MO HealthNet Managed Care
(Medicaid)

Healthy Blue

CCBHO billing guide

CCBHO trigger claim billing guidelines

The Q2 modifier is required for all Certified Community Behavioral Health Organization (CCBHO) claims, both trigger and shadow. If the modifier is not in the first position, the claim will not process correctly.

Prospective payment system (PPS)/trigger claim billing information:

- Must be billed with POS 99 and CPT® code T1040, and the billed amount should equal the CCBHO reimbursement rate from MO HealthNet Division (MHD).
- Must have the Q2 modifier in the first position.
- Must have the CCBHO NPI in box 24J and box 33a.

Note:

- If the trigger claim does not have these three requirements listed above, the claim will deny.
- T1040 and shadow claim must be submitted within seven days of each other, or claims will deny.

CCBHO shadow claim billing guidelines

- The shadow claim must have the place of service (POS) where the service was rendered (for example, 11-office, 12-home); do not use POS 50 as this is for Federally Qualified Health Clinic (FQHC) claims.
- The Q2 modifier must be in the first position, then the rendering provider's specialty modifier in the second position, and the detail of the services rendered (for example, 99212, 90837).
- Modifier order must be listed in same order as the qualifying service list located at: *CCBHC Service List for MCO* | dmh.mo.gov
- The rendering provider information is required to be in box 24J and the CCBHO NPI in box 33a.
- The T1040 and shadow claim must be submitted within seven days of each other for payment.

Note:

- If the provider receives a payment for a shadow claim, the overpayment process in the Healthy Blue *Provider Manual* should be followed.
- YRT and Q57 denial codes are expected as payment decision on shadow claims.

CCBHO secondary claims billing guidelines

Billing Healthy Blue as secondary payer:

- We prefer shadow claim to be filed first.
- The shadow claim should be billed as noted on slide 3 and include the coordination of benefit (COB) information.
- If the shadow claim with the COB information has not processed prior to Healthy Blue's receipt of the trigger claim, the trigger claim will deny for (need COB info).

Timely filing guidelines as secondary payer:

- Claims must be received within 365 days from date of service for first submission or resubmission, or within 90 days from the date of the primary *EOB*, if that is longer than 365 days from the date of service.

Rejected versus denied claims

There are two types of notices you may get in response to your claim submission: rejected or denied.

Rejected claims do not enter the adjudication system because they have missing or incorrect information; they will be on the electronic response reports.

Denied claims go through the adjudication process but are denied for payment.

- You can find claims status information on our provider website or by calling Provider Services at **833-405-9086**.
- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment (EOP)*, letter of explanation, and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

MO HealthNet Billing Manual

http://manuals.momed.com/manuals

Billing members

- Healthy Blue members should not be billed or reported to a collection agency for any **covered services** your office provides.
- Missouri code of state regulations title *13 CSR 70-4.030* states in part, “When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient’s Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules.”
- If a member receives a bill and contacts our office, a Healthy Blue staff member may contact your office as well to confirm the member will no longer be charged for the service.
- The provider’s office can file a claims dispute or appeal if the service was paid incorrectly or denied. The provider must submit the claims dispute or appeal within the appropriate time frames.

https://provider.healthybluemo.com

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross Blue Shield Association.

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