

# STATE OF MISSOURI



# DENTAL MANUAL



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## SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

### 1.1 INDIVIDUALS ELIGIBLE FOR MO HEALTHNET, MANAGED CARE OR STATE FUNDED BENEFITS

MO HealthNet benefits are available to individuals who are determined eligible by the local Family Support Division (FSD) office. Each eligibility group or category of assistance has its own eligibility determination criteria that *must* be met. Some eligibility groups or categories of assistance are subject to Day Specific Eligibility and some are *not* (refer to Section 1.6.A).

#### 1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

The following list includes a simple description and applicable ME codes for all categories of assistance:

##### 1.1.A(1) MO HealthNet

| ME CODE                        | DESCRIPTION   |
|--------------------------------|---|
| 01, 04, 11, 12, 13, 14, 15, 16 | Elderly, blind and disabled individuals who meet the MO HealthNet eligibility criteria in the community or a vendor facility; or receive a Missouri State Supplemental Conversion or Supplemental Nursing Care check.             |
| 03                             | Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.  |
| 55                             | Individuals who qualify to have their Medicare Part B Premiums paid by the state. These individuals are eligible for reimbursement of their Medicare deductible coinsurance and copay amounts only for Medicare covered services. |
| 18, 43, 44, 45, 61             | Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.  |
| 10, 19, 21, 24, 26             | Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.  |

|            |   |
|------------|---|
| 23, 41     | Children in a Nursing Facility/ICF/MR.  |
| 28, 49, 67 | Children placed in foster homes or residential care by DMH.   |
| 33, 34     | Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.  |
| 81         | Temporary medical eligibility code. Used for individuals reinstated to MHF for 3 months (January-March, 2001), due to loss of MO HealthNet coverage when their TANF cases closed between December 1, 1996 and February 29, 2000. Used for White v. Martin participants and used for BCCT. |
| 83         | Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility.  |
| 84         | Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT).  |
| 85         | Ticket to Work Health Assurance Program (TWHAP) participants--premium   |
| 86         | Ticket to Work Health Assurance Program (TWHAP) participants--non-premium   |

### **1.1.A(2) MO HealthNet for Kids**

| ME CODE | DESCRIPTION   |
|---------|---|
| 05, 06  | Eligible children under the age of 19 in MO HealthNet for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional MO HealthNet. |
| 60      | Newborns (infants under age 1 born to a MO HealthNet or managed care participant).  |

- 40, 62 Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.
- 07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70 Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.
- 36, 56 Children who receive a federal adoption subsidy payment.
- 71, 72 Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)
- 73 Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
- 74 Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
- 75 Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families *must* pay a monthly premium. There is a premium.



87 Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.

**1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP)**

ME CODE DESCRIPTION

58 Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility.

59 Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did *not* qualify for regular MO HealthNet benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter.

NOTE: Providers should encourage women with a TEMP card to apply for regular MO HealthNet.

**1.1.A(4) Voluntary Placement Agreement for Children**

ME CODE DESCRIPTION

88 Children seventeen (17) years of age or younger in need of mental health treatment whose parent, legal guardian or custodian has signed an out-of-home care Voluntary Placement Agreement (VPA) with the Department of Social Services (DSS) Children's Division.

**1.1.A(5) State Funded MO HealthNet**

ME CODE DESCRIPTION



- 02 Individuals who receive a Blind Pension check.
- 08 Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state funded foster care.
- 52 Children who are in the custody of the Division of Youth Services (DYS-GR) who do *not* meet MO HealthNet for Kids non-CHIP criteria. (NOTE: GR in this instance means general revenue as services are provided by all state funds. Services are *not* restricted.)
- 57 Children who receive a state only adoption subsidy payment.
- 64 Children who are in the custody of Juvenile Court who do *not* qualify for federally matched MO HealthNet under ME codes 30, 69 or 70.
- 65 Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.

**1.1.A(6) MO Rx**

| ME CODE | DESCRIPTION  |
|---------|--|
| 82      | Participants only have pharmacy Medicare Part D wrap-around benefits through the MoRx. |

**1.1.A(7) Women's Health Services**

| ME CODE | DESCRIPTION |
|---------|-------------|
|---------|-------------|



- 80 Uninsured women, ages 18 through 55, who do *not* qualify for other benefits, and lose their MO HealthNet for Pregnant Women eligibility 60 days after the birth of their child, will continue to be eligible for family planning and limited testing and treatment of Sexually Transmitted Diseases for up to one (1) year if the family income is at or below 196% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.
- 89 Women's Health Services Program provides family planning and limited testing and treatment of Sexually Transmitted Diseases to women, ages 18 through 55, who have family income at or below 201% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.

#### **1.1.A(8) ME Codes Not in Use**

The following ME codes are *not* currently in use:

09, 17, 20, 22, 25, 27, 31, 32, 35, 39, 42, 46, 47, 48, 51, 53, 54, 76, 77, 78, 79

## **1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD**

The Department of Social Services issues a MO HealthNet ID card for each MO HealthNet or managed care eligible participant. For example, the eligible caretaker and each eligible child receives his/her own ID card. Providers *must* use the card that corresponds to each individual/child to verify eligibility and determine any other pertinent information applicable to the participant. Participants enrolled in a MO HealthNet managed health care plan also receive an ID card from the



managed health care plan. (Refer to Section 1.2.C for a listing of MO HealthNet/MO HealthNet Managed Care Eligibility (ME) codes identifying which individuals are to receive services on a fee-for-service basis and which individuals are eligible to enroll in a managed health care plan.

*An ID card does **not** show eligibility dates or any other information regarding restrictions of benefits or Third Party Resource (TPR) information. Providers must verify the participant's eligibility status before rendering services as the ID card only contains the participant's identifying information (ID number, name and date of birth). As stated on the card, *holding the card does not certify eligibility or guarantee benefits.**

The local Family Support Division (FSD) office issues an approval letter for each individual or family at the time of approval to be used in lieu of the ID card until the permanent ID card can be mailed and received by the participant. The card should normally be received within a few days of the Eligibility Specialist's action. Replacement letters are also furnished when a card has been lost, destroyed or stolen until an ID card is received in the mail. Providers may accept these letters to verify the participant's ID number.

The card carrier mailer notifies participants *not* to throw the card away as they will *not* receive a new ID card each month. The participant *must* keep the ID card for as long as the individual named on the card qualifies for MO HealthNet or managed care. Participants who are eligible as spenddown participants are encouraged to keep the ID card to use for subsequent spenddown periods. Replacement cards are issued whenever necessary as long as the participant remains eligible.

Participants receive a new ID card within a few days of the Eligibility Specialist's action under the following circumstances:

- The participant is determined eligible or regains eligibility;
- The participant has a name change;
- A file correction is made to a date of birth which was invalid at time of card issue; or
- The participant reports a card as lost, stolen or destroyed.

### **1.2.A FORMAT OF MO HEALTHNET ID CARD**

The plastic MO HealthNet ID card will be red if issued prior to January 1, 2008 or white if issued on or after January 1, 2008. Each card contains the participant's name, date of birth and MO HealthNet ID number. The reverse side of the card contains basic information and the Participant Services Hotline number.

*An ID card does not guarantee benefits. It is important that the provider always check eligibility and the MO HealthNet/Managed Care Eligibility (ME) code on file for the date of service. The ME code helps the provider know program benefits and limitations including copay requirements.*



## **1.2.B ACCESS TO ELIGIBILITY INFORMATION**

Providers *must* verify eligibility via the Internet or by using the interactive voice response (IVR) system by calling (576) 751-2896 and keying in the participant ID number shown on the face of the card. Refer to Section 3 for information regarding the Internet and the IVR inquiry process.

Participants may be subject to Day Specific Eligibility. Refer to Section 1.6.A for more information.

## **1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES**

### **1.2.C(1) MO HealthNet Participants**

The following ME codes identify people who get a MO HealthNet approval letter and MO HealthNet ID card:

01, 02, 03, 04, 11, 12, 13, 14, 15, 16, 23, 28, 33, 34, 41, 49, 55, 67, 83, 84, 89

### **1.2.C(2) MO HealthNet Managed Care Participants**

MO HealthNet Managed Care refers to:

- some adults and children who used to get a MO HealthNet ID card
- people eligible under the MO HealthNet for Kids (SCHIP) and the uninsured parent's program
- people enrolled in a MO HealthNet managed care health plan\*

The following ME codes identify people who get a MO HealthNet Managed Care health insurance approval letter and MO HealthNet Managed Care ID Card

05, 06, 07, 08, 10, 18, 19, 21, 24, 26, 29, 30, 36, 37, 40, 43, 44, 45, 50, 52, 56, 57, 60, 61, 62, 63, 64, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75

\*An individual may be eligible for managed care and *not* be in a MO HealthNet managed care health plan because they do *not* live in a managed care health plan area. Individuals enrolled in MO HealthNet Managed Care also get a MO HealthNet Managed Care health plan card issued by the managed care health plan. Refer to Section 11 for more information regarding Missouri's managed care program.

### **1.2.C(3) TEMP**

A pregnant woman who has *not* applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits during pregnancy. The following ME codes identify people who have TEMP eligibility:

58, 59

#### **1.2.C(4) Temporary Medical Eligibility for Reinstated TANF Individuals**

Individuals who stopped getting a Temporary Assistance for Needy Families (TANF) cash grant between December 1, 1996 and February 29, 2000 and lost their MO HealthNet/MO HealthNet Managed Care benefits had their medical benefits reinstated for three months from January 1, 2001 to March 31, 2001.

ME code 81 identifies individuals who received an eligibility letter from the Family Support Division. These individuals are *not* enrolled in a MO HealthNet managed care health plan.

#### **1.2.C(5) Presumptive Eligibility for Children**

Children in families with income below 150% of the Federal Poverty Level (FPL) determined eligible for MO HealthNet benefits prior to having a formal eligibility determination completed by the Family Support Division (FSD) office. The families receive a MO HealthNet for Kids Presumptive Eligibility Authorization (PC-2) notice which includes the MO HealthNet for Kids number(s) and effective date of coverage.

ME code 87 identifies children determined eligible for Presumptive Eligibility for Children.

#### **1.2.C(6) Breast or Cervical Cancer Treatment Presumptive Eligibility**

Women determined eligible by the Department of Health and Senior Services' Breast and Cervical Cancer Control Project (BCCCCP) or the Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility (PE) Program receive a BCCT Temporary MO HealthNet Authorization letter which provides for limited MO HealthNet benefits while they wait for a formal eligibility determination by the FSD.

ME code 83 identifies women receiving benefits through BCCT PE.

#### **1.2.C(7) Voluntary Placement Agreement**

Children determined eligible for out-of-home care, per a signed Voluntary Placement Agreement (VPA), require medical planning and are eligible for a variety of children's treatment services, medical and psychiatric services. The Children's Division (CD) worker makes appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates.



ME code 88 identifies children receiving coverage under a VPA.

### **1.2.D THIRD PARTY INSURANCE COVERAGE**

When the MO HealthNet Division (MHD) has information that the participant has third party insurance coverage, the relationship code and the full name of the third party coverage are identified. The address information can be obtained through emomed. A provider *must* always bill the other insurance before billing MO HealthNet unless the service qualifies as an exception as specified in Section 5. For additional information, contact Provider Communications at (573) 751-2896 or the TPL Unit at (573) 751-2005.

NOTE: The provider *must* always ask the participant if they have third party insurance regardless of information on the participant file. *It is the provider's responsibility to obtain from the participant the name and address of the insurance company, the policy number, policy holder and the type of coverage.* See Section 5, Third Party Liability.

#### **1.2.D(1) Medicare Part A, Part B and Part C**

The eligibility file (IVR/Internet) provides an indicator if the MO HealthNet Division has information that the participant is eligible for Medicare Part A, Part B and/or Medicare Part C.

NOTE: The provider *must* always ask the participant if they have Medicare coverage, regardless of information on the participant file. It is also important to identify the participant's type of Medicare coverage. Part A provides for nursing home, inpatient hospital and certain home health benefits; Part B provides for medical insurance benefits; and Part C provides the services covered under Part A and Part B through a Medicare Advantage Plan (private companies approved by Medicare). When MO HealthNet is secondary to Medicare Part C, a crossover claim for coinsurance, deductible and copay may be reimbursed for participants who have MO HealthNet QMB (reference Section 1.5.E). For non-QMB participants enrolled in a Medicare Advantage/Part C Plan, MO HealthNet secondary claims will process in accordance with the established MHD coordination of benefits policy (reference Section 5.1.A).

### **1.3 MO HEALTHNET, STATE FUNDED MEDICAL ASSISTANCE AND MO HEALTHNET MANAGED CARE APPLICATION PROCESS**

If a patient who has *not* applied for MO HealthNet, state funded Medical Assistance or MO HealthNet Managed Care benefits is unable to pay for services rendered and appears to meet eligibility requirements, the provider should encourage the patient or the patient's representative (related or unrelated) to apply for benefits through the Family Support Division in the patient's

county of residence. Information can also be obtained by calling the FSD Call Center at (855) 373-4636. Applications for MO HealthNet Managed Care may be requested by phone by calling (888) 275-5908. The county office accepts and processes the application and notifies the patient of the resulting determination.

Any individual authorized by the participant may make application for MO HealthNet Managed Care, MO HealthNet and other state funded Medical Assistance on behalf of the client. This includes staff members from hospital social service departments, employees of private organizations or companies, and any other individual designated by the client. Clients *must* authorize non-relative representatives to make application for them through the use of the IM Authorized Representative form. A supply of this form and instructions for completion may be obtained from the Family Support Division county office.

#### **1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN**

A child born to a woman who is eligible for and is receiving MO HealthNet or under a federally funded program on the date the child is born is automatically eligible for MO HealthNet. Federally funded MO HealthNet programs that automatically cover newborn children are MO HealthNet for Families, Pregnant Women, Supplemental Nursing Care, Refugee, Supplemental Aid to the Blind, Supplemental Payments, MO HealthNet for Children in Care, Children's Health Insurance Program, and Uninsured Parents.

Coverage begins on the date of birth and extends through the date the child becomes one year of age as long as the mother remains continuously eligible for MO HealthNet or who would remain eligible if she were still pregnant and the child continues to live with the mother.

Notification of the birth should be sent immediately by the mother, physician, nurse-midwife, hospital or managed care health plan to the Family Support Division office in the county in which the mother resides and should contain the following information:

- The mother's name and MO HealthNet or Managed Care ID number
- The child's name, birthdate, race, and sex
- Verification of birth.

If the mother notifies the Family Support Division office of the birth, that office verifies the birth by contacting the hospital, attending physician, or nurse-midwife.

The Family Support Division office assigns a MO HealthNet ID number to the child as quickly as possible and gives the ID number to the hospital, physician, or nurse-midwife. Family Support Division staff works out notification and verification procedures with local hospitals.

The Family Support Division office explores the child's eligibility for other types of assistance beyond the newborn policy. However, the eligibility determination for another type of assistance does *not* delay or prevent the newborn from being added to the mother's case when the Family Support Division staff is notified of the birth.

#### **1.4.A NEWBORN INELIGIBILITY**

The automatic eligibility for newborns is *not* available in the following situations:

- The mother is eligible under the Blind Pension (state-funded) category of assistance.
- The mother has a pending application for assistance but is *not* receiving MO HealthNet at the time of the child's birth.
- The mother has TEMP eligibility, which is *not* considered regular MO HealthNet eligibility. If the mother has applied for and has been approved for a federally funded type of assistance at the time of the birth, however, the child is automatically eligible.
- MO HealthNet spenddown: if the mother's spenddown amount has *not* been met on the day of the child's birth, the child is *not* automatically eligible for MO HealthNet. If the mother has met her spenddown amount prior to or on the date of birth, the child is automatically eligible. Once the child is determined automatically eligible, they remain eligible, regardless of the mother's spenddown eligibility.
- Emergency Medical Care for Ineligible Aliens: The delivery is covered for the mother, however the child is *not* automatically eligible. An application *must* be filed for the newborn for MO HealthNet coverage and *must* meet CHIP or non-CHIP eligibility requirements.
- Women covered by the Extended Women's Health Services Program.

#### **1.4.B NEWBORN ADOPTION**

MO HealthNet coverage for an infant whose birth mother intends to relinquish the child continues from birth until the time of relinquishment if the mother remains continuously eligible for MO HealthNet or would if still pregnant during the time that the child continues to live with the mother. This includes the time period in which the child is in the hospital, unless removed from mother's custody by court order.

#### **1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT**

The managed care health plan *must* have written policies and procedures for enrolling the newborn children of program members effective to the time of birth. Newborns of program eligible mothers who were enrolled at the time of the child's birth are automatically enrolled with the mother's managed care health plan. The managed care health plan should have a

procedure in place to refer newborns to an enrollment counselor or Family Support Division to initiate eligibility determinations or enrollment procedures as appropriate. A mother of a newborn may choose a different managed care health plan for her child; unless a different managed care health plan is requested, the child remains with the mother's managed care health plan.

- Newborns are enrolled with the mother's managed care health plan unless a different managed care health plan is specified.
- The mother's managed care health plan shall be responsible for all medically necessary services provided under the standard benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one. When the newborn is assigned an ID number, the managed care health plan shall provide services to the child until the child is disenrolled from the managed care health plan. The managed care health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the managed care health plan.
- If there is an administrative lag in enrolling the newborn and costs are incurred during that period, it is essential that the participant be held harmless for those costs. The managed care health plan is responsible for the cost of the newborn.

## **1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS**

Participants may have restricted or limited benefits, be subject to administrative lock-in, be managed care enrollees, be hospice beneficiaries or have other restrictions associated with their category of assistance.

*It is the provider's responsibility to determine if the participant has restricted or limited coverage. Restrictions can be added, changed or deleted at any time during a month. The following information is furnished to assist providers to identify those participants who may have restricted/limited benefits.*

### **1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE**

Senate Bill 539 was passed by the 93rd General Assembly and became effective August 28, 2005. Changes in MO HealthNet Program benefits were effective for dates of service on or after September 1, 2005. The bill eliminated certain optional MO HealthNet services for individuals age 21 and over that are eligible for MO HealthNet under one of the following categories of assistance:

| ME CODE | DESCRIPTION |
|---------|-------------|
|---------|-------------|



|    |  |
|----|--|
| 01 | MO HealthNet for the Aged  |
| 04 | Permanently and Totally Disabled (APTD)                              |
| 05 | MO HealthNet for Families - Adult (ADC-AD)                           |
| 10 | Vietnamese or Other Refugees (VIET)                                  |
| 11 | MO HealthNet - Old Age (MHD-OAA)                                     |
| 13 | MO HealthNet - Permanently and Totally Disabled (MHD-PTD)            |
| 14 | Supplemental Nursing Care - MO HealthNet for the Aged                |
| 16 | Supplemental Nursing Care - PTD (NC-PTD)                             |
| 19 | Cuban Refugee  |
| 21 | Haitian Refugee  |
| 24 | Russian Jew  |
| 26 | Ethiopian Refugee  |
| 83 | Presumptive Eligibility - Breast or Cervical Cancer Treatment (BCCT) |
| 84 | Regular Benefit - Breast or Cervical Cancer Treatment (BCCT)         |
| 85 | Ticket to Work Health Assurance Program (TWHAP) --premium            |
| 86 | Ticket to Work Health Assurance Program (TWHAP) -- non-premium       |

MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package. Providers should refer to Section 13 of the applicable provider manual for specific restrictions or guidelines.

- Comprehensive Day Rehabilitation
- Dental Services
- Diabetes Self-Management Training Services
- Hearing Aid Program
- Home Health Services
- Outpatient Therapy
- Physician Rehabilitation Services
- Podiatry Services

NOTE: MO HealthNet participants residing in nursing homes are able to use their surplus to pay for federally mandated medically necessary services. This may be done by adjudicating claims through the MO HealthNet claims processing system to ensure best price, quality, and program integrity. MO HealthNet participants receiving home health services receive all



federally mandated medically necessary services. MO HealthNet children and those in the assistance categories for pregnant women or blind participants are *not* affected by these changes.

