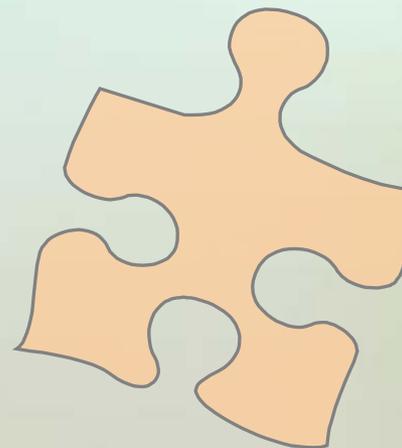
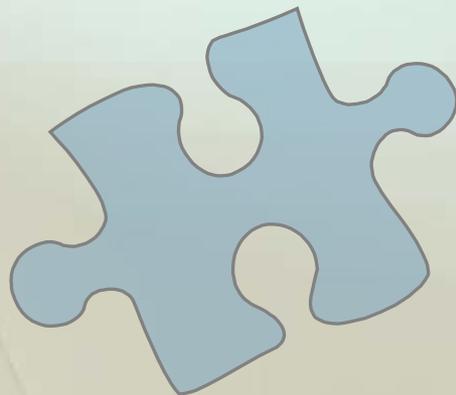
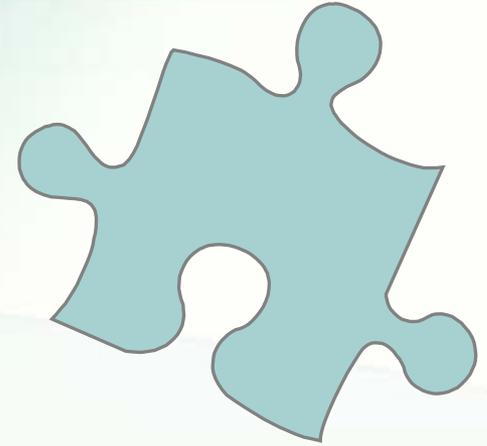


School-Based Medicaid



Presenters



Becky Rickard (Medicaid)

Division of Medical Services

(573) 751-2896

Shelley Witherbee (Education)

Division of Special Education

(573) 522-2523

shelley.witherbee@dese.mo.gov

Important Websites

www.dss.mo.gov/dms

Provider Enrollment, Provider Search, Provider Manuals and Bulletins, Internet Access

<http://www.dese.mo.gov/divspeced/Finance/index.html>

Further clarification on Medicaid changes, step-by-step instructions

www.emomed.com

Submit electronic claims, verify eligibility, add provider numbers

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Enroll for NPI Number

www.wpc-edi.com

Obtain HIPPA forms, codes, and software

Technical Assistance

Karri Thurman

Karrit_2000@yahoo.com

(573) 760-0154

Karri can help with enrollment and
billing questions.

Billing Agencies

Claim Care

Contact: Stacy Dye

PO Box 247

Paris, MO 65275

(877) 327-5308

claim@parismo.net

Maximus

Contact: Collin Swearingen

907 W Jaide Lane

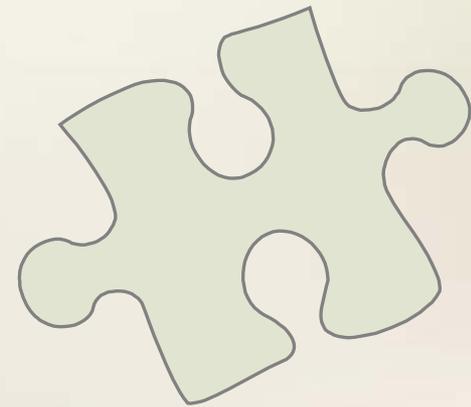
Olathe, KS 66061

(573) 673-2013

collinswearingen@maximus.com

Topics

- Provider Enrollment Changes
- National Provider Identifier (NPI)
- Provider Certification
- Documentation
- Procedure Codes & Allowed Amounts
- Diagnosis Codes
- eMOMED Claim Form
- Third Party Liability (TPL) Insurance
- Remittance Advice/Denial Codes
- Federal/State Ratio and Payment
- Timelines
- Batch Processing
- Audit Citations



Provider Enrollment Changes

- All school districts must obtain a clinic/group number called the BILLING provider number. This number begins with a "50" .
- All individual therapists employed by the district must obtain an individual provider number called the PERFORMING provider number. This number will begin with "46, 47, or 48"

Provider Differentiation

BILLING PROVIDER = SCHOOL DISTRICT



PERFORMING PROVIDER = INDIVIDUAL THERAPIST



Provider Enrollment Changes

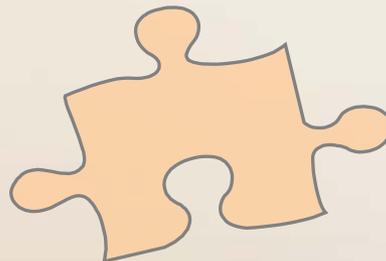
- Districts may continue to use their old district numbers that begin with 46, 47, and 48 until March 1, 2007.
- If a district has their "50" number and all of their individual therapist numbers, they may start using the new numbers any time.

Provider Enrollment Instructions

Instructions for both district and individual provider enrollment may be found on the DESE website and in your handouts. Each signature page needs to be faxed individually.

