



Section 13 – Benefits and Limitations

SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION 3

13.2 PROVIDER PARTICIPATION..... 3

 13.2.A ADEQUATE DOCUMENTATION..... 4

 13.2.B RETENTION OF RECORDS 4

 13.2.C NONDISCRIMINATION..... 5

 13.2.D PARTICIPANT NONLIABILITY 5

13.3 PARTICIPANT COPAY..... 5

13.4 PLACE OF SERVICE..... 5

13.5 MODIFIER..... 5

13.6 SURGICAL SERVICES 5

13.7 PROFESSIONAL SERVICES 6

13.8 PRESURGICAL, DIAGNOSTIC, AND OPERATIVE-RELATED SERVICES 6

 13.8.A ROUTINE SERVICES INCLUDED IN FACILITY CHARGE..... 6

13.9 POST-OPERATIVE CARE..... 7

13.10 ASSISTANT SURGEON’S SERVICES 7

13.11 RADIOLOGY AND EKG SERVICES..... 7

 13.11.A OTHER RADIOLOGY PROCEDURES 7

13.12 CORNEAL TRANSPLANTS 7

13.13 DENTAL SERVICES..... 8

13.14 PATHOLOGY AND LABORATORY 9

 13.14.A CLIA REQUIREMENTS..... 9

13.15 SECOND SURGICAL OPINION 9

 13.15.A SECOND SURGICAL OPINION POLICY 10

 13.15.B THIRD SURGICAL OPINION 10

 13.15.C CHOICE OF PHYSICIAN..... 10

 13.15.D PROCEDURE FOR OBTAINING SECOND OPINION 11

 13.15.E EXCEPTIONS TO THE SECOND SURGICAL OPINION REQUIREMENT 12



Section 13 – Benefits and Limitations

13.15.F SURGICAL PROCEDURES THAT REQUIRE A SECOND SURGICAL OPINION
 FORM 13

13.16 PRIOR AUTHORIZATION..... 13

13.16.A OUT-OF-STATE NONEMERGENCY SERVICES 13

13.16.A(1) Exceptions To Out-Of-State Prior Authorization (PA) Requests 14

13.17 EMERGENCY SERVICES..... 14

13.18 STERILIZATION PROCEDURES 14

13.19 OPERATIVE REPORT 15

13.20 CERTIFICATE OF MEDICAL NECESSITY 15

13.21 NONCOVERED SERVICES..... 15

13.22 NON-ALLOWABLE SERVICES 17

13.23 CIRCUMCISIONS 17



SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

By legislative enactment effective August 13, 1980, the legal basis for MO HealthNet coverage of services provided in an ambulatory surgical center facility was established. For program purposes, an ASC facility is defined as:

A free-standing facility functioning as an independent business and administrative entity which represents no physical nor fiscal relationship to a hospital. It is a facility designed, staffed, equipped, and operated for the primary purpose of providing surgical services. It is neither staffed nor equipped to provide overnight care to patients.

Program coverage is provided for those specific procedures and services listed in Section 19, Covered Ambulatory Surgical Center Procedure Codes.

13.2 PROVIDER PARTICIPATION

To participate in the MO HealthNet Ambulatory Surgical Center Program, the ambulatory surgical center facility *must* satisfy the following requirements:

- The ambulatory surgical center facility *must* be currently licensed by the Bureau of Hospital Licensing and Certification, Missouri Department of Health and Senior Services. Suspension or termination of licensure by the Department of Health and Senior Services requires comparable action be taken by the MO HealthNet Division.
- The facility *must* maintain an organized medical care staff of physicians and may include dentists and podiatrists, and *must* provide for continuous care and availability of attendance by currently licensed physician practitioners and registered professional nurses during such time as patients are in the facility.
- There *must* be a formal arrangement with a licensed General Medical and Surgical hospital within reasonable proximity to provide for emergency transfer of patients or overnight care in cases where so required.
- The charges for MO HealthNet covered services provided to MO HealthNet eligible participants *must* be no more than the usual and customary charges for comparable services to the general public.
- Acceptance of assignment of MO HealthNet benefits as full satisfaction of the charge for a MO HealthNet covered service is binding upon the provider's submission of a claim for service to the MO HealthNet Division.



