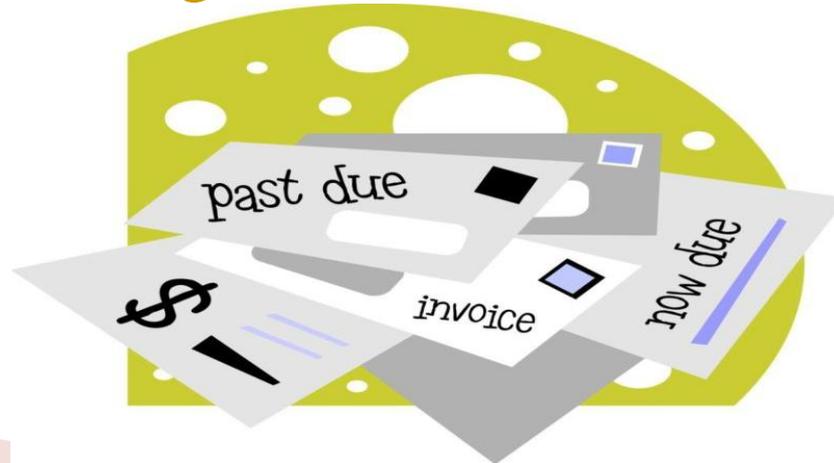
Participant Options to Meet Spenddown

- Submit full payment to MHD - coverage entire month
- Spenddown Automatic Withdrawal Form found on Participant Eligibility webpage, Participant Quick Links, at <http://dss.mo.gov/mhd/participants/>
- Incurred medical expenses may be used to meet spenddown
- Bills reach spenddown amount, participant submits to FSD
- Coverage starts day spenddown is met, ends last day of month
- MHD reimburses for services over spenddown amount

Provider Spenddown Form

- Incurred medical expenses
- SDU activates coverage, providers submit claims to MHD for services rendered
- Access form on Family Support Division, MHD for the Aged, Blind and Disabled webpage:

<http://dss.mo.gov/fsd/massist.htm>



Spenddown Provider Form

mhn-spend-down-provider (Read-Only) - Microsoft Word

Table Tools

Home Insert Page Layout References Mailings Review View Design Layout

Clipboard Font Paragraph Styles Editing WebEx

1 2 3 4 5 6 7 8



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
MO HealthNet Spend Down Provider Form

Provider Instructions: Please assist your patient by completing the following information. By completing this form, you are verifying medical expenses have been incurred and are owed by your patient. The "Total Daily Expense Patient is Responsible to Pay" column should reflect the patient's incurred expenses for which they are personally responsible to pay.

ATTENTION: All fields on this document are **required** to be completed, unless an attachment(s) verifying the required information for the incomplete field is provided.

Patient Name (Print): _____ MO HealthNet Number: _____

Provider Name: _____

Check One: Doctor Pharmacy Hospital: In-patient Out-patient Other _____

Date of Service	Service Description	Procedure Code	Name of Liable Third Party(s)	Total Amount of Charge	Amount of Expense Billable to Third Party	Write off or Other Discount (i.e. Indigent Waiver)	Total Daily Expense Patient is Responsible to Pay	Total Amount Billable to State Only Funds (i.e. DMH, DHSS contracts)
EXAMPLE: 08/01/2012	CPR Medication Services	90862	DMH	\$80.00	\$80.00	\$0.00	\$0.00	\$80.00

BY COMPLETING AND SIGNING THIS DOCUMENT, YOU ARE ATTESTING TO THE ACCURACY OF THE INFORMATION PROVIDED AND THAT THE PATIENT WILL BE BILLED FOR THE AMOUNT DUE. PLEASE INITIAL HERE IF THIS FORM IS COMPLETED BASED ON A GOOD FAITH ESTIMATE OF THE EXPENSES OWED/BILLABLE TO PATIENT: _____

THE FOLLOWING INFORMATION IS REQUIRED TO BE COMPLETED BY THE PROVIDER:

Name of Provider or Authorized Employee Completing Form (Please print): _____

Title: _____ Date: _____



Spenddown Unit (SDU)

- Review expenses to meet spenddown, determine MHD coverage dates and authorize coverage
- Scan and email Provider Spenddown form to **sesd@ip.sp.mo.gov**, including receipts and bills
- Fax form and documentation to one of the numbers below:
417-967-1043; 417-967-0259; 417-967-0372

Email and phone number set up just for providers:

