

**Missouri Association of
Rural Health Clinics**

**MO HealthNet for
Provider Based
Rural Health Clinics**

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MO HealthNet Updates

- New format for www.emomed.com pages and instant notification of status of a filed claim.
 - Capture date for electronic claims.
 - Paper remittance advices eliminated.
 - Direct deposit of provider checks required.
 - Termination of Chronic Care Improvement Program.
 - Possible statewide expansion of managed care health plan program.
 - Preventive Services and TPL policy.
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MO HealthNet Updates (cont.)

- New Adverse Events policy effective for dates of service and inpatient discharges on or after March 1, 2011 and after.
 - Possible changes to timely filing requirements:
 - Six months from date of service for first filing, 12 months to correct and refile.
 - Medicare crossovers, six months from date of service or six months from the date of the Medicare provider's notice of an allowed claim, whichever date is later.
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MO HealthNet Resources (cont.)

Participant Services

(800) 392-2161

Provider Enrollment

providerenrollment@dss.mo.gov

MO HealthNet Pharmacy and Medical

Pre-Certification Help Desk

(800) 392-8030

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MO HealthNet Resources (cont.)

Third Party Liability

(573) 751-2005

Provider Education/Training

(573) 751-6683

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Resource Publications

- ✓ AMA's Current Procedural Terminology
- ✓ International Classification of Diseases (ICD 9-CM)
- ✓ MO HealthNet Billing Books
- ✓ MO HealthNet Provider Manuals
- ✓ MO HealthNet Bulletins
- ✓ Health Care Procedure Coding System (HCPCS)

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Documentation Requirements

2.3.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section(2)(A) defines “adequate documentation” and “adequate medical records” as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

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Documentation Requirements (cont.)

- Evaluation and Management Codes 99201-99205 and 99211-99215.
- Surgery Codes.
- Modifiers, especially the 59 modifier. For example when billing with the 59 modifier, the documentation must make clear that it is being used to indicate that two or more distinct procedures were performed at *different* anatomic sites or at separate patient encounters on the same date of service.

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Documentation Requirements (cont.)

Electronic Health Records and Templates Questions

Does the template allow the provider to capture all the appropriate level of an E/M service?

Is the template determining the category of the E/M code?

Does the template clearly illustrate what services were actually performed?

Can a reviewer determine the provider of services?

It is clear what area(s) of the body or system(s) were examined?

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Documentation Requirements (cont.)

Electronic Health Records and Templates Questions

- Does the form prompt the user to document or check-off more services that what were provided?
- Does the documentation clearly illustrate the care rendered and the nature of the patient's presenting illness?
- Does the template appear to be designed toward achieving a higher level of service than what was actually rendered?
- Is there an annual review of the templates being used and appropriate updates made?

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Provider Communications

Provider Communications is staffed by Infocrossing Healthcare Services staff and answers approximately 18,000-20,000 phone calls a month. They also process an average of 600 written and e-mail inquiries a month.

Provider Communications
PO Box 5500
Jefferson City, MO 65102

(573) 751-2896 – Customer Service
(573) 635-3559 – Technical Help Desk



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www.emomed.com Provider Inquiry Option

- One inquiry per e-mail.
- Once submitted, you will receive on-screen notification of the receipt of the inquiry.
- For a claim inquiry, include specifics to include DCN, date of service, billed amount, billing provider's NPI, etc.
- For general inquiries, include specifics such as information on a sample claim because certain ME codes have restricted benefits.
- Be sure your callback telephone number is a valid number. If applicable, also leave your extension.

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MO HealthNet Eligibility

Can a provider afford to not check a participant's eligibility before each visit?

NO!

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MO HealthNet Eligibility

Patient's Responsibility to Advise


Every MO HealthNet participant is issued a MO HealthNet ID card. The back of the card states the following.

"You must present this card each time you get medical services."

"You must tell the provider of services if you have other insurance."

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MO HealthNet ID Card

MO HealthNet Department of Social Services	
Name of Participant	
Date of Birth XX-XX-XXXX	MO HealthNet ID Number 999999999
USE BY ANYONE WHOSE NAME IS NOT PRINTED ON THIS CARD IS FRAUDULENT AND SUBJECT TO PROSECUTION UNDER THE LAW	

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MO HealthNet ID Card

- You must present this card each time you get medical services.
- You must tell the provider or provider if you have other insurance.
- Some services may not be covered by MO HealthNet and you may have to pay for services that are not covered.

Participant Inquiries: 1-800-252-2161 OR 1-573-751-4527
 Fraud and Abuse: 1-877-751-5285 OR ASK.MHONET.MO.GOV

Possession of the card does not certify eligibility or guarantee benefits.

