SECTION 7
MEDICARE/MO HEALTHNET 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. Providers should wait thirty (30) days from the date of Explanation of Medicare Benefits (EOMB) showing payment before filing an electronic claim to MO HealthNet.

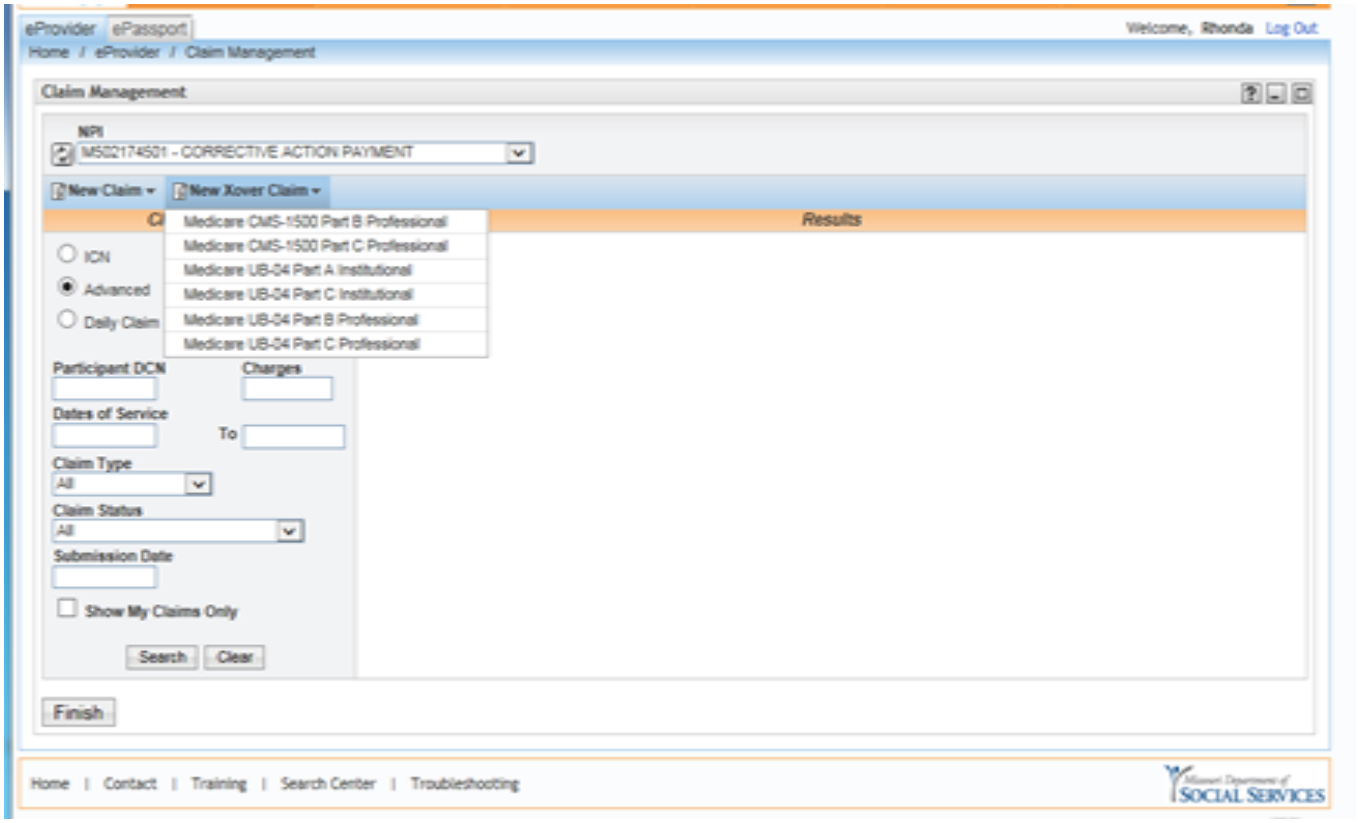
Claims do not cross over from Medicare to MO HealthNet for various reasons. Two of the most common are as follows:

- 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.
- MO HealthNet enrolled providers who have not provided the Provider Enrollment Unit with their National Provider Identifier (NPI) used to bill Medicare. Providers should contact the Provider Enrollment Unit by e-mail at mmac.providerenrollment@dss.mo.gov . Providers who have not submitted their Medicare NPI number 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 .

