

XI. BILLING PROCEDURES

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XI. BILLING PROCEDURES

Missouri Care uses the QNXT™ system to process and adjudicate claims. QNXT™ is a client/service-based managed care information system that operates in a Microsoft Windows™ and SQL Server environment. Missouri Care has preloaded all CPT, HCPCS, and revenue codes and identified those codes requiring prior authorization. The claims system is structured so claims are denied if they do not have a prior authorization number for codes requiring authorizations.

11.1 NATIONAL PROVIDER IDENTIFER (NPI)

The NPI will soon replace health care provider identifiers in use today in standard health care transactions. It will eliminate the need for providers to track and use multiple identifiers assigned to them by health plans and other payers. Please refer to the website <https://nppes.cms.hhs.gov> for information on how to apply for your NPI.

Missouri Care requires the use of NPI on all electronic and paper claim submissions. Please communicate your NPI directly to the Missouri Care Provider Relations Department as soon as you obtain one. You may mail or fax a copy of the return notification from CMS containing your new NPI to the address or fax number below:

Missouri Care Health Plan
 Attention: Provider Relations Department
 2404 Forum Boulevard
 Columbia, MO 65203
 Fax: (573) 441-2185

EDI CLAIMS INFO FOR CLEARINGHOUSES

When submitting claims electronically, please work with your vendor to ensure that your NPI is placed in NM109 using the Identification Code Qualifier of 'XX' in NM108, and your state issued Medicaid ID is placed in REF02 using the appropriate Identification Code Qualifier in REF01 within the Secondary Identifier segment.

11.2 ACCEPTABLE CLAIM FORMS

Missouri Care encourages all providers to submit electronic claims. If you are not yet submitting electronic claims, please contact your Provider Relations representative at 800-322-6027 for information.

Missouri Care requires all Providers to use one of the following forms when submitting paper claims.

A CMS 1500 (08-05) billing form is used when submitting claims for all professional services, including ancillary services and professional services billed by a hospital. DME and Home Health Services are also billed on a CMS 1500 (08-05).

Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB-04 billing form (see Section 11.4).

Missouri Care will not process claims received on any other type of claim form.

11.3 COMPLETING A CMS 1500 (08-05)

The CMS 1500 (08-05) form should be typed or legibly printed. If a correction needs to be made on the CMS 1500 (08-05), mark out the change, write the corrected information in or near the mark out and initial the change in the upper right hand corner of the claim form. **DO NOT USE WHITE OUT.** If white out is used, the claim will be returned.

When filing a claim on a CMS 1500 (08-05), there are certain fields on the form that are required to be completed. Listed in this section are the field numbers, along with explanations. The number of the field corresponds with the field number on the CMS 1500 (08-05) claim form.

CMS 1500 (08-05) FORM

The CMS 1500 (08-05) form (Attached) is used to bill professional services provided to our Members. The following is a field-by-field description of the current form. The items listed below are used for claims processing.

ITEM 1 PROGRAM

This field shows all type(s) of health insurance coverage applicable to this claim.

ITEM 1a INSURED'S ID NUMBER

This is the patient/Member's Missouri Care Identification number shown on the Member's Missouri Care Identification Card (Same as the MO HealthNet DCN).

ITEM 2 PATIENT'S NAME

Enter last name, first name, middle initial as appears on ID card.

ITEM 3 PATIENT'S BIRTH DATE, SEX

This is the birth date and sex of the Member. This data is required to verify that this is in fact a Missouri Care enrolled Member.

ITEM 4 INSURED'S NAME

If there is individual or group insurance besides Missouri Care, enter the name of the primary policyholder. If this field is completed, also complete fields #6, #7, #11 and #13. If no primary insurance is involved, LEAVE BLANK.

ITEM 5 PATIENT'S ADDRESS

Another possible verification for patient name and ID number.