Handout 1: District Enrollment Instructions

Handout 2: Individual Enrollment Instructions

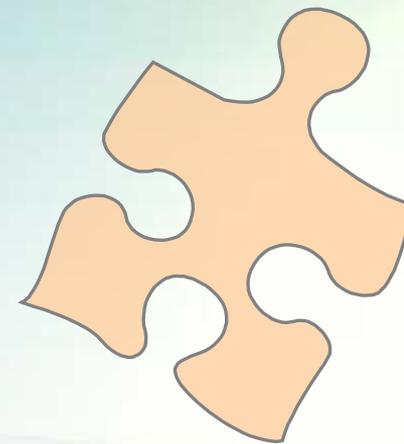


National Provider Identifier (NPI)

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the issuance of a unique number to each service provider nationwide.
- Both the district and state licensed individual therapists will have to enroll for an NPI number.

Handout 3: NPI Instructions

Exception to NPI



Therapists who are ONLY certified through DESE with a teaching certificate in Speech and Language and who do NOT hold a state license will NOT apply for the NPI.

They will be issued a pseudo-NPI from Medicaid. If they have both a license and DESE certificate - they need to apply for an NPI.

National Provider Identifier (NPI)

- NPI's must be obtained and reported to Medicaid by April 01, 2007.
- Districts will start using the NPI on the claim forms May 21, 2007.
- NPI can be submitted through emomed.com.



MO Medicaid and NPI

District - BILLING Provider

MO Medicaid Number (50)

National Provider Identifier (NPI)

Individual - PERFORMING Provider

MO Medicaid Number (46, 47, 48)

National Provider Identifier (NPI)

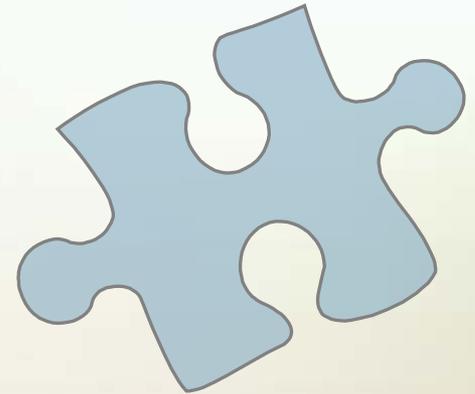
NPI Taxonomy Codes

Local Education Agency 251300000X
(School Districts)

Physical Therapist 225100000X

Speech Therapist 225X00000X

Occupational Therapist 235500000X



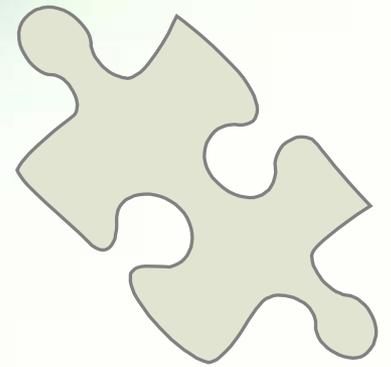
Provider Certification/Licensure

- Board of Healing Arts Certified/Licensed Speech-Language Pathologist
- Board of Healing Arts Certified/Licensed Physical Therapist
- Board of Occupational Therapy Certified/Licensed Occupational Therapist
- DESE Certified Speech-Language Teacher

Documentation - IEP/Plan of Care

All services billed to Medicaid must be included in the current Individualized Education Plan (IEP). The Plan of Care (IEP) must contain the diagnosis (disability), desired outcome (goals), nature of treatment (type of therapy), frequency of treatment (minutes), and duration (length of time).

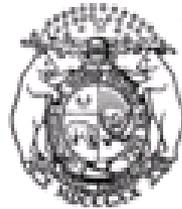
Documentation - Scripts



- All services billed to Medicaid must have a physician script signed by a Primary Care Provider or Medicaid enrolled provider.
- Scripts should contain Physician Medicaid Provider Number and signature, student name, date, type of therapy, and duration.
- Scripts are good for one year.
- Medicaid will accept scripts signed by a nurse practitioner.

Sample Script

D. Kent King
Commissioner of Education



P.O. Box 480
Jefferson City, MO 65102-0480
<http://dese.mo.gov>

Missouri Department of Elementary and Secondary Education

— Making a positive difference through education and service —

Date: 01/24/07

Student Name: Shelley Witherbee DOB: 07/31/78

Therapy: Speech Therapy

Frequency: 30 minutes/ 3 times per week

Duration: 2006-2007 School year

Diagnosis: Developmental Speech Delays

Physician Signature:

Dr. Patrick Sporleder

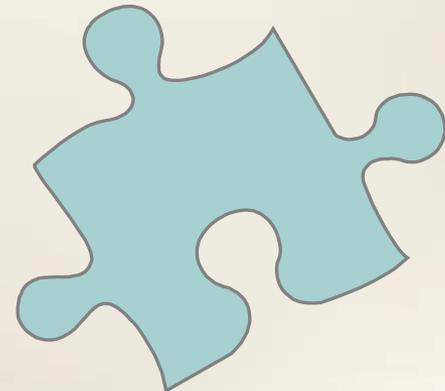
Date

Medicaid Provider #

100 W. Main St. Jefferson City, MO (573) 522-2523

Documentation - Therapy Logs

- All therapy logs must be dated
- All therapy logs must specify activity
- All therapy logs must specify time
- All therapy logs must be signed by the therapist



Therapy Logs Sample

Student Name: Shelley Witherbee			Therapist Name: Becky Rickard		
Month: January 2007			Student Medicaid Number: 41112322		
District Medicaid Number: 503654789			Therapist Medicaid Number: 463256978		
Date	Therapy	Modifier	Units	Time	Notes
01/20	Speech Eval	TM	2	10-10:30	Matching Game, Goal #3
01/22	Speech Therapy	TM	2	10-10:30	Sound Production Model
01/24	Speech Therapy	TM	2	10-10:30	Picture Book
		Therapist Signature:			

Documentation - Parental Consent

“Must obtain parental consent, consistent with §300.9, each time that access to public benefits or insurance is sought” and “Notify parents that the parents’ refusal to allow access to their public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.”