Section 13 – Benefits and Limitations

- The ambulatory surgical center facility *must* have a current MO HealthNet provider number and operate in full compliance with the terms and conditions of the Participation Agreement with the MO HealthNet Division. Medical and fiscal records as required by the terms of the Participation Agreement *must* be retained by the provider for a period of five years.
- In accordance with Federal regulations an ambulatory surgical center facility is classified as a “clinic” and is enrolled in the MO HealthNet Program as a clinic provider type.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.

13.2.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (1)(A) defines “adequate documentation” and “adequate medical records” as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

13.2.B RETENTION OF RECORDS

MO HealthNet providers *must* retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Division, and *must* furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider’s participation in the MO HealthNet Program. This policy continues to apply in the event of the provider’s discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance.



Section 13 – Benefits and Limitations

13.2.C NONDISCRIMINATION

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

13.2.D PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.3 PARTICIPANT COPAY

Services of the Ambulatory Surgical Center Program described in this manual are *not* subject to a copay amount. The provider *must* accept in full the amounts paid by the state agency.

13.4 PLACE OF SERVICE

All ambulatory surgical center services *must* use place of service 24.

13.5 MODIFIER

An ambulatory surgical center facility *must* bill all services rendered to MO HealthNet patients using the "SG" modifier.

13.6 SURGICAL SERVICES

Surgical services are limited to only those procedures listed in Section 19, Covered Ambulatory Surgical Center Procedure Codes. They are further limited to an ambulatory surgical center facility (place of service 24) as a medically appropriate alternative to inpatient hospitalization.



Section 13 – Benefits and Limitations

For Ambulatory Surgical Center Program coverage purposes, the surgical procedures listed may only be performed in an ambulatory surgical center facility by a currently licensed physician (medical or osteopathic), dentist, or podiatrist.

13.7 PROFESSIONAL SERVICES

Physician (M.D.'s and D.O.'s) (radiologist and anesthesiologist), dentist, and podiatrist professional service fees are *not* reimbursable through the Ambulatory Surgical Center Program. These services may only be covered and reimbursed through the performing provider's separate enrollment in their respective MO HealthNet service programs.

Physicians and other providers performing services in an ambulatory surgical center facility are *not* required to be MO HealthNet enrolled providers as a condition of coverage of the facility service. However, no MO HealthNet payment can be made to non-MO HealthNet providers.

13.8 PRESURGICAL, DIAGNOSTIC, AND OPERATIVE-RELATED SERVICES

The presurgical diagnostic services listed below are covered and separately allowable as additional ancillaries when provided by the facility within seven days prior to or on the date of the performance of the procedure and when meeting the coverage criteria expressed in this manual.

- X-ray, chest; single view
- X-ray, chest; two views, posteroanterior and lateral
- Electrocardiogram; routine EKG with at least 12 leads

13.8.A ROUTINE SERVICES INCLUDED IN FACILITY CHARGE

Presurgical, diagnostic, and operative-related services that are covered and included in the facility reimbursement fee when provided by the facility within seven days prior to or on the date of the performance of the procedure include the following:

- Routine preoperative lab work (CBC, Hematocrit, Hemoglobin, Urinalysis);
- Routine screening x-rays;
- Medication, IV Fluids;
- Anesthesia, operating, and recovery supplies;
- Surgical supplies, trays;
- Administrative and nursing services; and
- Preoperative, operating room and recovery.



Section 13 – Benefits and Limitations

13.9 POST-OPERATIVE CARE

Any indicated post-operative care or services provided by the facility is considered to be included in the total fee for service and *cannot* be reimbursed as a separate service.

13.10 ASSISTANT SURGEON’S SERVICES

Additional facility service charges as a result of an assistant surgeon’s services are *not* allowable.

13.11 RADIOLOGY AND EKG SERVICES

Reimbursement for the radiology and EKG services specifically listed in Section 19 is limited to those which are performed on-site by the facility. These services, if referred out or provided elsewhere, are *not* reimbursable to the facility. The services may be covered under the performing provider’s separate enrollment in the MO HealthNet Program.