### **1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN**

Some MO HealthNet participants are restricted or locked-in to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. When the participant has an administrative lock-in provider, the provider's name and telephone number are identified on the Internet or IVR when verifying eligibility.

Payment of services for a locked-in participant is *not* made to unauthorized providers for other than emergency services or authorized referral services. Emergency services are only considered for payment if the claim is supported by medical records documenting the emergency circumstances.

When a physician is the designated/authorized provider, they are responsible for the participant's primary care and for making necessary referrals to other providers as medically indicated. When a referral is necessary, the authorized physician *must* complete a Medical Referral Form of Restricted Participant (PI-118) and send it to the provider to whom the participant is referred. *This referral is good for 30 days only* from the date of service. This form *must* be mailed or submitted via the Internet (Refer to Section 23) by the unauthorized provider. The Referred Service field should be completed on the claim form. These referral forms are available on the Missouri Medicaid Audit and Compliance (MMAC) website at [www.MMAC.MO.GOV](http://www.MMAC.MO.GOV) or from MMAC, Provider Review & Lock-In Section, P.O. Box 6500, Jefferson City, Missouri 65102.

If a participant presents an ID card that has administrative lock-in restrictions to other than the authorized provider and the service is *not* an emergency, an authorized referral, or if a provider feels that a participant is improperly using benefits, the provider is requested to notify MMAC Provider Review, P.O. Box 6500, Jefferson City, Missouri 65102.

### **1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS**

Participants who are enrolled in MO HealthNet's Managed Care programs are identified on the Internet or IVR when verifying eligibility. The response received identifies the name and phone number of the participant's selected managed care health plan. The response also includes the identity of the participant's primary care provider in the managed care program areas. Participants who are eligible for MO HealthNet and who are enrolled with a managed care health plan *must* have their basic benefit services provided by or prior authorized by the managed care health plan.

MO HealthNet Managed Care health plans may also issue their own individual health plan ID cards. The individual *must* be eligible for MO HealthNet and enrolled with the managed



care health plan on the date of service for the managed care health plan to be responsible for services. MO HealthNet eligibility dates are different from managed care health plan enrollment dates. Managed care enrollment can be effective on any date in a month. Sometimes a participant may change managed care health plans and be in one managed care health plan for part of the month and another managed care health plan for the remainder of the month. Managed care health plan enrollment can be verified by the IVR/Internet.

Providers *must* verify the eligibility status including the participant's ME code and managed care health plan enrollment status on all MO HealthNet participants before providing service.

The following information is provided to assist providers in determining those participants who are eligible for inclusion in MO HealthNet Managed Care Programs. The participants who are eligible for inclusion in the health plan are divided into five groups.\* Refer to Section 11 for a listing of included counties and the managed care benefits package.

- Group 1 and 2 have been combined and are referred to as Group 1. Group 1 generally consists of the MO HealthNet for Families population (both the caretaker and child[ren]), the children up to age 19 of families with income under the applicable poverty standard, Refugee MO HealthNet participants and pregnant women. NOTE: Previous policy stated that participants over age 65 were exempt from inclusion in managed care. There are a few individuals age 65 and over who are caretakers or refugees and who do *not* receive Medicare benefits and are therefore included in managed care.

The following ME codes fall into Group 1: 05, 06, 10, 18, 19, 21, 24, 26, 40, 43, 44, 45, 60, 61 and 62.

- *Group 3 previously consisting of General Relief participants has been deleted from inclusion in the managed care program at this time.*
- Group 4 generally consists of those children in state care and custody. The following ME codes fall into this group: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70, and 88.
- Group 5 consists of uninsured children.

The following ME codes for uninsured children are included in Group 5: 71, 72, 73, 74 and 75.

\* Participants who are identified as eligible for inclusion in the managed care program are *not* enrolled with a managed care health plan until 15 days after they actually select or are assigned to a managed care health plan. When the selection or assignment is in effect, the name of the managed care health plan appears on the IVR/Internet information. If a managed care health plan name does *not* appear for a particular date of service, the participant is in a fee-for-service status for each date of service that a managed care health plan is *not* listed for the participant.

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the managed care program because they receive SSI disability payments, who meet the SSI disability definition as determined by the Department of Social Services, or who receive adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the managed care program. The option is entirely up to the

participant, parent or guardian.

### **1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program**

If a managed care health plan member elects a home birth, the member may be disenrolled from the managed care program at the request of the managed care health plan. The disenrolled member then receives all services through the fee-for-service program.

The member remains disenrolled from the managed care health plan if eligible under the MO HealthNet for Pregnant Women category of assistance. If the member is *not* in the MO HealthNet for Pregnant Women category and is disenrolled for the home birth, she is enrolled/re-enrolled in a managed care health plan six weeks post-partum or after a hospital discharge, whichever is later. The baby is enrolled in a managed care health plan once a managed care health plan number is assigned or after a hospital discharge, whichever is later.

### **1.5.D HOSPICE BENEFICIARIES**

MO HealthNet participants *not* enrolled with a managed care health plan who elect hospice care are identified as such on the Internet or IVR. The name and telephone number of the hospice provider is identified on the Internet or IVR.

Hospice care is palliative *not* curative. It focuses on pain control, comfort, spiritual and emotional support for a terminally ill patient and his or her family. To receive MO HealthNet covered hospice services the participant *must*:

- be eligible for MO HealthNet on all dates of service;
- be certified by two physicians (M.D. or D.O.) as terminally ill and as having less than six months to live;
- elect hospice services and, if an adult, waive active treatment for the terminal illness; and
- obtain all services related to the terminal illness from a MO HealthNet-participating hospice provider, the attending physician, or through arrangements by the hospice.

When a participant elects the hospice benefit, the hospice assumes the responsibility for managing the participant's medical care related to the terminal illness. The hospice provides or arranges for services reasonable and necessary for the palliation or management of the terminal illness and related conditions. This includes all care, supplies, equipment and medicines.

Any provider, other than the attending physician, who provides care related to the terminal illness to a hospice participant, *must* contact the hospice to arrange for payment. MO



HealthNet reimburses the hospice provider for covered services and the hospice reimburses the provider of the service(s).

For adults age 21 and over, curative or active treatment of the terminal illness is *not* covered by the MO HealthNet Program while the patient is enrolled with a hospice. If the participant wishes to resume active treatment, they *must* revoke the hospice benefit for MO HealthNet to provide reimbursement of active treatment services. The hospice is reimbursed for the date of revocation. MO HealthNet does *not* provide reimbursement of active treatment until the day following the date of revocation. Children under the age of 21 may continue to receive curative treatment services while enrolled with a hospice.

Services *not* related to the terminal illness are available from any MO HealthNet-participating provider of the participant's choice. Claims for these services should be submitted directly to Wipro Infocrossing.

Refer to the Hospice Manual, Section 13 for a detailed discussion of hospice services.

### **1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)**

To be considered a QMB an individual *must*:

- be entitled to Medicare Part A
- have an income of less than 100% of the Federal Poverty Level
- have resources of less than \$4000 (or no more than \$6000 if married)

Participants who are eligible only as a Qualified Medicare Beneficiary (QMB) are eligible for reimbursement of their Medicare deductible, coinsurance and copay amounts only for Medicare covered services whether or not the services are covered by MO HealthNet. QMB-only participants are *not* eligible for MO HealthNet services that are *not* generally covered by Medicare. When verifying eligibility, QMB-only participants are identified with an ME code 55 when verifying eligibility.

Some participants who are eligible for MO HealthNet covered services under the MO HealthNet or MO HealthNet spenddown categories of assistance may also be eligible as a QMB participant and are identified on the IVR/Internet by a QMB indicator "Y." If the participant has a QMB indicator of "Y" and the ME code is *not* 55 the participant is also eligible for MO HealthNet services and *not* restricted to the QMB-only providers and services.

QMB coverage includes the services of providers who by choice do *not* participate in the MO HealthNet Program and providers whose services are *not* currently covered by MO HealthNet but who are covered by Medicare, such as chiropractors and independent therapists. Providers who do *not* wish to enroll in the MO HealthNet Program for MO HealthNet participants and providers of Medicare-only covered services may enroll as QMB-



only providers to be reimbursed for deductible, coinsurance, and copay amounts only for QMB eligibles. Providers who wish to be identified as QMB-only providers may contact the Provider Enrollment Unit via their e-mail address: [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

Providers who are enrolled with MO HealthNet as QMB-only providers need to ascertain a participant's QMB status in order to receive reimbursement of the deductible and coinsurance and copay amounts for QMB-only covered services.

#### **1.5.F WOMEN'S HEALTH SERVICES PROGRAM (ME CODES 80 and 89)**

The Women's Health Services Program provides family planning and family planning-related services to low income women, ages 18 through 55, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), Medicare, or health insurance that provides family planning services.

Women who have been sterilized are not eligible for the Women's Health Services Program. Women who are sterilized while participating in the Women's Health Services Program become ineligible 90 days from the date of sterilization.

Services for ME codes 80 and 89 are limited to family planning and family planning-related services, and testing and treatment of Sexually Transmitted Diseases (STDs) which are provided in a family planning setting. Services include:

- approved methods of birth control including sterilization and x-ray services related to the sterilization
- family planning counseling and education on birth control options
- testing and treatment for Sexually Transmitted Diseases (STDs)
- pharmacy, including birth control devices & pills, and medication to treat STDs
- Pap Test and Pelvic Exams

All services under the Women's Health Services Program must be billed with a primary diagnosis code within the ranges of Z30.011-Z30.9.

#### **1.5.G TEMP PARTICIPANTS**

The purpose of the Temporary MO HealthNet During Pregnancy (TEMP) Program is to provide pregnant women with access to *ambulatory prenatal care* while they await the formal determination of MO HealthNet eligibility. Certain qualified providers, as determined by the Family Support Division, may issue TEMP cards. These providers have the responsibility for making limited eligibility determinations for their patients based on preliminary information that the patient's family income does *not* exceed the applicable MO HealthNet for Pregnant Women income standard for a family of the same size.



If the qualified provider makes an assessment that a pregnant woman is eligible for TEMP, the qualified provider issues her a white paper temporary ID card. The participant may then obtain ambulatory prenatal services from any MO HealthNet-enrolled provider. If the woman makes a formal application for MO HealthNet with the Family Support Division during the period of TEMP eligibility, her TEMP eligibility is extended while the application is pending. If application is *not* made, the TEMP eligibility ends in accordance with the date shown on the TEMP card.

Infants born to mothers who are eligible under the TEMP Program are *not* automatically eligible for MO HealthNet benefits. Information regarding automatic MO HealthNet Eligibility for Newborn Children is addressed in this manual.

Providers and participants can obtain the name of MO HealthNet enrolled Qualified Providers in their service area by contacting the local Family Support Division Call Center at (855) 373-4636. Providers may call Provider Relations at (573) 751-2896 and participants may call Participant Services at (800) 392-2161 for questions regarding TEMP.

#### **1.5.G(1) TEMP ID Card**

Pregnant women who have been determined presumptively eligible for Temporary MO HealthNet During Pregnancy (TEMP) do *not* receive a plastic MO HealthNet ID card but receive a white paper TEMP card. A valid TEMP number begins with the letter "P" followed by seven (7) numeric digits. The 8-character temporary number should be entered in the appropriate field of the claim form until a permanent number is issued to the participant. The temporary number appearing on the claim form is converted to the participant's permanent MO HealthNet identification number during claims processing and the permanent number appears on the provider's Remittance Advice. Providers should note the new number and file future claims using the permanent number.

A white paper TEMP card can be issued by qualified providers to *pregnant* women whom they presume to be eligible for MO HealthNet based on income guidelines. A TEMP card is issued for a limited period but presumptive eligibility may be extended if the pregnant woman applies for public assistance at the county Family Support Division office. The TEMP card may only be used for ambulatory prenatal services. Because TEMP services are limited, providers should verify that the service to be provided is covered by the TEMP card.

The start date (FROM) is the date the qualified provider issues the TEMP card, and coverage expires at midnight on the expiration date (THROUGH) shown. A TEMP replacement letter (IM-29 TEMP) may also be issued when the TEMP individual has formally applied for MO HealthNet and is awaiting eligibility determination.

Third party insurance information does *not* appear on a TEMP card.

### **1.5.G(2) TEMP Service Restrictions**

TEMP services for pregnant women are limited to *ambulatory prenatal services* (physician, clinic, nurse midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services). Risk Appraisals and Case Management Services are covered under the TEMP Program. Services other than those listed above (i.e. dental, ambulance, home health, durable medical equipment, CRNA, or psychiatric services) may be covered with a Certificate of Medical Necessity in the provider's file that testifies that the pregnancy would have been adversely affected without the service. Proof of medical necessity must be retained in the patient's file and be available upon request by the MO HealthNet Division. Inpatient services, including miscarriage or delivery, are *not* covered for TEMP participants.

Other noncovered services for TEMP participants include; global prenatal care, postpartum care, contraceptive management, dilation and curettage and treatment of spontaneous/missed abortions or other abortions.

### **1.5.G(3) Full MO HealthNet Eligibility After TEMP**

A TEMP participant may apply for full MO HealthNet coverage and be determined eligible for the complete range of MO HealthNet-covered services. Regular MO HealthNet coverage may be backdated and may or may not overlap the entire TEMP eligibility period. Approved participants receive an approval letter that shows their eligibility and type of assistance coverage. These participants also receive an ID card within a few days of approval. The services that are *not* covered under the TEMP Program may be resubmitted under the new type of assistance using the participant's MO HealthNet identification number instead of the TEMP number. The resubmitted claims are then processed without TEMP restrictions for the dates of service that were *not* included under the TEMP period of eligibility.

### **1.5.H PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

Missouri and the Centers for Medicare & Medicaid (CMS) have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St. Louis. PACE is an integrated service system that includes primary care, restorative therapy, transportation, home health care, inpatient acute care, and even long-term care in a nursing facility when home and community-based services are no longer appropriate. Services are provided in the PACE center, the home, or the hospital, depending upon the needs of the individual. Refer to Section 11.11.E.

The target population for this program includes individuals age 55 and older, who are identified by the Missouri Department of Health and Senior Services, Division of Senior Services and Regulation through a health status assessment with specific types of eligibility categories and at least 21 points on the nursing home level of care assessment. These targeted individuals *must* reside in the St. Louis area within specific zip codes. Refer to Section 11.11.A.

Lock-in information is available to providers through the Internet or Interactive Voice Response (IVR). Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time. Refer to Section 11.11.D.

### **1.5.I MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT**

The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law: 101-354) established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to reduce the morbidity and mortality rates of breast and cervical cancers. The NBCCEDP provides grants to states to carry out activities aimed at early screenings and detection of breast and/or cervical cancer, case management services, education and quality assurance. The Missouri Department of Health and Senior Services, Division of Chronic Disease Prevention and Health Promotion's grant application was approved by the Centers for Disease Control and Prevention (CDC) to provide funding to establish the Missouri Breast and Cervical Cancer Control Project (BCCCP), known as Show Me Healthy Women. Matching funds were approved by the Missouri legislation to support breast and cervical cancer screening and education for low-income Missouri women through the Show Me Healthy Women project. Additional federal legislation was signed allowing funded programs in the NBCCEDP to participate in a new program with the MO HealthNet Breast and Cervical Cancer Treatment (BCCT) Act. State legislation authorized matching funds for Missouri to participate.

Most women who are eligible for Show Me Healthy Women, receive a Show Me Healthy Women-paid screening and/or diagnostic service and are found to need treatment for either breast and/or cervical cancer, are eligible for MO HealthNet coverage. For more information, providers may reference the Show Me Healthy Women Provider Manual at <http://www.dhss.mo.gov/BreastCervCancer/providerlist.pdf>.

#### **1.5.I(1) Eligibility Criteria**

To qualify for MO HealthNet based on the need for BCCT, all of the following eligibility criteria *must* be met:

- Screened by a Missouri BCCCP Provider;



- Need for treatment for breast or cervical cancer including certain pre-cancerous conditions;
- Under the age of 65 years old;
- Have a Social Security Number;
- Citizenship or eligible non-citizen status;
- Uninsured (or have health coverage that does *not* cover breast or cervical cancer treatment);
- A Missouri Resident.

### **1.5.I(2) Presumptive Eligibility**

Presumptive Eligibility (PE) determinations are made by BCCCP MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued and provides for temporary, limited MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment. This allows for minimal delays for women in receiving the necessary treatment. Women receiving coverage under Presumptive Eligibility are assigned ME code 83. PE coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is later.

### **1.5.I(3) Regular BCCT MO HealthNet**

The BCCT MO HealthNet Application *must* be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be approved, if the woman was eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.



#### **1.5.I(4) Termination of Coverage**

MO HealthNet coverage is date-specific for BCCT cases. A date-specific termination can take effect in the future, up to the last day of the month following the month of the closing action.

#### **1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM**

Implemented August 28, 2007, the Ticket to Work Health Assurance Program (TWHAP) eligibility groups were authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) and Missouri Senate Bill 577 (2007). TWHAP is for individuals who have earnings and are determined to be permanently and totally disabled or would be except for earnings. They have the same MO HealthNet fee-for-service benefits package and cost sharing as the Medical Assistance for the Permanently and Totally Disabled (ME code 13). An age limitation, 16 through 64, applies. The gross income ceiling for this program is 300% of the Federal Poverty Level (FPL) for an individual or a Couple. Premiums are charged on a sliding scale based on gross income between 101% - 300% FPL. Additional income and asset disregards apply for MO HealthNet. Proof of employment/self-employment is required. Eligible individuals are enrolled with ME code 85 for premium and ME code 86 for non-premium. Eligibility for the Ticket to Work Health Assurance Program is determined by the Family Support Division.

##### **1.5.J(1) Disability**

An individual must meet the definition of Permanent and Total Disability. The definition is the same as for Medical Assistance (MA), except earnings of the individual are not considered in the disability determination.

##### **1.5.J(2) Employment**

An individual and/or spouse must have earnings from employment or self-employment. There is no minimum level of employment or earnings required. The maximum gross income allowed is 250% of the federal poverty level, excluding any earned income of the worker with a disability between 250 and 300% of the federal poverty level. "Gross income" includes all income of the person and the person's spouse. Individuals with gross incomes in excess of 100% of the federal poverty level shall pay a premium for participation.

##### **1.5.J(3) Premium Payment and Collection Process**

An individual whose computed gross income exceeds 100%, but is not more than 300%, of the FPL must pay a monthly premium to participate in TWHAP. TWHAP premium amounts are based on a formula specified by State statute. On new approvals, individuals in the premium group must select the beginning date of



coverage, which may be as early as the first month of the prior quarter (if otherwise applicable) but no later than the month following approval. If an individual is not in the premium group, coverage begins on the first day of the first month the client is eligible.

Upon approval by Family Support Division, the MO HealthNet Division (MHD) sends an initial Invoice letter, billing the individual for the premium amount for any past coverage selected through the month following approval. Coverage does not begin until the premium payment is received. If the individual does not send in the complete amount, the individual is credited for any full month premium amount received starting with the month after approval and going back as far as the amount of paid premium allows.

Thereafter, MHD sends a Recurring Invoice on the second working day of each month for the next month's premium. If the premium is not received prior to the beginning of the new month, the individual's coverage ends on the day of the last paid month.

MHD sends a Final Recurring Invoice after the individual has not paid for three consecutive months. It is sent in place of the Recurring Invoice, on the second working day of the month for the next month's premium. The Final Recurring Invoice notifies the individual that the case will be closed if a payment is not received by the end of the month.

MHD collects the premiums as they do for the Medical Assistance (MA) Spenddown Program and the managed care program.

#### **1.5.J(4) Termination of Coverage**

MO HealthNet coverage end dates are the same as for the Medical Assistance Program. TWHAP non-premium case end dates are date-specific. TWHAP premium case end dates are not date-specific.