Handout 4: Sample Parental Consent Form

Handout 5: Copy of Regulation

Handout 6: OSEP Clarification Letter

Parental Consent Components

- Entity Releasing the Information
- Student Name and DOB
- Date of Services
- Entity Information is Released to
- Purpose of Disclosure
- Information to be Disclosed
- Signature of Parent or Legal Guardian
- Date of Signature
- Statement saying that they may refuse to sign and still receive services/treatment.

Common Procedure Codes & Allowed Amt

CODE	PROCEDURE	ALLOWED AMT
92506	Speech Evaluation	\$10.00/unit
92507	Individual Speech Therapy	\$10.00/unit
92508	Speech Therapy - Group	\$3.00/unit
97001	Physical Therapy Evaluation	\$10.00/unit
97535	Physical Therapy	\$10.00/unit
97003	Occupational Therapy Evaluation	\$10.00/unit
97110	Occupational Therapy	\$10.00/unit

1 Unit = 15 minutes of therapy time

Rounding Up Guidance

Medicaid states that a district may claim a full unit of service if:

The remaining amount of time that is not face-to-face therapy is directed toward the student. For example, making more detailed therapy notes, or preparing materials for the next session with that child.

Diagnosis Codes

May verify billable status for free at

www.flashcode.com

Green = Non-Billable

Red = Billable

Records 1-4 of 4		< Prev Next >	 non-billable code, click for next level	 billable code	Flash Co
Copy	315.3		Developmental Speech Or Language Disorder		
Link					
Notes	H S 3 4 5				
Copy	315.31		Expressive Language Disorder Developmental aphasia; Word deafness		
Link					
Notes	H S 3 4 5				

Handout 7: Diagnosis Codes

Introduction to eMOMED.com

Go to internet site

Verify Eligibility

Submit Claims

Update/Add Provider Info

Check status of claims

Check payment status of claims

View Remittance Advice

View Denial Codes

Handout 8: eMOMED Main Page

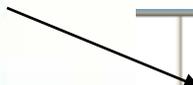


eMOMED - Main Page

<p>Submit Claims</p> <p>Medical (HCFA 1500)</p> <p>Inpatient (UB-92) Medicare UB92 Part A Crossover</p> <p>Outpatient (UB-92) Medicare UB92 Part B of A Crossover</p> <p>Dental Medicare CMS 1500 Part B Crossover</p> <p>Nursing Home</p> <p>Pharmacy</p>	<p>Submit Claim Attachments</p> <p>Certificate of Medical Necessity Sterilization Consent</p> <p>Second Surgical Opinion Oxygen and Respiratory Equipment Medical Justification</p> <p>Acknowledgement of Receipt of Hysterectomy Information Medical Referral of Restricted Recipient (SURS 118)</p>
<p>Maintain Submitter Information</p>	<p>Send Files</p> <p>Send Test File Send HIPAA Test File</p>
<p>Daily Claims Summary</p>	<p>Receive HIPAA Test Files</p> <p>NCPDP(Test) RA 835(Test)</p> <p>FA 997(Test) CC (Test)</p> <p>Elig 271(Test) CIm St 277(Test)</p>
<p>Real Time Queries</p> <p>Verify Recipient Eligibility View Claim Status</p> <p>Check Inquiry View Attachment Status</p> <p>View PA Status</p>	<p>Request Aged RAs</p>
<p>Receive Provider Files</p> <p>Claim Confirmation Eligibility Verification</p> <p>Remittance Advice (835) Printable Remittance Advice (RA)</p>	<p>Public Files</p> <p>Claim Adjustment Reason Codes and Remittance Advice Remark Codes</p> <p>Claims Processing Schedule</p>

eMOMED - Verifying Eligibility

Verify Student Eligibility

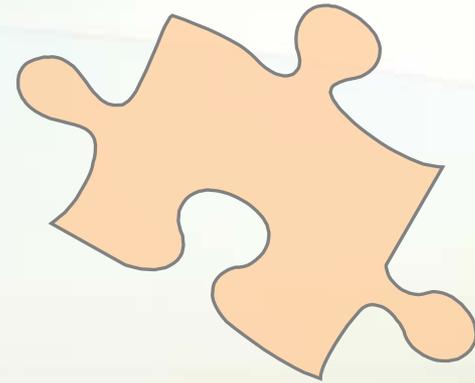


Verify Recipient Eligibility	View Claim Status	
Check Inquiry	View Attachment Status	
View PA Status		
Receive Provider Files		Public Files
Claim Confirmation	Eligibility Verification	Claim Adjustment Reason Codes and Remittance Advice Remark Codes
Remittance Advice (835)	Printable Remittance Advice (RA)	Claims Processing Schedule
Proprietary Remittance Advice	Printable Aged RAs	
Functional Acknowledgement (997)	NCPDP	
Eligibility Verification (271) Response	Claim Status(277) Response	

eMOMED - Verifying Eligibility

Search Methods:

- Medicaid Number
 - or -
- Date of Birth and Full Name
 - or -
- Date of Birth and Social Security Number



Handout 9: eMOMED Eligibility Verification

eMOMED Eligibility Verification Screen

Subscriber Medicaid ID <input type="text"/>		Subscriber Date of Birth (mm/dd/ccyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Subscriber Last Name <input type="text"/>	Subscriber First Name <input type="text"/>	Subscriber Middle Initial <input type="text"/>	
Subscriber Social Security Number <input type="text"/>			
Casehead Medicaid ID <input type="text"/>		Child's Date of Birth (mm/dd/ccyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
First Date of Service (mm/dd/yy) * <input type="text"/> / <input type="text"/> / <input type="text"/>		Last Date of Service (mm/dd/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>	
Patient Account <input type="text"/>			

