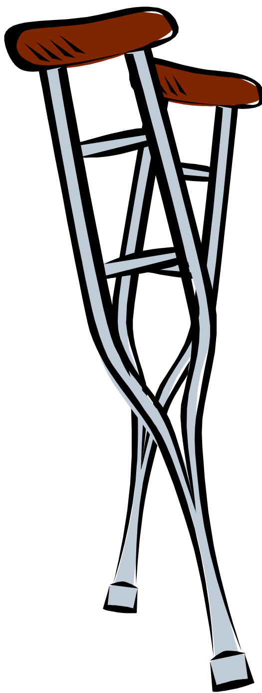
Durable Medical Equipment Billing Book



Created by the Provider Education Unit

MO HealthNet Durable Medical Equipment Billing Book

PREFACE

This DME (Durable Medical Equipment) training booklet contains information to help you submit claims correctly. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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SECTION 1
MO HEALTHNET PROGRAM RESOURCES

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

CONTACTING MO HEALTHNET

PROVIDER COMMUNICATIONS
573-751-2896

MO HealthNet providers can contact the Provider Communications Unit with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

The IVR (Interactive Voice Response) system is accessed by calling the 573-751-2896 number. The IVR system can address participant eligibility, last two check amounts and claim status inquiries. At anytime during the IVR options, providers may select "0" to speak with the next available specialist. Calls are put into a queue and will be answered in the order received. Providers must use a touchtone phone to access the IVR.

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 at www.emomed.com. Once logged in and on the eProvider page, click on the ‘Provider Communications Management’ icon, this opens the ‘Manage Provider Communications’ page. From here, click on ‘New Request’ to open the ‘Create New Request’ form to enter and submit an inquiry. 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 responds to written inquiries. Written inquiries should be sent to:

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

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 and procedures for MO HealthNet claims. Contact the unit for training information and scheduling. Providers may also send E-mails 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 CALL CENTER
800-392-8030

Providers can call this toll free number to:

- Request pre-certification for specific DME items;
- 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;
- Request information on Medicare Part D;
- Request a drug prior authorization; or,
- Request medical pre-certification for a CT scan or MRI.

Providers are encouraged to sign up for the MO HealthNet Web-based tool, CyberAccess^{sm} which automates the pre-certification process. To become a CyberAccess^{sm} user, contact the Xerox Care and Quality Solutions help desk at 888-581-9797 or 573-632-9797 or send an E-mail to CyberAccessHelpdesk@xerox.com. The CyberAccess^{sm} tool allows each pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and 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 http://dss.mo.gov/mhd/providers/ and 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 and ACS X12 Version 5010 Companion Guide links.

For information on the MO HealthNet Trading Partner Agreement, click on the link to Section 1- Getting Started; then select Trading Partner Registration.

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 NPI (National Provider Identifier) number 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 listed below. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

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 ID 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 (MHD), in cooperation with Wipro Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers. 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 www.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 http://dss.mo.gov/mhd/providers/. At this site choose the "Apply for Electronic/Internet system access" link in the right hand column. 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 www.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, www.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. 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 (NCPCD)

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.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

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

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

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

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

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

RECEIVE PUBLIC FILES THROUGH THE INTERNET

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

MO HEALTHNET PROVIDER MANUALS AND BULLETINS ONLINE http://dss.mo.gov/mhd/providers/

MO HealthNet provider manuals are available online at the MHD Web site, http://dss.mo.gov/mhd/providers/. To access the provider manuals, click on the "Provider Manuals" link at the bottom of the page or in the right hand column under “Featured Links”. This brings up the External Link http://manuals.momed.com/manuals/ where a search by manual and specific criteria can be done.

MO HealthNet provider bulletins are also available at the MHD 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 (08-05) 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.
> PO Box 5600
> Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the MO HealthNet Provider Manual available at http://dss.mo.gov/mhd/providers/index.htm.

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 indicates a field is required in specific situations.

Field number and name	Instructions for completion
1.Type of Health Insurance	Show the type of health insurance coverage 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 participant's ID card.
2.*Patient's Name	Enter last name, first name, middle initial in that order as it appears on the 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.
5.Patient's Address	Enter address and telephone number if available.
6.Patient's Relationship	Mark appropriate box if there is other to Insured insurance.
7.Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available.
8.Patient Status	Not used.

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

Field number and name	Instructions for completion
9.**Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. See Note(1)
9a.**Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance Group Number policy number or group number, if the insurance is through a group such as an employer, union, etc. See Note(1)
9b.**Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. See Note(1)
9c.**Employer's Name	Enter the secondary policyholder's employer name. See Note(1)
9d.**Insurance Plan	Enter the other insured's insurance plan or Program Name program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1)
10a.-10c. Is 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.
10d. Reserved for Local Use	May be used for comments/descriptions.
11.**Insured's Policy or	Enter the primary policyholder's insurance Group Number policy number or group number, if the insurance is through a group, such as an employer, union, etc. See Note(1)
11a.** Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. See Note(1)
11b.**Employer's Name	Enter the primary policyholder's employer name. See Note(1)
11c.**Insurance Plan 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)

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

Field number and name	Instructions for completion
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. See Note(1)
12.Participant'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.
14.Date of Current Illness, Injury	Not required for DME or Pregnancy
15.Date Same/Similar Illness	Leave blank.
16.Dates Patient Unable	Leave blank. To Work
17.Name of Referring Physician	Not required for DME or Other source
17a.Other I.D.	Not required for DME
17b.NPI	Not required for DME
18.Hospitalization Dates	Not required for DME
19.Reserved for Local Use	Providers may use this field for additional remarks or descriptions.
20.Lab Work Performed	Not required for DME Outside Office
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.