- Email any questions or issues to
SpendDown.Unit@dss.mo.gov
- Call SDU (Texas Co FSD office) at 417-967-4551, Option 1, or extension 250 for a Manager

Resources to Verify MHD Eligibility

November 10, 2014

- Several resources to assist providers on verifying eligibility
 - Provider Communication at (573)751-2896
 - Email Provider Communications Unit from eMOMED
 - Access Provider Manuals, Section 1.1.A, Description of Eligibility Categories
- Links from Provider Participant Page, General Information
 - Puzzled by Terminology?
 - Benefit Matrix

Participant Eligibility Training Tool

Hot Tip

December 22, 2014

- Determining Eligibility PowerPoint
 - Walks through checking eligibility
- Located on Provider Participation webpage
- <http://dss.mo.gov/mhd/providers/>



Checking Eligibility on eMOMED

The screenshot displays the MO HealthNet Portal website. At the top, there is a navigation bar with links for **Login**, **Contact**, **Search Center**, and **Troubleshooting**. Below this is a banner image featuring a diverse group of healthcare professionals and patients, with the **MoHealthNet** logo prominently displayed. The main content area is divided into several sections:

- External Links:** A list of links including "State of Missouri Web site", "Department of Social Services", and "MO HealthNet Division".
- Public News:** A section titled "eNews" with a list of recent news items, such as "03/14/2014 ICD-10 Testing" and "12/23/2013 *Effective 12/23/2013* ERA Enrollment Form".
- Welcome:** A central section with a "Welcome to the New MO HealthNet Web Portal" message, accompanied by an image of a healthcare worker and text stating "The complete source for all MO HealthNet Participant and Provider related services."
- Login:** A form with fields for "User ID" and "Password", a "Login" button, and links for "Click Here!" and "Register Now!".
- ERA Enrollment:** A section for "Provider Sign up for Electronic Remittance Advice (ERA)" with a "Click Here!" link.
- Clinical Scenarios:** A section for "Attention: Coders ICD-10 Survey" with a "Click Here!" link.

At the bottom of the page, there is a footer with navigation links and logos for the Missouri Department of Social Services and Norton Secured, powered by VeriSign.



eProvider ePassport

Home / eProvider

External Links

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

- Provider Information
- Provider Enrollment Application
- Participant Information

eProvider News

New!
05/16/2011

eProvider Welcome



Welcome to eProvider



Claim Management
Submit new claims. View claim status.
Void/Replace existing claims.



Nur
Man
hom



Attachment Management
Submit new stand-alone attachments.
View attachment status.



File
Sen
Print



Participant Eligibility
Verify participant eligibility.



Pay
View
two



Participant Eligibility

Eligibility / Benefit Information 1 of 1

Eligibility / Benefit Code	Service Type	Plan Code	Time Period	Monetary Qualifier Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
1 - Active Coverage	30 - Health Benefit Plan Coverage	13	34 - Month	\$0.00	MC - MO HealthNet	291		12/19/2011
	1 - Medical Care							
	86 - Emergency Services							
	88 - Pharmacy							
	98 - Professional (Physician) Visit - Office							



- 1 - Active
- 6 - Inactive
- B - Co-Payment
- D - Benefit Description
- F - Limitations
- L - Primary Care Provider
- N - Services Restricted to Following Provider
- R - Other or Additional Payer
- U - Contact Following Entity for Eligibility or Benefit Information.
- Y - Spenddown

Spenddown “Monetary Amount” = Spenddown amount due each month



Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
6 - Inactive	{ 30 - Health Benefit Plan Coverage }				MC - MO HealthNet	291		05/01/2013 05/01/2013

Eligibility / Benefit Information 2 of 4



Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
Y - Spend Down	{ 30 - Health Benefit Plan Coverage }			\$192.00	MC - MO HealthNet	291		05/01/2013 05/31/2013



Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
7 - Day	\$0.00	MC - MO HealthNet		291	04/23/2011



The Time Period Qualifier represents the eligibility information.