-OR-

-OR-

Submit

Reset

eMOMED Eligibility Verification Run

Eligibility/Benefit Information: 1 of 5

Eligibility/Benefit Code	1 - Active Coverage ←		
Plan Code	36 ←	Date Qualifier	307 - Eligibility
Time Period Qualifier	34 ←	From Date	12/01/2006
Monetary Amount	\$0.00	To Date	01/31/2007
Insurance Type	MC - Medicaid		

Eligibility/Benefit Information: 2 of 5

Eligibility/Benefit Code	R - Other or additional payer		
Plan Code	AM,DM,HH,HI,HO	Date Qualifier	348 - Benefit Begin
Time Period Qualifier		From Date	01/01/2006
Monetary Amount	\$0.00	To Date	00/00/0000
Insurance Type	OT - Other		

Third Party Liability Information ←

ANTHEM BLUE CROSS BLUE SHIELD SL	Policy Number	WMW03568419W
PO BOX 14882	Group Number	
	Group Name	
ST LOUIS , MO 631784882		

Medicaid Eligibility (ME) Codes

MEDICAID	
01, 04, 11, 12, 13, 14, 15, 16	Elderly, blind and disabled individuals who meet the Medical Assistance eligibility criteria in the community or a vendor facility; or receive a Missouri State Supplemental Conversion or Supplemental Nursing Care check.
03	Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.
55	Individuals who do <i>not</i> qualify for a public assistance program but who meet the Qualified Medicare Beneficiary (QMB) eligibility criteria
23,41	Children in a Nursing Facility/ICF/MR
28,49,67	Children placed in foster homes or residential care by DMH.
33,34	Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.
83	Women under age 65 determined eligible for Medical Assistance based on Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibilit
84	Women under age 65 determined eligible for Medical Assistance based on Breast or Cervical Cancer Treatment (BCCT).

MC+ Eligibility Codes

MC +	
05,06	Eligible children under the age of 19 in Medical Assistance for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional Medical Assistance.
60	Newborns (infants under age 1 born to a Medicaid or MC+ recipient).
40,62	Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.
18,43,44,45,61	Pregnant women who meet eligibility factors for the MC+ for Pregnant Women Program.
07, 29, 30, 37, 50, 63, 66, 68, 69, 70	Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MC+ non-CHIP criteria.
36,56	Children who receive a federal adoption subsidy payment.

MC+ Eligibility Codes cont'd

71,72	Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% (text rev. 3/06) of the FPL. (Also known as MC+ for Kids.) 150% (text rev. 3/06) of the FPL. (Also known as MC+ for Kids.)
73	Covers uninsured children under the age of 19 in families with gross income above 185% of the FPL. (Also known as MC+ for Kids.)
74	Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL. (text rev. 3/06) (Also known as MC+ for Kids.) (text del. 3/06)
75	Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MC+ for Kids.) (text del. 3/06) Families must pay a monthly premium.

MC+ Eligibility Codes cont'd

	premium.
80	Uninsured women who do <i>not</i> qualify for other benefits, and lose their MC+ for Pregnant Women eligibility 60 days after the birth of their child, will continue to be eligible for family planning and limited testing and treatment of Sexually Transmitted Diseases, regardless of income, for one year after the MC+ for Pregnant Women coverage ends.
81	Temporary medical eligibility code. Used for individuals reinstated to MAF for 3 months (January-March, 2001), due to loss of Medicaid coverage when their TANF cases closed between December 1, 1996 and February 29, 2000. Used for White v. Martin recipients. Used for BCCT.
87	Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.
10,19,21,24,26	Individuals eligible for Medicaid under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.

Temporary Assistance Eligibility Codes

Employee Education Assistance Act of 1990.

Temporary Assistance

58	Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of Medicaid or MC+ eligibility.
59	Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did not qualify for regular Medicaid or MC+ benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter.
88	Children seventeen (17) years of age or younger in need of mental health treatment whose parent, legal guardian or custodian has signed an out-of-home care Voluntary Placement Agreement (VPA) with the Department of Social Services (DSS) Children's Division.

State Funded Medical Assistance Eligibility Codes

State Funded Medical Assistance	
2	Individuals who receive a Blind Pension check.
8	Children and youth under age 21 in DES Children's Division foster homes or who are receiving state funded foster care.
52	Children who are in the custody of the Division of Youth Services (DYS-GR) who do <i>not</i> meet MC+ non-CHIP criteria. (NOTE: GR in this instance means general revenue as services are provided by all state funds. Services are <i>not</i> restricted.)
57	Children who receive a state only adoption subsidy payment.
64	Children who are in the custody of Juvenile Court who do <i>not</i> qualify for federally matched Medicaid under ME codes 30, 69 or 70.
65	Children placed in residential care by their parents, if eligible for MC+/Medicaid on the date of placement.

eMOMED - Adding a Provider

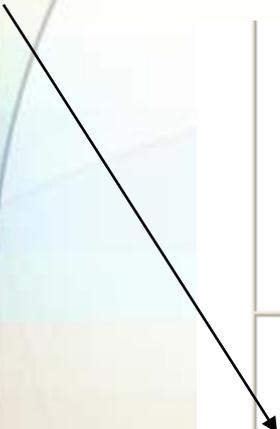
- Go to www.emomed.com
- Choose "Maintain Provider List"
- Enter Provider Number and PIN