ITEM 6 PATIENT RELATIONSHIP TO INSURED

Mark appropriate box if there is other insurance. If no primary insurance is involved, LEAVE BLANK.

ITEM 7 INSURED'S ADDRESS

Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no primary insurance is involved, LEAVE BLANK.

ITEM 8 PATIENT STATUS

This indicates the patient's marital status and whether employed or a student.

ITEM 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 primary insurance is involved, LEAVE BLANK.

ITEM 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 primary insurance is involved, LEAVE BLANK.

ITEM 9b OTHER INSURED'S DATE OF BIRTH

Enter the secondary policyholder's date of birth and mark the appropriate box for sex. If no primary insurance is involved, LEAVE BLANK.

ITEM 9c EMPLOYER'S NAME OR SCHOOL NAME

Enter the secondary policyholder's employer name. If no primary insurance is involved, LEAVE BLANK.

ITEM 9d INSURANCE PLAN NAME OR PROGRAM NAME

Enter the secondary policyholder's insurance plan name. If no primary insurance is involved, LEAVE BLANK.

ITEM 10 IS PATIENT'S CONDITION RELATED TO:

This identifies if the claim is work related, due to an auto accident or other type of accident. If services are not accident related, LEAVE BLANK.

ITEM 11 INSURED'S POLICY GROUP OR FECA NUMBER

Enter the secondary policyholder's insurance policy group number. If no primary insurance is involved, LEAVE BLANK.

ITEM 11a INSURED'S DATE OF BIRTH

This lists the other insured's date of birth and sex for verification. If no primary insurance is involved, LEAVE BLANK.

ITEM 11b EMPLOYERS NAME OR SCHOOL NAME

This lists the name of the employer or school that this coverage is provided under. If no primary insurance is involved, LEAVE BLANK.

ITEM 11c INSURED'S PLAN NAME OR PROGRAM NAME

Enter primary insurance plan name. If no primary insurance is involved, LEAVE BLANK.

ITEM 11d IS THERE ANOTHER HEALTH BENEFIT PLAN?

This is used to identify additional coverage, which will be listed in Item 9.

ITEM 12 PATIENT'S SIGNATURE

Leave blank.

ITEM 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

This authorizes the insurance carrier to release payment directly to the Provider. Required when primary insurance is involved.

ITEM 14 DATE OF CURRENT: ILLNESS, INJURY OR PREGNANCY

This field is required only when billing global obstetric care codes, delivery codes, or initial case management. The date should reflect the initial prenatal visit.

ITEM 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

This is the date of onset of same or similar illness, injury, or pregnancy for use in determining pre-existing conditions.

ITEM 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Leave blank.

ITEM 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

This is the name of the referring provider.

ITEM 17a OTHER ID NUMBER OF REFERRING PROVIDER

Any other ID number for the referring, ordering, or supervising provider is reported in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

- OB State License Number
- 1D Medicaid Provider Number
- ZZ Provider Taxonomy

ITEM 17b NATIONAL PROVIDER IDENTIFIER (NPI)

Enter the NPI number of the referring, offering, or supervising provider.

- ITEM 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
If the services on the claim were provided in an inpatient hospital setting, enter the admit and discharge dates. This field is required when the place of service is an inpatient setting.
- ITEM 19 RESERVED FOR LOCAL USE
Leave blank.
- ITEM 20 OUTSIDE LAB
This indicates if laboratory services were provided outside of the office but are included in this billing.
- ITEM 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
List the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
- ITEM 22 MEDICAID RESUBMISSION CODE
Leave blank.
- ITEM 23 PRIOR AUTHORIZATION NUMBER
Enter the Missouri Care prior authorization number if applicable.
- ITEM 24a DATE(S) OF SERVICE
Enter the date of service under “from” in month/day/year format (mm/dd/yy). All line items must have a “from” date. A “to” date is required when billing for subsequent physician hospital visits on consecutive days.
- ITEM 24b PLACE OF SERVICE
This code indicates where the service took place (e.g. provider’s office, inpatient hospital, outpatient hospital etc.). For ambulance services, the place of service is the destination of the ambulance trip. (See Attachment XI.B).
- ITEM 24c EMG
This box is for the emergency code: Y = emergency; leave blank for non-emergency.
- ITEM 24d PROCEDURES, SERVICES, OR SUPPLIES

This indicates the service provided using the appropriate CPT or HCPCS codes and applicable modifiers (including State specific codes and modifiers).