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

Field number and name	Instructions for completion
23.Prior Authorization Number	Leave blank.
24a.*Date of Service	Enter the date of service under “from” in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a "from" date. A "from" and "to" date is required when billing for DME rental.
24b.*Place of Service	Enter the appropriate place of service code. See Section 15.6 of the DME MO HealthNet Provider Manual for the list of appropriate place of service codes.
24c.EMG-Emergency	Not required for DME
24d.*Procedure Code	Enter the appropriate HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (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 the field. The system automatically plugs a “1” if the field is left blank. DME rental equipment under the regular DME program, the "from" and "to" dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity must always be a "1". When billing ostomy supplies under A4421, the quantity is always a "1".
24h. EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter “E.”

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

Field number and name	Instructions for completion
24i.ID Qualifier	Enter the provider taxonomy qualifier ZZ in the shaded area if the rendering 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.
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 the insurance amount paid (field 29).
31.Provider Signature	Leave blank.
32.**Name and Address of Facility	If 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.
32a.NPI#	Enter the 10-digit NPI number of the service facility location in 32.
32b.**Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in field 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 code.
33.*Provider Name/ Number	Affix the billing provider label or write or type /Address the information exactly as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

Field number and name	Instructions for completion
33a.* NPI #	Enter the NPI number of the billing provider in 33.
33b. Other ID #	Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in field 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 code.

* These fields are mandatory on all CMS-1500 claim form.
** These fields are mandatory 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

SECTION 3
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.

Providers receive real time notification of receipt for adjustments for claim credits submitted via the Internet. The status of the adjustment is provided.

Paid Claim Options on eMomed

Only claims in „paid" or „to be paid" status can be voided or replaced. Voiding and replacing claims are done through "Claim Management" on the emomed.com website. Providers may do claim search by the ICN (Internal Control Number), the participant"s DCN (MO HealthNet ID number) or by the date the claim was originally submitted.

VOID - To void a claim from the claim status screen on eMomed, select „Void" from the menu bar. When the claim is brought up, 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.

REPLACEMENT – To replace a claim from the claim status screen on eMomed, select „Replacement" from the menu bar. When the claim is brought up, corrections can be made to the claim by selecting the appropriate edit button then saving the changes. Once all corrections have been made scroll to the bottom of the claim and click on the highlighted „Submit Claim" button. The replacement claim with corrections has now been submitted.

Resubmitting Denied Claims on eMomed

Providers can resubmit denied claims electronically on the eMomed website. Claims may be resubmitted by entering a new claim. Claims may also be resubmitted by selecting „Timely Filing" or „Copy Claim" from the menu bar.

Timely Filing – To reference timely filing, choose the „Timely Filing" tab on the claim status screen on eMomed. This function automatically places the ICN of the claim chosen. Make certain the ICN chosen meets MO HealthNet"s timely filing criteria. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted „Submit Claim" button.

Copy Claim/Original – This option is used to copy a claim just as it was originally entered on eMomed. Corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted „Submit Claim".

Copy Claim/Advanced – This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual or performing provider NPI and should have been submitted under the

group 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. An example would be if the claim was submitted as a crossover claim and should have been submitted as a medical claim.

Claim Status Codes

Once a claim is submitted, „Claim Received" is given in real time on the „Claim Status" page. In addition, one of the following claim status codes is provided:

C – Claim has been **Captured** (*in suspense*) and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – Claim is to be **Paid.**

K – Claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

SECTION 4
MEDICARE 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. It is advised providers wait sixty (60) days from the date of Medicare's explanation of benefits (EOMB) showing payment before filing an electronic claim. This will avoid possible duplicate payments from MO HealthNet.

Claims may not cross over from Medicare to MO HealthNet for various reasons. Two of the most common reasons 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 their National Provider Identifier (NPI) used to bill Medicare to the Missouri Medicaid Audit Compliance (MMAC), Provider Enrollment Section, also causes claims to not cross over electronically from Medicare. Providers in doubt as to what NPI is on file should contact the Provider Enrollment by e-mail at mmac.providerenrollment@dss.mo.gov. Providers who have not submitted their Medicare NPI 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 EOB with the exception of the participant's name and HIC; these should be stated as they appear in the MO HealthNet eligibility file.