#### **1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN**

The Balanced Budget Act of 1997 (The Act) created Section 1920A of the Social Security Act which gives states the option of providing a period of presumptive eligibility to children when a qualified entity determines their family income is below the state's applicable MO HealthNet or SCHIP limit. This allows these children to receive medical care before they have formally applied for MO HealthNet for Kids. Missouri selected this option and effective March 10, 2003, children under the age of 19 may be determined eligible for benefits on a temporary basis prior to having a formal eligibility determination completed.

Presumptive eligible children are identified by ME code 87. These children receive the full range of MO HealthNet for Kids covered services subject to the benefits and limitations specified in each MO HealthNet provider manual. These children are *NOT* enrolled in managed care health plans but receive all services on a fee-for-service basis as long as they are eligible under ME code 87.

### **1.5.K(1) Eligibility Determination**

The Act allows states to determine what type of Qualified Entities to use for Presumptive Eligibility determinations. Currently, Missouri is limiting qualified entities to children's hospitals. Designated staff of qualified entities makes Presumptive Eligibility determinations for children by determining the family meets the income guidelines and contacting the MO HealthNet for Kids Phone Centers to obtain a MO HealthNet number. The family is then provided with a MO HealthNet Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers *must* check eligibility as for any client. Coverage for each child under ME code 87 continues until the last day of the second month of Presumptive Eligibility, unless the Family Support Division determines eligibility or ineligibility for MO HealthNet for Kids prior to that day. Presumptive Eligibility coverage ends on the date the child is approved or rejected for a regular MO HealthNet Program. Presumptive Eligibility is limited to one period during a rolling 12 month period.

Qualified entities making temporary eligibility determinations for children facilitate a formal application for MO HealthNet for Kids. Children who are then determined by the Family Support Division to be eligible for MO HealthNet for Kids are placed in the appropriate MO HealthNet eligibility category (ME code), and are subsequently enrolled with a MO HealthNet Managed Care health plan if residing in a managed care health plan area and under ME codes enrolled with managed care health plans.

### **1.5.K(2) MO HealthNet for Kids Coverage**

Children determined presumptively eligible for MO HealthNet for Kids receive the same coverage during the presumptive period. The children active under Presumptive Eligibility for Children are *not* enrolled in managed care. While the children *must* obtain their presumptive determination from a Qualified Entity (QE), once eligible, they can obtain covered services from any enrolled MO HealthNet fee-for-service provider. Coverage begins on the date the QE makes the presumptive eligibility determination and coverage ends on the later of:



- the 5th day after the Presumptive Eligibility for Children determination date;
- the day a MO HealthNet for Kids application is approved or rejected; or
- if no MO HealthNet for Kids application is made, the last date of the month following the month of the presumptive eligibility determination.

A presumptive eligibility period has no effect on the beginning eligibility date of regular MO HealthNet for Kids coverage. Prior quarter coverage may be approved. In many cases the MO HealthNet for Kids begin dates may be prior to the begin date of the presumptive eligibility period.

### **1.5.L MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION**

Changes to eligibility requirements may allow incarcerated individuals (both juveniles and adults), who leave the public institution to enter a medical institution or individuals who are under house arrest, to be determined eligible for temporary MO HealthNet coverage. Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts or terminates the inmate status. Upon an inmate's admittance, the Family Support Division office in the county in which the penal institution is located may take the appropriate type of application for MO HealthNet benefits. The individual, a relative, an authorized representative, or penal institution designee may initiate the application.

When determining eligibility for these individuals, the county Family Support Division office considers all specific eligibility groups, including children, pregnant women, and elderly, blind or disabled, to determine if the individual meets all eligibility factors of the program for which they are qualifying. Although confined to a public institution, these individuals may have income and resources available to them. If an individual is ineligible for MO HealthNet, the application is rejected immediately and the appropriate rejection notice is sent to the individual.

MO HealthNet eligibility is limited to the days in which the individual was an inpatient in the medical institution. Once the individual returns to the penal institution, the county Family Support Division office verifies the actual inpatient dates in the medical institution and determines the period of MO HealthNet eligibility. Appropriate notification is sent to the individual. The approval notice includes the individual's specific eligibility dates and a statement that they are *not* currently eligible for MO HealthNet because of their status as an inmate in a public institution.

Some individuals may require admittance into a long term care facility. If determined eligible, the period of MO HealthNet eligibility is based on the length of inpatient stay in the



long term care facility. Appropriate MO HealthNet eligibility notification is sent to the individual.

### **1.5.L(1) MO HealthNet Coverage Not Available**

Eligibility for MO HealthNet coverage does *not* exist when the individual is an inmate and when the facility in which the individual is residing is a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily to a state or federal prison, jail, detention facility or other penal facility. An individual voluntarily residing in a public institution is *not* an inmate. A facility is a public institution when it is under the responsibility of a government unit, or a government unit exercises administrative control over the facility.

MO HealthNet coverage is *not* available for individuals in the following situations:

- Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial;
- Inmates involuntarily residing at a wilderness camp under governmental control;
- Inmates involuntarily residing in half-way houses under governmental control;
- Inmates receiving care on the premises of a prison, jail, detention center, or other penal setting; or
- Inmates treated as outpatients in medical institutions, clinics or physician offices.

### **1.5.L(2) MO HealthNet Benefits**

If determined eligible by the county Family Support Division office, full or limited MO HealthNet benefits may be available to individuals residing in or under the control of a penal institution in any of the following circumstances:

- Infants living with the inmate in the public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release (except when reporting to a public institution for overnight stay); or
- Individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (for example, transfer to a community residence).



All specific eligibility groups, including children, pregnant women, and elderly, blind or disabled are considered to determine if the individual meets all eligibility factors of the program for which they are applying.

### **1.5.M VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES**

With the 2004 passage of House Bill 1453, the Voluntary Placement Agreement (VPA) was introduced and established in statute. The VPA is predicated upon the belief that no parent should have to relinquish custody of a child solely in order to access clinically indicated mental health services. This is a written agreement between the Department of Social Services (DSS)/Children's Division (CD) and a parent, legal guardian, or custodian of a child under the age of eighteen (18) solely in need of mental health treatment. A VPA developed pursuant to a Department of Mental Health (DMH) assessment and certification of appropriateness authorizes the DSS/CD to administer the placement and out-of-home care for a child while the parent, legal guardian, or custodian of the child retains legal custody. The VPA requires the commitment of a parent to be an active participant in his/her child's treatment

#### **1.5.M(1) Duration of Voluntary Placement Agreement**

The duration of the VPA may be for as short a period as the parties agree is in the best interests of the child, but under no circumstances shall the total period of time that a child remains in care under a VPA exceed 180 days. Subsequent agreements may be entered into, but the total period of placement under a single VPA or series of VPAs shall *not* exceed 180 days without express authorization of the Director of the Children's Division or his/her designee.

#### **1.5.M(2) Covered Treatment and Medical Services**

Children determined eligible for out-of-home care, (ME88), per a signed VPA, are eligible for a variety of children's treatment services, medical and psychiatric services. The CD worker makes the appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates. Providers should contact the local CD staff for payment information.

#### **1.5.M(3) Medical Planning for Out-of-Home Care**

Medical planning for children in out-of-home care is a necessary service to ensure that children receive the needed medical care. The following includes several medical service alternatives for which planning is necessary:

- Routine Medical/Dental Care;



- Human Immunodeficiency Virus (HIV) Screening;
- Emergency and Extraordinary Medical/Dental Care (over \$500.00);
- Children's Treatment Services;
- Medical/Dental Services Program;
- Bureau for Children with Special Health Care Needs;
- Department of Mental Health Services;
- Residential Care;
- Private Psychiatric Hospital Placement; or
- Medical Foster Care.

## 1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

Most participants are eligible for coverage of their services on a fee-for-service basis for those retroactive periods of eligibility from the first of the month of application until approval, or until the effective date of their enrollment in a MO HealthNet managed care health plan. This is often referred to as the period of “backdated eligibility.”

Eligibility for MO HealthNet participants (except ME codes 71, 72, 73, 74, 75 and 89) is from the first day of the month of application through the last day of each subsequent month for which they are eligible unless the individual is subject to the provisions of Day Specific Eligibility. Some MO HealthNet participants may also request and be approved for prior quarter coverage.

Participants with ME codes 71, 72 and 89 are eligible for MO HealthNet benefits from the first day of the month of application and are subject to the provisions of Day Specific Eligibility. Codes 71 and 72 are eligible from date of application. ME Code 80 is Extended Women's Health Care and eligibility begins the beginning of the month following the 60 day post partum coverage period for MPW (if *not* insured).

MO HealthNet for Kids participants with ME codes 73, 74, and 75 who *must* pay a premium for coverage are eligible the later of 30 days after the date of application or the date the premium is paid. The 30 day waiting period does *not* apply to children with special health care needs. Codes 73 and 74 are eligible on the date of application or date premium is paid, whichever is later. Code 75 is eligible for coverage the later of 30 days after date of application or date premium is paid. All three codes are subject to day specific eligibility (coverage ends date case/eligibility is closed).

MO HealthNet participants with ME code 83 are eligible for coverage beginning on the day the BCCCP provider determines the woman is in need of treatment for breast or cervical cancer. Presumptive Eligibility coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is last.



MO HealthNet participants with ME code 84 are eligible for coverage beginning the 1st day of the month of application. Prior quarter coverage may also be approved, if the woman is eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001.

MO HealthNet children with ME code 87 are eligible for coverage during the presumptive period (fee-for-service only). Coverage begins on the date of the presumptive eligibility determination and ends on the later of 5th day after the eligibility determination or the day a MO HealthNet for Kids application is approved or rejected or if no MO HealthNet for Kids application is made, the last day of the month following the month of the presumptive eligibility determination.

For those participants who reside in a MO HealthNet managed care county and are approved for a category of assistance included in MO HealthNet managed care, the reimbursement is fee-for-service or covered services for the period from the date of eligibility until enrollment in a managed care health plan. Once a participant has been notified they are eligible for assistance, they have 15 days to select a managed care health plan or have a managed care health plan assigned for them. After they have selected the managed care health plan, they are *not* actually enrolled in the managed care health plan for another 15 days.

The ID Card is mailed out within a few days of the caseworker's eligibility approval. Participants may begin to use the ID Card when it is received. Providers should honor the approval/replacement/case action letter until a new card is received. MO HealthNet and managed care participants should begin using their new ID Card when it is received.

### **1.6.A DAY SPECIFIC ELIGIBILITY**

Certain MO HealthNet participants are subject to the provisions of Day Specific Eligibility. This means that some MO HealthNet participants lose eligibility at the time of case closure, which may occur anytime in the month. Prior to implementation of Day Specific Eligibility, participants in all categories of assistance retained eligibility through the last date of the month if they were eligible on the first of the month. As of January 1, 1997, this varies for certain MO HealthNet participants.

As with all MO HealthNet services, the participant *must* be eligible on the date of service. When the participant is in a Day Specific Eligibility category of assistance, the provider is *not* able to check eligibility on the Internet or IVR for a future date during the current month of eligibility.

In order to convey to a provider that a participant's eligibility is day specific, the MO HealthNet Division provides a verbal message on the IVR system. The Internet also advises of day specific eligibility.

Immediately following the current statement, "The participant is eligible for service on MONTH, DAY, YEAR through MONTH, DAY, YEAR with a medical eligibility code of

XX,” the IVR says, “This participant is subject to day specific eligibility.” The Internet gives this information in the same way as the IVR.

If neither the Internet nor IVR contains a message that the participant is subject to day specific eligibility, the participant’s eligibility continues through the last day of the current month. Providers are able to check eligibility for future dates for the participants who are *not* subject to day specific eligibility.

It is important to note that the message regarding day specific eligibility is only a reminder to providers that the participant’s type of assistance is such that should his/her eligibility end, it may be at any time during that month. The Internet and IVR will verify the participant’s eligibility in the usual manner.

Providers *must* also continue to check for managed care health plan enrollment for those participant’s whose ME codes and county are included in managed care health plan enrollment areas, because participant’s enrollment or end dates can occur any date within the month.

### **1.6.B SPENDDOWN**

In the MO HealthNet for the Aged, Blind, and Disabled (MHABD) Program some individuals are eligible for MO HealthNet benefits only on the basis of meeting a periodic spenddown requirement. Effective October 1, 2002, eligibility for MHABD spenddown is computed on a monthly basis. If the individual is eligible for MHABD on a spenddown basis, MO HealthNet coverage for the month begins with the date on which the spenddown is met and ends on the last day of that month when using medical expenses to meet spenddown. MO HealthNet coverage begins and ends without the case closing at the end of the monthly spenddown period. The MO HealthNet system prevents payment of medical services used to meet an individual's spenddown amount.

The individual may choose to meet their spenddown by one of the following options:

- submitting incurred medical expenses to their Family Support Division (FSD) Eligibility Specialist; or
- paying the monthly spenddown amount to the MO HealthNet Division (MHD).

Effective July 1, 2012, a participant can meet spenddown by using a combination of incurred expenses and paying the balance to MHD.

Individuals have the option of changing the method in which their spenddown is met each month. A choice is made to either send the payment to MHD or to send bills to the FSD Eligibility Specialist. For those months that the individual does *not* pay-in or submit bills, no coverage is available.



### **1.6.B(1) Notification of Spenddown Amount**

MHD mails a monthly invoice to active spenddown cases on the second working day of each month. The invoice is for the next month's spenddown amount. The invoice gives the participant the option of paying in the spenddown amount to MHD or submitting bills to FSD. The invoice instructs the participant to call the MHD Premium Collections Unit at 1 (877) 888-2811 for questions about a payment.

MHD stops mailing monthly invoices if the participant does *not* meet the spenddown for 6 consecutive months. MHD resumes mailing invoices the month following the month in which the participant meets spenddown by bills or pay-in for the current month or past months.

### **1.6.B(2) Notification of Spenddown on New Approvals**

On new approvals, the FSD Eligibility Specialist *must* send an approval letter notifying the participant of approval for spenddown, but MO HealthNet coverage does *not* begin until the spenddown is met. The letter informs the participant of the spenddown amount and the months for which coverage may be available once spenddown is met. If the Eligibility Specialist has already received bills to meet spenddown for some of the months, the letter includes the dates of coverage for those months.

MHD sends separate invoices for the month of approval and the month following approval. These invoices are sent on the day after the approval decision. Notification of the spenddown amount for the months prior to approval is only sent by the FSD Eligibility Specialist.

### **1.6.B(3) Meeting Spenddown with Incurred and/or Paid Expenses**

If the participant chooses to meet spenddown for the current month using incurred and/or medical expenses, MO HealthNet coverage begins on the date the incurred and/or expenses equal the spenddown amount. The bills do *not* have to have been paid. In order to determine whether or not the participant has met spenddown, the FSD Eligibility Specialist counts the full amount of the valid medical expenses the participant incurred and/or paid to establish eligibility for spenddown coverage. The Eligibility Specialist does *not* try to estimate amounts, or deduct estimated amounts, to be paid by the participant's insurance from the amount of incurred and/or paid expenses. The QMB Program provides MO HealthNet payment of the Medicare premium, and coinsurance, deductibles and copay for all Medicare covered services. Therefore, the cost of Medicare covered services *cannot* be used to meet spenddown for participants approved for QMB.



Upon receipt of verification that spenddown has been met with incurred and/or paid expenses for a month, FSD sends a Notification of Spenddown Coverage letter to inform the participant spenddown was met with the incurred and/or paid expenses. The letter informs the participant of the MO HealthNet start date and the amount of spenddown met on the start date.

#### **1.6.B(4) Meeting Spenddown with a Combination of Incurred Expenses and Paying the Balance**

If the participant chooses to meet spenddown for a month using incurred expenses and paying the balance of their spenddown amount, coverage begins on the date of the most recent incurred expense once the balance is paid and received by MHD. The participant must take the incurred expenses to their FSD Eligibility Specialist who will inform them of the balance they must pay to MHD.

#### **1.6.B(5) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown**

On spenddown cases, MO HealthNet only reimburses providers for covered medical expenses that exceed a participant's spenddown amount. MO HealthNet does *not* pay the portion of a bill used to meet the spenddown. To prevent MO HealthNet from paying for an expense used to meet spenddown, MHD withholds the participant liability amount of spenddown met on the first day of coverage for a month. The MHD system tracks the bills received for the first day of coverage until the bills equal the participant's remaining spenddown liability. For the first day of coverage, MHD denies or splits (partially pays) the claims until the participant's liability for that first day is reduced to zero. After MHD has reduced the liability to zero for the first day of coverage, other claims submitted for that day of spenddown coverage are paid up to the MO HealthNet rate. Claims for all other days of spenddown coverage process in the same manner as those of non-spenddown participants. MHD notifies both the provider and the participant of any claim amount *not* paid due to the bill having been used to meet spenddown.

When a participant has multiple expenses on the day spenddown is met and the total expenses exceed the remaining spenddown, the liability amount may be withheld from the wrong claim. This can occur if Provider A submits a claim to MHD and Provider B does *not* (either because the bill was paid or it was a non-MO HealthNet covered service). Since the MHD system can only withhold the participant liability from claims submitted, the liability amount is deducted from the bill of the Provider A. Provider B's bill may have been enough to reduce the liability to zero, which would have allowed MO HealthNet to pay for Provider A's claim. MHD Participants Services Unit authorizes payment of the submitted claim



upon receipt of verification of other expenses for the day which reduced the liability to zero. The Participant Services Unit may request documentation from the case record of bills FSD used to meet spenddown on the day it was met.

#### **1.6.B(6) Spenddown Pay-In Option**

The pay-in option allows participants to meet spenddown requirements by making a monthly payment of the spenddown amount to MHD. Participants who choose to pay-in may pay by sending a check (or money order) each month to MHD or having the spenddown amount automatically withdrawn from a bank account each month. When a participant pays in, MHD creates a coverage period that begins on the first day of the month for which the participant is paying. If the participant pays for the next month prior to the end of the current month, there is no end date on the coverage period. If a payment has been missed, the coverage period is *not* continuous.

Participants are given the option of having the spenddown amount withdrawn from an existing bank account. Withdrawals are made on the 10th of each month for the following month's coverage. The participant receives a monthly notification of withdrawal from MHD.

In some instances, other state agencies, such as Department of Mental Health, may choose to pay the spenddown amount for some of their clients. Agencies interested in this process work with MHD to identify clients the agency intends to pay for and establish payment options on behalf of the client.

#### **1.6.B(7) Prior Quarter Coverage**

The eligibility determination for prior quarter MO HealthNet coverage is separate from the eligibility determination for current MO HealthNet coverage. A participant does *not* have to be currently eligible for MO HealthNet coverage to be eligible for prior quarter coverage. Prior quarter coverage can begin no earlier than the first day of the third month prior to the month of the application and can extend up to but *not* including the first day of the month of application. The participant *must* meet all eligibility requirements including spenddown/non-spenddown during the prior quarter. If the participant becomes eligible for assistance sometime during the prior quarter, the date on which eligibility begins depends on whether the participant is eligible as a non-spenddown or spenddown case.

MO HealthNet coverage begins on the first day in which spenddown is met in each of the prior months. Each of the three prior quarter month's medical expenses are compared to that month's spenddown separately. Using this process, it may be that the individual is eligible for one, two or all three months, sometimes *not*



consecutively. As soon as the FSD Eligibility Specialist receives bills to meet spenddown for a prior quarter month, eligibility is met.

### **1.6.B(8) MO HealthNet Coverage End Dates**

MO HealthNet coverage is date-specific for MO HealthNet for the Aged, Blind, and Disabled (MHABD) non-spenddown cases at the time of closing. A date-specific closing can take effect in the future, up to the last day of the month following the month of closing. For MHABD spenddown cases MO HealthNet eligibility and coverage is *not* date-specific at the time of the closing. When an MHABD spenddown case is closed, MO HealthNet eligibility continues through the last day of the month of the closing. If MO HealthNet coverage has been authorized by pay-in or due to incurred expenses, it continues through the last day of the month of the closing.