ITEM 24e DIAGNOSIS POINTER

Enter the line number from Item 21 that relates to the service(s) performed.

ITEM 24f CHARGES

Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.

ITEM 24g DAYS OR UNITS

If a service is provided over a number of days or in excess of a single unit, the quantity will be listed here. **Note: Anesthesia time must be reported in units (1 unit = 15 minutes).**

ITEM 24h EPSDT/FAMILY PLANNING

This indicates the services provided were related to the EPSDT or Family Planning programs.

ITEM 24i ID QUALIFIER

If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms.

ITEM 24j RENDERING PROVIDER NPI

This is a **REQUIRED** field. The NPI of the individual performing/rendering the service is reported in 24j. Enter the NPI number in the unshaded area of the field. For services paid at a group or institutional level (e.g., ambulance, DME, home health, public health), the organizational (Type 2) NPI must be entered here and should match the billing NPI in Item 33a.

ITEM 25 FEDERAL TAX ID NUMBER

This is a **REQUIRED** field. Enter the appropriate EIN or SSN for the billing provider identified in Item 33.

ITEM 26 PATIENT ACCOUNT NUMBER

This item is for Provider's reference.

ITEM 27 ACCEPTS ASSIGNMENT

This field is completed if the Provider/supplier accepts assignment of Medicare benefits.

ITEM 28 TOTAL CHARGE

This is the total amount the Provider is billing for the services provided.

ITEM 29 AMOUNT PAID

This is the amount paid by any other payer. This amount is documented on the attached Explanation of Benefits.

ITEM 30 BALANCE DUE (IF DIFFERENT THAN ITEM 28)

This indicates the amount due after any deductions from other payers.

ITEM 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

This **must** be indicated. The acceptable signatures are as follows:

- Provider's signature (must be legible), or
- Provider's signature rubber stamped (on all copies), or
- Computer generated claim form with the Provider's name in BLOCK LETTERS.

ITEM 32 SERVICE FACILITY LOCATION INFORMATION

This is the location where the actual services were provided. This may or may not match the billing address listed in item 33.

ITEM 32a Enter the service facility NPI if applicable.

ITEM 32b Enter the service facility legacy number if applicable.

ITEM 33 BILLING PROVIDER INFO & PH #

This information is **REQUIRED** and should include the correct pay-to name and address. This information must be consistent with the owner of the federal tax ID entered in Item 25.

ITEM 33a This is a **REQUIRED** field. Enter the billing provider NPI.

ITEM 33b Enter the billing provider legacy number if applicable.

11.3.1 CMS 1500 DOCUMENTATION

All claims that involve other insurance must be accompanied by an explanation of benefits (EOB) from the primary insurer.

If a referral for services is required, specialists should fax a copy of the specialty referral form from the PCP for the services being rendered to the Missouri Care Prior Authorization department, and reference the referral/PA number in field 23 of the CMS 1500 form.

11.3.2 BILLING GUIDELINES FOR OBSTETRICAL SERVICES

COVERED GLOBAL OB SERVICES

Global obstetric services include: initial care, all antepartum care (physical exams, medical history, vital signs, fetal heart tones, fetal monitor strip, maternity counseling, amino-infusion, prostaglandin gel insertion, external version, Pitocin induction), routine laboratory services (if performed in the office as per contract), any false labor including hospitalization, delivery regardless of routine, postpartum care (hospital, office visits, and outpatient care up to six weeks), one ultrasound performed in the office, one non-stress test performed in the office. Additional ultrasounds and non-stress tests may be performed in the office and reimbursed separately.