Coverage of x-rays or EKG’s as ancillary services to the surgical procedure is limited to those which are warranted by the diagnosis; or when, in the opinion of the surgeon or anesthesiologist, the procedure is indicated as medically necessary, as in the case of an older patient. A Certificate of Medical Necessity *must* be attached to the claim form in these cases, reference Section 13.20.

Reimbursement for all other radiology services associated with the performance of any of the identified procedures in Section 19 is included in the facility’s reimbursement for the procedure.

Coverage is further limited to only such additional ancillaries as may be provided within seven days prior to or on the date of performance of the surgical procedure.

13.11.A OTHER RADIOLOGY PROCEDURES

Radiological supervision and interpretation are covered for procedure code 74740, hysterosalpingography, and procedure code 74742, transcervical catheterization of fallopian tube.

13.12 CORNEAL TRANSPLANTS

The cost of acquiring corneal tissue for corneal transplants may be billed in addition to the ambulatory surgical center (ASC) facility charge. Procedure codes 65710, 65730, 65750 and 65755 are manually priced to include the current MO HealthNet fee for the facility charge and the cost of acquiring the corneal tissue. An invoice from an eye bank or organ procurement organization showing the actual cost of acquiring the tissue *must* be attached to claims in order to receive



Section 13 – Benefits and Limitations

reimbursement for the facility charge and the corneal tissue. Claims submitted for corneal transplant procedure codes without the required invoice are denied.

The following ASC facility fees are added to the actual procurement cost of the corneal tissue:

PROC CODE	DESCRIPTION	MO HEALTHNET ASC FACILITY FEE
65710.....	Keratoplasty (corneal transplant); lamellar.....	\$812.00
65730.....	Keratoplasty (corneal transplant); penetrating.....	\$812.00 (except in aphakia)
65750.....	Keratoplasty (corneal transplant); penetrating.....	\$812.00 (in aphakia)
65755.....	Keratoplasty (corneal transplant); penetrating.....	\$853.00 (in pseudophakia)

13.13 DENTAL SERVICES

Certain dental rehabilitation services are covered in a free standing ambulatory surgical center facility for those patients unable to cooperate in the conventional dental setting due to age, disability or psychological problems.

The following are examples of patients who may be treated in an ambulatory surgical center as an alternative to hospitalization:

- Children under 36 months of age with severe dental decay;
- Mentally and physically disabled patients;
- Accident patients; and
- Dental phobic patients.

Covered dental services in an ASC (for individuals meeting the above criteria only) include the following:

- Tooth extraction;
- Wisdom tooth/impacted tooth extraction;
- Pedodontic restoration. (This may include one or more of the following procedures: complete clinical examination, prophylaxis, fluoride treatment, composite/amalgam restorations, extractions, removal of wisdom/impacted teeth, pulpotomies, root canal, and crowns.)

NOTE: Immediate dentures are *not* covered in any setting.



Section 13 – Benefits and Limitations

Physicians, anesthesiologists, dentists, podiatrists, etc., performing services in an ambulatory surgical center facility are *not* required to be MO HealthNet enrolled providers as a condition of coverage of the facility service. However, they *must* be enrolled in order for them to receive direct MO HealthNet payment for their professional services.

13.14 PATHOLOGY AND LABORATORY

13.14.A CLIA REQUIREMENTS

ASC's may perform diagnostic laboratory testing as described in Section 13.8 of this manual; however, the facility *must* meet the requirements discussed in this section.

Under the Clinical Laboratory Improvement Amendments Act of 1988 (CLIA), all laboratory testing sites (including ASCs), as defined at 42 CFR 493.2, *must* have either a CLIA Certificate of Waiver or Certificate of Registration to legally perform clinical laboratory testing anywhere in the United States or be exempt by virtue of the fact that the lab is licensed by an approved state program.

CLIA applies to any entity that performs laboratory testing of human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings. Every lab that meets the above definitions *must* apply to the Centers for Medicare & Medicaid (CMS) for a CLIA certificate and pay a fee to CMS.

