



Section 14 - Special Documents Requirements

SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

14.1 REQUIRED ATTACHMENTS..... 2

14.2 CERTIFICATE OF MEDICAL NECESSITY 2

 14.2.A USE OF THE CERTIFICATE OF MEDICAL NECESSITY FOR EXCEPTIONS TO
 STATED POLICY 3

 14.2.B SPONTANEOUS ABORTIONS 3

 14.2.C EMERGENCY SERVICES REQUIRING A SECOND OPINION OR PRIOR
 AUTHORIZATION..... 3

 14.2.C(1) Definition of Emergency Services 3

 14.2.D NONBORDERING OUT-OF-STATE PROVIDERS 3

 14.2.E LOCK-IN PARTICIPANTS 4

 14.2.E(1) Lock-In Emergency Services..... 4

14.3 PRIOR AUTHORIZATION REQUEST..... 4

14.4 OPERATIVE REPORT 4

14.5 SECOND SURGICAL OPINION FORM 5

 14.5.A SECOND SURGICAL OPINION FORM INSTRUCTIONS..... 5

14.6 (STERILIZATION) CONSENT FORM 6

 14.6.A EXCEPTIONS TO THE (STERILIZATION) CONSENT FORM REQUIREMENT 6

 14.6.A(1) Premature Delivery or Emergency Abdominal Surgery..... 6

 14.6.A(2) Other 6

Section 14 - Special Documents Requirements



SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Sections 15, Billing Instructions, and 16, Medicare/MO HealthNet Crossover Claims, for further information. Refer to Sections 1-11 and 20 for general program documentation requirements.

Although most procedures requiring attachments or special documentation are listed in this section, the section is *not* to be considered “all-inclusive.” Certain other situations *not* listed in this section may, because of their complexity or uniqueness, require an attachment in order to fully document or describe the procedure performed.

Please be aware that when a specific 5-digit procedure code requires an attachment, and that same procedure code exists with a modifier, such as “50” bilateral, any attachment requirements applicable to the 5-digit code remain a positive requirement for the code with the modifier.

14.1 REQUIRED ATTACHMENTS

When submitting claims requiring attachments, be sure to:

- include the correct attachment(s) for the service being billed. (Some procedures require more than one attachment.)
- staple the attachment to the claim to which it applies.
- check that the name of the participant is the same on both the attachment and the claim.
- attach a legible copy if *not* submitting an original.
- check that all required information and signatures appear on the attachment.
- check that the dates of service are consistent with dates on the attachment.

Claim form documentation and clarification are of vital importance to the State Medical Consultant when pricing claims.

14.2 CERTIFICATE OF MEDICAL NECESSITY

Certain services, procedures, or circumstances require that a Certificate of Medical Necessity be attached to the claim for payment. If the Certificate of Medical Necessity form supports the need for the service and/or why another policy can *not* be followed, the service may be payable.

Section 7 of this manual contains a copy of the Certificate of Medical Necessity form and instructions for completion. Reference Section 13.20 for procedures that require a Certificate of



Section 14 - Special Documents Requirements

Medical Necessity. The following circumstances also require a completed Certificate of Medical Necessity.

14.2.A USE OF THE CERTIFICATE OF MEDICAL NECESSITY FOR EXCEPTIONS TO STATED POLICY

There are situations that normally require specific policy documentation, but because of an unusual or exceptional situation, a form *cannot* be completed or is inappropriate for the situation. *In these unusual or exceptional instances, a Certificate of Medical Necessity form must be completed fully describing the circumstances.*

14.2.B SPONTANEOUS ABORTIONS

A Certificate of Medical Necessity form is not to be used for any procedure performed as an emergency that normally requires the (Sterilization) Consent Form or Acknowledgement of Receipt of Hysterectomy Information form(s). Refer to Sections 10 and 13.18 for specific exception information.

14.2.C EMERGENCY SERVICES REQUIRING A SECOND OPINION OR PRIOR AUTHORIZATION

When a procedure that normally requires prior authorization or a second opinion is performed as an emergency service, the word “Emergency” *must* be entered in Field #19 of the CMS-1500 claim form *and* a Certificate of Medical Necessity form, documenting the medical necessity of the procedure, *must* be attached to the claim. A Certificate of Medical Necessity form may *not* be used instead of the Prior Authorization Request form except in emergency situations.

14.2.C(1) Definition of 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.

14.2.D NONBORDERING OUT-OF-STATE PROVIDERS

Nonbordering out-of-state providers *must* have all non-emergency services prior authorized before the services are provided. For emergency services, a Certificate of Medical Necessity



Section 14 - Special Documents Requirements

form *must* be attached to the claim submitted for payment. The form *must* explain the emergency circumstance.

14.2.E LOCK-IN PARTICIPANTS

Services provided to participants who are locked-in to a physician or hospital require a Medical Referral Form of Restricted Participant (PI-118) unless the services are provided in response to an emergency situation. If emergency services are provided, a completed Certificate of Medical Necessity form which states in detail the nature of the emergency *must* be attached to the claim when it is submitted for payment.