7 – Day *

34 - Month

Eligibility / Benefit Information 1 of 6

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
F - Limitations	30 - Health Benefit Plan Coverage	55	34 - Month	\$0.00	MC - MO HealthNet	291		12/19/2011

Valid values are:

MA – Medicare Part A

MB – Medicare Part B

MC – MO HealthNet

HM – Health Maintenance Organization (HMO)

HN – Health Maintenance Organization (HMO) Medicare Risk (Medicare Part C – Replacement Plan)

OT – Other

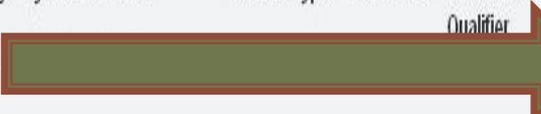
QM – Qualified Medicare Beneficiary

Spend
Down
Indicator


Eligibility / Benefit Information 3 of 6

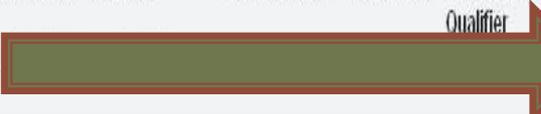
Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
Y - Spend Down	30 - Health Benefit Plan Coverage			\$112.00	MC - MO Health			12/31/2011

Spend
Down
Amount


Medicare
Part A


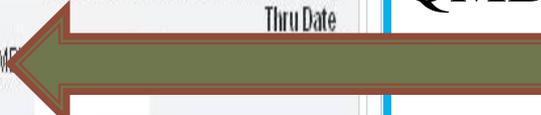
Eligibility / Benefit Information 4 of 6

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
R -				00	MA - Medicare Part A	4000000000A	291	12/19/2011

Medicare
Part B


Eligibility / Benefit Information 5 of 6

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
R -				00	MB - Medicare Part B	4000000000A	291	12/19/2011

QMB


Eligibility / Benefit Information 6 of 6

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
R - Other or Additional Payor				\$0.00	QM - Qualified Medicare Beneficiary (QMB)			



Administrative Lock-In

Participants locked-in to another provider

- ▶ Must be referred by Authorized Lock-In Provider for services using Medical Referral Form of Restricted Participants (PI-118)

- ▶ Provider Participation webpage:

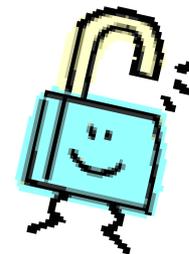
<http://dss.mo.gov/mhd/providers/>

- ▶ MO HealthNet Forms:

<http://manuals.momed.com/manuals/presentation/forms.jsp>

- ▶ Medical Referral Form of Restricted Participants [PI-118]:

[http://manuals.momed.com/forms/Medical_Referral_Form_of_Restricted_Participants\[PI-118\].pdf](http://manuals.momed.com/forms/Medical_Referral_Form_of_Restricted_Participants[PI-118].pdf)

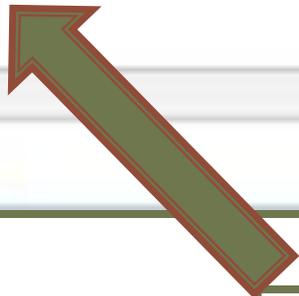


Eligibility / Benefit Information 2 of 7

Eligibility / Benefit Code	Service Type	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier	From Date Thru Date
N - Services Restricted to Following Provider				\$0.00			291	10/07/2011

Lockin Information

Name	Office Phone	Hotline Number
GOOD HOSPICE OF ANYTOWN	(573) 111-1111	



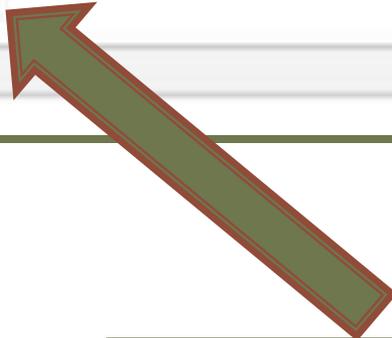
Hospice Lock-in

Eligibility / Benefit Information 3 of 4

Eligibility / Benefit Code	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier
N - Services Restricted to Following Provider			0.0			307 - Eligibility

Lockin Information

Name	Office Phone	Hotline Number
MEDICAL CLINIC OF WILLOW	(417)469-3116	



Lock-in to Medical Clinic

Eligibility / Benefit Information 4 of 4

Eligibility / Benefit Code	Plan Code	Time Period Qualifier	Monetary Amt	Insurance Type	Medicare Nbr	Date Qualifier
N - Services Restricted to Following Provider			0.0			307 - Eligibility

Lockin Information

Name	Office Phone	Hotline Number
MEDICINE CHEST (THE)	(417)256-7706	

Reference Information

Confirmation Number



Lock-in to Pharmacy

Reference Information

Confirmation Number

12121212121

Print Finish

Confirmation Number

Print eligibility screen after completing inquiry

Electronic Claim Filing Overview



Provider Protection against Nonpayment

- Eligibility verification - key to a paid claim
- Bill all other insurances as primary
- Bill claim as soon as possible with diagnosis participant was being seen for on that date of service
- Obtain all pre-certs before services are provided
- If participant has limited benefit plan - ensure they understand and sign appropriate forms that they understand they are responsible if non-covered service