The CLIA number is a ten position number. Laboratories are initially issued either a registration certificate or a certificate of waiver as appropriate. The registration certification is valid for a period of two years, or until the lab is inspected or accredited as meeting CLIA standards. The schedule for inspections is based on the number of tests a laboratory performs. Regulations mandate biannual onsite surveys. The goals are to ensure safe and accurate laboratory work, to preserve patient access to clinical tests and to encourage technological innovation.

13.15 SECOND SURGICAL OPINION

Missouri Revised Statutes Section 208.152 requires that MO HealthNet payments for certain elective surgeries, and any costs related directly to such surgery, shall be made by the MO HealthNet Division only when a second medical opinion by a licensed physician as to the need for the surgery has been obtained before the surgery is performed.

The intent of the Second Surgical Opinion Program is to provide the eligible MO HealthNet patient with a second opinion as to the medical necessity of certain elective surgical operations. The surgical



Section 13 – Benefits and Limitations

procedures of concern are those in which there commonly may be a significant difference of opinion from one physician to another.

It is believed a second opinion should enable the MO HealthNet patient to make a more informed decision, given the opportunity to discuss the proposed surgical operation with more than one physician.

For the purpose of the second opinion requirement, non-emergency, elective surgical operations shall be defined as those in which the patient's life will *not* be threatened and the patient's health will *not* be permanently impaired by any delay in performing the surgery.

13.15.A SECOND SURGICAL OPINION POLICY

Elective surgical operations as specified in this section and all costs directly related thereto shall require a second surgical opinion before the surgery is performed if MO HealthNet is to reimburse for the services. The physician performing the surgery and the hospital or ambulatory surgical center providing direct patient care *must* attach a copy of the completed Second Surgical Opinion Form to their claims. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed Second Surgical Opinion Form. A copy of that form and instructions for completion are in Section 14.

When the eligible MO HealthNet patient has obtained a proper second surgical opinion, regardless of whether or not it confirms the primary recommendation for the specific surgery, the final decision to undergo or forego the surgery shall remain with the patient.

13.15.B THIRD SURGICAL OPINION

A third surgical opinion, provided by a third physician, shall be allowed by MO HealthNet if the second opinion fails to confirm the primary recommendation that there is medical need for the specific surgical operation, and if the eligible MO HealthNet patient desires the third opinion.

If a third surgical opinion is obtained, whether it confirms either the primary or the secondary opinion, the final decision to undergo or forego the specific surgery shall remain with the eligible MO HealthNet patient. MO HealthNet does *not* cover a further opinion.

13.15.C CHOICE OF PHYSICIAN

A physician providing a surgical opinion is *not* required to be either Board-eligible or Board-certified. However, the MO HealthNet patient is encouraged to seek a surgical opinion from a specialist in the appropriate medical field, whenever possible.



Section 13 – Benefits and Limitations

MO HealthNet patients may seek a second (or third) opinion from a physician of their own choice, or the primary physician may refer the patient to a professional colleague, if agreeable with the patient.

The second (or third) opinion may be provided by a physician associated with the same medical practice as the primary physician, although the MO HealthNet patient is encouraged to seek the second (or third) opinion from a physician *not* associated with the same practice.

The physicians involved in the case may know each other's identity. No attempt shall be made by MO HealthNet to suppress such knowledge. Cooperation between the physicians is encouraged for the benefit of the MO HealthNet patient.

Neither staff interns nor residents may be permitted to provide the second or third physician opinion.

13.15.D PROCEDURE FOR OBTAINING SECOND OPINION

The primary physician sends the patient's related history and physical report with laboratory data, x-rays, etc., to the second opinion physician once the patient has decided upon that physician and has signed any required release form. The primary physician initiates the Second Surgical Opinion Form by completing Section I, and refers the form to the second opinion physician.

Unless the second opinion physician is to perform the specific surgical operation, the physician returns all material sent by the primary physician and includes a confirming or nonconfirming recommendation to the primary physician. The physician also returns the Second Surgical Opinion Form, having completed the necessary information in Section II. A second opinion *must* be obtained within 60 days after the primary recommendation appointment date in Section I.