GLOBAL OB BILLING

Global obstetric services **MUST** be billed using the following CPT codes: 59400, 59510, 59610, 59618. If you are billing for only antepartum global services, you **MUST** use 59425 or 59426. Global obstetric services **MUST** be billed on the date of delivery and should include the post-partum visit. Appropriate authorizations must be received for the global obstetrical services provided.

ENCOUNTER DATA

Providers must report prenatal and post-partum encounters in an appropriate manner prior to submitting global obstetric service claims to Missouri Care. To do so, provider should submit timely claims for all prenatal and post-partum visits utilizing generic evaluation and management codes (99201-99205, 99211-99215), with the following parameters:

- The beginning Date of Service (Item 14) is equal to the initial prenatal visit.
- A \$.01 or \$.00 charge for the office visit should be entered in the charge column (Item 24f).

11.3.3 STERILIZATION CONSENT FORMS

If the Provider is performing a sterilization procedure, which may **only** be performed on patients age twenty-one (21) and above who appear to be mentally competent, the federal Sterilization Consent Form (Attachment XI.C) must be completed. Sterilization procedures also require prior authorization from Missouri Care.

Providers must wait thirty (30) days between the patient signing the consent form and performance of the procedure, except in the case of premature delivery or emergency abdominal surgery. Once the thirty (30) days have elapsed, fax or mail the consent form to Missouri Care and Missouri Care will provide your office with a PA number. You will not receive a PA number if the thirty (30) day requirement has not been satisfied. The consent expires 180 days from the Member's date of signature. A new consent form is required if the procedure is to be performed after the 180 day period.

The proper and timely completion of the consent form is closely monitored by federal government auditors and Missouri Care is required to insist on proper adherence to the requirements.

11.3.4 ANESTHESIA GUIDELINES

- A) Claims must be submitted on a CMS 1500 form.
- B) Missouri Care recognizes anesthesia CPT codes (00100-01999) billed in conjunction with the appropriate modifier:
 - AA Anesthesia Service performed personally by anesthesiologist
 - QK Medical direction of two-to-four concurrent procedures involving qualified professionals
 - QX CRNA service with medical direction by physician
 - QZ CRNA service without medical direction
- C) Subject to national coding guidelines (e.g., CMS CCI edits), anesthesia providers may bill separately for insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation and epidurals. These surgical codes should be billed without modifiers.
- D) Bill using **units of time (one unit = 15 minutes)** in Field 24g of the CMS 1500. Bill only for actual anesthesia time; base units for the procedure must **NOT** be included. The actual anesthesia time may be included in procedure field if desired.
- E) If claims are received with minutes instead of units, they will be denied.

11.4 COMPLETING THE UB-04

The UB-04 (Attached) is used to bill facility services provided. The following is a field by field description of the form:

- ITEM 1 PROVIDER NAME, ADDRESS & TELEPHONE NUMBER
The name of the Provider submitting the bill and the complete mailing address to which the Provider wishes payment sent.
- ITEM 2 PAY TO NAME, ADDRESS, CITY, AND STATE
This field is required when the pay to name and address information is different that the billing Provider information.
- ITEM 3 PATIENT CONTROL NUMBER
Patient's unique alphanumeric number assigned by the Provider to facilitate retrieval of individual financial records and posting of payment.
- ITEM 4 TYPE OF BILL
A code indicating the specific type of bill (inpatient, outpatient, etc.).
- ITEM 5 FEDERAL TAX NUMBER
The number assigned to the provider by the federal government for tax reporting purposes.
- ITEM 6 STATEMENT COVERS PERIOD
The beginning and ending service dates of the period included on this claim.
- ITEM 7 NOT USED
- ITEM 8 PATIENT NAME
The provider enters the patient's last name, first name, and if any, middle initial, along with patient ID (if different than the subscriber insured's ID).
- ITEM 9 PATIENT ADDRESS
The Provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.
- ITEM 10 BIRTHDATE

The provider enters the month, day and year of birth (MMDDCCYY) of patient.