14.2.E(1) Lock-In Emergency Services

For participants with physician or hospital restrictions, only those providers listed when verifying eligibility through the interactive voice response (IVR) system, or at the billing web site at www.emomed.com, are authorized to provide services with the following exception:

- Emergency services, as defined in Section 14.2.C(1). If emergency services are provided, a completed Certificate of Medical Necessity form *must* be attached to the claim when it is submitted for payment.

14.3 PRIOR AUTHORIZATION REQUEST

Under the MO HealthNet Program, certain covered services and equipment require prior approval by the MO HealthNet Division. *Prior authorization is used to promote the most effective and appropriate use of available resources.* Reference Section 8 for a copy of the Prior Authorization Request form and instructions. Reference Section 13.16 for further information.

14.4 OPERATIVE REPORT

An operative or special descriptive report (as indicated by the procedure) may be required in order for the State Medical Consultant to determine the exact procedure(s) performed and subsequent reimbursement.

Procedures/examples of situations for which an appropriate report should be attached:

- Multiple surgical procedures performed on the same date, at the same or different time, for the same patient.
- Separate/incidental services. When a procedure that is ordinarily a component of a larger procedure (and therefore nonpayable) is performed alone for a specific purpose, it may be considered as a separate procedure when documented by an operative report.



Section 14 - Special Documents Requirements

- Surgeries involving co-surgeons. (Each surgeon should attach a copy of the operative report to the claim.)
- Therapeutic radiology procedures. The operative report should state the procedure, area of body treated, and type of therapy (e.g., kilovoltage, megavoltage, radium, isotopes, etc.).
- “Unlisted” procedures, including both those ending in “29,” “89” and “99” and those *not* ending in “99” (e.g., 96549). An “unlisted” code is *not to be billed instead of* a procedure code that is non-covered.

14.5 SECOND SURGICAL OPINION FORM

Certain procedures require that a second opinion be obtained and documented on the Second Surgical Opinion Form. See also Section 13.15 for complete information regarding obtaining a second (or third) opinion. See the MO HealthNet fee schedule for the procedures that require a Second Surgical Opinion Form.

14.5.A SECOND SURGICAL OPINION FORM INSTRUCTIONS

The Second Surgical Opinion Form is divided into four sections. Section 1 should be completed by the primary or first physician. Complete all fields.

The patient should then take the form to the second physician who completes Section 2. *A second opinion must be obtained within 60 days after the first opinion.* The 60-day period begins with the appointment date shown in Section 1 and ends with the appointment date shown in Section 2.

If the second physician does *not* agree with the primary physician and the patient wants a third opinion, then Section 3 should be completed by a third physician. *The third opinion must be obtained within 60 days of the second opinion.* Again, the appointment dates in Section 2 and Section 3 are the basis for determining the time period.

The physician who performs the surgery *must* retain the patient’s medical material (history, laboratory data, X-rays, etc.) and the completed Second Surgical Opinion Form. If surgery is performed, Section 4 of the form *must* be completed by the surgeon. *The surgery must be performed within 150 days after the primary recommendation.* The appointment date in Section 1 and the date of surgery in Section 4 are the fields that are reviewed to determine the 150-day period.

The surgeon is responsible for furnishing a copy of the form to the ambulatory surgical center where the surgery was performed. The ambulatory surgical center is required to attach a copy of the completed form to the claim each time one of the surgical procedures identified



Section 14 - Special Documents Requirements

in the MO HealthNet fee schedule that require a second surgical opinion is performed, unless an exemption applies.

14.6 (STERILIZATION) CONSENT FORM

Please refer to Section 10, Family Planning, for complete information regarding sterilizations, including a sample of the official (Sterilization) Consent Form and Section 13.18 for a list of the procedures requiring a (Sterilization) Consent Form.

The (Sterilization) Consent Form *must* be attached to every claim for a sterilization-related procedure (surgeon, assistant surgeon, anesthesiologist, ambulatory surgical center). Legible copies are also accepted.

14.6.A EXCEPTIONS TO THE (STERILIZATION) CONSENT FORM REQUIREMENT

14.6.A(1) Premature Delivery or Emergency Abdominal Surgery

For those situations involving premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form, the lower right hand portion of the (Sterilization) Consent Form *must* be completed indicating the circumstances.

14.6.A(2) Other

An operative report *must* be attached to all claims containing one of the procedures requiring a (Sterilization) Consent Form but which does *not* render the participant sterile; i.e., oophorectomy, unilateral.

An operative report that fully documents the situation is also required in the following situations:

- When a claim is submitted containing one of the procedures, but the participant was already sterile at the time the procedure was performed.
- For non-voluntary emergency situations requiring surgery that results in sterilization.

END OF SECTION

[TOP OF PAGE](#)