All individual therapist numbers need to be added under the district's 50 number.

eMOMED - Adding a Provider

Update Provider Info

Add "50" and Therapist Numbers



Dental	Medicare CMS 1500 Part B Crossover	Acknowledgement of Receipt of Hysterectomy Information	Medical Referral of Restricted Recipient (PI-118)
Nursing Home			
Pharmacy			
Maintain Submitter Information		Submit Batch Files	
Maintain Provider List		Send Files	
		Send Test File	Send HIPAA Test File
Daily Claims Summary		Receive HIPAA Test Files	
		NCPDP(Test)	RA 835(Test)
		FA 997(Test)	CC (Test)
		Elig 271(Test)	Clm St 277(Test)
Real Time Queries		Request Aged RAs	

eMOMED - Adding NPI number

- Go to internet site.
- Choose provider number from drop box.
- Click Add/View NPI.
- Will see a box with provider name and address. Under this is a field to enter the NPI.
- Click the submit button.

eMOMED - Claim Form

Choose Provider Number from Drop Down Box

Enter Student Medicaid Number

Enter Student Name (Real Full Name)

Enter Claim Frequency Type Code

Enter Dates of Service (Same date for to and from)

Enter Diagnosis Code (no decimals)

Enter Place of Service (03) and Procedure Code

Enter Modifier (TM)

Enter the Reference Box for the Diagnosis Code

Enter the total charges and number of units (must multiply)

Check EPSDT Box

Enter the Performing Provider Number

Handout 10: eMOMED Claim Form

eMOMED - Claim Form

 = Required Field

Patient's I.D.* <input type="text"/>		Patient's Name * (Last Name, First Name) <input type="text"/> <input type="text"/>		
Related Causes Code: <input type="text"/>		Claim Frequency Type Code: <input type="text"/>		
LMP Date (mm/dd/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>		I.D. Number of Referring Physician <input type="text"/>		
Hospitalization Dates Related to Current Services (mm/dd/yy) From <input type="text"/> / <input type="text"/> / <input type="text"/> To <input type="text"/> / <input type="text"/> / <input type="text"/>		Service Facility Location? <input type="text"/>		
Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i> 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>		Medicaid Resubmission <input type="text"/>		
Dates of Service * (mm/dd/yy)	Place of Service *		Diagnosis Code *	Conditions
	CPT / HCPCS ProcCode * Modifiers		Charges *\$	Performing Provider
1. <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text"/>
<input type="button" value="ADD DET"/>				
Patient Account No. <input type="text"/>		Total Charge \$ <input type="text"/>		
Facility Name <input type="text"/>				

eMOMED - Claim Form cont'd

Enter
Student's
Medicaid
Number

Patient's I.D.* <input type="text" value="38113099"/>	Patient's Name* (Last Name, First Name) <input type="text"/> <input type="text"/>
Related Causes Code: <input type="text" value="v"/>	Claim Frequency Type Code: <input type="text" value="v"/>
LMP Date (mm/dd/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>	I.D. Number of Referring Physician <input type="text"/>
Hospitalization Dates Related to Current Services (mm/dd/yy) From <input type="text"/> / <input type="text"/> / <input type="text"/> To <input type="text"/> / <input type="text"/> / <input type="text"/>	Service Facility Location? <input type="text" value="v"/>
Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i> 1. <input type="text"/> * 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	Medicaid Resubmission <input type="text"/>

eMOMED - Claim Form cont'd

<p>Patient's I.D.*</p> <input type="text" value="38113099"/>	<p>Patient's Name* (Last Name, First Name)</p> <input type="text" value="Witherbee"/> <input type="text" value="Michelle"/>
<p>Related Causes Code:</p> <input type="text"/>	<p>Claim Frequency Type Code:</p> <input type="text"/>
<p>LMP Date (mm/dd/yy)</p> <input type="text"/> / <input type="text"/> / <input type="text"/>	<p>I.D. Number of Referring Physician</p> <input type="text"/>
<p>Hospitalization Dates Related to Current Services (mm/dd/yy)</p> <p>From <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>To <input type="text"/> / <input type="text"/> / <input type="text"/></p>	<p>Service Facility Location?</p> <input type="text"/>
<p>Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i></p> <p>1. <input type="text"/>* 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/></p>	<p>Medicaid Resubmission</p> <input type="text"/>

*Enter
Student's
Full Real
Name*

eMOMED - Claim Form cont'd

Patient's I.D.* <input type="text" value="38113099"/>	Patient's Name* (Last Name, First Name) <input type="text" value="Witherbee"/> <input type="text" value="Michelle"/>
Related Causes Code: <input type="text" value=""/>	Claim Frequency Type Code: <input type="text" value="1-Original"/>
LMP Date (mm/dd/yy) <input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>	I.D. Number of Referring Physician <input type="text" value=""/>
Hospitalization Dates Related to Current Services (mm/dd/yy) From <input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/> To <input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>	Service Facility Location? <input type="text" value=""/>
Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i> 1. <input type="text" value=""/> * 2. <input type="text" value=""/> 3. <input type="text" value=""/> 4. <input type="text" value=""/>	Medicaid Resubmission <input type="text" value=""/>