### **1.6.C PRIOR QUARTER COVERAGE**

Eligibility determination for prior quarter Title XIX coverage is separate from the eligibility determination of current Title XIX coverage. An individual does *not* have to be currently eligible for Title XIX coverage to be eligible for prior quarter coverage and vice versa.

Eligible individuals may receive Title XIX coverage retroactively for up to 3 months prior to the month of application. This 3-month period is referred to as the prior quarter. The effective date of prior quarter coverage for participants can be no earlier than the first day of the third month prior to the month of the application and can extend up to, but *not* include, the first day of the month of application.

MO HealthNet for Kids (ME codes 71-75) who meet federal poverty limit guidelines and who qualify for coverage because of lack of medical insurance are *not* eligible to receive prior quarter coverage.

The individual *must* have met all eligibility factors during the prior quarter. If the individual becomes eligible for assistance sometime during the prior quarter, eligibility for Title XIX begins on the first day of the month in which the individual became eligible or, if a spenddown case, the *date* in the prior 3-month period on which the spenddown amount was equaled or exceeded.

***Example of Prior Quarter Eligibility on a Non-Spenddown Case:*** An individual applies for assistance in June. The prior quarter is March through May. A review of the eligibility requirements during the prior quarter indicates the individual would have been eligible on March 1 because of depletion of resources. Title XIX coverage begins March 1 and extends through May 31 if an individual continues to be eligible during April and May.

### **1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS**

The Social Security Act provides MO HealthNet coverage for emergency medical care for ineligible aliens, who meet all eligibility requirements for a federally funded MO HealthNet program except citizenship/alien status. *Coverage is for the specific emergency only.* Providers should contact the local Family Support Division office and identify the services and the nature of the emergency. State staff identify the emergency nature of the claim and add or deny coverage for the period of the emergency only. Claims are reimbursed only for the eligibility period identified on the participant's eligibility file. An emergency medical condition is defined as follows:

An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

## **1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE**

It is common for MO HealthNet participants to be issued an eligibility letter from the Family Support Division or other authorizing entity that may be used in place of an ID card. Participants who are new approvals or who need a replacement card are given an authorization letter. These letters are valid proof of eligibility in lieu of an ID Card. Dates of eligibility and most restrictions are contained in these letters. Participants who are enrolled or who will be enrolled in a managed care health plan may *not* have this designation identified on the letter. It is important that the provider verify the managed care enrollment status for participants who reside in a managed care service area. If the participant does *not* have an ID Card or authorization letter, the provider may also verify

eligibility by contacting the IVR or the Internet if the participant's MO HealthNet number is known. Refer to Section 3.3.A

The MO HealthNet Division furnishes MO HealthNet participants with written correspondence regarding medical services submitted as claims to the division. Participants are also informed when a prior authorization request for services has been made on their behalf but denied.

### **1.7.A NEW APPROVAL LETTER**

An Approval Notice (IM-32, IM-32 MAF, IM-32 MC, IM-32 MPW or IM-32 PRM, IM-32 QMB) is prepared when the application is approved. Coverage may be from the first day of the month of application or the date of eligibility in the prior quarter until the last day of the month in which the case was approved or the last day of the following month if approval occurs late in the month. Approval letters may be used to verify eligibility for services until the ID Card is received. The letter indicates whether an individual will be enrolled with a MO HealthNet managed care health plan. It also states whether the individual is required to pay a copay for certain services. Each letter is slightly different in content.

Spenddown eligibility letters cover the date spenddown is met until the end of the month in which the case was approved. The eligibility letters contain Yes/No boxes to indicate Lock-In, Hospice or QMB. If the "Yes" box is checked, the restrictions apply.

#### **1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals**

Reinstated Temporary MO HealthNet for Needy Families (TMNF) individuals have received a letter from the Family Support Division that serves as notification of temporary medical eligibility. They may use this letter to contact providers to access services.

#### **1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter**

Presumptive Eligibility (PE) determinations are made by Breast and Cervical Cancer Control Project (BCCCP) MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued which provides for temporary, full MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment.

#### **1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice**

Eligibility determinations for Presumptive Eligibility for Children are limited to qualified entities approved by the state. Currently only children's hospitals are approved. Upon determination of eligibility, the family is provided with a



Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers should be checking eligibility as for any client.

### **1.7.B REPLACEMENT LETTER**

A participant may also have a replacement letter, which is the MO HealthNet Eligibility Authorization (IM-29, IM-29 QMB and IM-29 TEMP), from the Family Support Division county office as proof of MO HealthNet eligibility in lieu of a MO HealthNet ID card. This letter is issued when a card has been lost or destroyed.

There are check-off boxes on the letter to indicate if the letter is replacing a lost card or letter. A provider should use this letter to verify eligibility as they would the ID Card. Participants who live in a managed care service area may *not* have their managed care health plan identified on the letter. Providers need to contact the IVR or the Internet to verify the managed care health plan enrollment status.

A replacement letter is only prepared upon the request of the participant.

### **1.7.C NOTICE OF CASE ACTION**

A Notice of Case Action (IM-33) advises the participant of application rejections, case closings, changes in the amount of cash grant, or ineligibility status for MO HealthNet benefits resulting from changes in the participant's situation. This form also advises the participant of individuals being added to a case and authorizes MO HealthNet coverage for individuals being added.

### **1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS**

The MO HealthNet Division randomly selects 300 MO HealthNet participants per month to receive a Participant Explanation of MO HealthNet Benefits (PEOMB) for services billed or managed care health plan encounters reported. The PEOMB contains the following information:

- Date the service was provided;
- Name of the provider;
- Description of service or drug that was billed or the encounter reported; and
- Information regarding how the participant may contact the Participant Services Unit by toll-free telephone number and by written correspondence.

The PEOMB sent to the participant clearly indicates that it is *not* a bill and that it does *not* change the participant's MO HealthNet benefits.



The PEOMB does *not* report the capitation payment made to the managed care health plan in the participant's behalf.

### **1.7.E PRIOR AUTHORIZATION REQUEST DENIAL**

When the MO HealthNet Division *must* deny a Prior Authorization Request for a service that is delivered on a fee-for-service basis, a letter is sent to the participant explaining the reason for the denial. The most common reasons for denial are:

- Prior Authorization Request was returned to the provider for corrections or additional information.
- Service or item requested does *not* require prior authorization.
- Authorization has been granted to another provider for the same service or item.
- Our records indicate this service has already been provided.
- Service or item requested is *not* medically necessary.

The Prior Authorization Request Denial letter gives the address and telephone number that the participant may call or write to if they feel the MO HealthNet Division was wrong in denying the Prior Authorization Request. The participant *must* contact the MO HealthNet Division, Participant Services Unit, within 90 days of the date on the letter, if they want the denial to be reviewed.

Participants enrolled in a managed care health plan do *not* receive the Prior Authorization Request Denial letter from the MO HealthNet Division. They receive notification from the managed care health plan and can appeal the decision from the managed care health plan. The participant's member handbook tells them how to file a grievance or an appeal.

### **1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER**

A participant may send written correspondence to:

Participant Services Agent  
P.O. Box 3535  
Jefferson City, MO 65102

The participant may also call the Participant Services Unit at (800) 392-2161 toll free, or (573) 751-6527. Providers should *not* call the Participant Services Unit unless a call is requested by the state.

## **1.8 TRANSPLANT PROGRAM**

The MO HealthNet Program provides limited coverage and reimbursement for the transplantation of human organs or bone marrow/stem cell and related medical services. Current policy and procedure

is administered by the MO HealthNet Division with the assistance of its Transplant Advisory Committee.

#### **1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS**

With prior authorization from the MO HealthNet Division, transplants may be provided by MO HealthNet approved transplant facilities for transplantation of the following:

- Bone Marrow/Stem Cell
- Heart
- Kidney
- Liver
- Lung
- Small Bowel
- Multiple organ transplants involving a covered transplant

#### **1.8.B PATIENT SELECTION CRITERIA**

The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient *must* have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

Bone Marrow/Stem Cell transplant candidates *must* also meet the general diagnosis and donor guidelines established by the Bone Marrow/Stem Cell Transplant Advisory Committee.

All transplant requests for authorization are reviewed on a case-by-case basis. If the request is approved, an agreement is issued to the transplant facility that *must* be signed and returned to the MO HealthNet Division.

#### **1.8.C CORNEAL TRANSPLANTS**

Corneal transplants are covered for eligible MO HealthNet participants and do *not* require prior authorization. Corneal transplants have certain restrictions that are discussed in the physician and hospital manuals.

#### **1.8.D ELIGIBILITY REQUIREMENTS**



For the transplant facility or related service providers to be reimbursed by MO HealthNet, the transplant patient *must* be eligible for MO HealthNet on each date of service. A participant *must* have an ID card or eligibility letter to receive MO HealthNet benefits.

Human organ and bone marrow/stem cell transplant coverage is restricted to those participants who are eligible for MO HealthNet. Transplant coverage is *NOT* available for participants who are eligible under a state funded MO HealthNet ME code. (See Section 1.1).

Individuals whose type of assistance does *not* cover transplants should be referred to their local Family Support Division office to request application under a type of assistance that covers transplants. In this instance the MO HealthNet Division Transplant Unit should be advised immediately. The MO HealthNet Division Transplant Unit works with the Family Support Division to expedite the application process.

### **1.8.E MANAGED CARE PARTICIPANTS**

Managed care members receive a transplant as a fee-for-service benefit reimbursed by the MO HealthNet Division. The transplant candidate is allowed freedom of choice of Approved MO HealthNet Transplant Facilities

The transplant surgery, from the date of the transplant through the date of discharge or significant change in diagnosis not related to the transplant surgery and related transplant services (procurement, physician, lab services, etc.) are *not* the managed care health plan's responsibility. The transplant procedure is prior authorized by the MO HealthNet Division. Claims for the pre-transplant assessment and care are the responsibility of the managed care health plan and *must* be authorized by the MO HealthNet managed care health plan.

Any outpatient, inpatient, physician and related support services rendered prior to the date of the actual transplant surgery *must* be authorized by the managed care health plan and are the responsibility of the managed care health plan.

The managed care health plan is responsible for post-transplant follow-up care. In order to assure continuity of care, follow-up services *must* be authorized by the managed care health plan. Reimbursement for those authorized services is made by the managed care health plan. Reimbursement to non-health plan providers *must* be no less than the current MO HealthNet FFS rate.

The MO HealthNet Division only reimburses providers for those charges directly related to the transplant including the organ or bone marrow/stem cell procurement costs, actual inpatient transplant surgery costs, post-surgery inpatient hospital costs associated with the transplant surgery, and the transplant physicians' charges and other physicians' services associated with the patient's transplant.

### **1.8.F MEDICARE COVERED TRANSPLANTS**



Kidney, heart, lung, liver and certain bone marrow/stem cell transplants are covered by Medicare. If the patient has both Medicare and MO HealthNet coverage and the transplant is covered by Medicare, the Medicare Program is the first source of payment. In this case the requirements or restrictions imposed by Medicare apply and MO HealthNet reimbursement is limited to applicable deductible and coinsurance amounts.

Medicare restricts coverage of heart, lung and liver transplants to Medicare-approved facilities. In Missouri, St. Louis University Hospital, Barnes-Jewish Hospital in St. Louis, St. Luke's Hospital in Kansas City, and the University of Missouri Hospital located in Columbia, Missouri are Medicare-approved facilities for coverage of heart transplants. St. Luke's Hospital in Kansas City, Barnes-Jewish Hospital and St. Louis University are also Medicare-certified liver transplant facilities. Barnes-Jewish Hospital is a Medicare approved lung transplant facility. Potential heart, lung and liver transplant candidates who have Medicare coverage or who will be eligible for Medicare coverage within six months from the date of imminent need for the transplant should be referred to one of the approved Medicare transplant facilities. MO HealthNet only considers authorization of a Medicare-covered transplant in a non-Medicare transplant facility if the Medicare beneficiary is too ill to be moved to the Medicare transplant facility.

**END OF SECTION**

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## **SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION**

### **2.1 PROVIDER ELIGIBILITY**

To receive MO HealthNet reimbursement, a provider of services *must* have entered into, and maintain, a valid participation agreement with the MO HealthNet Division as approved by the Missouri Medicaid Audit and Compliance Unit (MMAC). Authority to take such action is contained in 13 CSR 70-3.020. Each provider type has specific enrollment criteria, e.g., licensure, certification, Medicare certification, etc., which *must* be met. The enrollment effective date cannot be prior to the date the completed application was received by the MMAC Provider Enrollment office. The effective date cannot be backdated for any reason. Any claims billed by a non-enrolled provider utilizing an enrolled provider's National Provider Identifier (NPI) or legacy number will be subject to recoupment of claim payments and possible sanctions and may be grounds for allegations of fraud and will be appropriately pursued by MMAC. Refer to Section 13, Benefits and Limitations, of the applicable provider manual for specific enrollment criteria.

#### **2.1.A QMB-ONLY PROVIDERS**

Providers who want to enroll in MO HealthNet to receive payments for only the Qualified Medicare Beneficiary (QMB) services *must* submit a copy of their state license and documentation of their Medicare ID number. They *must* also complete a short enrollment form. For a discussion of QMB covered services refer to Section 1 of this manual.

#### **2.1.B NON-BILLING MO HEALTHNET PROVIDER**

MO HealthNet managed care health plan providers who have a valid agreement with one or more managed care health plans but who are *not* enrolled as a participating MO HealthNet provider may access the Internet or interactive voice response (IVR) system if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued a provider identifier that permits access to the Internet or IVR; however, it is *not* valid for billing MO HealthNet on a fee-for-service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at: [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

#### **2.1.C PROVIDER ENROLLMENT ADDRESS**

Specific information about MO HealthNet participation requirements and enrollment can be obtained from:

Provider Enrollment Unit  
Missouri Medicaid Audit and Compliance Unit

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P. O. Box 6500  
Jefferson City, Missouri 65102  
mmac.providerenrollment@dss.mo.gov

### **2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION**

A provider wishing to submit claims or attachments electronically or access the Internet web site, [www.emomed.com](http://www.emomed.com), *must* be enrolled as an electronic billing provider. Providers wishing to enroll as an electronic billing provider may contact the Wipro Infocrossing Help Desk at (573) 635-3559.

Providers wishing to access the Internet web site, [www.emomed.com](http://www.emomed.com), *must* complete the on-line Application for MO HealthNet Internet Access Account. Please reference <http://manuals.momed.com/Application.html> and click on the Apply for Internet Access link. Providers are unable to access [www.emomed.com](http://www.emomed.com) without proper authorization. An authorization is required for each individual user.

### **2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES**

In accordance with the Affordable Care Act of 2010 (the Act), MO HealthNet must comply with the Medicaid payment provision located in Section 6505 of the Act, entitled "Prohibition on Payment to Institutions or Entities Located Outside of the United States." The provision prohibits MO HealthNet from making any payments for items or services provided under the State Plan or under a waiver to any financial institutions, telemedicine providers, pharmacies, or other entities located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If it is discovered that payments have been made to financial institutions or entities outside of the previously stated approved regions, MO HealthNet must recover these payments. This provision became effective January 1, 2011.

## **2.2 NOTIFICATION OF CHANGES**

A provider *must* notify the Provider Enrollment Unit of any changes affecting the provider's enrollment records within ninety (90) days of the change, in writing, using the appropriate enrollment forms specified by the Provider Enrollment Unit, with the exception of a change in ownership or control of any provider. Change in ownership or control of any provider *must* be reported within thirty (30) days. The Provider Enrollment Unit is responsible for determining whether a current MO HealthNet provider record should be updated or a new MO HealthNet provider record should be created. A new MO HealthNet provider record is not created for any changes including, but not limited to, a change in ownership, a change of operator, tax identification



change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations.

## **2.3 RETENTION OF RECORDS**

MO HealthNet providers *must* retain for 5 years (7 years for the Nursing Home, CSTAR and Community Psychiatric Rehabilitation Programs), from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to MO HealthNet 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.

### **2.3.A ADEQUATE DOCUMENTATION**

All services provided *must* be adequately documented in the medical record. 13 CSR 70-3.030, Section(2)(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.

## **2.4 NONDISCRIMINATION POLICY STATEMENT**

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.

## **2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER**

Providers of services and supplies to MO HealthNet participants *must* comply with all laws, policies, and regulations of Missouri and the MO HealthNet Division, as well as policies, regulations, and laws of the federal government. A provider *must* also comply with the standards and ethics of his or her business or profession to qualify as a participant in the program. The Missouri Medicaid Audit and Compliance Unit may terminate or suspend providers or otherwise apply sanctions of administrative actions against providers who are in violation of MO HealthNet Program requirements. Authority to take such action is contained in 13 CSR 70-3.030.

## **2.6 FRAUD AND ABUSE**

The Department of Social Services, Missouri Medicaid Audit and Compliance Unit is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Title XIX Medicaid Program by either providers or participants. Section 1909 of the Social Security Act contains federal penalty provisions for fraudulent acts and false reporting on the part of providers and participants enrolled in MO HealthNet.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal and State laws, regulations and policies.

Abuse is defined as provider, supplier, and entity practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are *not* medically necessary or that fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary costs to the Medicaid program.

Frequently cited fraudulent or abusive practices include, but are *not* limited to, overcharging for services provided, charging for services *not* rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

The penalties for such acts range from misdemeanors to felonies with fines *not* to exceed \$25,000 and imprisonment up to 5 years, or both.

Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are *not* limited to, the following:

- Review of participant profiles of use of services and payment made for such.
- Review of provider claims and payment history for patterns indicating need for closer scrutiny.
- Computer-generated listing of duplication of payments.
- Computer-generated listing of conflicting dates of services.
- Computer-generated overutilization listing.
- Internal checks on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, participant eligibility, etc.
- Medical staff review and application of established medical services parameters.
- Field auditing activities conducted by the Missouri Medicaid Audit and Compliance Unit or its representatives, which include provider and participant contacts.

In cases referred to law enforcement officials for prosecution, the Missouri Medicaid Audit and Compliance Unit has the obligation, where applicable, to seek restitution and recovery of monies wrongfully paid even though prosecution may be declined by the enforcement officials.

#### **2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS**

It is the responsibility of each provider to ensure the accuracy of all data transmitted on claims submitted to MO HealthNet, regardless of the media utilized. As provided in 13 CSR 70.3.030, sanctions may be imposed by MO HealthNet against a provider for failure to take reasonable measures to review claims for accuracy. Billing errors, including but not limited to, incorrect ingredient indicators, quantities, days supply, prescriber identification, dates of service, and usual and customary charges, caused or committed by the provider or their employees are subject to adjustment or recoupment. This includes, but is not limited to, failure to review remittance advices provided for claims resulting in payments that do not correspond to the actual services rendered. Ongoing, overt or intentionally misleading claims may be grounds for allegations of fraud and will be appropriately pursued by the agency.

#### **2.7 OVERPAYMENTS**

The Missouri Medicaid Audit and Compliance Unit routinely conduct postpayment reviews of MO HealthNet claims. If during a review an overpayment is identified, the Missouri Medicaid Audit and Compliance Unit is charged with recovering the overpayment pursuant to 13 CSR 70-3.030. The Missouri Medicaid Audit and Compliance Unit maintains the position that all providers are held responsible for overpayments identified to their participation agreement regardless of any extrinsic relationship they may have with a corporation or other employing entity. The provider is responsible

for the repayment of the identified overpayments. Missouri State Statute, Section 208.156, RSMo (1986) may provide for appeal of any overpayment notification for amounts of \$500 or more. An appeal *must* be filed with the Administrative Hearing Commission within 30 days from the date of mailing or delivery of the decision, whichever is earlier; except that claims of less than \$500 may be accumulated until such claims total that sum and, at which time, the provider has 90 days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the Commission.

Compliance with this decision does *not* absolve the provider, or any other person or entity, from any criminal penalty or civil liability that may arise from any action that may be brought by any federal agency, other state agency, or prosecutor. The Missouri Department of Social Services, Missouri Medicaid Audit and Compliance Unit, has no authority to bind or restrict in any way the actions of other state agencies or offices, federal agencies or offices, or prosecutors.