- The Other Payer Detail Summary must contain the same number of line items as detail lines that were 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 will assist you in successfully filing your Medicare Advantage/Part C crossover claims:

- From Claim Management choose the CMS-1500 Part C Professional format under the 'New Xover Claim' column.
- 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 www.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 needs to be checked for each date of service. The Part C format can only be used if the participant is QMB eligible on the date of service.

Providers are not to submit crossover claims for participants enrolled in a Medicare Advantage/Part C plan who are non-QMB. These services are to be filed as Medical claims.

Under no circumstances may providers submit crossover claims, Medicare Part B and Medicare Advantage/Part C QMB to Wipro Infocrossing Healthcare Services as paper claims.

SECTION 5
FORMS & ATTACHMENTS

Prior Authorization

Providers are required to seek prior authorization (PA) 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 under the age of 21 through the Healthy Children and Youth (HCY) Program. Some of these expanded services also require PA. A complete list of the HCY services can be found in Section 19.1 of the MO HealthNet Durable Medical Equipment (DME) provider manual.

The following general guidelines pertain to all prior authorized services.

- PA requests can be completed and mailed to Wipro Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, MO, 65102. Providers are encouraged to submit their PA requests by facsimile (fax) to 573-659-0207. Regardless if the PA request is mailed or faxed, providers should keep a legible copy of the original PA request form in the participant's record as the form is not returned to the provider. **Do not mail PA requests that have been faxed.** This will cause duplicate requests in the system and result in processing delays.
- 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 prescribed by a physician or nurse practitioner.
- PA requests are not to be submitted for services prescribed to an ineligible participant. State Consultants review for medical necessity only and do not verify a participant's eligibility.
- Expanded HCY (EPSDT) services are limited to participants under the age of 21 and are **not** reimbursed for participants 21 and over even if prior authorized.
- 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, a new PA request **must** be completed and mailed to Wipro Infocrossing Healthcare Services.
- An approved PA **does not** guarantee payment.

Providers must adhere to the following criteria when submitting PA requests by fax.

- Only one PA request may be submitted per fax call. Multiple PA requests per call will not be processed because the system views the multiple requests as attachments to the first request received from that call.
- Only PA requests may be faxed. Any other type of request/document (i.e., questions, certificate of medical necessity) that is faxed will not be processed.
- Do not scale down attachments in an attempt to fit multiple pages on one sheet. This causes the document to be difficult to read. Requests that cannot be read will be returned to the provider for resubmission.
- Use a business fax cover sheet when faxing the PA request. The cover sheet should include the return fax number. This will assist the return of dispositions letters by fax.

Regardless if the PA request is approved or denied, the provider will receive a MO HealthNet Authorization Determination (disposition) letter containing all of the detail information related to the PA request. PA requests that are received via fax will receive a faxed disposition letter; those PA requests received by mail will receive their disposition letter by mail. For those requests received by fax, ensure the fax number from which the PA request is sent is not a blocked number. A blocked fax number will prevent the disposition letter from being returned by fax. Disposition letters that cannot be successfully returned via fax will be mailed to the provider. All other documentation submitted with the PA request will not be returned.

A request for change (RFC) to an **approved** PA must be indicated on the disposition letter and submitted to Wipro Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted. A RFC should not be submitted for PA requests with a denied (D) or incomplete (I) status but must be resubmitted to Wipro Infocrossing as a new PA request. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request with additional documentation as needed. In order to avoid duplication of RFCs, the following should be kept in mind.

- Do not submit a RFC if a disposition letter has not been received from the initial PA request.
- Do not submit a RFC if a disposition letter has not been received on a previous RFC for the same item.
- For participants who have or need both a power and manual wheelchair, the RFC for the accessories must state which wheelchair the accessories are for. This becomes especially important when some of the accessories have been compiled in to procedure code K0108 on both wheelchairs.
- A RFC may be submitted to correct a procedure code and/or modifier; however providers need to explain the reason a different procedure code is being requested and supply additional documentation as necessary.

PA requests and a RFC for the same participant, for the same or similar items, will be denied as duplicate requests.

Instructions for completing the PA request form are found in Section 8 of the MO HealthNet *Provider's Manual* available on the Internet at http://manuals.momed.com/manuals/ Instructions are also self-contained on the back of the PA request form.

Certificate of Medical Necessity

The Certificate of Medical Necessity (MN) attachment should be submitted electronically. The attachment and instructions are available at www.emomed.com. Providers are required to obtain a signed MN to be retained in the MO HealthNet participant's medical record.

Section 19 of the MO HealthNet Durable Medical Equipment (DME) provider manual contains the reimbursement guidelines for covered DME items. Those items stating MNF, Certificate of Medical Necessity on File, do not have to have a MN filed to MO HealthNet. These items do require a MN be kept in the participant's file.

General Guidelines for the MN Attachment

- The medical reason why the item, service, or supplies are needed must be stated fully and clearly on the MN attachment relating to the particular participant involved.

