MO HealthNet Managed Care
(Medicaid)

Healthy Blue

Dental outpatient hospital and ambulatory surgical center billing guide

D7999

- With the implementation of the Outpatient simplified fee schedule (OSFS), **D7999** is no longer a payable code.
- Hospitals should discontinue the use of **D7999** and bill with the applicable D code listed in the OSFS.
- On the following slides, the example listed shows **D7999** as no longer payable per the fee schedule, with instructions on how to view allowable codes for billing.

Outpatient simplified fee schedule

The Outpatient Fee Schedule is now listed within the MO HealthNet fee schedule at https://dss.mo.gov/mhd/providers/pages/cptagree.htm.

To view an allowed amount, please refer to the following steps:

- Select **Outpatient Hospital**.
- Type in the CPT® code (procedure code) field.
- Your results are then listed.

Outpatient simplified fee schedule (cont.)

Example only:

Select the link for the appropriate category for the CPT code or modifier for which you want to view the allowed amount or modifier information.

Next, select the radio button next to the *Proc Code* or *Modifier* and type in the procedure code or modifier.

The search will show you if the CPT code and/or modifier combination are payable. Listed below **D7999** is not payable.

Fee Schedule Search

Outpatient Hospital

ProcCode	M1	M2	PA1	PA2	PA3	PI	EffDate	RelVal	Spec Fee	Qty
D7999			0			9	07/01/2023	0.00	$0.00	1

Billing tips

- Ambulatory Surgery Centers (ASC) should bill on a *CMS-1500* form, using the appropriate dental codes listed on the Ambulatory Surgery Center Fee Schedule.
- Outpatient hospital facility charges should be billed on a *UB-04* form using the appropriate Rev codes and D codes allowed on the Outpatient simplified fee schedule.
- Professional charges should be billed on a *CMS-1500* with the appropriate dental codes and submitted directly to **DentaQuest**.
- ASC and hospital facility charges are submitted directly to **Healthy Blue** for processing.

* Please note, all dental surgeries require prior authorization.

Dispute appeal state fair hearing process

Definitions:

- **Provider Services:** Did you know that most questions and issues can be resolved by contacting Provider Services? Questions such as claims, payment details, prior authorizations, member benefits, and eligibility status can also be answered by calling Provider Services at **833-405-9086**.
- **Availity Essentials:** Please use the Availity platform for inquiries like payment disputes, provider data updates, claims status, member eligibility, etc. You can also live chat with a Healthy Blue associate within Availity Essentials, **Availity.com.**
- **State complaint:** Many providers seek assistance from the Missouri Department of Insurance when claims are delayed, denied, or unsatisfactorily settled by the health plan. **Before filing a state complaint,** ensure you have completed the submission of a dispute and appeal by checking **here** and contacting your provider relationship account manager about your issue.
- **State fair hearing via MO HealthNet:** You have the right to submit a state fair hearing, when our appeal process is complete, and the denial of services has been upheld and was not resolved wholly in your favor.
- **Provider relationship management representative:** Each provider has an assigned representative who is here to work collaboratively with you, as needed, to ensure you receive the necessary assistance and maintain satisfaction with Healthy Blue.
- *State complaints should **only** be submitted after unsuccessful attempts to work with the health plan.*

Dispute appeal state fair hearing process quick chart

Issue type	Outreach process
Claim payment, denial, or rejection questions/concerns/assistance:	Provider Services, provider representative, Availity Essentials platform
Member benefit/eligibility concerns:	Provider Services
Claim rejection assistance:	Electronic data interchange (EDI) Help Desk
Unsatisfactory appeal final decision determination received:	State fair hearing process
Unsuccessful attempts to work with the health plan:	State complaint
General health plan questions:	Provider Services, provider representative, Availity chat

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 an 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

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