- Restrictions may apply to some participants or for certain services.
- Services are covered as specified in the Rules and Regulations of the Family Support Division or the MO HealthNet Division.
- The holder of this card has made an assignment of rights to the Department of Social Services for payment of medical care from a third-party.


MO HealthNet Eligibility Provider's Responsibility to Check

Once the participant tells the provider he/she has MO HealthNet, it's the provider's responsibility to check the person's eligibility. This must be done **before** every visit, preferably the day of the visit.

There are several ways to check eligibility:

- + Internet at www.emomed.com;
- + IVR (Interactive Voice Response) at 573/751-2896 or 573/635-8908; or,
- + Batch eligibility through the 271 Eligibility Verification Response.
- + Point of Service "swipe" machines.

Reasons to Check Eligibility



- ✓ Name
- ✓ Eligibility on date of service
- ✓ Medical eligibility code
- ✓ Medicare eligibility including Part C
- ✓ Commercial insurance
- ✓ MO HealthNet Managed Care enrollment
- ✓ Administrative Lock-in
- ✓ Hospice Lock-in

Pre-Certification for Radiology Procedures



MO Health requires pre-certification for approximately 240 radiology procedures to be done in conjunction with routine care before the delivery of the service unless provided in an inpatient hospital (POS 21) or emergency room (POS 23) setting.

There is NO retroactive approval with the exception of participant retro-active eligibility. Contact the MSI Help Desk at 800/575-4517 for assistance in these instances. Be sure to state your call pertains to retro eligibility for a participant.

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Pre-Certification for Radiology Procedures (cont.)



For a list of the procedure codes requiring a pre-certification and their criteria, go to:

http://www.medsolutions.com/implementation/mo_health/index.html

Click on one of the links displayed for information.

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Pre-Certification for Radiology Procedures (cont.)



Radiology Benefit Management Program

- Retro certifications for MRIs/CAT scans.
- Policy on MRIs/CAT scans for the same patient first done without contrast and later done with contrast.
- Policy when a lower code/service was requested but then actually did a higher level service.
- Mass adjustment of claims on the February 11, 2011 cycle should take care of currently known issues.
- Problem with new 2011 CPT codes.
- Patients with Medicare HMOs and no QMB eligibility.
- MSI Help Desk, 800/575-4517 for issues pertaining to:
 - Retro-eligibility.
 - Requested lower level service but did higher level service.

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Pre-Certification for Radiology Procedures (cont.)



Providers are encouraged to sign up for the Web-based CyberAccess program for doing pre-certifications. Sign up by sending an e-mail to:

MoMedCyberaccess@heritage-info.com

Details on the new Radiology Benefit Management Program were in MHD e-news blasts on June 16, 2010 and July 8, 2010.

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CyberAccess

CyberAccess is a Web-based tool that can be used by a provider to:

- Obtain MHD paid claim data for a patient to include services and procedures; diagnosis codes and prescriptions;
- Obtain prior approvals for MRI and CAT scans;
- Identify clinical issues affecting a patient's care;
- Determine if a drug to be prescribed for a patient is a preferred agent or requires an edit override; and,
- Other important information about a patient.

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CyberAccess - Patient Data

Patient Profile -

- Demographics
- Review Profile
- Drug History
- Claims
- Prior Authorizations (medications, MRIs, CAT scans, etc.)

Medical History -

- History
- Procedures
- Diagnoses
- Medications

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Electronic Printable RA

- Available Monday after the Friday financial cycle
- On www.emomed.com for 62 days (last four claim cycles).
- Open and view in Adobe pdf format.
- Mailing of paper RAs was eliminated late this past year as a cost saving measure. They are available only through www.emomed.com

Tip – you can save the RA to your computer system for future reference.


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Temp MO HealthNet

- ✓ MO HealthNet for women who are pregnant.
- ✓ Medical eligibility codes 58-59.
- ✓ Good through the end of the month following the month made eligible for TEMP; then the patient must be recertified again.
- ✓ Claim must have a pregnancy related diagnosis - V22.0-V23.9 or V28.0-V28.9.
- ✓ Only routine ambulatory prenatal services are covered.
- ✓ Services for Undocumented Immigrants.