*Enter 1 for
an original
claim*

eMOMED - Claim Form cont'd

<p>Patient's I.D.*</p> <input type="text" value="38113099"/>	<p>Patient's Name* (Last Name, First Name)</p> <input type="text" value="Witherbee"/> <input type="text" value="Michelle"/>
<p>Related Causes Code:</p> <input type="text"/>	<p>Claim Frequency Type Code:</p> <input type="text" value="1-Original"/>
<p>LMP Date (mm/dd/yy)</p> <input type="text"/> / <input type="text"/> / <input type="text"/>	<p>I.D. Number of Referring Physician</p> <input type="text"/>
<p>Hospitalization Dates Related to Current Services (mm/dd/yy)</p> <p>From <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>To <input type="text"/> / <input type="text"/> / <input type="text"/></p>	<p>Service Facility Location?</p> <input type="text"/>
<p>Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i></p> <p>1. <input type="text" value="31593"/> * 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/></p>	<p>Medicaid Resubmission</p> <input type="text"/>

Enter the dx code with no decimals



eMOMED - Claim Form cont'd

Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i> 1. <input type="text" value="31593"/> * 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>				Medicaid Resubmission <input type="text"/>	
Dates of Service * (mm/dd/yy)	Place of Service *		Diagnosis Code *	Conditions	
	CPT / HCPCS ProcCode * Modifiers		Charges *\$	Days or Units *	Performing Provider
1. <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/> <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text"/>		<input type="text"/>	<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan.	<input type="text"/>
<input type="button" value="ADD DETAILS"/>					

Enter the date of service. These two dates should be the same.

eMOMED - Claim Form cont'd

Diagnosis or Nature of Illness or Injury <i>(Do not include the decimal)</i>				Medicaid Resubmission					
1.	<input type="text" value="31593"/> *	2.	<input type="text"/>	3.	<input type="text"/>	4.	<input type="text"/>	<input type="text"/>	
Dates of Service * (mm/dd/yy)	Place of Service *				Diagnosis Code *	Conditions			
	CPT / HCPCS ProcCode * Modifiers				Charges *\$	Performing Provider			
1.	<input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="03-School"/> <input type="button" value="v"/>				<input type="text"/>	<input type="checkbox"/> Emergency		
	<input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> EPSDT	<input type="checkbox"/> Fam. Plan.		
								<input type="text"/>	
								<input type="button" value="ADD DATA"/>	

Enter the place of service code. This should always be 03 for a school district.

eMOMED - Claim Form cont'd

(Do not include the decimal)

1. * 2. 3. 4.

Dates of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions
		Charges *\$	
CPT / HCPCS ProcCode *		Days or Units *	Performing Provider
Modifiers			
1. <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/> <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	03-School <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text"/>
	<input type="text"/> <input type="text"/> <input type="text" value="92506"/> <input type="text"/>	<input type="text"/>	

Enter the procedure code.

eMOMED - Claim Form cont'd

(Do not include the decimal)

1. * 2. 3. 4.

Dates of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions
		Charges *\$	
CPT / HCPCS ProcCode *		Days or Units *	Performing Provider
Modifiers			
1. <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/> <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="03-School"/> <input type="text" value="92506"/> <input type="text" value="TM"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text"/>

Patient Account No. <input type="text"/>	Total Charge \$ <input type="text"/>
Facility Name <input type="text"/>	

Enter the modifier. This should always be TM.

eMOMED - Claim Form cont'd

(Do not include the decimal)

1. * 2. 3. 4.

1.	Dates of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions	
			Charges *\$		
		CPT / HCPCS ProcCode *	Days or Units *	Performing Provider	
		Modifiers			
1.	<input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/> <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="03-School"/> <input type="text" value="TM"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text" value="92506"/> <input type="text"/>	<input type="text" value="1"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text"/>

ADD DETAIL

Patient Account No.

Total Charge

\$

Facility Name

Enter the box number that refers to the dx code.

eMOMED - Claim Form cont'd

(Do not include the decimal)

1. * 2. 3. 4.

Dates of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions
		Charges *\$	
CPT / HCPCS ProcCode *		Days or Units *	Performing Provider
Modifiers			
1. <input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="03-School"/>	<input type="text" value=""/>	<input type="checkbox"/> Emergency
<input type="text" value="12"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="92506"/>	<input type="text" value="40.00"/>	<input type="checkbox"/> EPSDT
	<input type="text" value="TM"/>	<input type="text" value="4"/>	<input type="checkbox"/> Fam. Plan.

ADD DETAIL

Patient Account No.

Total Charge

\$

Facility Name

Enter the charges and units here. One unit = \$10. You must multiply this yourself. Four Units - \$40 (\$10 x 4 units).

eMOMED - Claim Form cont'd

(Do not include the decimal)

1. 31593 * 2. 3. 4.

Dates of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions
		Charges *\$	
CPT / HCPCS ProcCode *		Days or Units *	Performing Provider
Modifiers			
1. <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/>	03-School <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> 40.00 <input type="text"/>	<input type="checkbox"/> Emergency <input checked="" type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text"/>
	TM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

ADD DET

Patient Account No.

Total Charge

\$

Facility Name

Check the EPSDT box and enter the Performing Provider Number.

eMOMED - Claim Form cont'd

Date of Service * (mm/dd/yy)	Place of Service *	Diagnosis Code *	Conditions	Detail Line Attachments
		Charges *\$		
CPT / HCPCS ProcCode *		Days or Units *	Performing Provider	
Modifiers				
01 / 06	03-School	1	<input type="checkbox"/> Emergency <input checked="" type="checkbox"/> EPSDT <input type="checkbox"/> Fam. Plan. <input type="text" value="485614729"/>	[Other Payers] [Medical Nec]
01 / 06	<input type="text" value="92506"/> <input type="text" value="TM"/>	<input type="text" value="40.00"/> <input type="text" value="4"/>		
			<input type="button" value="ADD DETAIL LINES"/>	
Account No.		Total Charge		
<input type="text"/>		\$ <input type="text"/>		
Name				
<input type="text"/>				

Choose "ADD DETAIL LINES" to add another date of service.

