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The MO HealthNet Program requires that the Certificate of Medical Necessity form accompany claims for reimbursement for certain procedures, services or circumstances. Section 13, Benefits and Limitations, identifies circumstances for which a Certificate of Medical Necessity form is required for each program. Additional information regarding the use of this form may also be found in Section 14, Special Documentation Requirements.

Listed below are several examples of claims for payment that *must* be accompanied by a completed Certificate of Medical Necessity form. This list is *not* all inclusive.

- Claims for services that are performed as emergency procedures which, under non-emergency circumstances, require special documentation such as a Prior Authorization Request.
- Claims for inpatient hospital private rooms unless all patient rooms in the facility are private.
- Claims for services for TEMP participants that are *not* covered by the TEMP Program but without which the pregnancy would be adversely affected.
- Claims for specific durable medical equipment such as a wide heavy-duty wheelchair.

Use of this form for other than the specified conditions outlined in the provider's manual has *no* bearing on the payment of a claim.

The medical reason why the item, service, or supplies were needed *must* be stated fully and clearly on the Certificate of Medical Necessity form. The form *must* be related to the particular patient involved and *must* detail the risk to the patient if the service(s) had *not* been provided.

The Certificate of Medical Necessity form *must* be attached to the original claim form when it is submitted, except claims submitted by a Durable Medical Equipment provider. See Section 7.1.A. If a claim is resubmitted, the provider *must* again attach a copy of the Certificate of Medical Necessity form.

Medical consultants and medical review staff review the Certificate of Medical Necessity form and the claim form to make a determination regarding payment of the claim. If the medical necessity of the service is supported by the documentation, the claim is approved for further processing. If medical necessity is *not* documented or supported, the claim is denied for payment.

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7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS

The Certificate of Medical Necessity for durable medical equipment should *not* be submitted with a claim form. This attachment may be submitted via the Internet (see Section 3.9 and Section 23) or mailed to:

Infocrossing Healthcare Services
P.O. Box 5900
Jefferson City, MO 65102

The status of the Certificate of Medical Necessity is reflected on a Claim Attachment Remittance Advice (RA). See Section 23.

If the Certificate of Medical Necessity is approved, the approved time period is six months from the prescription date. Any claim matching the criteria (including the type of service) on the Certificate of Medical Necessity for the approved time period can be processed for payment without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Patient Name	Enter last name, first name and middle initial as shown on the ID card.
2. MO HealthNet ID Number	Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant's ID card or letter of eligibility.
3. Procedure/Revenue Codes	Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).
4. Description of Item/Service	For each procedure/revenue code listed, describe in detail the service or item being provided.
5. Reason for Service	For each procedure/revenue code listed, state clearly the medical necessity for this



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| | service/item. |
| 6. Months Item Needed
(DME only) | For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only). |
| 7. Months Item Needed
(DME only) | For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only). |
| 8. Name and Signature of
Prescriber | The prescriber's signature, when required, <i>must</i> be an original signature. A stamp, facsimile, or the signature of a prescriber's employee is <i>not</i> acceptable. A signature is <i>not</i> required here if the prescriber is the provider (Fields #12 thru #14). |
| 9. Prescriber's MO HealthNet
Provider Identifier | Enter the nine-digit MO HealthNet provider identifier if the prescriber participates in the MO HealthNet Program. |
| 10. Date Prescribed | Enter the date the service or item was prescribed or identified by the prescriber as medically necessary in month/date/year numeric format, if required by program. This date <i>must</i> be prior to or equal to the date of service. |
| 11. Diagnosis | Enter the appropriate ICD-9 code(s) that prompted the request for this service or item, if required by program. |
| 12. Prognosis | Enter the participant's prognosis and the anticipated results of the requested service or item. |
| 13. Provider Name and Address | Enter provider's name, address, and telephone number or use provider label. |
| 14. MO HealthNet Provider
Identifier | Enter provider's nine-digit MO HealthNet provider identifier. |
| 15. Provider Signature | The provider <i>must</i> sign here with an original signature. This certifies that the information given on the form is true, accurate and |

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complete.

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