## **2.8 POSTPAYMENT REVIEW**

Services reimbursed through the MO HealthNet Program are subject to postpayment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in monetary recoupments according to 13 CSR 70-3.030 (5) and the provider may be subjected to prepayment review on all MO HealthNet claims.

## **2.9 PREPAYMENT REVIEW**

MMAC may conduct prepayment reviews for all providers in a program, or for certain services or selected providers. When a provider has been notified that services are subject to prepayment review, the provider *must* follow any specific instructions provided by MMAC in addition to the policy outlined in the provider manual. In the event of prepayment review, the provider *must* submit all claims on paper. Claims subject to prepayment review are sent to the fiscal agent who forwards the claims and attachments to the MMAC consultants.

MMAC consultants conduct the prepayment review following the MO HealthNet Division's guidelines and either recommend approval or denial of payment. The claim and the recommendation for approval or denial is forwarded to the MO HealthNet fiscal agent for final processing. Please note, although MMAC consultants recommend payment for a claim, this does *not* guarantee the claim is paid. The claim *must* pass all required MO HealthNet claim processing edits before actual payment is determined. The final payment disposition on the claim is reported to the provider on a MO HealthNet Remittance Advice.



## 2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

MO HealthNet providers *must* complete a [Direct Deposit for Individual Provider](#) form to receive reimbursement for services through direct deposit into a checking or savings account. The application should be downloaded, printed, completed and mailed along with a voided check or letter from the provider's financial institution to:

Missouri Medicaid Audit and Compliance (MMAC)

Provider Enrollment Unit

P.O. Box 6500

Jefferson City, MO 65102

This form *must* be used for initial enrollment, re-enrollment, revalidation, or any update or change needed. All providers are required to complete the Application for Provider Direct Deposit form regardless if the reimbursement for their services will be going to another provider.

In addition to completion of the Application for Provider Direct Deposit form, all clinics/groups *must* complete the [Direct Deposit for Clinics & Groups](#) form.

Direct deposit begins following a submission of a properly completed application form to the Missouri Medicaid Audit and Compliance Unit, the successful processing of a test transaction through the banking system and the authorization to make payment using direct deposit. The state conducts direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply, as limited or modified by law.

The Missouri Medicaid Audit and Compliance Unit will terminate or suspend the direct deposit for administrative or legal actions, including but *not* limited to: ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

All payments are direct deposited.

For questions regarding direct deposit or provider enrollment issues, please send an email to [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov)

The MO HealthNet Remittance Advice is available on line. The provider *must* apply online via the [Application for MO HealthNet Internet Access Account](#) link.

Once a user ID and password is obtained, the [www.emomed.com](http://www.emomed.com) website can be accessed to retrieve current and aged remittance advices.

Please be aware that any updates or changes made to the emomed file will *not* update the provider master file. Therefore updates or changes should be requested in writing. Requests can be emailed to

Dental



the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section  
([www.mmac.providerenrollment@dss.mo.gov](mailto:www.mmac.providerenrollment@dss.mo.gov)).

**END OF SECTION**

**[TOP OF SECTION](#)**



## **SECTION 3 - STAKEHOLDER SERVICES**

### **3.1 PROVIDER SERVICES**

The MHD has various units to assist providers with questions regarding proper claims filing, claims resolution and disposition, payment problems, participant eligibility verification, prior authorization status, coverage inquiries, and proper billing methods and procedures.

Additionally, the Missouri Medicaid Audit and Compliance Unit (MMAC) assists providers with enrollment as an MHD provider, enrollment questions and verifications. Assistance can be obtained by contacting the appropriate unit.

#### **3.1.A MHD TECHNICAL HELP DESK**

The MHD Technical Help Desk provides assistance in establishing the required electronic claims and Remittance Advice (RA) formats, network communication, Health Insurance Portability and Accountability (HIPAA) trading partner agreements, and Internet billing service.

This help desk is for use by Fee-For-Service providers, electronic billers, and Managed Care health plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

- Front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission, as well as assistance in the use and maintenance of billing software developed by the MHD.
- Front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- Front-line assistance to Managed Care health plans in establishing required electronic formats, network communications, and ongoing operations.
- Front-line assistance to providers in submitting claim attachments via the Internet.

### **3.2 Missouri Medicaid Audit & Compliance (MMAC)**

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating and preventing fraud, waste, and abuse. MMAC can be contacted at (573) 751-3399, or access the webpage at <http://mmac.mo.gov/>.



### **3.2.A PROVIDER ENROLLMENT UNIT**

The MMAC Provider Enrollment Unit processes provider enrollment packets, enrollment applications, and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained by emailing the unit at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

### **3.3 PROVIDER COMMUNICATIONS UNIT**

The Provider Communications Unit responds to specific provider inquiries concerning MHD eligibility and coverage, claim filing instructions, concerns and questions regarding proper claim filing, claims resolution and disposition, and billing errors. The dedicated telephone number is (573) 751-2896.

Current, old or lost RAs can be obtained from the MHD electronic billing website at [www.emomed.com](http://www.emomed.com).

- In the section "File Management," the provider can request and print a current RA by selecting "Printable Remittance Advice."
- To retrieve an older RA, select "Request Aged RAs," fill out the required information and submit. The next day, the RA will be under "Printable Aged RAs."
- The requested RA will remain in the system for 5 days.

Providers can verify participant eligibility, check amount information, claim information, provider enrollment status and participant annual review date by calling the Provider Communications Unit, by emailing from the eMOMED Contact tab or by utilizing the Interactive Voice Response (IVR) system.

#### **3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM**

The Interactive Voice Response (IVR) system at (573) 751-2896 allows an active MO HealthNet provider five Main inquiry options:

1. For MO HealthNet Participant Eligibility, Press 1.
2. For Check Amount Information, Press 2.
3. For Claim Information, Press 3.
4. For Provider Enrollment Status, Press 4.
5. For Participant Annual Review Date, Press 5.

The IVR system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service that occurred during their period of enrollment as an active MO HealthNet provider. The 10-digit



National Provider Identification (NPI) number *must* be entered each time any of the IVR options are accessed.

***The provider should listen to all eligibility information, particularly the sub-options.***

### **Main Option 1. Participant Eligibility**

The caller is prompted to enter the following information:

- Provider's 10 digit NPI number.
- 8-digit MO HealthNet participant's ID (MO HealthNet Identification Number), or 9-digit Social Security Number (SSN) or case-head ID.
- If the inquiry is by the SSN, once the 9-digit SSN is entered, the IVR prompts for the Date of Birth.
- 6-digit Date of birth (mm/dd/yy).
- Dependent date of birth (if inquiry by case-head ID).
- Once the participant's ID is entered, the IVR prompts for dates of service.
- First date of service (mm/dd/yy): Enter in the 6-digit first date of service.
- Last date of service (mm/dd/yy): Enter the 6-digit last date of service
- Upon entry of dates of service, the IVR retrieves coverage information.

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may **not** exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may **not** inquire on dates that exceed one year, prior to the current date. The caller is limited to ten inquiries per call.

The caller is given standard MO HealthNet eligibility coverage information, including the Medicaid Eligibility (ME) code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits.

The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under Qualified Medicare Beneficiary (QMB) or the Presumptive Eligibility (TEMP) Program. Please reference all the applicable sections of the provider's program manual for QMB and TEMP provisions.

Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a Sub-Option menu.

The Sub-Options menu options include:

- For Health plan and Lock-in Information, Press 1.
- For eye glass and eye exam information, Press 2.



- For Third Party Liability Information, Press 3.
- For Medicare and QMB Information, Press 4.
- For MO HealthNet ID, Name, spelling of name and eligibility information, Press 5.
- For Confirmation Number, Press 6.
- For Another MO HealthNet Participant, Press 7.
- To Return to the Main Menu, Press 8.
- To End this Call, Press 9.
- To speak with a MO HealthNet specialist, Press 0.

The MHD eligibility information is confidential and must be used only for the purpose of providing services and for filing MHD claims.

### **Sub-Option 1. Health Plan and Lock-in Information**

The Health plan and Lock-in Option sub-option 1, if applicable, provides the health plan lock-in information, Primary Care Provider (PCP) lock-in, and other applicable provider lock-in information.

If no lock-in exists for participant, the IVR will state that the participant is not locked in on the date of service requested.

If lock-in exists, then IVR will read up to three records to the caller.

- If health plan lock-in exists, the IVR states the health plan name for services on the applicable dates.
  - “This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Are Code (XXX-XXX-XXXX on file).”
- If PCP lock-in exists, the IVR states the provider’s name and phone number for services on the applicable dates.
  - “This participant is locked into Provider (Provider Name) for services on (from date) through (to date). The participant’s primary care provider is (PCP Name). The lock-in provider’s phone number is Area Code (XXX-XXX-XXXX on file).”

This information is also available on [www.emomed.com](http://www.emomed.com).

### **Sub-Option 2. Eye Glass and Eye Exam Information**

The participant’s eyeglass information and last eye exam information can be obtained through the sub-option 2.

- If no eyeglass information exists, the IVR reads that the participant has not received an eye exam and has not received eye glass frames or lenses to date under the MO HealthNet program.



- If frames, lens, and/or exam information exist, then the IVR will read different types of responses based on the data. A couple of examples include:
  - If frames, lens, and exam information exists and all occur on the same date.
  - Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
  - If frames, lens exist for different dates and no exam date.
  - Eye glass frames were last issued on (Frames Date).
  - Eye glass lenses were last issued on (Lens Date).
  - This participant has not had an eye examination to date under the MO HealthNet program.

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

### **Sub-Option 3. Third Party Liability (TPL) Information**

The participant's TPL information on file will be provided through sub-option 3.

- If no TPL exists for the participant or TPL Name is blank, the IVR reads that information.
- If Medicare Part C exists, the IVR reads that information.
- If TPL Part C information is not available, the IVR reads to contact the participant for the information.
- If Medicare Part C does not exist, the IVR reads that this participant does not have Third party coverage on the dates of service requested.
- If TPL exists, then IVR will read up to **five** records to the caller.
  - Third party insurance is provided by (TPL NAME).
  - If Court Ordered, the IVR will read that this coverage is court ordered.
  - If Policy Number = 'unknown, the IVR will read that the Policy number is unknown.
  - If Policy Number is known, the IVR will read the policy number is (Policy Number).
  - If Group Number = 'unknown, the IVR will read that the group number is unknown.
  - If the Group Number is known, the IVR will read that the group number is (Group Number).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

### **Sub-Option 4 Medicare and QMB Information**

If no Part A, B, or QMB information exists on file for the participant, then nothing is read.

If Part A, B, and/or QMB information exists then the IVR will read different types of responses based on the data on file. A couple of examples include:

- If Part A, B, QMB exists and all have same dates, the IVR will read that this participant has Medicare Part A, Part B, and QMB coverage on (from date) through (to date).
- If Part A, B exists for same dates and QMB has different dates, the IVR will read that this participant has Medicare Part A and Part B coverage on (from date) through (to date). This participant has QMB coverage on (QMB from date) through (QMB to date).
- If Part C exists, the IVR will read that this participant has Medicare Part C coverage on (from date) through (to date).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

### **Main Option 2. Provider IVR Check Inquiry**

Once the provider's 10 digit NPI number is entered, the IVR retrieves the information. The IVR will read if the provider is eligible to submit electronic claims, or if the provider is not eligible to submit electronic claims.

- The IVR will read the most recent provider check information available from the Remittance Advice number (RA Number) dated (RA Date). The check amount is (RA Amount).
- If there has not been checks issued, the IVR will read that the NPI Number (XXXXXXXXXX) has not been issued any checks to date.

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

- For another Check Inquiry, Press 1. If the caller presses 1, the IVR goes back to Provider Check Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR goes back to the Main Menu
- To Speak with a MO HealthNet specialist, Press 0.
- Else, Press 3.

### **Main Option 3. Provider IVR Claim Information**

The provider can access claim status information, including processing status, denial, and approved status.



- Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID.
- Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.
- Once 6 digit number is entered, the IVR prompts for the type of claim.
  - If Drug claim is selected, then IVR prompts for prescription number entry.

Once inputs are received, the IVR retrieves the following results:

- If claim is in process:
  - The IVR reads that the claim accessed with this date of service is being processed.
- If claim is denied:
  - The IVR will read up to five Explanation of Benefits (EOB) applicable codes. The claim accessed with this date of service has been denied with EOB (EOB Code 1-5).
  - After EOB codes are read, the IVR prompts to hear EOB descriptions.
  - Press 1 for EOB Description. If the caller presses 1, the IVR will read the EOB descriptions for the EOB codes (up to **five**).
- IVR then reads RA information. If the claim is denied, the IVR reads that the claim accessed with this date of service is denied on the (RA Number) Remittance Advice dated (RA Date).
- If claim is approved for payment:
- The IVR reads that the claim accessed with this date of service has been approved for payment.
- If claim paid and the claim is being recouped or adjusted, the IVR reads for more information, speak with a MO HealthNet Specialist.
- If claim paid, the IVR will read that the claim accessed with this date of service was paid on the (RA Number) Remittance Advice dated (RA Date) in the amount of (RA Amount).

This information is also available on the eMOMED website. The IVR then reads the following navigation options:

- For another Claim inquiry, Press 1. If the caller presses 1, IVR goes back to Provider Claim Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, IVR repeats Response information.
- To speak with a MO HealthNet specialist, Press 0.
- If the caller presses 3, IVR goes back to the Main Menu.

#### **Main Option 4. Provider Enrollment Status**



The provider's enrollment status can be obtained through this option. The following will be repeated up to five times depending on the number of providers for the inquiry. The caller is prompted to enter the provider's NPI number.

- Please enter the 10 digit NPI number. Once 10 digit NPI number is entered, the IVR prompts for NPI number in which being inquired.
- Please enter the 10 digit NPI number in which being inquired. Once 10 digit number is entered, the IVR prompts for date of service.
- Please enter the 6 digit Date of Service in (MM/DD/YY) format. Once inputs are received, the IVR retrieves results.

The following will be repeated up to **five** times depending on the number of providers for the inquired NPI.

- The Provider Enrollment Status for NPI (NPI Number) with a provider type of (Provider Type Description) is (Active/Not Active) for the date of service (DOS). The confirmation number is (Confirmation Number).

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

- For another Provider Enrollment Status Inquiry, Press 1. If the caller presses 1, the IVR goes back to the Provider Enrollment Option.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR repeats the Provider Enrollment response.
- To Speak with a MO HealthNet specialist, Press 0
- If the caller presses 3, the IVR goes back to the Main Menu.

### **Main Option 5. Participant Annual Review Date**

The participant's annual review date can be obtained through this option. The only information retrieved is the annual review date. For specific information, call the Family Support Division at 1-855-373-4636.

The caller is prompted to enter the following information.

- Please enter the 10 digit NPI number. Once a valid 10 digit number is entered, the IVR prompts for the participant MO HealthNet ID.
- Please enter the 8 digit MO HealthNet ID. Once a valid 8 digit number is entered, the IVR retrieves Data.
- If valid annual review date found, the IVR reads the following.
  - MO HealthNet ID (MO HealthNet ID) is registered to (First, Last Name). Annual Review Date (date on file). For information specific to the MO



HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.

•If Annual Review Date is not on file, the IVR reads the following:

“MO HealthNet ID (MO HealthNet ID) Annual Review Date is not on file. For information specific to the MO HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.”

After valid or error response IVR then reads menu options.

- For Another MO HealthNet Participant, Press 1. If the caller presses 1, IVR goes back to Enter MO HealthNet ID prompt.
- To repeat the information that you just heard, Press two. If the caller presses 2, IVR repeats the Annual Review Date response.
- If the caller presses 3, the IVR goes back to the Main Menu.
- If the provider selects to speak to a specialist, the IVR will route to a specialist.

### **Transfer Routine**

The provider must go through one of the available options on the IVR, prior to requesting an agent. If the inquiry cannot be answered through the IVR, please go through an option and wait to be prompted to be routed to a specialist. The IVR will respond to please hold while we transfer you to a MO HealthNet Specialist. Please have your NPI number ready.

#### **Number of Inquiries**

There are 10 inquiries allowed per caller. If 10 inquiries are accessed, the IVR will read that you have used your allotted 10 participant inquiries per call, thank you for calling, and hangs up.

#### **3.3.A(1) Using the Telephone Key Pad**

Both alphabetic and numeric entries may be required on the telephone key pad. In some cases, the IVR instructs the caller which numeric values to key to match alphabetic entries.

Please listen and follow the directions given by the IVR, as it prompts the caller for the various information required by each option. Once familiar with the IVR, the caller does *not* have to wait for the entire voice prompt. The caller can enter responses before the prompts are given.

#### **3.3.B MO HEALTHNET SPECIALIST**



Specialists are on duty between the hours of 8:00 AM and 5:00 PM, Monday through Friday (except holidays) when information is not clearly provided or available through the IVR system. The IVR number is (573) 751-2896. Providers are urged to do the following prior to calling:

- Review the provider manual and bulletins before calling the IVR.
- Have all material related to the problem (such as RA, claim forms, and participant information) available for discussion.
- Have the provider's NPI number available.
- Limit the call to three questions. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.
- Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

Please note that there are no limits on how many inquiries you can access through the MHD web-based [www.emomed.com](http://www.emomed.com) system. Limitations associated with the number of inquiries are only applicable to the IVR, speaking with a specialist, and email communications.

### 3.3.C INTERNET

Providers may submit claims on the internet via the MHD web based electronic claims filing system. The website address is [www.emomed.com](http://www.emomed.com). Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please access the application <http://manuals.momed.com/Application.html> and select the Apply for Internet Access link. Providers are unable to access [www.emomed.com](http://www.emomed.com) without proper authorization. An authorization is required for each individual user.

The internet inquiry options, located at [www.emomed.com](http://www.emomed.com), include the same inquiry options available through the IVR system (without limited number of inquiry restrictions). Providers are encouraged to use [www.emomed.com](http://www.emomed.com) as the first option, prior to accessing the IVR. The provider will be able to read and review the data and results, instead of having to call to hear the results. All the same functions and additional functions compared to the IVR are available and include: eligibility verification by Participant ID, case head ID and child's date of birth, or Social Security Number and date of birth, claim status, and check inquiry, provider enrollment status, and participant annual review date. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.



Providers also have the capability to receive and download their RAs from [www.emomed.com](http://www.emomed.com). Access to this information is restricted to users with authorization. In addition to the RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this website ([www.emomed.com](http://www.emomed.com).) include: claim submission, claim attachment submission, inquiries on claim status, attachment status, and check amounts, and credit adjustment(s). Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

### 3.3.D WRITTEN INQUIRIES

Letters directed to the MHD are answered by MO HealthNet specialists in the Provider Communications Unit. Written or telephone responses are provided to all inquiries. A provider who encounters a complex billing problem, numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage, or wishes to submit a complaint should submit the inquiry or complaint in writing to:

Provider Communications Unit  
MO HealthNet Division  
P.O. Box 5500  
Jefferson City, MO 65102-5500

A written inquiry should state the problem as clearly as possible and should include the following:

- Provider's name
- NPI number
- Address
- Telephone number
- MO HealthNet participant's full name
- MO HealthNet participant's identification number
- MO HealthNet participant's birthdate
- A copy of all pertinent information such as the following:
  - Remittance Advice forms
  - Invoices
  - Applicable Participant Information
  - Form letters
  - Timely filing documentation *must* be included with the written inquiry, if applicable.



### 3.4 PROVIDER EDUCATION UNIT

The Provider Education Unit serves as a communication and assistance liaison between the MHD and the provider community. Provider Education Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MHD. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to educate providers and other groups on proper billing methods and procedures for MHD claims. The representatives provide assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, and Webinar trainings for individuals and associations to provide instructions on procedures, policy changes, and benefit changes, which affect the provider community.