- The item, service, or supply must be prescribed by a physician or nurse practitioner.
- The appropriate modifier must be stated with the HCPCS code on the MN attachment.
- An approved MN attachment is valid for six (6) months from the “Date Prescribed”. Any claim received matching the criteria, including the modifier, on the MN for that time period can be processed for payment. Additional MN attachments must be obtained every six months if the participant’s medical need for the service continues.
- Medical consultants and medical review staff review the MN attachment to make a determination regarding approval of the service. Approval of the MN attachment does not guarantee payment of claims.

Information on the MN attachment can be found in Section 14.1 of the MO HealthNet DME manual available on the Internet at http://manuals.momed.com/manuals/.

SECTION 6
HEALTHY CHILDREN AND YOUTH (HCY)

Medically necessary items or services normally non-covered through the DME program may be considered for participants under the age of 21. A complete list of HCY (Healthy Children and Youth) services can be found in Section 19.1 of the MO HealthNet DME manual located on the Internet at http://manuals.momed.com/manuals/. For those items not having specific Health Care Procedure Coding System (HCPCS codes) may be considered by utilizing one of the following miscellaneous or not otherwise classified codes as appropriate for the supplies or equipment prescribed:

A9270 NU EP	A9999 NU EP	E1399 NU EP	T1999 NU EP
A9270 RB EP	A9999 RB EP	E1399 RB EP	T5999 NU EP
A9270 RR EP	A9999 RR EP	E1399 RR EP	A9900 NU EP

Section 19.1 contains the reimbursement guidelines, including required attachments, and quantity limitations. Should the participant require a quantity in excess of the established MO HealthNet limitation, the prescribing physician must provide the DME provider with documentation why the participant medically needs the requested quantity. It is important to keep in mind the documentation must clearly express the medical need for the participant, not additional quantities at the request of the caregiver or for the convenience of the caregiver.

INCONTINENCE PRODUCTS

Disposable underpads and diapers/briefs are covered for participants age four (4) through twenty (20) when:

- The items are prescribed and determined to be appropriate where there is the presence of a medical condition causing bowel/bladder incontinence; and
- The participant would not benefit from or has failed a bowel/bladder training program.

Protective underwear/pull-ons are covered for participants age four (4) through twenty (20) when:

- They are prescribed and determined to be appropriate where there is presence of a medical condition causing bowel/bladder incontinence; and
- The participant is actively participating and demonstrating definitive progress in a bowel or bladder program with reassessment of progress every six (6) months; or
- The participant has the cognitive ability to independently care for his/her toileting needs; or
- There is documentation of the medical necessity for pull-on protective underwear instead of diapers/briefs.

All procedure codes for diapers, pull-ons and underpads require pre-certification. The EP modifier is required when the pre-certification is for an excess of the 186

monthly limit; the EP modifier is not required for a monthly quantity of 186 or less. Procedure codes for diapers, pull-ons and underpads can be found in Section 19.1 of the DME provider manual.

ENTERAL NUTRITION AND SUPPLIES

The following enteral nutrition procedure codes should not be date spanned, but billed with a single date of service and the NU modifier. Requested amounts must be over the WIC (Women, Infant and Children) allotment. The quantities are to reflect the total number of units, calculated at one unit = 100 calories. As an example, the doctor prescribes 2 cans per day with each can containing 300 calories. The number of units billed for a 31-day month is 186. It is not necessary for a provider to bill an entire month's supply at once. If the parent/caregiver picks up enough enteral nutrition for a week or two, the provider should only bill the amount of calories dispensed at that time; however, providers may not dispense more that what was prescribed by the physician in a single month. The date of service is the date the enteral nutrition is dispensed.

B4149 EP BA	B4149 EP BO	B4150 EP BA	B4150 EP BO
B4152 EP BA	B4152 EP BO	B4153 EP BA	B4153 EP BO
B4154 EP BA	B4154 EP BO	B4155 EP BA	B4155 EP BO
B4157 EP BA	B4157 EP BO	B4158 EP BA	B4158 EP BO
B4159 EP BA	B4159 EP BO	B4160 EP BA	B4160 EP BO
B4161 EP BA	B4161 EP BO	B4162 EP BA	B4162 EP BO

The following procedure codes are to be date spanned. The number of units must equal the number of days spanned, i.e., 01/11/11-01/31/11 = 21.

B4034 EP BA NU	B4035 EP BA NU	B4036 EP BA NU	B9000 EP BA NU
B9002 EP BA NU	E0776 EP BA RR		

NOTE: If billing E0776 EP BA as a purchase (NU modifier), do not date span.

The following procedure codes are to be billed as a single date of service with only one unit. Additionally, each code is to be billed with the NU modifier.

B4081 EP BA	B4082 EP BA	B4083 EP BA

The following procedure codes are to be billed as a single date of service along with the NU modifier. The quantity billed needs to reflect the total number of units/items dispensed according to the description of the HCPCS code and based on the physician's order.