Claim Adjustments & Resubmissions

Local Public Health Department Billing Booklet

Section 5

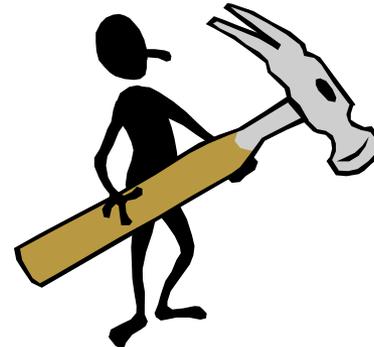
- **Void Claim** - used when the claim *paid* and should never have been billed, i.e., wrong billing NPI or wrong DCN
- Choose “Void” tab to bring up paid claim, scroll to the bottom of the claim and click on the highlighted “submit claim” button. The claim has now been submitted to be voided or credited in the system



Adjustments & Resubmissions continued



- **Replacement Claim** – used when a claim *paid* that been billed incorrectly
- Choose “Replacement” tab to bring up paid claim, select “edit” button to make changes, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button. The replacement claim has now been submitted



Adjustments & Resubmissions

continued



- **Copy Claim - Original**— used when a claim or any line of a claim *denied* that needs to be corrected. This will copy a claim just as it was entered
- Choose “Copy Claim” tab to bring up claim, choose “original,” select “edit” button to make changes, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button. The corrected claim has now been submitted



Adjustments & Resubmissions continued



- **Copy Claim - Advanced**– used when a claim *denied* that had been filed using the wrong NPI or wrong claim form
- Choose “Copy Claim” tab to bring up claim, choose “advanced,” select “edit” button to edit NPI, then save the changes. Scroll to the bottom of the claim and click highlighted “submit” button
- If claim was filed on wrong form, only DCN and Name will transfer to correct form. Key in claim and click “submit” button

Major Reasons for Claim Denials



Reason Codes on Denial of Claims

Hot Tip

February 10, 2014

- ▶ Washington Publishing Company provides HIPAA related code lists:
- ▶ Webpage: <http://www.wpc-edi.com/reference/>.
 - Claim Adjustment Reason Codes (CARC)
 - Remittance Advice Remark Codes (RARC)
 - Claim Status Category Codes
 - Claim Status Codes

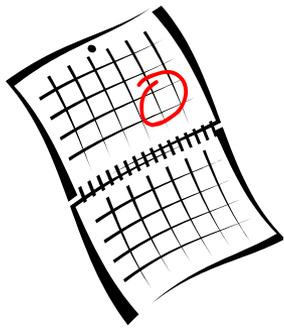
Participant is Enrolled in a Managed Care Health Plan

- If the provider is enrolled with the referenced managed care plan, file the claim with the plan
- If the provider is not enrolled with the plan, the provider cannot bill the plan, MO HealthNet, or the participant
- Obtain a referral from the participant's Primary Care Provider (PCP) or the plan



Limited Benefit Package - Women's Health

- This claim is for a female participant who had Medical Eligibility code (ME) 80 or 89 on the date of service and the claim did not have a primary diagnosis of family planning, V25-V25.9
- If the service is unrelated to family planning, would not be covered under the ME 80/89 plan
- (Follow provisions of ME plans)



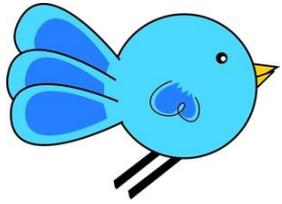
Exceeds Timely Filing Limit

- A claim initially must be filed within 12 months of the date of service
- A Medicare crossover claim must be filed within 12 months of the date of service or 6 months of the date of the Medicare provider's notice of an allowed claim, whichever date is later
- The final deadline to correct and re-file for all claims is 24 months from the date of service



Exact/Suspect Duplicate Claim

- A duplicate to a paid claim is currently being processed or is in the paid claim history file
- There is duplicate information on the same claim



Takeaways

- Provider Communications – First line of contact for claim issues, denials
 - 573-751-2896 or email from eMOMED
- Eligibility – Check on date of service before service is rendered
- Spenddown – Determined by Family Support Division



Q & A

You have

Questions

We have

Answers