The Provider Education Unit can be contacted for training information and scheduling via telephone at (573) 751-6683 or email at [mhd\\_provtrain@dss.mo.gov](mailto:mhd_provtrain@dss.mo.gov). Providers can visit the Provider Participation page at <http://dss.mo.gov/mhd/providers> to schedule training.

### 3.5 PARTICIPANT SERVICES

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services, unpaid medical bills, premium collections questions, and payment information. The Participant Services Number is (800) 392-2161 or (573) 751-6527.

Providers may direct participants to the MO HealthNet Participant Services Unit when they need assistance in any of the above-mentioned situations. For example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

When participants have problems or questions concerning their MO HealthNet coverage, they should be directed to call or write to the Participant Services Unit at:

Participant Services Unit  
MO HealthNet Division  
P.O. Box 3535  
Jefferson City, MO 65102-3535

All calls or correspondence from providers are referred to the Provider Communications Unit. Please **do not** give participants the Provider Communications' telephone number.

### 3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is **not** received within 60 days, providers should call the Provider Communications Unit at 573-751-2896, to discuss submission of a new claim or status of the previously submitted claim. However, providers should not resubmit a new claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of the claim. Reference the Provider Manuals Section 17 for further discussion of the RA and Suspended Claims.

### 3.7 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MHD website at [www.dss.mo.gov/mhd/providers/index.htm](http://www.dss.mo.gov/mhd/providers/index.htm). Choose the “MO HealthNet forms” link in the right column.

### 3.8 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MHD billing site at [www.emomed.com](http://www.emomed.com). Most claims that require attachments may also be submitted at this site.

Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in the Provider Manuals Section 15. **NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.**

### 3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

- (Sterilization) Consent Form.
- Acknowledgment of Receipt of Hysterectomy Information.
- Medical Referral Form of Restricted Participant (PI-118).
- Certificate of Medical Necessity (for Durable Medical Equipment providers only).

These attachments may *not* be submitted via the Internet when additional documentation is required. The web site address for these submissions is [www.emomed.com](http://www.emomed.com).

### 3.10 Pharmacy & Clinical Services Unit



This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by emailing [MHD.ClinicalServices@dss.mo.gov](mailto:MHD.ClinicalServices@dss.mo.gov), or visit the MHD webpage at <http://dss.mo.gov/mhd/cs/>.

Providers with problems or questions regarding policies and programs, which cannot be answered by any other means, should email [Ask.MHD@dss.mo.gov](mailto:Ask.MHD@dss.mo.gov).

### **3.11 Pharmacy and Medical Pre-certification Help Desk**

The MHD requires pre-certification for certain radiological procedures. Certain drugs require a Prior Authorization (PA) or Edit Override (EO), prior to dispensing. To obtain these pre-certifications, PA's or EO's, providers can call 800-392-8030, or use the [CyberAccess](#) website, a web tool that automates this process for MO HealthNet providers.

To become a CyberAccess user, contact the help desk at 888-581-9797 or 573-632-9797, or email [cyberaccesshelpdesk@xerox.com](mailto:cyberaccesshelpdesk@xerox.com). For non-emergency service or equipment exception requests only, please use Fax #: (573) 522-3061; Drug PA Fax #: (573) 636-6470.

### **3.12 Third Party Liability (TPL)**

Providers should contact the TPL Unit to report any MO HealthNet participant who has sustained injuries due to an accident or when they have problems obtaining a response from an insurance carrier. Any unusual situations concerning third party insurance coverage for a MO HealthNet participant should also be reported to the TPL Unit. The TPL Unit's number is 573-751-2005.

## **SECTION 4 - TIMELY FILING**

### **4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING**

#### **4.1.A MO HEALTHNET CLAIMS**

Claims from participating providers who request MO HealthNet reimbursement *must* be filed by the provider and *must* be received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. Refer to Section 4.5, Definitions, for a detailed explanation of terms.

#### **4.1.B MEDICARE/MO HEALTHNET CLAIMS**

Claims that initially have been filed with Medicare within the Medicare timely filing requirement and that require separate filing of a claim with the MHD meet the timely filing requirement by being submitted by the provider and received by the state agency within 12 months from the date of service or 6 months from the date on Medicare's provider notice of the allowed claim, whichever is later. Claims denied by Medicare *must* be filed by the provider and received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. The counting of the 6-month period begins with the date of adjudication of Medicare payment and ends with the date of receipt.

Refer to Section 16 for billing instructions of Medicare/MO HealthNet (crossover) claims.

#### **4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY**

Claims for participants who have other insurance *must* first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim *must* still meet the MHD timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does *not* serve to extend the filing requirement.) If the provider has *not* had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait *no* longer than 6 months after the date of service before contacting the TPL Unit. If the MHD waives the requirement that the third-party resource's adjudication *must* be attached to the claim, documentation indicating the third-party resource's adjudication of the claim *must* be kept in the provider's records and made available to the division at its request. The claim *must* meet the MHD timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.

The 12 month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the 12 months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may *not* have initially filed a claim with the MHD. Under this set of circumstances, the provider may file a claim with the MHD later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MHD may accept and pay this specific type of claim without regard to the 12 month timely filing rule; however, all claims *must* be filed for MO HealthNet reimbursement within 24 months from the date of service in order to be paid.

## **4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM**

Claims that were originally submitted and received within 12 months from the date of service and were denied or returned to the provider *must* be resubmitted and received within 24 months of the date of service.

### **4.2.A CLAIMS FILED AND DENIED**

Claims that are denied may be resubmitted. A resubmission filed beyond the 12-month filing limit *must* either include an attachment, a Remittance Advice or Return to Provider letter, or the claim *must* have the original ICN entered in the appropriate field for electronic or paper claims (reference Section 15 of the applicable provider manual). Either the attachment or the ICN *must* indicate the claim had originally been filed within 12 months of the date of service. The same Remittance Advice, letter or ICN can be used for each resubmission of that claim.

### **4.2.B CLAIMS FILED AND RETURNED TO PROVIDER**

Some paper claims received by the fiscal agent *cannot* be processed because the wrong claim form is submitted or additional data is required. These claims are *not* processed through the system but are returned to the provider with a Return to Provider letter. When these claims are resubmitted more than 12 months after the date of service (and had been filed timely), a copy of the Return to Provider letter should be attached instead of the required Remittance Advice to document timely filing as explained in the previous paragraph. The date on the letter determines timely filing.

### 4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

In accordance with 13 CSR 70-3.100, claims that are *not* submitted in a timely manner as described in this section are denied. However, at any time in accordance with a court order, the the MHD may make payments to carry out a hearing decision, corrective action or court order to others in the same situation as those directly affected by it. As determined by the state agency, the MHD *may* make payment if a claim was denied due to state agency error or delay. In order for payment to be made, the MHD *must* be informed of any claims denied due to the MHD error or delay within 6 months from the date of the remittance advice on which the error occurred; or within 6 months of the date of completion or determination in the case of a delay; or 12 months from the date of service, whichever is longer.

### 4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT

Adjustments to MO HealthNet payments are only accepted if filed within 24 months from the date of service. If the processing of an adjustment necessitates filing a new claim, the timely limits for resubmitting the new, corrected claim is 24 months from the date of service. Providers can resubmit an adjusted claim via the MHD billing website located at [www.emomed.com](http://www.emomed.com). When overpayments are discovered, it is the responsibility of the provider to notify the state agency. Providers must submit a [Provider Initiated Self Disclosure Report Form \(here\)](#). The form must be submitted within 24 months of the date of service. Only adjustments or disclosures that are the result of lawsuits or settlements are accepted beyond 24 months.

### 4.5 DEFINITIONS

**Claim:** Each individual line item of service on a claim form for which a charge is billed by a provider for all claim form types except inpatient hospital. An inpatient hospital service claim includes all the billed charges contained on one inpatient claim document.

**Date of Service:** The date that serves as the beginning point for determining the timely filing limit. For such items as dentures, hearing aids, eyeglasses, and items of durable medical equipment such as an artificial larynx, braces, hospital beds, or wheelchairs, the date of service is the date of delivery or placement of the device or item. It applies to the various claim types as follows:

- **Nursing Homes:** The last date of service for the billing period indicated on the participant's detail record. Nursing Homes *must* bill electronically, unless attachments are required.
- **Pharmacy:** The date dispensed.
- **Outpatient Hospital:** The ending date of service for each individual line item on the claim form.



- **Professional Services:** The ending date of service for each individual line item on the claim form.
- **Dental:** The date service was performed for each individual line item on the claim form.
- **Inpatient Hospital:** The through date of service in the area indicating the period of service.

**Date of Receipt:** The date the claim is received by the fiscal agent. For a claim that is processed, this date appears as the Julian date in the internal control number (ICN). For a claim that is returned to the provider, this date appears on the Return to Provider letter.

**Date of Adjudication:** The date that appears on the Remittance Advice indicating the determination of the claim.

**Internal Control Number (ICN):** The 13-digit number printed by the fiscal agent on each document that processes through the claims processing system. The first two digits indicate the type of claim. The year of receipt is indicated by the 3rd and 4th digits, and the Julian date appears as the 5th, 6th, and 7th digits. For example, in the number 4912193510194, “49” is an eMOMED claim, “17” is the year 2017, and “193” is the Julian date for July 11.

**Julian Date:** The number of a day of the year when the days of the year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 2016, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2016.

**Date of Payment/Denials:** The date on the Remittance Advice at the top center of each page under the words “Remittance Advice.”

**Twelve-Month Time Limit Unit:** 366 days.

**Six-Month Time Limit:** 181 days.

**Twenty-four-Month Time Limit:** 731 days.

END OF SECTION

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## SECTION 5-THIRD PARTY LIABILITY

### 5.1 GENERAL INFORMATION

The purpose of this section of the provider manual is to provide a good understanding of Third Party Liability (TPL) and MO HealthNet. The federal government defines a third party resource (TPR) as:

“Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan.”

The following is a list of common TPRs; however, the list should *not* be considered to be all inclusive.

- Assault—Court Ordered Restitution
- Automobile—Medical Insurance
- CHAMPUS/CHAMPVA
- Health Insurance (Group or Private)
- Homeowner’s Insurance
- Liability & Casualty Insurance
- Malpractice Insurance
- Medical Support Obligations
- Medicare
- Owner, Landlord & Tenant Insurance
- Probate
- Product Liability Insurance
- Trust Accounts for Medical Services Covered by MO HealthNet
- Veterans’ Benefits
- Worker’s Compensation.

#### 5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

MO HealthNet funds are used after all other potential resources available to pay for the medical service have been exhausted. There are exceptions to this rule discussed later in this section. The intent of requiring MO HealthNet to be payer of last resort is to ensure that tax dollars are *not* expended when another liable party is responsible for all or a portion of the medical service charge. It is to the provider’s benefit to bill the liable TPR before billing MO HealthNet because many resources pay in excess of the maximum MO HealthNet allowable.

Federal and state regulations require that insurance benefits or amounts resulting from litigation are to be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. See 42 CFR 433 subpart D and RSMo 208.215 for further reference. In essence, MO HealthNet does *not* and should *not* pay a claim for medical



expenses until the provider submits documentation that all available third party resources have considered the claim for payment. Exceptions to this rule are discussed later in this section of the provider manual.

All TPR benefits for MO HealthNet covered services *must* be applied against the provider's charges. These benefits *must* be indicated on the claim submitted to MO HealthNet. Subsequently, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable and the TPR benefit amount, capping the payment at the MO HealthNet allowable. For example, a provider submits a charge for \$100 to the MO HealthNet Program for which the MO HealthNet allowable is \$80. The provider received \$75 from the TPR. The amount MO HealthNet pays is the difference between the MO HealthNet allowable (\$80) and the TPR payment (\$75) or \$5.

### **5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES**

Managed care health plans in the MO HealthNet Managed Care program *must* ensure that the health plan and its subcontractors conform to the TPL requirements specified in the managed care contract. The following outlines the agreement for the managed health care plans.

The managed care health plan is responsible for performing third party liability (TPL) activities for individuals with private health insurance coverage enrolled in their managed care health plan.

By law, MO HealthNet is the payer of last resort. This means that the managed care health plan contracted with the State of Missouri shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., pay and chase). The managed care health plan shall act as an agent of the state agency for the purpose of coordination of benefits.

The managed care health plan shall cost avoid all claims or services that are subject to payment from a third party health insurance carrier. If a third party health insurance carrier (other than Medicare) requires the managed care health plan member to pay any cost-sharing amount (such as copayment, coinsurance or deductible), the managed care health plan is responsible for paying the cost-sharing (even to an out-of-network provider). The managed care health plan's liability for such cost-sharing amounts shall *not* exceed the amount the managed care health plan would have paid under the managed care health plan's payment schedule.

If a claim is cost-avoided, the establishment of liability takes place when the managed care health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.

If the probable existence of a Third Party Resource (TPR) *cannot* be established or third party benefits are *not* available at the time the claim is filed, the managed care health plan *must* pay the full amount allowed under the managed care health plan's payment schedule.

The requirement to cost avoid applies to all covered services except claims for labor and delivery and postpartum care; prenatal care for pregnant women; preventative pediatric services; or if the claim is for a service provided to a managed care health plan member on whose behalf a child support enforcement order is in effect. The managed care health plan is required to provide such services and then recover payment from the third party health insurance carrier (pay and chase).

In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances:

- Worker's Compensation
- Tort-feasors
- Motorist Insurance
- Liability/Casualty Insurance

The managed care health plan shall immediately report to the MO HealthNet Division any cases involving a potential TPR resulting from any of the above circumstances. The managed care health plan shall cooperate fully with the MO HealthNet Division in all collection efforts. If the managed care health plan or any of its subcontractors receive reimbursement as a result of a listed TPR, that payment *must* be forwarded to the MO HealthNet Division immediately upon receipt.

**IMPORTANT:** Contact the MO HealthNet Division, Third Party Liability Unit, at (573) 751-2005 for questions about Third Party Liability.

### **5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR**

The provider may *not* bill the participant for any unpaid balance of the total MO HealthNet covered charge when the other resource represents all or a portion of the MO HealthNet maximum allowable amount. The provider is *not* entitled to any recovery from the participant except for services/items which are *not* covered by the MO HealthNet Program or services/items established by a written agreement between the MO HealthNet participant and provider indicating MO HealthNet is *not* the intended payer for the specific service/item but rather the participant accepts the status and liability of a private pay patient.

Missouri regulation does allow the provider to bill participants for MO HealthNet covered services if, due to the participant's action or inaction, the provider is *not* reimbursed by the MO HealthNet Program. It is the provider's responsibility to document the facts of the case. Otherwise, the MO HealthNet agency rules in favor of the participant.

### **5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 contained a number of changes affecting the administration of a state's Medicaid TPL Program. A provision of this law implemented by Federal Regulations effective February 15, 1990, is described below:

Under law and federal regulation, a provider may *not* refuse to furnish services covered under a state's Medicaid plan to an individual eligible for benefits because of a third party's potential liability for the service(s). See 42 CFR 447.20(b).

This provision prohibits providers from discriminating against a MO HealthNet participant based on the possible existence of a third party payer. A participant may *not* be denied services based solely on this criterion. Federal regulation does provide the state with authority to sanction providers who discriminate on this basis.

A common misconception is that incorrect information regarding third party liability affects participant eligibility. Providers have refused services to participants until the third party information available to the state is either deleted or changed. Third party information reflects the participant's records at the time the MO HealthNet eligibility is verified and is used to notify providers there is probability of a third party resource. Current MO HealthNet third party information is used when processing provider claims. Therefore, incorrect third party information does *not* invalidate the participant's eligibility for services. The federal regulation cited in the paragraph above prohibits providers from refusing services because of incorrect third party information in the participant's records.

## **5.2 HEALTH INSURANCE IDENTIFICATION**

Many MO HealthNet participants are dually eligible for health insurance coverage through a variety of sources. The provider should always question the participant or caretaker about other possible insurance coverage. While verifying participant eligibility, the provider is provided information about possible insurance coverage. The insurance information on file at the MO HealthNet Division (MHD) does *not* guarantee that the insurance(s) listed is the only resource(s) available nor does it guarantee that the coverage(s) remains available.



### **5.2.A TPL INFORMATION**

MO HealthNet participants may contact Participant Services, (800) 392-2161, if they have any questions concerning their MO HealthNet coverage. Providers may reference a point of service (POS) terminal, the Internet or they may call the interactive voice response (IVR) system at (573) 635-8908 for TPL information. Refer to Sections 1 and 3 for further information.

In addition to the insurance company name, city, state and zip code, the Internet, IVR or POS terminal also gives a code indicating the type of insurance coverage available (see Section 5.3). For example, if “03” appears in this space, then the participant has hospital, professional and pharmacy coverage. If the participant does *not* have any additional health insurance coverage either known or unknown to the MO HealthNet agency, a provider *not* affected by the specified coverage, such as a dental provider, does *not* need to complete any fields relating to TPL on the claim form for services provided to that participant.

### **5.2.B SOLICITATION OF TPR INFORMATION**

There may be coverage available to the participant that is *not* known to MHD. It is the provider’s responsibility and in his/her best interest to solicit TPR information from the participant or caretaker at the time service is provided whether or not MHD is aware of the availability of a TPR. The fact that the TPR information is unknown to MHD at the time service is provided does *not* release the liability of the TPR or the underlying responsibility of the provider to utilize those TPR benefits.

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse’s employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.
- CHAMPUS/CHAMPVA or veteran’s benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the “Improved Pension Program,” effective in 1979.
- If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency requirement for aliens or refugees) and the Part B premium be paid. Individuals who



have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)

- If the participant is disabled, coverage may exist under Medicare, Worker's Compensation, or other disability insurance carriers.
- If the participant is an over age disabled dependent (in or out of school), coverage may exist as an over age dependent on most group plans.
- If the participant is in school, coverage may exist through group plans.
- A relative may be paying for health insurance premiums on behalf of the participant.

### 5.3 INSURANCE COVERAGE CODES

Listed below are the codes that identify the type of insurance coverage the participant has:

|    |  |
|----|--|
| AC | Accident   |
| AM | Ambulance  |
| CA | Cancer   |
| CC | Nursing Home Custodial Care  |
| DE | Dental   |
| DM | Durable Medical Equipment  |
| HH | Home Health  |
| HI | Inpatient Hospital   |
| HO | Outpatient Hospital—includes outpatient and other diagnostic services  |
| HP | Hospice  |
| IN | Hospital Indemnity—refers to those policies where benefits <i>cannot</i> be assigned and it is <i>not</i> an income replacement policy |
| MA | Medicare Supplement Part A   |
| MB | Medicare Supplement Part B   |
| MD | Physician—coverage includes services provided and billed by a health care professional   |
| MH | Medicare Replacement HMO   |
| PS | Psychiatric—physician coverage includes services provided and billed by a health care professional                                     |

Dental



RX Pharmacy

SC Nursing Home Skilled Care

SU Surgical

VI Vision

## 5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

Employers frequently offer commercial managed health care plans to their employees in an effort to keep insurance costs more reasonable. Most of these policies require the patient to use the plan's designated health care providers. Other providers are considered "out-of-plan" and those services are *not* reimbursed by the commercial managed health care plan unless a referral was made by the commercial managed health care plan provider or, in the case of emergencies, the plan authorized the services (usually within 48 hours after the service was provided). Some commercial managed-care policies pay an out-of-plan provider at a reduced rate.

At this time, MO HealthNet reimburses providers who are *not* affiliated with the commercial managed health care plan. The provider *must* attach a denial from the commercial managed-care plan to the MO HealthNet claim form for MO HealthNet to consider the claim for payment.

Frequently, commercial managed health care plans require a copayment from the patient in addition to the amounts paid by the insurance plan. MO HealthNet does *not* reimburse copayments. This copayment may *not* be billed to the MO HealthNet participant or the participant's guardian caretaker. In order for a copayment to be collected the parent, guardian or responsible party *must* also be the subscriber or policyholder on the insurance policy and *not* a MO HealthNet participant.