If the patient desires a third opinion because the second opinion did *not* confirm the primary one, the primary physician follows the same basic steps described above and sends the Second Surgical Opinion Form to the physician who is to perform the third opinion, who *must* complete Section III of the form (within 60 days after the appointment date in Section II).

Existing laboratory data, x-rays, etc., should be used by the second (or third) opinion physician in every case it is needed to make an informed surgical opinion.

Additional diagnostic services believed to be essential by the second (or third) opinion physician should be ordered from a provider participating in MO HealthNet if the MO HealthNet Program is to reimburse for such services.

Section 13 – Benefits and Limitations

Unless the third opinion physician is to perform the specific surgical operation, the physician returns all material sent by the primary physician including the completed Section III of the Second Surgical Opinion Form.

The primary physician retains the patient's material if this physician is to perform the specific surgical operation. If a physician other than the primary physician or the physician rendering the second or third opinion is to perform the surgery, the primary physician *must* send the Second Surgical Opinion Form and necessary patient material to the surgeon. Whoever performs the surgery *must* complete Section IV of the form and is responsible for furnishing a copy of the completed form to the appropriate hospital or ambulatory surgical center.

The date of the surgery in Section IV *must* be within 150 days of the first appointment date in Section I.

NOTE: Neither the first nor second opinion can be made by an advanced practice nurse.

13.15.E EXCEPTIONS TO THE SECOND SURGICAL OPINION REQUIREMENT

- Medicare/MO HealthNet crossover claims are exempt.
- Inpatient services are exempt from the second opinion requirement if the participant has Medicare Part B but no Part A. Enter information in Field #11 (Insured's Policy Group or FECA Number) on the CMS-1500.
- The Second Surgical Opinion Form is *not* required if the surgeon does *not* participate in the MO HealthNet Physician Program. The provider *must* submit a claim along with a Certificate of Medical Necessity form, and indicate on the Certificate of Medical Necessity form the surgeon's full name and indicate "non-participating."
- Those surgical operations specified are exempt from the second opinion requirement if any one of them is performed incidental to a more major surgical procedure that does *not* require a second opinion.
- If the service was performed as an emergency and a second opinion could *not* be obtained prior to rendering the service, submit a claim along with a Certificate of Medical Necessity form. The provider *must* state on the Certificate of Medical Necessity form, in detail, the reason for the emergency provision of service. For a definition of emergency, reference Section 13.17.

Claims containing emergency services suspend and are reviewed by a medical consultant. If the Certificate of Medical Necessity is *not* attached, or the reason does *not* substantiate the provision of the service on an emergency basis, the claim is denied.



Section 13 – Benefits and Limitations

- The participant was *not* eligible for MO HealthNet at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. If the eligibility approval letter or the Certificate of Medical Necessity form is *not* submitted, the claim is denied. See Section 7 for instructions for completing the Certificate of Medical Necessity form.

13.15.F SURGICAL PROCEDURES THAT REQUIRE A SECOND SURGICAL OPINION FORM

Refer to the fee schedule for a list of surgical procedures requiring a second opinion.

13.16 PRIOR AUTHORIZATION

13.16.A OUT-OF-STATE NONEMERGENCY SERVICES

All nonemergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants, and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization Request *form* is *not* required for out-of-state nonemergency services. To obtain prior authorization for out-of-state, nonemergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request *must* include:



Section 13 – Benefits and Limitations

1. A brief past medical history.
2. Services attempted in Missouri.
3. Where the services are being requested and who will provide them.
4. Why services can't be done in Missouri

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

13.16.A(1) Exceptions To Out-Of-State Prior Authorization (PA) Requests

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims.
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a Foster Care child.
3. Emergency ambulance services.
4. Independent laboratory services.