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TEMP MO HealthNet Eligibility Card

 MISSOURI DEPARTMENT OF SOCIAL SERVICES FAMILY SUPPORT DIVISION TEMPORARY MO HEALTHNET DURING PREGNANCY I.D. NO. P044	
TEMPORARY MO HEALTHNET I.D. CARD RECIPIENT NAME (LAST, FIRST, MIDDLE)	CARE HEALTH DATES FROM _____ THROUGH _____ DATE OF BIRTH _____
RESTRICTED SERVICES This card entitles the above-named individual to receive Ambulatory Prenatal Care during the time period listed. Ambulatory Prenatal services are limited to physician/clinic, nurse-midwife, diagnostic x-ray and lab, pharmacy, and outpatient hospital services while the individual is pregnant. It does not cover the client if she is no longer pregnant, Delivery, D&C's, Inpatient hospital, dental, optical, or any other services which are not Ambulatory Prenatal services are not covered.	PRESCRIPTION LIMIT FOR MONTH OF _____ FOR NUMBER OF _____ QUALIFIED PROVIDER NAME _____ AUTHORIZED BY _____
MISSOURI 5-99 DISTRIBUTION: WAVE PARTICIPANT CLAIMER FIRM PLAN PROVIDER QP 3-99	

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Surgery




Multiple surgeries on the same day for the same patient require the submission of the operative report with the claim. The claim currently must be filed as a paper claim with the operative notes attached. It cannot be filed as an electronic claim.

Tip - Bilateral procedures must be billed with a quantity of 1.

Tip - If you are **not** going to provide post-op care, bill the surgery code with the 54 modifier.

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10 Major Reasons for RHC Claim Denials



Monthly reports are prepared to track the ten major reasons for claims denials for each provider type. The data is used by staff to assist providers in reducing their denials. The following reasons are for RHCs, both independent and provider based.

Each slide contains the denial title, the claim adjustment reason code(s) on the left side and the remittance advice remark code(s) on the right side. The codes are listed on the provider's remittance advice.

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#1 Lock-In Participant

- ◆ Patient is locked-in to a provider and no valid PI-118 referral form is on file.
- ◆ The provider needs a valid PI-118 from the lock-in provider.
- ◆ The PI-118 referral is valid for 30 days following the date of service.
- ◆ Be sure the effective date for the referral on the PI-118 form covers the date of service.
- ◆ Be sure the correct lock-in provider NPI is on the form (paper and electronic forms).
- ◆ If this was an emergency, file a paper claim with a CMN clearly documenting nature of the emergency service provided.

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2 Procedure/Modifier Not on File

- ◆ Should only be for provider based RHC claims.
- ◆ An invalid procedure code or modifier was listed on the UB-04 or HIPAA 837 claim form.
- ◆ Likely is the result of the incorrect use of a modifier or use of a HCPCS code.
- ◆ Contact Provider Communications, 573/751-2896, for more assistance. You can also contact them by using the e-mail inquiry option at emomed.com.

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3 Exact Duplicate Claim Current vs. Current

- ◆ This claim is an exact duplicate to a claim that is currently being processed.
- ◆ It can continue to process if the duplicate is no longer suspended or auto deny as a duplicate.

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#4 Suspect Duplicate

This occurs when the current claim is:

- ◆ A duplicate to a paid claim in history file;
- ◆ An identical claim in process; or,
- ◆ There is duplicate information on the same claim.

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#5 One T1015 Per Day

- ◆ This can be a claim for an independent RHC that billed two visits on the same day. The RHC must file both encounter codes on same claim and include a Certificate of Medical Necessity detailing the need for *each* visit on the same day. If one visit has already been paid, the RHC must recoup the paid claim and file a new claim with both visits on it along with a CMN for **each** visit.
- ◆ It also could be that the patient had a visit with another independent RHC on the same date of service and that claim has been filed and paid. Refile your claim on paper with the office notes.

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#6 One Hospital/Office Visit Per Day

- ◆ This occurs when more than one provider based RHC visit is billed for the same patient by the same or a different RHC on the same date of service.
- ◆ This could be a duplicate that is already paid for the billing RHC or is a separate claim from another RHC provider for the same patient for the same date of service. If the paid claim is for another RHC, refile your claim on paper with the office notes for the visit/encounter.

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#7 Patient Locked Into Hospice

- ◆ This occurs when the patient is locked into a hospice for the same dates of service as being billed by the rural health clinic.
- ◆ A diagnosis on the claim is related to the patient's terminal illness diagnosis code.
- ◆ Contact the hospice for billing/payment information.
- ◆ Attempt to date and time stamp the hospice termination form if one is presented.
- ◆ Always check eligibility!

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#9 Potential Other Insurance

- The eligibility file indicates the patient has commercial insurance and the provider has left the insurance fields blank.
- You must file to the commercial carrier first before filing to Medicaid.
- Insurance was indicated on the claim but no payment was listed.

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#10 Presumptive Diagnosis Invalid

- This occurs when the RHC bills for services for a participant with me code 58-59 (TEMP MO HealthNet) and the diagnosis code is not pregnancy related.
- The diagnosis code in the claim must a pregnancy/prenatal diagnosis (V22.0-V23.9 or V28-V28.9) and the services must be related to routine ambulatory prenatal care only. Any services unrelated to these services are billable to the patient.

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Your Questions!



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