B4100 EP BO	B4103 EP BA	B4103 EP BO	B4104 EP BA
B4104 EP BO	B9998 EP BA	B9998 EP BO	A5200 EP BA
S9434 EP BA	S9434 EP BO	S9435 EP BA	S9435 EP BO

UROLOGICAL SUPPLIES

Claims for the urological procedure codes stated below require pre-certification with quantity limitations established for each. In addition to the NU modifier, the EP modifier is also required as long as pre-certification is within the established quantity limitations; if the pre-certification is in excess of the quantity limitations, the EP modifier is not required. Supplies approved for quantities in excess of the allowed amount for procedure codes A4331, A4357, A4402 and A5102 are authorized utilizing the modifiers NU and AU.

A4310	A4311	A4312	A4313	A4314
A4315	A4316	A4320	A4322	A4326
A4327	A4328	A4331	A4332	A4333
A4334	A4335	A4338	A4340	A4344
A4346	A4349	A4351	A4352	A4353
A4354	A4355	A4556	A4357	A4358
A4402	A5102	A5105	A5112	A5200

Procedure codes A4313, A4316, A4320, A4322, A4326, A4331, A4335, A4340, A4346, A4352, A4355, A4356, A5102, A5102, and A5200 are considered specialty items or items that are rarely used or only used in unusual situations. Pre-certification of these items require the physician (physician office) contact the help desk through submission of a CyberAccess℠ help ticket or by calling 800-392-8030.

HCY BILLING REMINDERS

- Participants must be under the age of 21
- Manually priced items requiring a prior authorization (PA) require an invoice of cost attached to the PA request.
- Manually priced items requiring a certificate of medical necessity may either attach the invoice of cost to a paper claim form or complete an electronic invoice of cost via a link within the Medical CMS-1500 format on emomed.com.
- All manually priced HCY items are priced at cost plus 20%.

SECTION 7
BENEFITS & LIMITATIONS

General Information

The MO HealthNet Program reimburses qualified participating durable medical equipment (DME) providers for certain DME items such as: prosthetics; orthotics; respiratory care equipment; parenteral nutrition; ostomy supplies; wheelchairs, hospital beds, etc. These items must be for use in the participant's home when ordered in writing by the participant's physician or advanced practice nurse.

- A participant's home may be:
- His/her own dwelling;
- An apartment;
- A relative's home; or
- A boarding home
- An institution may not be considered a participant's home if the institution:
- Meets at least the basic requirements of a hospital; or
- Meets the basic requirements of a nursing home.

Services Provided in a Nursing Home

DME is not covered for participants residing in a nursing home. DME is included in the nursing home per diem rate and not paid for separately with the exception of the following items:

- augmentative communication devices and accessoires
- custom wheelchairs
- power wheelchairs
- orthotic and prosthetic devices
- total parenteral nutrition (TPN)
- volume ventilators

Wheelchair Requirements For Participants Residing In A Nursing Home

To assist in ensuring MO HealthNet participants receive the least costly medically appropriate equipment, the following are requirements for wheelchairs for participants residing in a nursing home. Providers are reminded any item of durable medical equipment provided to a MO HealthNet participant must be the least costly medically appropriate alternative.

When submitting a prior authorization request for a custom or power wheelchair, there must be comprehensive written documentation submitted with the prior authorization request. Letters of medical necessity/medical necessity documentation must be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the

physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers). In addition, letters of medical necessity generated by the supplier must be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers).

Letters of medical necessity must clearly and specifically explain the following:

- The diagnosis/comorbidites and conditions relating to the need for a custom or power wheelchair
- Description and history of limitations/functional deficits
- Description of physical and cognitive abilities to utilize equipment
- History of previous interventions/past use of mobility devices
- Description of existing equipment, age and specifically why it is not meeting the participant's needs
- Why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, manual wheelchair)
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment
- Documentation/explanation as requested by the State consultant.

Assistive Technology Professional

Custom or power wheelchairs for participants residing in a nursing home must be supplied by a provider that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP must have direct, in-person involvement in the wheelchair selection for the participant.

Physician Face-to-Face Evaluation

For a custom or power wheelchair to be covered for a participant residing in a nursing home, the treating physician must conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. Physicians shall document the face-to-face examination in a detailed narrative note in the participants' chart in the format they use for other entries. Supplier or facility created forms the physician completes are not a substitute for the comprehensive medical record/chart note indicated above. The physician face-to-face examination must provide information about the following elements but may include other details.

• History of the present condition(s) and past medical history that is relevant to mobility needs:

- symptoms that limit ambulation;

- diagnoses that are responsible for symptoms;
- progression of ambulation difficulty over time;
- other diagnoses that may relate to ambulatory problems;
- cardiopulmonary examination; and
- weight and height.

- Physical examination that is relevant to mobility needs:
  - existing ambulatory assistance (cane, walker, wheelchair, caregiver) that is currently being utilized;
  - musculoskeletal examination to include arm and leg strength and range of motion;
  - neurological examination to include documentation of functional ambulation and balance and coordination;
  - distance participant can walk without stopping;
  - pace of ambulation;
  - ability to stand up from a seated position without assistance; and,
  - description of the ability to perform activities of daily living.