13.17 EMERGENCY SERVICES

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

13.18 STERILIZATION PROCEDURES

The following voluntary, elective sterilization procedures performed on eligible MO HealthNet participants by either in-state or out-of-state providers require attaching a (Sterilization) Consent Form to the claim form:

PROC



Section 13 – Benefits and Limitations

CODE	DESCRIPTION
55250.....	Vasectomy, unilateral or bilateral (separate procedure); including postoperative semen examination(s)
58600.....	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58670.....	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671.....	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)

The participant *must* be at least 21 years old at the time consent is obtained. *There are no exceptions.* The participant *must not* be mentally incompetent or institutionalized and *must* have voluntarily given informed consent in accordance with federal and state requirements. The federal and state requirements for documentation and claim submission applicable to voluntary, elective sterilization procedures are described in Sections 10 and 14. Voluntary sterilizations have been designated as family planning procedures.

13.19 OPERATIVE REPORT

All procedure codes designated as BR (By Report) require that an Operative Report be submitted with the claim for service. The report *must* demonstrate that it relates to the described covered procedure and provides sufficient operative and anesthesia history detail to ensure an adequate State Medical Consultant Review of the service is possible. When the report is required in conjunction with use of a procedure code ending in -29, -89, or -99, “Unusual Complications,” the report *must* demonstrate that it relates to one of the described covered procedures within the system grouping and provides detail sufficiently explanatory of the unusual, additional requirements of facility time, care, materials, supplies, etc., involved in its performance.

13.20 CERTIFICATE OF MEDICAL NECESSITY

Certain services require that a Certificate of Medical Necessity form be completed and attached to the claim form. Reference Sections 7 and 14 for a sample form and details of completion.

13.21 NONCOVERED SERVICES

The following listing represents services, drugs, supplies, etc., which are *not* covered by MO HealthNet as ambulatory surgical center services. This is *not* intended to be an all-inclusive listing,



Section 13 – Benefits and Limitations

and assumption of coverage by reason of exclusion should *not* be made. Providers should refer to the specifically listed or designated covered services in this manual. Some services may be covered in another MO HealthNet Program.

- Corn removal;
- Cosmetic surgery with primary objective of beautification, e.g.:
 - augmentation mammoplasty
 - dermabrasion and Chemabrasion
 - hair transplant
 - otoplasty; protruding or loop ears
 - rhinoplasty
- tattoo removal;
- Durable medical equipment or supplies provided patient for home use;
- Implantation of nuclear-powered pacemaker;
- Laceration debridement;
- Pathology or Radiology services provided outside of or referred out of the facility;
- Penile prosthesis or insertion of;
- Preparation of special reports sent to insurance companies;
- Prosthetic/Orthotic devices (braces, splints, artificial members, etc.);
- Records preparation or forms processing;
- Routine foot care;
- Serology testing (VDRL, RPR, FTA);
- Specimen handling charges;
- “Standby,” “Stat,” or “Call-back” additional service charges;
- Sterilization services when compliance with the Federal requirements for documentation is *not* provided;
- Take-home drugs;
- Transportation services to or from the facility;
- Transsexual surgical procedures for gender change, such as:
 - labial revision
 - mastectomy



Section 13 – Benefits and Limitations

- penile construction
- release of vaginal adhesions;
- vaginoplasty;
- Tuboplasty and Vasovasotomy;
- Venipuncture for blood drawing.

13.22 NON-ALLOWABLE SERVICES

The following services are included in the MO HealthNet provider's reimbursement for the procedure/surgery and are *not* separately allowable, billable to the participant or to the MO HealthNet Program.

- Claim filing;
- Drawing fees;
- Handling and/or conveyance of specimen to an independent laboratory for interpretation;
- Incidental surgical procedures performed through the same incision;
- Medical testimony;
- Postage;
- Services considered part of a MO HealthNet covered service/procedure;
- Services *not* directly related to the participant's diagnosis, symptoms or medical history or services in excess of those deemed medically necessary to treat the patient's condition;
- Services or supplies covered through another MO HealthNet Program;
- Services or supplies furnished free of charge by any governmental body (e.g., injectable material);
- Telephone calls.

13.23 CIRCUMCISIONS

For policy regarding circumcision procedures, reference Section 13.74 of the Physician Manual.

END OF SECTION

[TOP OF PAGE](#)