Important Billing and Payment Reminders

home state health

Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH

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The following guidance applies to both Home State Health and Show Me Healthy Kids (Health Plan).

For Additional information: HSH - SMHK - Provider Reference Manual 2023 (homestatehealth.com).

Providers Must Be Enrolled with MO HealthNet

The Health Plan, under its agreement with MO HealthNet, pays providers who are contracted with the Health Plan **and** whose NPIs (individual, group, billing) are enrolled with MO HealthNet.

Providers who do not wish to submit claims with their group/billing NPIs to MO HealthNet for Fee-For-Service Medicaid members may enroll group/billing NPIs as **MCO Only** at no cost.

Providers may access the **MCO Only** application at: https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Organization-MCO-Network-Provider-Application-03-2022.pdf. Please fax or mail the completed application to the Missouri Medicaid Audit & Compliance (MMAC) unit as outlined on the cover page of the application. If MO HealthNet agrees to enroll an NPI retrospectively, please contact our provider data team for updates at CHHS_Provider_Roster@Centene.com **with this verification before requesting claim reconsideration.**

Failure to enroll with MO HealthNet will result in denial of claims or retrospective recoupment of services not accepted through the Health Plan's encounter data submission process.

Timely Filing Requirements

Unless outlined differently in a provider's specific contract, the following claim filing deadlines apply to all providers for covered services.

- First Time Claims (also referred to as Original Claims): 180 calendar days
- Corrected Claims: 180 days from the date of the Evidence of Payment (EOP) or remit
- Claims for Secondary Payment: 365 days (one year) from the Primary Payor's EOP or remit

Claims received outside of these timeframes will deny for untimely submission. Members cannot be billed for claims denied as timely filing.

Third Party Liability

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. TPL may also be referred to as Coordination of Benefits (COB) or Other Insurance Coverage (OIC).

The Health Plan, as a Medicaid Managed Care Organization, is considered payor of last resort when members have other insurance coverage.

The Health Plan only reimburses providers if the third-party has paid as primary or there is a legitimate denial from the third-party. The Health Plan is not responsible for payment of claims denied by the third party in the following circumstances:

- All required forms were not submitted to the third party
- The third party's claim filing instructions were not followed
- The third party needs additional information to process the claim
- Any other payment precondition was not met

Information on **Electronic Secondary Claims** submission, including field requirements for submission in the 5010 format, is available in the HealthPlan online Provider Manual.

Payment Policies

Health Plan Payment Policies are guidelines used to identify whether health care services are correctly coded for reimbursement. Each Payment Policy is sourced by one or more generally accepted coding principles from nationally recognized organizations including but not limited to:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition tos using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.

Policies found at Clinical & Payment Policies | Home State Health apply to all providers whether they are listed as Home State Health or Centene in the heading. The Health Plan, may from time to time, employ a vendor that applies its Payment Policies to specific services; in such circumstances, the vendor's guidelines may also be used to determine whether a service has been correctly coded.

Claim Reconsideration Requests

When providers have medical record or other documentation to support Timely Filing, Third Party Liability, Payment Policy or other claim reconsideration for specific claims, they may submit reconsideration requests via the Health Plan's secure portal. Providers are strongly encouraged to attach a completed reconsideration form to their request.

Advancing Prenatal Health Outcomes – Group Prenatal Benefits

As announced in MO HealthNet's Provider bulletin, Volume 45 Number 31 issued on December 5th, Group Prenatal Care is now a covered benefit for dates of service on or after December 1, 2023. To receive reimbursement, providers must submit a claim for each group prenatal care visit using CPT code 99078 with the TH modifier.

To qualify for reimbursement, group sessions must be led by trained facilitators (e.g., obstetricians or other obstetric care providers) who engage groups of eight to 10 pregnant patients of similar gestational age through a tailored curriculum covering a range of topics related to nutrition, labor expectations, postpartum adjustments and more. Each session should be at least 90 minutes.

Members are covered for up to 10 group prenatal care visits per rolling calendar year.