Third Party Liability (TPL) Insurance

- Medicaid is required by Federal law to bill any primary insurance (TPL) before paying claims.
- School districts may access primary insurance (TPL) through Medicaid if it does not:
 - Decrease available lifetime coverage or any other insured benefit.
 - Result in the family paying for services that would otherwise be covered
 - Increase premiums or lead to discontinuation of benefits
 - Risk loss of eligibility for home and community-based waivers.

Third Party Liability (TPL) Insurance

Districts may send a letter to insurance stating not to pay IEP Services if one of the previous situations apply. It is very important that the district's legal council review letter before sending.



Handout 11: Sample TPL Letter

TPL Eligibility Verification

Insurance Type	OT - Other		
Third Party Liability Information			
ANTHEM BLUE CROSS BLUE SHIELD SL PO BOX 14882 ST LOUIS , MO 631784882	Policy Number Group Number Group Name	WMW03568419W	
Eligibility/Benefit Information: 3 of 5			
Eligibility/Benefit Code	R - Other or additional payer		
Plan Code	HP,MD,PS,SC	Date Qualifier	348 - Benefit Begin
Time Period Qualifier		From Date	01/01/2006
Monetary Amount	\$0.00	To Date	00/00/0000
Insurance Type	OT - Other		
Third Party Liability Information			
ANTHEM BLUE CROSS BLUE SHIELD SL PO BOX 14882 ST LOUIS , MO 631784882	Policy Number Group Number Group Name	WMW03568419W	
Eligibility/Benefit Information: 4 of 5			
Eligibility/Benefit Code	R - Other or additional payer		
Plan Code	RX	Date Qualifier	348 - Benefit Begin

Insurance Plan/Coverage Codes

AC	Accident	
AM	Ambulance	
CA	Cancer	
CC	Nursing Home Custodial Care	
DE	Dental	
DM	Durable Medical Equipment	
HH	Home Health	
HI	Inpatient Hospital	
HO	Outpatient Hospital—includes outpatient and other diagnostic services	
HP	Hospice	
IN	Hospital Indemnity—refers to those policies where benefits <i>cannot</i> be assigned and it is <i>not</i> an income replacement policy	
MA	Medicare Supplement Part A	
MB	Medicare Supplement Part B	
MD	Physician—coverage includes services provided and billed by a health care professional	
MH	Medicare Replacement HMO	
PS	Psychiatric—physician coverage includes services provided and billed by a health care professional	
RX	Pharmacy	
SC	Nursing Home Skilled Care	
SU	Surgical	
VI	Vision	

eMOMED - TPL Claim Attachment

Modifiers				
1.	12 / 01 / 06	03-School	1	<input type="checkbox"/> Emergency
	12 / 01 / 06	92506	40.00	<input checked="" type="checkbox"/> EPSDT
		TM	4	<input type="checkbox"/> Fam. Plan.
				485614729

[ADD DETAIL](#)

Patient Account No. <input type="text"/>	Total Charge \$ <input type="text"/>
Facility Name <input type="text"/>	

Claim Attachment Actions:

[Add Header Other Payers](#) [View All Other Payers](#) [Add/View Invoice Of Cost](#)

[Calculate Line Charges](#) [Continue...](#) [Reset](#)

[Home](#) [Help](#)

Choose "ADD HEADER OTHER PAYER" to add denial letter information.

eMOMED - TPL Claim Attachment

Other Payer Header Information

Enter Other Payer(s) Header Information for Medical claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	CI-Commercial Insurance Co	Other Payer Name*	ANTHEM				
Paid Amount \$	0.00	Paid Date (mm/dd/yy)*	01	/	01	/	07
Header Allowed Amount \$		Total Denied Amount \$	0.00				
Group Codes, Reason Codes & Adjustment Amounts							
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$		
PR-Patient Responsibility	096	40.00					
Add Reason Codes							

Choose "CI" for Commercial Insurance.

Type in the Name of the Insurance.

eMOMED - TPL Claim Attachment

Other Payer Header Information

Enter Other Payer(s) Header Information for Medical claim.

Fields marked * must be filled in.

Other Payer #1					
Filing Indicator*	CI-Commercial Insurance Co	Other Payer Name*	ANTHEM		
Paid Amount \$	0.00	Paid Date (mm/dd/yy)*	01	/	01 / 07
Header Allowed Amount \$		Total Denied Amount \$	0.00		
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
PR-Patient Responsibility	096	40.00			
Add Reason Codes					

Enter the date on the denial letter.

eMOMED - TPL Claim Attachment

Other Payer Header Information

Enter Other Payer(s) Header Information for Medical claim.

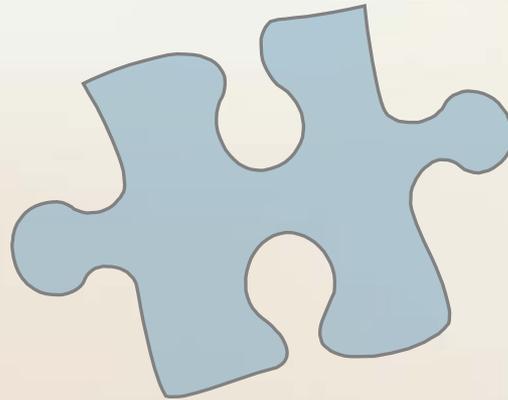
Fields marked * must be filled in.