ITEM 11 PATIENT'S SEX

The provider enters an "M" (male) or an "F" (female).

ITEM 12 ADMISSION DATE

Required for Inpatient and Home Health. The hospital enters the date the patient was admitted for inpatient care (MMDDYY).

ITEM 13 ADMISSION HOUR

The hour during which the patient was admitted for inpatient or outpatient care.

ITEM 14 TYPE OF ADMISSION/VISIT

Required on inpatient bills only. This is the code indicating priority of this admission.

ITEM 15 SOURCE OF ADMISSION

The code indicating the source of this admission.

ITEM 16 DISCHARGE HOUR

Hour that the patient was discharged from inpatient care.

ITEM 17 PATIENT STATUS

A code indicating patient status as of the ending service date of the period covered on this claim, as reported in ITEM 6.

ITEM 18-28 CONDITION CODES

Code(s) used to identify conditions relating to this claim that may affect payer processing. For all claims subject to an outlier provision defined in the provider contract, condition code 61 MUST be billed.

ITEM 29 ACCIDENT STATE

Not Used.

ITEM 30 UNLABELED FIELD

This field is reserved for National use.

ITEM 31-34 OCCURRENCE CODES AND DATES

The code and associated date defining a significant event relating to this claim that may affect payer processing.

- ITEM 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.
- ITEM 37 UNTITLED
- ITEM 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the claim.
- ITEM 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified elements necessary to process this claim as qualified by the payer organization.
- ITEM 42 REVENUE CODE
A code which identifies a specific accommodation, ancillary service or billing calculation. Use the most recent codes established.
- ITEM 43 REVENUE DESCRIPTION
A narrative description of the related revenue categories included in this claim.
- ITEM 44 HCPCS/RATES
The accommodation rate for inpatient claims and the Health Care Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient claims.
- ITEM 45 SERVICE DATE
The date the indicated service was provided.
- ITEM 46 UNITS OF SERVICE
A quantitative measure of services rendered by revenue category to or for the patient to include such items as number of accommodation days, miles, pints of blood, treatments, etc.
- ITEM 47 TOTAL CHARGES (BY REVENUE CODE CATEGORY)
Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
- ITEM 48 NON-COVERED CHARGES
To reflect non-covered charges for the primary payer pertaining to the related revenue code.

- ITEM 49 UNLABELED FIELD
This field is reserved for National use.
- ITEM 50 PAYER IDENTIFICATION
Names and, if required, number identifying each payer organization from which the Provider might expect some payment for the claim.
- ITEM 51 PROVIDER NUMBER
The number assigned to the Provider by the payer indicated in ITEM 50.
- ITEM 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the Provider has on file a signed statement permitting the Provider to release data to other organizations in order to adjudicate the claim.
- ITEM 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the Provider has a signed form authorizing the third party payer to pay the Provider.
- ITEM 54 PRIOR PAYMENTS - PAYERS AND PATIENT
The amount the hospital has received toward payment of this claim prior to the billing date by the indicated payer.
- ITEM 55 ESTIMATED AMOUNT DUE
The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
- ITEM 56 NATIONAL PROVIDER IDENTIFIER
Provider's NPI number.
- ITEM 57 OTHER PROVIDER ID
Not required.
- ITEM 58 INSURED'S NAME
The name of the individual in whose name the insurance is carried.
- ITEM 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.
- ITEM 60 INSURED'S UNIQUE ID

Insured's unique identification number assigned by the payer organization (i.e., the Member's Missouri Care/MO HealthNet Identification Number.)

ITEM 61 INSURED GROUP NAME

Name of the group or plan through which the insurance is provided to the insured.