## 5.5 MEDICAL SUPPORT

It is common for courts to require (usually in the case of divorce or separation) that the noncustodial parent provide medical support through insurance coverage for their child(ren). Medical support is included on all administrative orders for child support established by the Family Support Division.

At the time the provider obtains MO HealthNet and third party resource information from the child's caretaker, the provider should ask whether this type of resource exists. Medical support is a primary resource. There are new rules regarding specific situations for which the provider can require the MO HealthNet agency to collect from the medical support resource. Refer to Section 5.7 for details.

It *must* be stressed that if the provider opts *not* to collect from the third party resource in these situations, recovery is limited to the MO HealthNet payment amount. By accepting MO HealthNet reimbursement, the provider gives up the right to collect any additional amounts due from the



insurance resource. Federal regulation requires any excess amounts collected by the MO HealthNet agency be distributed to the participant/policyholder.

## **5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS**

MO HealthNet is *not* responsible for payment of claims denied by the third party resource if all required forms were *not* submitted to the TPR, if the TPR's claim filing instructions were *not* followed, if the TPR needs additional information to process the claim or if any other payment precondition was *not* met. Postpayment review of claims may be conducted to verify the validity of the insurance denial. The MO HealthNet payment amount is recovered if the denial is related to reasons noted above and MO HealthNet paid the claim. MO HealthNet's timely filing requirements are *not* extended due to difficulty in obtaining the necessary documentation from the third party resource for filing with MO HealthNet. Refer to Section 4 regarding timely filing limitations.

If the provider or participant is having difficulty obtaining the necessary documentation from the third party resource, the provider should contact Program Relations, (573) 751-2896, or the TPL Unit directly, (573) 751-2005, for further instructions. *Because difficulty in obtaining necessary TPR documentation does not extend MO HealthNet's timely filing limitations, please contact the TPL Unit or Provider Relations early to obtain assistance.*

### **5.6.A EXCEPTION TO TIMELY FILING LIMIT**

The 12-month initial filing rule can be extended if a third party payer, after making a payment to a provider, being satisfied that the payment is proper and correct, later reverses the payment determination, sometimes after 12 months have elapsed, and requests the provider to return the payment. Because TPL was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the State agency. The problem occurs when the provider, after having repaid the third party, wishes to file the claim with MO HealthNet, and is unable to do so because more than 12 months have elapsed since the date of service. Under this set of circumstances, the provider may file a claim with the MO HealthNet agency later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The state may accept and pay this type of claim without regard to the 12-month rule; however, the 24-month rule as found in 45 CFR 95.7 still applies.



### **5.6.B TPR CLAIM PAYMENT DENIAL**

If the participant eligibility file indicates there is applicable insurance coverage relating to the provider's claim type and a third party payment amount is *not* indicated on the claim, or documentation is *not* attached to indicate a bonafide denial of payment by the insurance company, the claim is denied for MO HealthNet payment.

A bonafide denial is defined as an explanation of benefits from an insurance plan that clearly states that the submitted services are *not* payable for reasons other than failure to meet claim filing requirements. For instance, a denial from a TPR stating the service is *not* covered by the plan, exceeds usual and customary charges, or was applied to a deductible are all examples of bonafide denials. The MO HealthNet agency *must* be able to identify that the denial originated from the TPR and the reason for the denial is clearly stated. If the insurance company uses denial codes, be sure to include the explanation of that code. A handwritten note from the provider or from an unidentifiable source is *not* a bonafide denial.

The claim is denied if the "Other" accident box in Field #10 of the CMS-1500 claim form is marked and the eligibility file indicates there is an insurance coverage code of 40. MO HealthNet denies payment if the claim does *not* indicate insurance payment or there is no bonafide TPR denial attached to the claim. Do *not* mark this box unless the services are applicable to an accident.

To avoid unnecessary delay in payment of claims, it is extremely important to follow the claim completion instructions relating to third party liability found in the provider manual. Incorrect completion of the claim form may result in denial or a delay in payment of the claim.

### **5.7 THIRD PARTY LIABILITY BYPASS**

There are certain claims that are *not* subjected to Third Party Liability edits in the MO HealthNet payment system. These claims are paid subject to all other claim submission requirements being met. MO HealthNet seeks recovery from the third party resource after MO HealthNet reimbursement has been made to the provider. If the third party resource reimburses MO HealthNet more than the maximum MO HealthNet allowable, by federal regulation this overpayment *must* be forwarded to the participant/policyholder.

The provider may choose *not* to pursue the third party resource and submit a claim to MO HealthNet. The provider's payment is limited to the maximum MO HealthNet allowable. The following services bypass Third Party Liability edits in the MO HealthNet claims payment system:

- The claim is for personal care or homemaker/chore services.
- The claim is for adult day health care.

- The claim is for intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is for a child who is covered by a noncustodial parent's medical support order.
- The claim is related to preventative pediatric care for participants under age 21 and the preventative service is the primary diagnosis on the claim.
- The claim relates to prenatal care for pregnant women and has a primary diagnosis of pregnancy or has one of the following procedure codes listed:

|              |                         |
|--------------|-------------------------|
| 59400        | Global Delivery—Vaginal |
| 59425, 59426 | Global Prenatal         |
| 59510        | Global Cesarean         |

## 5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

Many times a provider may learn of a change in insurance information prior to MO HealthNet as the provider has an immediate contact with their patients. If the provider learns of new insurance information or of a change in the TPL information, they may submit the information to the MO HealthNet agency to be verified and updated to the participant's eligibility file.

The provider may report this new information to the MO HealthNet agency using the MO HealthNet Insurance Resource Report. Complete the form as fully as possible to facilitate the verification of the information. Do *not* attach claims to process for payment. They *cannot* be processed for payment due to the verification process.

Please allow six to eight weeks for the information to be verified and updated to the participant's eligibility file. Providers wanting confirmation of the state's response should indicate so on the form and ensure the name and address information is completed in the spaces provided.

## 5.9 LIABILITY AND CASUALTY INSURANCE

Injuries resulting from an accident/incident (i.e., automobile, work-related, negligence on the part of another person) often place the provider in the difficult position of determining liability. Some situations may involve a participant who:

- is a pedestrian hit by a motor vehicle;
- is a driver or passenger in a motor vehicle involved in an accident;
- is employed and is injured in a work-related accident;
- is injured in a store, restaurant, private residence, etc., in which the owner may be liable.

The state monitors possible accident-related claims to determine if another party may be liable; therefore, information given on the claim form is very important in assisting the state in researching

accident cases. 13 CSR 4.030 and 13 CSR 4.040 requires the provider to report the contingent liability to the MO HealthNet Division.

Often the final determination of liability is *not* made until long after the accident. In these instances, claims for services may be billed directly to MO HealthNet prior to final determination of liability; however, it is important that MO HealthNet be notified of the following:

- details of the accident (i.e., date, location, approximate time, cause);
- any information available about the liability of other parties;
- possible other insurance resources;
- if a lien was filed prior to billing MO HealthNet.

This information may be submitted to MO HealthNet directly on the claim form, by calling the TPL Unit, (573) 751-2005, or by completing the Accident Report. Providers may duplicate this form as needed.

#### **5.9.A TPL RECOVERY ACTION**

Accident-related claims are processed for payment by MO HealthNet. The Third Party Liability Unit seeks recovery from the potentially liable third party on a postpayment basis. Once MO HealthNet is billed, the MO HealthNet payment precludes any further recovery action by the provider. The MO HealthNet provider may *not* then bill the participant or his/her attorney.

#### **5.9.B LIENS**

Providers may *not* file a lien for MO HealthNet covered services after they have billed MO HealthNet. If a lien was filed prior to billing MO HealthNet, and the provider subsequently receives payment from MO HealthNet, the provider *must* file a notice of lien withdrawal for the covered charges with a copy of the withdrawal notice forwarded to:

MO HealthNet Division  
Third Party Liability Unit  
P.O. Box 6500  
Jefferson City, MO 65102-6500.

#### **5.9.C TIMELY FILING LIMITS**

MO HealthNet timely filing rules are *not* extended past specified limits, if a provider chooses to pursue the potentially liable third party for payment. If a court rules there is no liability or the provider is *not* reimbursed in full or in part because of a limited settlement amount, the provider may *not* bill the participant for the amounts in question even if MO Healthnet's timely filing limits have been exceeded.



### **5.9.D ACCIDENTS WITHOUT TPL**

MO HealthNet should be billed directly for services resulting from accidents that do *not* involve any third party liability or where it is probable that MO HealthNet is the only coverage available.

Examples are:

- An accidental injury (e.g., laceration, cut, broken bone) occurs as a result of the participant's own action.
- A MO HealthNet participant is driving (or riding in) an uninsured motor vehicle that is involved in a *one* vehicle accident and the participant or driver has no uninsured motorists insurance coverage.

If the injury is obviously considered to be “no-fault” then it should be clearly stated. *Providers must be sure to fill in all applicable blocks on the claim form concerning accident information.*

### **5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION**

The following procedures should be followed when a MO HealthNet participant requests a copy of the provider’s billing or medical records for a claim paid by or to be filed with MO HealthNet.

- If an attorney is involved, the provider should obtain the full name of the attorney.
- In addition, the provider should obtain the name of any liable party, the liable insurance company name, address and policy number.
- Prior to releasing bills or medical records to the participant, the provider *must* either contact the MO HealthNet Division, Third Party Liability Unit, P.O. Box 6500, Jefferson City, MO 65102-6500, (573) 751-2005, or complete a MO HealthNet Accident Report or MO HealthNet Insurance Resource Report as applicable. If the participant requires copies of bills or medical records for a reason other than third party liability, it is *not* necessary to contact the Third Party Liability Unit or complete the forms referenced above.
- Prior to releasing bills or medical records to the participant, the provider *must* stamp or write across the bill, “Paid by MO HealthNet” or “Filed with MO HealthNet” in compliance with 13 CSR 70-3.040.

### **5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE**

If the provider receives payment from a third party resource after receiving MO HealthNet reimbursement for the covered service, the provider *must* promptly submit an Individual Adjustment Request form to MO HealthNet for the partial or full recovery of the MO HealthNet payment. The

amount to be refunded *must* be the full amount of the other resource payment, *not* to exceed the amount of the MO HealthNet payment. Refer to Section 6 for information regarding adjustments.

## **5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM**

The Health Insurance Premium Payment (HIPP) Program is a MO HealthNet Program that pays for the cost of health insurance premiums for certain MO HealthNet participants. The program purchases health insurance for MO HealthNet-eligible participants when it is determined cost effective. Cost effective means that it costs less to buy the health insurance to cover medical care than to pay for the same services with MO HealthNet funds. The HIPP Program *cannot* find health insurance policies for MO HealthNet participants, rather it purchases policies already available to participants through employers, former employers, labor unions, credit unions, church affiliations, other organizations, or individual policies. Certain participants may have to participate in this program as a condition of their continued MO HealthNet eligibility. Other participants may voluntarily enroll in the program. Questions about the program can be directed to:

MO HealthNet Division  
TPL Unit - HIPP Section  
P.O. Box 6500  
Jefferson City, MO 65102-6500  
or by calling (573) 751-2005.

## **5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY**

**COINSURANCE:** Coinsurance is a percentage of charges for a specific service, which is the responsibility of the beneficiary when a service is delivered. For example, a beneficiary may be responsible for 20 percent of the charge of any primary care visits. MO HealthNet pays only up to the MO HealthNet allowable minus any amounts paid by the third party resource regardless of any coinsurance amount.

**COMPREHENSIVE INSURANCE PLAN:** The comprehensive plan is also sometimes called a wraparound plan. Despite the name, comprehensive plans do not supply coverage as extensive as that of traditional insurance. Instead these plans are labeled “comprehensive” because they have no separate categories of insurance coverage. A comprehensive plan operates basically like a full major medical plan, with per-person and per-family deductibles, as well as coinsurance requirements.

**COPAYMENT:** Copayments are fixed dollar amounts identified by the insurance policy that are the responsibility of the patient; e.g., \$3 that a beneficiary must pay when they use a particular



service or services. MO HealthNet cannot reimburse copayment amounts. An insurance plan's copayment requirements should not be confused with the MO HealthNet cost sharing (copayment, coinsurance, shared dispensing fee) requirements established for specific MO HealthNet services.

**DEDUCTIBLE:** Deductibles are amounts that an individual must pay out-of-pocket before third party benefits are made available to pay health care costs. Deductibles may be service specific and apply only to the use of certain health care services, or may be a total amount that must be paid for all service use, prior to benefits being available. MO HealthNet pays only up to the MO HealthNet allowable regardless of the deductible amount.

**FLEXIBLE BENEFIT OR CAFETERIA PLANS:** Flexible benefit plans operate rather like a defined contribution pension plan in that the employer pays a fixed and predetermined amount. Employees generally share some portion of the plan's premium costs and thus are at risk if costs go up. Flexible benefit plans allow employees to pick what benefits they want. Several types of flexible programs exist, and three of the more popular forms include modular packages, core-plus plans, and full cafeteria plans.

Modular plans offer a set number of predetermined policy options at an equal dollar value but includes different benefits. Core-plus plans have a set "core" of employer-paid benefits, which usually include basic hospitalization, physician, and major medical insurance. Other benefit options, such as dental and vision, can be added at the employees' expense. Full cafeteria plans feature employer-paid "benefit dollars" which employees can use to purchase the type of coverage desired.

**MANAGED CARE PLANS:** Managed care plans generally provide full protection in that subscribers incur no additional expenses other than their premiums (and a copay charge if specified). These plans, however, limit the choice of hospitals and doctors.

Managed care plans come in two basic forms. The first type, sometimes referred to as a staff or group model health maintenance organization, encompasses the traditional HMO model used by organizations like Kaiser Permanente or SANUS. The physicians are salaried employees of the HMO, and a patient's choice of doctors is often determined by who is on call when the patient visits.

The second type of managed care plan is known as an individual (or independent) practice association (IPA) or a preferred provider organization (PPO), each of which is a network of doctors who work individually out of their own offices. This arrangement gives the patient some degree of choice within the group. If a patient goes outside the network, however, the plan reimburses at a lower percentage. Generally an IPA may be prepaid, while a PPO is similar to a traditional plan, in that claims may be filed and reimbursed at a predetermined rate if the services of a participating doctor are utilized. Some IPAs function as HMOs.



**SELF-INSURANCE PLANS:** An alternative to paying premiums to an insurance company or managed-care plan is for an employer to self-insure. One way to self-insure is to establish a section 501(c)(9) trust, commonly referred to as a VEBA (Voluntary Employee Benefit Association). The VEBA must represent employees' interest, and it may or may not have employee representation on the board. It is, in effect, a separate entity or trust devoted to providing life, illness, or accident benefits to members.

A modified form of self-insurance, called minimum premium, allows the insurance company to charge only a minimum premium that includes a specified percentage of projected annual premiums, plus administrative and legal costs (retention) and a designated percentage of the annual premium. The employer usually holds the claim reserves and earns the interest paid on these funds.

Claims administration may be done by the old insurance carrier, which virtually guarantees replication of the former insurance program's administration. Or the self-insurance program can be serviced through the employer's own benefits office, an option commonly employed by very large companies of 10,000 or more employees. The final option is to hire an outside third-party administrator (TPA) to process claims.

**TRADITIONAL INSURANCE PLAN:** Provides first-dollar coverage with usually three categories of benefits: (1) hospital, (2) medical/surgical, and (3) supplemental major medical, which provides for protection for medical care not covered under the first two categories. Variations and riders to these plans may offer coverage for maternity care, prescription drugs, home and office visits, and other medical expenses.

**END OF SECTION**

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## SECTION 6-ADJUSTMENTS

### 6.1 GENERAL REQUIREMENTS

MO HealthNet Division (MHD) continues to improve their billing website at [www.emomed.com](http://www.emomed.com) to provide real-time direct access for administrators, providers, and clearinghouse users. This describes the process and tools providers should use to adjust claims.

### 6.2 INSTRUCTIONS FOR ADJUSTING CLAIMS WITHIN 24 MONTHS OF DATE OF SERVICE

MHD developed an easy to use, web-based tool to adjust incorrectly billed and/or paid Medicaid and Medicare crossover claims. Providers shall utilize the web-based adjustment tool to adjust or void their own claims, if the date of service (DOS) on the claim to be adjusted was within two (2) years of the date of the Remittance Advise on which payment was made.

#### 6.2.A NOTE: PROVIDERS MUST BE ENROLLED AS AN ELECTRONIC BILLING PROVIDER BEFORE USING THE ONLINE CLAIM ADJUSTMENT TOOL

Providers *must* be enrolled as an electronic billing provider before using the online claim adjustment tool. See Section 2.1.D.

To apply for Internet access, please access the [emomed](http://emomed.com) website found on the following website address: [www.emomed.com](http://www.emomed.com). Access the “[Register Now!](#)” hyperlink to apply online for Internet access and follow the instructions provided. Providers must have proper authorization to access [www.emomed.com](http://www.emomed.com), for each individual user.

#### 6.2.B ADJUSTING CLAIMS ONLINE

Providers may adjust claims within two (2) years of the DOS, by logging onto the MHD billing site at [www.emomed.com](http://www.emomed.com). To find the claim to be adjusted, the provider should enter the participant Departmental Client Number (DCN) and DOS in the search box, and choose the highlighted Internal Control Number (ICN). Paid claims can be adjusted by the “Void” option or “Replacement” option. Denied claims can be adjusted by the “Copy Claim Original” or Copy Claim Advanced” option.

##### 6.2.B(1) Options for Adjusting a Paid Claim

If there is a paid claim in the MHD emomed system, then the claim can be voided or replaced.



The provider should choose “Void” to delete a paid claim. A voided claim credits the system and reverses the payment. A void option should be chosen when the entire claim needs to be canceled and the payment is reversed and credited in the system. Providers do not void claims often because this option is only chosen when a claim should not have been submitted. This includes when the wrong DCN or billing Nations Provider Identifier (NPI) was entered on the claim.

The provider should choose “Replacement” to make corrections or additions to a paid claim. A replacement option should be chosen when editing a paid claim. Providers will use this option more often than the void option because the claim was billed incorrectly. This includes when the wrong DOS, diagnosis, charge amount, modifier, procedure code, or POS was entered on the claim.

#### **6.2.B(1)(i) Void**

To void a claim from the claim status screen on emomed, choose the void tab. This will bring up the paid claim in the system; scroll to the bottom of the claim and chose select the highlighted ‘submit claim’ button. The claim now has been submitted to be voided or credited in the system.

#### **6.2.B(1)(ii) Replacement**

To replace a claim from the claim status screen on emomed, choose the replacement tab. This will bring up the paid claim in the system; here corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Now scroll to the bottom of the claim and select the highlighted ‘submit claim’ button. The replacement claim with corrections has now been submitted.

### **6.2.B(2) Options for Adjusting a Denied Claim**

If there is a denied claim in the MHD emomed system, then the claim can be resubmitted as a New Claim. A denied claim can also be resubmitted by choosing Timely Filing, Copy Claim-original, or Copy Claim-advanced.

#### **6.2.B(2)(i) Timely Filing**

To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the ICN of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and select the highlighted ‘submit claim’ button. The claim has now been submitted for payment.



### **6.2.B(2)(ii) Copy Claim – Original**

This option is used to copy a claim just as it was entered originally on emomed. Corrections can be made to the claim by selecting the appropriate edit button, and then saving the changes. Now scroll to the bottom of the claim and select the highlighted submit claim button. The claim has now been submitted with the corrections made.

### **6.2.B(2)(iii) Copy Claim – Advanced**

This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual provider NPI and should have been submitted under the group provider NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and Name information will transfer over to the new claim type. An example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

## **6.2.C CLAIM STATUS CODES**

After the adjusted claim is submitted, the claim will have one of the following status indicator codes.

C – This status indicates that the claim has been Captured and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – This status indicates that the claim is to be Paid.

K – This status indicates that the claim is to be Denied. This claim can be corrected and resubmitted immediately.