- Providers must submit claims to MO HealthNet with the same NPI they used to bill Medicare.
- From Claim Management choose the Medicare CMS-1500 Part B Professional form under the 'New Xover Claim' column.
- 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 EOMB with the exception of the participant's name and HIC; these must be entered as they appear in the MO HealthNet participant eligibility file.

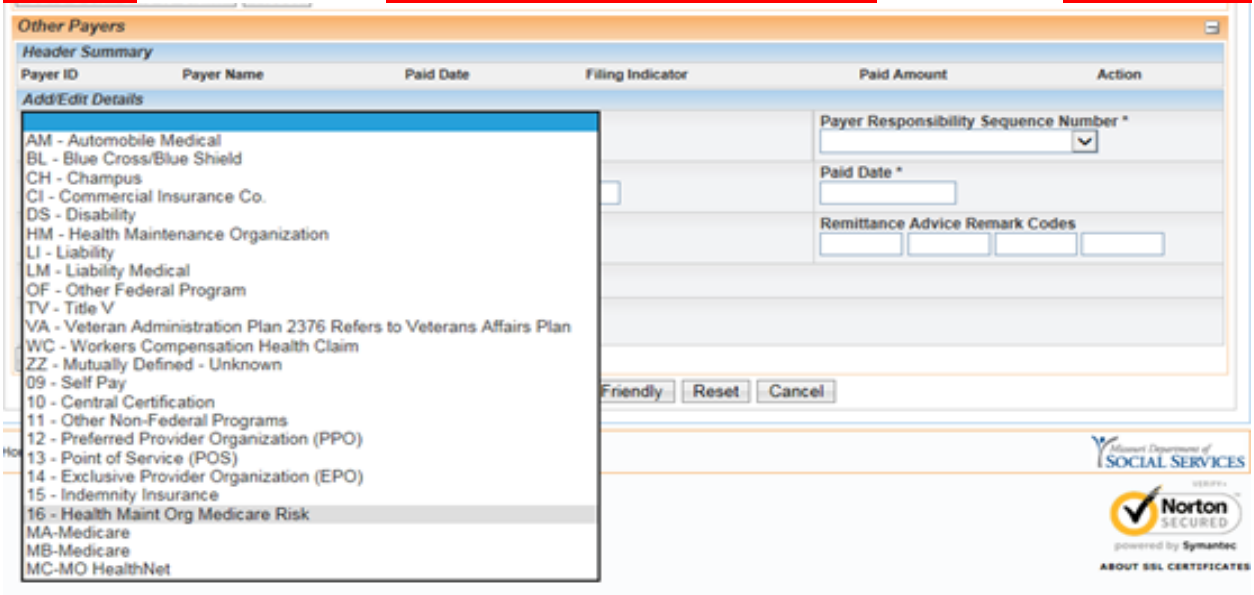
- The Other Payer Detail Summary must contain the same number of line items as the number of detail lines entered. Do not check the 'Payer at Header Level' box on the Header Summary for Medicare crossover claims.



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 provide assistance in successfully filing Medicare Advantage/Part C crossover claims:

- From "Claim Management" choose the Medicare CMS-1500 Part C Professional under the 'New Xover Claim' drop down box.
- 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 must be checked prior to each date of service. The Medicare CMS-1500 Part C professional form can only be used if the participant is QMB eligible on the date of service.



Providers must **not** use the crossover claim forms to submit claims for **non-QMB** participants enrolled in a Medicare Advantage/Part C plan. These services are to be filed as regular medical claims with the Part C information shown as though it is commercial insurance information. Under "Other Payers" Filing Indicator, select "16 –Health Maintenance Organization Medicare Risk" from the drop down box.

Under **no** circumstances are providers to submit crossover claims, Medicare or Medicare Advantage/Part C QMB, as paper claims.