The physician examination must be tailored to the individual participant's condition. The history must clearly illustrate the participant's functional abilities and limitations on a typical day. It must contain as much objective data as possible. The physical examination must be focused on the body systems responsible for the participant's ambulatory difficulty or impact the participant's ambulatory ability. A copy of the physical or occupational therapy evaluation completed by a licensed physical or occupational therapist may be utilized for the physical exam. (The physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers. There is no separate reimbursement outside the nursing home per diem for a physical or occupational therapy evaluation.) All areas noted above for the physical exam must be addressed. All face-to-face required documentation must be signed by the physician prior to the physician order for equipment being written.

The face-to-face examination must be completed prior to any examination performed by the DME provider. The DME provider must receive the written report of this examination within 90 days after completion of the face-to-face physician examination.

A date stamp or equivalent must be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination must be submitted with the prior authorization request.

Physician Order

For custom or power wheelchairs for participants residing in a nursing home, a physician order must be received by the DME provider within 90 days after completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician order must contain all of the following:

- Participant's name

- Description of the item that is ordered (may be general such as power wheelchair, manual wheelchair)
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair
- Length of need
- Physician's signature
- Date of the physician signature

A date stamp or equivalent must be used to document receipt date.

Power Wheelchairs and Accessories For Participants In A Nursing Home

In addition to the requirements above, requests for Group 2 power wheelchairs for participants residing in a nursing home must:

A. Document one of the following diagnoses:

- Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
- Other spinal cord diseases (336.0-336.3)
- Multiple Sclerosis (340)
- Other demyelinating disease (341.0-341.9)
- Cerebral Palsy (343.0-343.9)
- Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335.23-335.9)
- Post polio paralysis (138)
- Traumatic brain injury resulting in quadriplegia (344.09)
- Spina Bifida (741.00-741.93)
- Childhood cerebral degeneration (330.0-330.9)
- Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (must be noted and described by the physician in the face-to-face visit; justification must document what other types of skin protection measures have been utilized)
- Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (must be documented by the physician in the face-to-face visit)

B. Explain why a less costly mobility device is unable to meet the participant's needs including a description of equipment trials and their effectiveness.

Requests for Group 3 power wheelchairs will only be considered when the following criteria are met:

- All criteria for a Group 2 power wheelchair are met; and
- Medical justification provides extensive documentation of why a Group 2 power wheelchair and other less costly devices will not meet the participant's needs; and

- Documentation includes the length of time the participant has resided in the nursing home; and
- One of the following
  - Documentation includes a copy of the discharge plan from the nursing home's patient record that clearly states the participant's discharge date is in the next 90 days to an independent or less restrictive living environment and that the participant will be involved in activities that require the client to utilize a wheelchair in the community on a frequent basis (e.g. work, shopping, self-transport to appointments). Supporting documentation from a physician, social worker or OT/PT explaining the participant's discharge plans and mobility needs must accompany the discharge plan; or
  - The medical necessity justification provides clear documentation the participant requires specialty controls other than a joy stick to independently operate the wheelchair.

The following equipment is not considered medically necessary for participants residing in a nursing home:

- Group 1 power wheelchairs;
- Group 4 power wheelchairs;
- Multiple power seat function (i.e., power tilt and recline); and
- Power elevating leg rests/lower extremity power articulating platform.

Custom Wheelchairs For Participants In A Nursing Home

When prior authorized, MO HealthNet will reimburse for medically necessary custom wheelchairs for participants residing in a nursing home. All prior authorization requests must indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B and C below describe the various criteria utilized for a wheelchair to be considered custom. Criteria for individual HCPCS codes are listed following criteria A, B and C below.

A. Any wheelchair with a custom seating system. A custom seating system is a wheelchair seating system which is individually made for a participant using a plaster model of a participant, a computer generated model of the participant (i.e. CAD-CAM technology), or the detailed measurements of the participant to create either:
   - a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or
   - a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not easily be re-adapted for use by another individual.

To qualify for a custom seating system, an individual must meet all the requirements of a custom fabricated seat cushion or a custom fabricated back cushion as described in

Section 13.29.G of the Durable Medical Equipment Provider Manual. The prior authorization request must document all of the following:

- Why a prefabricated system is not sufficient to meet the participant's seating and positioning needs.
- What orthopedic deformity is present and its fixed or flexible presentation.
- What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning.
- Why any existing system is not meeting the participant's seating and positioning needs.

B. A specially sized or constructed wheelchair that is provided to a participant whose anatomical measurements require the following:
- A wheelchair seat width of 25 inches or more; or
- A wheelchair with a weight capacity for 351 or more pounds; or
- A wheelchair with a seat to floor height of less than 15 ½ inches.