ITEM 62 INSURANCE GROUP NUMBER

The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

ITEM 63 TREATMENT AUTHORIZATION CODE

A number or other indicator that designates that the treatment covered by this claim has been authorized by the payer.

ITEM 64 DOCUMENT CONTROL NUMBER (DCN)

The number issued by the health plan's fiscal agent as part of their internal control.

ITEM 65 EMPLOYER NAME

The name of the employer that might or does provide health care coverage for the insured individual identified in ITEM 58.

ITEM 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER

The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

ITEM 67 PRINCIPAL DIAGNOSIS CODE

The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

ITEM 67A-Q OTHER DIAGNOSIS CODES

The ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

ITEM 68 NOT USED

ITEM 69 NOT USED

ITEM 70A-C NOT USED

ITEM 71 NOT USED

ITEM 72 NOT USED.

ITEM 73 NOT USED

ITEM 74 PRINCIPAL PROCEDURE CODE AND DATE

The CPT code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

ITEM 74A-E OTHER PROCEDURE CODES AND DATES

The codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.

ITEM 75 NOT USED

ITEM 76 ATTENDING PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)

The name and/or number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

ITEM 77 OPERATING PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)

The name and ID number of the individual with the primary responsibility for performing the surgical procedure.

ITEM 78-79 OTHER PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)

The name and/or number of the licensed provider other than the attending provider as defined by the payer organization.

ITEM 80 REMARKS

Notations relating specific State and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill State reporting requirements.

ITEM 81 CODE – CODE FIELD

To report additional codes related to a form locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

11.5 TIMELY CLAIM SUBMISSION REQUIREMENTS

Missouri Care as Primary Payer: Missouri Care requires that you initially submit your claim within 180 days from the date of service. Providers have 365 days from the date of service to correct and resubmit claims if the initial submission time period has been met.

Missouri Care as Secondary Payer: Claims must be received within 365 days from the date of service or 90 days from the date of the EOB, whichever time period is longer.

Out of network providers have 365 days to submit a claim.

A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the Provider of service or from a third party. If any corrections are made on an original claim, the correction must be initialed to ensure the integrity of the claim. Failure to adhere to this requirement may result in the denial of your claims.

For paper submission, please mail all claims and encounter information to:

Missouri Care Claims Submission
P.O. Box 61625
Phoenix, Arizona 85082-1625

11.6 EXPLANATION OF BENEFIT REPORT (See Place of Service Codes Attachment)

11.7 RESUBMITTING A CLAIM

If you feel your claim has not been properly processed, Missouri Care has set up a procedure to help you resolve those issues and resubmit your claim.

After you have met the initial one hundred eighty (180) day submission requirement, you have up to 365 days from the date of service to resubmit your claim for adjustment. Missouri Care will readjudicate claims resubmitted by the Provider only if the initial claim had been filed within the prescribed submission deadline.

If you want to resubmit a claim, you must do the following:

1. Make a copy of the claim and mark clearly as a resubmission.

2. Mail the claim and all attachments to:

Missouri Care Claims Resubmission
P.O. Box 61625
Phoenix, Arizona 85082-1625

3. Resubmissions must not be submitted electronically.

11.8 INQUIRING ABOUT A CLAIM

Missouri Care has staff to help with inquiries you may have about your claims. The claims staff will take telephone or written inquiries from Providers concerning claims issues. By following a few guidelines, you can help Missouri Care provide you with prompt, efficient service. Please have all of the information ready before you call.

1. Please limit telephone inquiries to check on claim status to a maximum of three (3) claims per call.
2. Please provide the Member's Missouri Care ID Number, date of service, procedure code, Provider's name and claim number (if known).
3. To check on claims status, call (800) 322-6027 (Option 2, 4)
4. If you have questions about a specific remittance advice or a denial please call (800) 322-6027 (Option 2, 4).
5. Written inquiries should be directed to the claims staff at:

Missouri Care
Attn: Claims Review
2404 Forum Blvd.
Columbia, MO 65203

11.9 THIRD PARTY RESOURCES

Missouri Care is, by law, the payer of last resort for MO HealthNet Managed Care Program members. Therefore, you must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing Missouri Care, as required by your contract.