Other Payer #1					
Filing Indicator*	CI-Commercial Insurance Co	Other Payer Name*	ANTHEM		
Paid Amount \$	0.00	Paid Date (mm/dd/yy)*	01	/	01 / 07
Header Allowed Amount \$		Total Denied Amount \$	0.00		
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
PR-Patient Responsibility	096	40.00			
Add Reason Codes					

Enter "PR" for Patient Responsibility. Enter 096 for the reason code. Then enter the total charges from the Medicaid Claim.

Daily Claims Summary

This allows the biller to view all the claims submitted for that session. Check for accuracy at this time.



Claim Confirmation Report

This report is available the day after claims are submitted. This is a heads-up before the Remittance Advice is available to research denied claims. Claim status codes are:

I - To Be Paid

K - To Be Denied

C - Suspended (Still processing)

M - Medical Claim

Handout 12: Claim Confirmation Report

Claim Confirmation Example

Claim Confirmation

ICHI	Recipient #	Claim Type	From DOS	Billed Amount	Reason Cd1	Patient Account #
Provider #	Recipient Name	Claim Status	Thru DOS	Paid Amount	Reason Cd2	Error Message
4907054079896		M	05/09/2006	0000250.00	A2	
486112402		I	09/28/2006	0000240.00		
4907054079897		M	10/05/2006	0000220.00	D21	
486112402		K	11/16/2006	0000000.00		
4907054079898		M	12/07/2006	0000040.00	A2	
486112402		I	12/14/2006	0000040.00		
4907054079899		M	08/22/2006	0000220.00	A2	
486112402		I	09/26/2006	0000220.00		
4907054079900		M	10/05/2006	0000280.00	A2	
486112402		I	11/28/2006	0000280.00		
4907054079901		M	12/05/2006	0000080.00	A2	
486112402		I	12/19/2006	0000060.00		
4907054079902		M	08/22/2006	0000140.00	A2	
486112402		I	09/25/2006	0000140.00		
4907054079903		M	08/22/2006	0000200.00	31	
486112402		K	10/31/2006	0000000.00		
4907054079904		M	11/09/2006	0000140.00	A2	
486112402		I	12/19/2006	0000140.00		

Remittance Advice & Denial Codes

See example in handouts.

The RA will provide the following information:

Student Name

Separate Line for each claim

Date of Service and Procedure Code

Group Code, Reason & Remark Code

Quantity Billed, Allowed Amt, & Paid Amt

Handout 13: Remittance Advice Report

Claim Processing Schedule

The claims processing schedule lists the dates the cycles are run and their corresponding check dates.

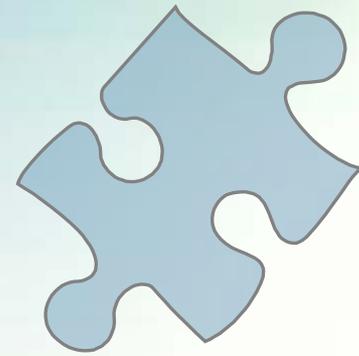
Checks are mailed or directly deposited in to a provider's account twice each month, the 5th and the 20th, for any amounts due.

Handout 14: Claim Processing Schedule 2007

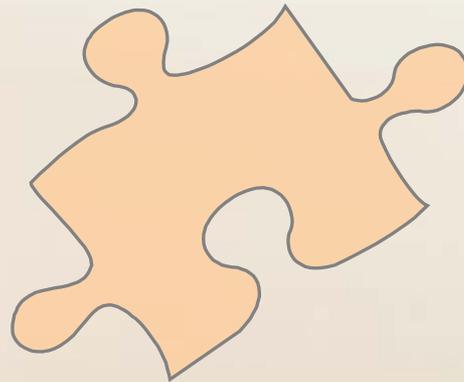
Federal/State Ratio & Payment

- Medicaid will pay approximately 60% of the Federal portion of the allowed amount. If \$10.00 is allowed for one unit, Medicaid will pay approx. \$6.00.
- The District is responsible for the remaining 40% State portion.
- Direct Services reimbursement should go back into the Direct Services program.

Timelines



- One Year from Date of Service to Submit Claims
- If claim is denied, you have one additional year to resubmit from date of service.



Batch Processing

For Large Districts, verifying eligibility may be more efficiently done by batching software. This is where you send in multiple names in a specified format to verify student eligibility. Software for batching may be purchased from one of the vendors listed at www.wpc-edi.com

Batch Formats

Submission Formats:

270 Eligibility Inquiry

276 Claims Status Inquiry

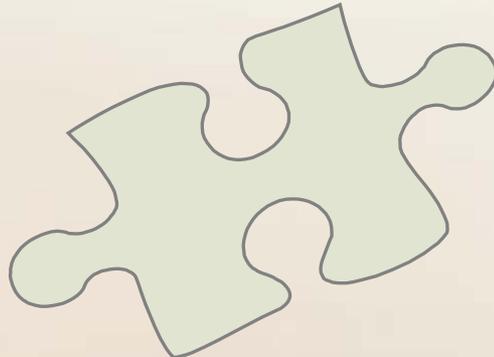
237 Claim Submission

Response Formats:

271 Eligibility Response

277 Claim Status Response

835 Remittance Advice



Audit Citations from Other States

- Expired IEPs
- No referrals or prescriptions
- Therapy Notes don't support IEP, or don't exist.
- Billed for services provided free to non-Medicaid students.
- Billing for dates student was absent.
- Duplicate claims filed
- Personnel did not possess required certifications.
- District did not support share with local or state funds.
- No Proof that IEP services were delivered.
- Services not billed at the appropriate level of reimbursement.
- Billed for unallowable services not specified in IEP.
- Parental Consent Not Obtained