C. A wheelchair for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses or conditions:
- Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
- Other spinal cord diseases (336.0-336.3)
- Multiple Sclerosis (340)
- Other demyelinating disease (341.0-341.9)
- Cerebral Palsy (343.0-343.9)
- Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335-23-225.9)
- Post polio paralysis (138)
- Traumatic brain injury resulting in quadriplegia (344.09)
- Spina Bifida (741.00-741.93)
- Childhood cerebral degeneration (330.0-330.9)
- Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (must be noted and described by the physician in the face-to-face visit; justification must document what other types of skin protection measures are being utilized)
- Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (must be noted and described by the physician in the documentation of the face-to-face visit)

Wheelchair Option/Accessory Replacement and Repair

Reimbursement will be made for wheelchair option/accessory replacement and repair for patient owned custom or power wheelchairs for participants residing in a nursing home; however, the SC modifier must be included with the appropriate HCPCS code and RB modifier.

- The appropriate HCPCS code for the specific option/accessory must be billed. The RB modifier must always be used when the accessory is a replacement for the same part.
- Procedure code Z0160RB or Z0160RBSC may be used for replacement items that do not have a HCPCS code and have a Manufacturer's Suggested Retail Price (MSRP) of $500.00 or less. Items with an MSRP greater than $500.00 must be prior authorized using K0108RB and K0108RBSC.
- Items that are new additions or upgrades to a wheelchair must not be billed with the RB modifier; the RB modifier is only to be used for replacement of existing options/accessories.
- Labor required for replacement of options or accessories, or repair of a wheelchair, may be billed under procedure code K0739RB or K0739RBSC, repair or non-routine service for DME requiring the skill of a technician, labor component, per 15 minutes. One unit of labor is equal to 15 minutes of time.
- A Certificate of Medical Necessity Form (MN) is required for most option/accessory replacement codes and the labor code. The labor and option/accessory codes should be included on the same MN form. The MN must document the following:
    - Make and model name of the wheelchair;
    - The initial date of service for purchase of the wheelchair;
    - Medical necessity for replacement for each option/accessory code; and
    - An explanation of the time involved.

Repair of Durable Medical Equipment

Repair of participant-owned durable medical equipment or prosthetic or orthotic device (whether purchased by MO HealthNet outright, purchased through rental payments or paid for by the participant) is covered if

- The item to be repaired is a covered item under the DME program.
- The repairs do not exceed 60% of the cost of a new piece of equipment, or orthotic or prosthetic device.
- The item is not under the provider's or manufacturer's warranty.
- The repairs are not required as a result of participant abuse.
- The participant is not in an institution unless the repair is for a custom or power wheelchair or augmentative communication, orthotic or prosthetic device.
- The equipment is not being rented.
- There is a continuing medical need for the item.
- The repairs are not a result of a defect in materials or workmanship.

Prior Authorization Request Wheelchairs

When submitting a PA request for a custom wheelchair or power mobility device, there must be comprehensive written documentation submitted with the PA request that clearly and specifically explains **all** the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair

- Description and history of limitations/functional deficits
- Description of physical and cognitive abilities to utilize equipment
- History of previous interventions/past use of mobility devices
- Description of existing equipment, age and specifically why it is not meeting the participant's needs
- Why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, standard wheelchair)
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment

Basic Equipment Package

Power wheelchairs, power operated vehicles and manual wheelchairs are required to include certain items on initial issue. These items are considered the basic equipment package. There is no separate billing/reimbursement for these items at the time of initial issue. MO HealthNet follows Medicare's guidelines regarding basic equipment packages. A complete list of items included in the basic equipment package for power wheelchairs, power operated vehicles and manual wheelchairs can be found in Section 13 of the DME provider manual located on the MO HealthNet Web page at http://manuals.momed.com/manuals/.

Coverage of DME for Participants in a Hospital

DME items dispensed to a participant while receiving inpatient or outpatient care is included in the hospital payment and not paid for separately under the DME program. A hospital enrolled as a DME provider *cannot* be paid through the DME program for any item covered under the DME program that is used for inpatient/outpatient care.

Orthopedic Shoes/Modifications

Orthopedic shoes and modifications or additions to shoes are covered only in the following situations:

- The shoe(s) is an integral part of a brace. “Integral” means the shoe(s) is necessary for completing the brace. A pair of shoes may be reimbursed even if only one shoe is an integral part of a unilateral brace.
- The shoe(s) and/or modification are medically necessary for a participant under the age of 21.

Modifiers

All claims submitted to MO HealthNet for consideration of payment must be submitted with a modifier in addition to the HCPCS procedure code. Services covered in the DME program may be approved for purchase, rental, or repair. Section 19 of the MO HealthNet DME Manual documents coverage of services. One of the following modifiers is required for billing services through the DME program:

NU = Purchase
RR = Rental
RB = Repair

Rental of Durable Medical Equipment

The Certificate of Medical Necessity (CMN) or PA request for equipment are reviewed in order to determine initially if the item should be purchased or rented based on the diagnosis and prognosis of the participant and the anticipated period of need prescribed by the participant's physician. If the period of need indicates it is less expensive to purchase the equipment, the MO HealthNet Division (MHD) elects to purchase the equipment; likewise, if it is less expensive to rent the equipment, MHD elects to rent the equipment. The following are guidelines for rental of DME.