Once you have billed the other carrier and received an Explanation of Benefits (EOB), you may then submit the claim to Missouri Care. Please attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason. You have 90 days from the date of the primary EOB to submit your claim and the EOB to Missouri Care, or within 365 days from the date of service, whichever is longer. Claims submitted without an EOB will be denied for lack of the EOB. Claims may also be denied if the other insurance carriers' requirements are not met.

If you require assistance with the billing of third party payers please contact your Missouri Care Provider Relations Representative.

11.10 ELECTRONIC SUBMISSION OF CLAIMS

Missouri Care encourages all providers to submit their claims electronically and will work with each interested Provider to assist in setting up this process. Please contact your Provider Relations representative at (800) 322-6027 for additional information.

11.11 TECHNICAL ASSISTANCE

If Providers need technical assistance related to encounter/claims submissions, please contact your assigned Provider Relations Representative. Technical assistance sessions can be scheduled to discuss areas of difficulty.

11.12 REFUNDS / REVERSALS AND VOIDS

A claim adjustment form is required when filing a refund, reversal or void. For claims adjustment forms, please visit the provider forms section of our website at www.missouricare.com/forms.html, or contact your Provider Relations Representative.

To send a Refund Check:

- Include copy of remit page
- Copy of primary EOB (If Applicable)
- Detailed explanation of why the refund is being sent
- New claim form (If Applicable)

To submit a Claim Reversal (Does not include a Check)

- Include copy of remit page
- Copy of primary EOB (If Applicable)
- Detailed explanation of why the reversal is being requested
- New claim form (If Applicable)

To submit request for Check Void:

- Include original health plan check
- Copy of entire remit
- Explanation of why the check needs to be voided
- Copy of primary EOB (If Applicable)
- New claim form (If Applicable)

The following is a list of why you might send a reversal, refund or void to Missouri Care:

- Provider did not render services to member; claim billed in error
- Both primary insurance and Missouri Care paid
- Entire remit was paid incorrectly
- Provider was partially paid and wishes to rebill unpaid portion of claim
- Co-pay was not deducted from provider's payment

Claim adjustments forms and required documentation should be sent to:

Missouri Care Health Plan
Attn: Claims Reconciliation
2404 Forum Blvd
Columbia, MO 65203
Fax: 573-441-2179

11.13 MEMBER BILLING

It is against the law for a provider to bill a Medicaid beneficiary for services included in their benefit package. In accordance with Title 13 CSR 70-030, when an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient's Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules. The only exception to this rule is if the member failed to present their Medicaid ID card.

The Code of Federal Regulations Title 42 CFR 447.15 states, A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan.

The Code of Federal Regulations Title 42 CFR 447 states that providers must accept, as payment in full, the amounts paid by the agency. The provider may not deny services to any eligible individual on account of the individual's inability to pay. Furthermore, if a provider seeks to collect from an individual the amount that exceeds an amount specified, the Medicaid agency may provide for a reduction of any payment amount other wise due to the provider in addition to any other sanction available to the agency. The reduction may be equal to up to three times the amount that the provider sought to collect.

PRIVATE PAY AGREEMENT

In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed

costs. This agreement shall only be overcome by written evidence of an agreement between the provider and the member indicating the member accepts the status and liabilities of a private pay patient. The health plan shall make it clear to members that all covered services are available to the member at no cost subject to any applicable co-pays. **The private pay agreement shall only be for services not included in the comprehensive benefit package.**

If you have questions regarding billing or the benefits covered by Missouri Care, please contact the Missouri Care Provider Relations Department at (800) 322-6027.