- If a participant is ineligible for the MO HealthNet program during a portion of the rental month, rental is paid only for the days the participant is eligible.
- When rental payments reach the MO HealthNet allowed purchase price, the item becomes the property of the participant.
- With the exception of electronic crossover claims, DME providers are to bill by calendar month. Billing for the rental of equipment should state only one month for each line item, billing multiple line items for multiple months on the same claim is acceptable. Claims for participants who are on spenddown will deny if the they are not billed by calendar month.
- The MO HealthNet program does not reimburse the provider or the participant for replacement of a rented DME item that is stolen, lost or destroyed.
- When billing for the rental of a DME item, the from and to dates of the claim must always be completed. The units of service should always be "1" unless otherwise specified.

Pre-Certification Process for Durable Medical Equipment

The MHD is implementing pre-certification (Smart PA™) requirements for DME services. Pre-certification serves as a utilization management tool, allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to MO HealthNet participants.

Pre-certification requests for DME is a two-step process. Requests for pre-certification are initiated by enrolled MO HealthNet providers who write prescriptions for items covered under the DME program. Authorized DME prescribers include physicians or nurse practitioners who have a collaborative practice agreement with a physician allowing for prescription of such items. The enrolled DME provider accesses the pre-certification initiated by the prescriber to complete the second step of the pre-certification process. All requests must be approved by the MHD.

Requests for pre-certification must meet medical criteria established by the MHD in order to be approved. Medical criteria is published in the DME Pre-Certification Criteria Documents on the MHD Web site located at http://dss.mo.gov/mhd/cs/dmeprecert/.

Manual Pricing

DME items, services or supplies, which do not have a MO HealthNet maximum allowed amount established, are manually priced according to the following guidelines:

- HCY = cost + 20%
- Ostomy = cost + 20%
- Manually priced custom wheelchairs and accessories = 80% of the MSRP
- Manually priced power mobility devices and accessories = 85% of the MSRP
- Augmentative communication devices and accessories = 85% of the MSRP
- Orthotics and prosthetics = cost + 20%
- K0108NUSC = wheelchair accessory code for nursing home residents, 40% of the MSRP for custom wheelchairs and 45% of the MSRP for power wheelchairs

SECTION 8
CUSTOM-MADE ITEMS

MO HealthNet payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom HCY equipment when the participant becomes ineligible (either through complete loss of MO HealthNet benefits or change of assistance category to one which the particular service is *not* covered) or dies after the item is ordered or fabricated and *prior* to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The participant must have been eligible for MO HealthNet benefits when the service was first initiated (and following receipt of an approved prior authorization (PA) request if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item must have been delivered or placed if the participant is living; and,
- The provider must have entered "See Attachment" in field #19 of the CMS -1500 claim form and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is not possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimates is represented in cases where delivery or placement is not possible.

Payment of Custom-Made Items and Devices

A. If the item is received by the participant following loss of MO HealthNet benefits or eligibility for the service, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable for the total service.
B. If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable for the total service. The "net billed charge" is the provider's usual and customary billed charge(s) as reduced by any salvage value amount.
    - ✓ Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. A custom-made wheelchair is an example of an

item whose components represent a salvage value. The salvage value must be clearly documented in the participant's medical record.

- ✓ Any provider determined retail salvage of the unplaced, or undelivered item must be subtracted by the provider from the billed charge for the item or device and only the net reduced charge entered on the claim form. These items are subject to review for salvage value adjustments represented in the billed charge.

C. The date of service shown on the claim form for the item or device when situation A or B applies must be the last date on which service is provided to the eligible participant (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant's eligibility for MO HealthNet benefits each time a service is provided. Use of a date of service for which the participant is no longer eligible for MO HealthNet benefits results in a denial of the claim. The CMS-1500 claim form, along with the attachment, is to be submitted to Infocrossing Heathcare Services at P.O. Box 5600, Jefferson City, MO, 65102.

Payments made as described in A or B constitute the allowable MO HealthNet payment for the service, no further collection from the participant or other persons is permitted.

If the provider determines the participant lost eligibility for MO HealthNet benefits after the service was first initiated and before the custom-made item is actually ordered or fabricated, the participant must be immediately advised completion of the work, and delivery or placement of the item is not covered by MO HealthNet. It then becomes the participant's choice whether to request completion of the work on a private payment basis. If the participant's death is the reason for loss of MO HealthNet benefits, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does not reimburse the provider. The custom-made policy can be found in section 13.15 of the MO HealthNet DME manual.

SECTION 9
RESOURCE PUBLICATIONS FOR PROVIDERS

ICD-9-CM & Health Care Procedure Coding System (HCPCS)

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 claim forms and attachments. The accuracy of the code that describes the participant's condition is important.

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.

Both of the above publications can be ordered from the following:

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://pmiconline.com

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

SECTION 10
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

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

If there is no evidence of this written agreement, the provider cannot bill the participant 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, Second Surgical Opinion, etc.), the participant 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 RECIPIENT REIMBURSEMENT (MRR)

The Medicaid Recipient Reimbursement program (MRR) 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