Provider Communications Unit may be contacted at (573) 751-2896, for questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verifications. Please contact Provider Education Unit at (573) 751-6683 or email [mhd.provtrain@dss.mo.gov](mailto:mhd.provtrain@dss.mo.gov) for education and training on proper billing methods and procedures for MHD claims.

## **6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS**

Providers who are paid incorrectly for a claim that is older than 24 months are required to complete a Self-Disclosure letter to be submitted to Missouri Medicaid Audit and Compliance (MMAC). Access the MMAC website for the Self-Disclosure Form located at the following website address: <http://mmac.mo.gov/providers/self-audits-Self-Disclosures/>.



MMAC encourages providers and entities to establish and implement a compliance integrity plan. MMAC also encourages providers and entities to self-disclose or report those findings along with funds to compensate for the errors or a suggested repayment plan, which requires MMAC approval, to the Financial Section of MMAC at the address below:

Missouri Medicaid Audit & Compliance  
Financial Section – SELF-DISCLOSURE  
P.O. Box 6500  
Jefferson City, MO 65102-6500

In an effort to ensure Provider Initiated Self-Disclosures are processed efficiently, make sure to complete the form and include the participant’s name, DCN, DOS, ICN, Paid Amount, Refund Amount and Reason for Refund. Providers can direct questions regarding Self-Disclosures to MMAC Financial Section at [mmac.financial@dss.mo.gov](mailto:mmac.financial@dss.mo.gov) or by calling 573-751-3399.

#### **6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS**

There are two (2) types of adjustment transactions:

1. An adjustment that credits the original payment and then repays the claim based on the adjusted information appears on the Remittance Advice as a two-step transaction consisting of two ICN’s.
  - An ICN that credits (recoups) the original paid amount and
  - An ICN that repays the claim with the corrected payment amount.
2. An adjustment that credits or recoups the original payment but does not repay the claim (resulting in zero payment) appears on the Remittance Advice with one ICN that credits (recoups) the original paid amount.

**END OF SECTION**

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## SECTION 7-MEDICAL NECESSITY

### 7.1 CERTIFICATE OF MEDICAL NECESSITY

The MO HealthNet Program requires that the Certificate of Medical Necessity form accompany claims for reimbursement of 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 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.

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 either submitted electronically with the electronic claim or submitted on paper attached to the original claim form. For information regarding submission of the Certificate of Medical Necessity for 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.



### **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 3.8 and Section 23) or mailed to:

Wipro Infocrossing  
P.O. Box 5900  
Jefferson City, MO 65102-5900

If the Certificate of Medical Necessity is approved, the approved time period is six (6) 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. Participant 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 service/item.  |



- |   |   |
|---|---|
| 6. Months Item Needed<br>(DME only)                 | For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).  |
| 7. Name and Signature of<br>Prescriber              | The prescriber's signature, when required, <i>must</i> be an original signature. A stamp 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). |
| 8. Prescriber's MO HealthNet<br>Provider Identifier | Enter the NPI number if the prescriber participates in the MO HealthNet Program.  |
| 9. 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.                          |
| 10. Diagnosis                                       | Enter the appropriate ICD code(s) that prompted the request for this service or item, if required by program.   |
| 11. Prognosis                                       | Enter the participant's prognosis and the anticipated results of the requested service or item.   |
| 12. Provider Name and Address                       | Enter provider's name, address, and telephone number.   |
| 13. MO HealthNet Provider<br>Identifier             | Enter provider's NPI number.  |
| 14. 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 complete.  |

**END OF SECTION**

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## SECTION 8-PRIOR AUTHORIZATION

### 8.1 BASIS

Under the MO HealthNet Program, certain covered services and equipment require approval prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.

A prior authorization or precertification determines medical necessity of service(s) provided to the participant. It does *not* guarantee payment nor does it guarantee participant eligibility.

A prior authorization or precertification determines the number of units, hours and/or the types of services that may be provided to a participant based on the medical necessity of that service. The provider should *not* submit claims solely on the basis of the prior authorization and/or precertification, but *must* submit claims upon actual services rendered. Providers *must* retain the appropriate documentation that services were provided on the date of service submitted on the claim. Documentation should be retained for five (5) years.

Please refer to Sections 13 and 14 of the applicable provider manual for program-specific information regarding prior authorization.

### 8.2 PRIOR AUTHORIZATION GUIDELINES

Providers are required to seek prior authorization for certain specified services *before* delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization. Certain services require prior authorization only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in Sections 13 and 14 of the applicable provider manuals.

The following general guidelines pertain to all prior authorized services:

- A Prior Authorization (PA) Request *must* be completed and mailed to the appropriate address. Unless otherwise specified in Sections 13 and 14 of the applicable provider manual, mail requests to:

Wipro Infocrossing  
P.O. Box 5700  
Jefferson City, MO 65102-5700

A PA Request form may be printed and completed by hand or the form may be completed in Adobe and then printed. To enter information into a field, either click in the field or tab to the

field and complete the information. When all the fields are completed, print the PA Request and send to the address listed above.

- The provider performing the service *must* submit the PA Request form. Sufficient documentation or information *must* be included with the request to determine the medical necessity of the service.
- The service *must* be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do *not* request prior authorization for services to be provided to an ineligible person (see Sections 1 and 13 of the applicable provider manual).
- Expanded HCY (EPSDT) services are limited to participants 20 years of age and under and are *not* reimbursed for participants 21 and over even if prior authorized.
- See Section 20 for specific criteria and guidelines regarding prior authorization of non-covered services through the Exceptions Process for participants 21 and over.
- Prior authorization does *not* guarantee payment if the participant is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is *not* made for services initiated before the approval date on the PA Request form or after the authorization deadline.
- For services to continue after the expiration date of an existing PA Request, a new PA Request *must* be completed and submitted prior to the end of the current PA.

### **8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION**

Complete the Prior Authorization (PA) Request form describing in detail those services or items requiring prior authorization and the reason the services or items are needed. With the exception of x-rays, dental molds, and photos, documentation submitted with the PA Request is *not* returned. Providers should retain a copy of the original PA Request and any supporting documentation submitted for processing. Instructions for completing the PA Request form are on the back of the form. *Unless otherwise stated in Section 13 or 14 of the applicable provider manual*, mail the PA Request form and any required attachments to:

Wipro Infocrossing  
P.O. Box 5700  
Jefferson City, Missouri 65102-5700

The appropriate program consultant reviews the request. A MO HealthNet Authorization Determination is returned to the provider with any stipulations for approval or reason for denial. If approved, services may *not* exceed the frequency, duration or scope approved by the consultant. If the service or item requested is to be manually priced, the consultant enters the allowed amount on the MO HealthNet



Authorization Determination. The provider should keep the approved MO HealthNet Authorization Determination for their files; do *not* return it with the claim.

After the authorized service or item is provided, the claim form *must* be completed and submitted in the usual manner. **Providers are cautioned that an approved authorization approves only the medical necessity of the service and does *not* guarantee payment. Claim information *must* still be complete and correct, and the provider and the participant *must* both be eligible at the time the service is rendered or item delivered. Program restrictions such as age, category of assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible participants are *not* reimbursed.**

If the PA Request is denied, the provider receives a MO HealthNet Authorization Determination (reference Section 8.7 of this manual). The participant is notified by letter each time a PA Request is denied. (Reference Section 1 of this manual for additional information regarding the PA Request Denial letter.)

## 8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

- Medicare crossovers when Medicare makes the primary reimbursement and MO HealthNet pays only the coinsurance and deductible.
- Procedures requiring prior authorization that are performed incidental to a major procedure.
- Services performed as an emergency. An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
  1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
  2. Serious impairment of bodily functions; or
  3. Serious dysfunction of any bodily organ or part; or
  4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
  5. Injury to self or bodily harm to others; or
  6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.



In the case of an emergency when prior authorization *cannot* be obtained before the service or item is rendered, the necessary and appropriate emergency service should be provided. Complete the claim form and write “emergency” across the top of the claim form. Do *not* submit a Prior Authorization (PA) Request form.

Attach a Certificate of Medical Necessity form to the claim and submit it to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form, in detail, the reason for the emergency provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.)

Emergency requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service on an emergency basis, the claim is denied.

- The participant was *not* eligible for MO HealthNet at the time of service, but eligibility was made retroactive to that time. Submit a claim along with a Certificate of Medical Necessity form to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form that the participant was *not* eligible on the date of service, but has become eligible retroactively to that date. The provider *must* also include, in detail, the reason for the provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.) Retroactive eligibility requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service, the claim is denied.

## **8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION (PA) REQUEST FORM**

Instructions for completing the Prior Authorization (PA) Request form are printed on the back of the form. Additional clarification is as follows:

- Section II, HCY Service Request, is applicable for participants 20 years of age and under and should be completed when the information is known.
- In Section III, Service Information, the gray area is for state use only.

Field #24 in Section III, in addition to being used to document medical necessity, can also be used to identify unusual circumstances or to provide detailed explanations when necessary. Additional pages may be attached to the PA Request for documentation.

Also, the PA Request forms *must* reflect the appropriate service modifier with procedure code and other applicable modifiers when requesting prior authorization for the services defined below:



Dental

| Modifier | Definition   |
|----------|--|
| 26       | Professional Component   |
| 54       | Surgical Care Only   |
| 55       | Postoperative Management Only  |
| 80       | Assistant Surgeon  |
| AA       | Anesthesia Service Performed Personally by Anesthesiologist                                      |
| NU       | New Equipment (required for DME service)   |
| QK       | Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals |
| QX       | CRNA (AA) Service; with Medical Direction by a Physician   |
| QZ       | CRNA Service; without Medical Direction by a Physician   |
| RB       | Replacement and Repair (required for DME service)  |
| RR       | Rental (required for DME service)  |
| SG       | Ambulatory Surgical Center (ASC) Facility Services   |
| TC       | Technical Component  |

- Complete each field in Section IV. See Sections 13 and 14 of the applicable provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.
- Section V, Prescribing/Performing Practitioner, *must* be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which are prescribed by a physician/practitioner that require prior authorization. Reference the applicable provider manual for additional instructions.

The provider receives a MO HealthNet Authorization Determination (refer to Section 8.6) indicating if the request has been approved or denied. Any comments made by the MO HealthNet/MO HealthNet managed care health plan consultant may be found in the comments section of the MO HealthNet Authorization Determination. The provider does *not* receive the PA Request or a copy of the PA Request form back.

*It is the provider’s responsibility to request prior authorization or reauthorization, and to notify the MO HealthNet Division of any changes in an existing period of authorization.*

**8.5.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST**

Providers may submit a Prior Authorization (PA) Request to:

- Initiate the start of services that require prior authorization.
- Request continued services when services continue to be medically necessary beyond the current approved period of time.



1. The dates for the services requested *cannot* overlap dates that are already approved and *must* be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.
- Correct a participant MO HealthNet number if the original PA Request had a number on it and services were approved.
    1. When submitting a PA Request due to an error in the participant MO HealthNet number on the original PA Request, attach a copy of the MO HealthNet Authorization Determination giving original approval to the new request.
    2. Fields #17 through #23 in Section III *must* be identical to the original approval.
    3. The PA Request form should be clearly marked as a “correction of the participant MO HealthNet number” and the error *must* be explained in detail in Field #24 of Section III.
    4. Mark the PA Request “*Special Handle*” at the top of the form.
  - Change providers within a group during an approved authorization period.
    1. When submitting a PA Request due to a change of provider *within a group*, attach a copy of the MO HealthNet Authorization Determination showing the approval to the new PA Request form.
    2. Section III, Field #19 “FROM” *must* be the date the new provider begins services and Field 20 “THROUGH” *cannot* exceed the through date of the previously approved PA Request.
    3. The PA Request form should be clearly marked at the top “change of provider,” and the change *must* be explained in Field #24 of Section III.
    4. Mark the PA Request “*Special Handle*” at the top of the form. Use Field #24 to provide a detailed explanation.

## 8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

The MO HealthNet Authorization Determination is sent to the provider who submitted the Prior Authorization (PA) Request. The MO HealthNet Authorization Determination includes all data pertinent to the PA Request. The MO HealthNet Authorization Determination includes the PA number; the authorized National Provider Identifier (NPI); name and address; the participant's DCN, name, and date of birth; the procedure code, the from and through dates (if approved), and the units or dollars (if approved); the status of the PA Request on each detail line ("A"-approved; "C"-closed; "D"-denied; and "I"-incomplete); and the applicable Explanation of Benefit (EOB) reason(s), with the reason code description(s) on the reverse side of the determination.



### 8.6.A A DENIAL OF PRIOR AUTHORIZATION (PA) REQUESTS

The MO HealthNet Authorization Determination indicates a denied authorization by reflecting a status on each detail line of "D" for a denial of the requested service or "I" for a denial due to incomplete information on the form. With a denial status of "D" or "I", a new PA Request form *must* be submitted for the request to be reconsidered.

### 8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

The following lists the fields found on the MO HealthNet Authorization Determination and an explanation of each field.

| FIELD NAME                   | EXPLANATION OF FIELD  |
|------------------------------|---|
| Date                         | Date of the disposition letter  |
| Request Number (No.)         | Prior Authorization Number  |
| Receipt Date                 | Date the Prior Authorization (PA) Request was received by the fiscal agent  |
| Service Provider             | Authorized NPI number, name and address   |
| Participant                  | Participant's DCN, name, date of birth and sex  |
| Procedure Code               | The procedure code  |
| Modifier                     | The modifier(s)   |
| Authorization Dates          | The authorized from and thru dates  |
| Units                        | The units requested, units authorized (if approved), units used   |
| Dollars                      | The dollar amount requested, dollar amount authorized (if approved), dollar amount used                           |
| Status                       | The status codes of the PA Request<br>The status codes are:<br>A—Approved<br>C—Closed<br>D—Denied<br>I—Incomplete |
| Reason                       | The applicable EOB reason(s)  |
| Comments                     | Comments by the consultant which may explain denials or make notations referencing specific procedure code(s)     |
| Physician/Provider Signature | Signature of provider when submitting a Request for Change  |

|                         |  |
|-------------------------|--|
|                         | (RFC)  |
| Date                    | Date of provider's signature when submitting a RFC |
| Reason Code Description | Reason code description(s) listed in Reason field  |

## 8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST

To request a change to an approved Prior Authorization (PA) Request, providers are required to make the applicable changes on the MO HealthNet Authorization Determination. Attach additional documentation per program requirement if the requested change is in frequency, amount, duration or scope or if it documents an error on the original request, e.g., plan of care, physician orders, etc. The amended MO HealthNet Authorization Determination *must* be signed and dated and submitted with applicable documentation to the address below. When changes to an approved PA Request are made on the MO HealthNet Authorization Determination, the MO HealthNet Authorization Determination is referred to as a Request For Change (RFC). **Requests for reconsideration of any detail lines that reflect a "D" or "I" status *must not* be included on a RFC. Providers *must* submit a new PA Request form for reconsideration of denied detail lines.**

When a RFC is approved, a MO HealthNet Authorization Determination incorporating the requested changes is sent to the provider. When a RFC is denied, the MO HealthNet Authorization Determination sent to the provider indicates the same information as the original MO HealthNet Authorization Determination that notified the provider of approval, with an Explanation of Benefit (EOB) stating that the requested changes were considered but were *not* approved.

Providers *must not* submit changes to PA Requests until the MO HealthNet Authorization Determination from the initial request is received.

*Unless otherwise stated in Section 13 or 14 of the applicable provider manual, PA Request forms and RFCs should be mailed to:*

Wipro Infocrossing  
P. O. Box 5700  
Jefferson City, MO 65102

### 8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

- Correct a procedure code.
- Correct a modifier.
- Add a new service to an existing plan of care.
- Correct or change the “from” or “through” dates.

1. The “from” date may *not* precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.
  2. The “through” date *cannot* be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.
- Increase or decrease requested units or dollars.
    1. An increase in frequency and or duration in some programs require additional or revised information.
  - Correct the National Provider Identifier (NPI). The NPI number can only be corrected if both of the following conditions are met:
    - The number on the original request is in error; and
    - The provider was *not* reimbursed for any units on the initial Prior Authorization Request.
  - Discontinue services for a participant.

## **8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)**

Prior Authorization (PA) Requests and Requests For Change (RFC) for the Personal Care and Home Health Programs' services for children under the age of 21 *must* be submitted to Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN submits the request to Wipro Infocrossing. The BSHCN staff continues to complete and submit PA Requests and RFCs for Private Duty Nursing and Medically Fragile Adult waiver services.

PA Requests and RFCs for AIDS Waiver and Personal Care Programs' services for individuals with HIV/AIDS continue to be completed and submitted by the DHSS, Bureau of HIV, STD and Hepatitis contract case management staff.

All services authorized by the DHSS, Division of Senior and Disability Services (DSDS) or it's designee, are authorized utilizing the Home and Community Based Services (HCBS) Web Tool, a component of the Department of Social Services, MO HealthNet Division's Cyber Access system.

Please reference the provider manual for further information.

## **8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES**

All non-emergency, 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 or 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 PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, *a written request must* be submitted by a physician to:

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

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

The written request *must* include:

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

### **8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION 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, non-emergency 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; and
4. Independent laboratory services.

**END OF SECTION**

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## **SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM**

### **9.1 GENERAL INFORMATION**

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). The Social Security Act authorizes Medicaid coverage of medical and dental services necessary to treat or ameliorate defects and physical and mental illness identified by an HCY screen. These services are covered by Medicaid regardless of whether the services are covered under the state Medicaid plan. Services identified by an HCY screening that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope, and prognosis. Prior authorization (PA) of services may be required for service needs and for services of extended duration. Reference Section 13, Benefits and Limitations, for a description of requirements regarding the provision of services.

Every applicant under age 21 (or his or her legal guardian) is informed of the HCY Program by the Family Support Division income-maintenance Eligibility Specialists at the initial application for assistance. The participant is reminded of the HCY Program at each annual redetermination review.

The goal of the Medicaid agency is to have a health care home for each child—that is, to have a primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child’s health needs. The health care home should follow the screening periodicity schedule, perform interperiodic screens when medically necessary, and coordinate the child’s specialty needs.

### **9.2 PLACE OF SERVICE (POS)**

A full or partial HCY screen may be provided in the following places of service (POS):

- 03 School
- 11 Office
- 12 Home
- 19 Off Campus Outpatient Hospital
- 21 Inpatient Hospital
- 22 On Campus Outpatient Hospital
- 25 Birthing Center
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 99 Other



### 9.3 DIAGNOSIS CODE

The Early Periodic Screening diagnosis code *must* appear as the primary diagnosis on a claim form submitted for HCY screening services. The appropriate HCY screening procedure code should be used for the initial HCY screen and all other full or partial screens.

### 9.4 INTERPERIODIC SCREENS

Medically necessary screens outside the periodicity schedule that do *not* require the completion of all components of a full screen may be provided as an interperiodic screen or as a partial screen. An interperiodic screen has been defined by the Centers for Medicare & Medicaid Services (CMS) as any encounter with a health care professional acting within his or her scope of practice. This screen may be used to initiate expanded HCY services. Providers who perform interperiodic screens may use the appropriate level of Evaluation/Management visit (CPT) procedure code, the appropriate partial HCY screening procedure code, or the procedure codes appropriate for the professional's discipline as defined in their provider manual. Office visits and full or partial screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record. The diagnosis for the medical condition necessitating the interperiodic screening *must* be entered in the primary diagnosis field, and the appropriate screening diagnosis should be entered in the secondary diagnosis field.

The interperiodic screen does *not* eliminate the need for full HCY screening services at established intervals based on the child's age.

If not all components of the full or unclothed physical are met, the Reduced Preventive Screening codes *must* be billed.

#### PROCEDURE

| CODE          | DESCRIPTION                            |
|---------------|--|
| 99381 - 99385 | Preventive Screen; new patient         |
| 99391 - 99395 | Preventive Screen; established patient |

### 9.5 FULL HCY/EPSDT SCREEN

#### PROCEDURE

| CODE                | DESCRIPTION                          |
|---------------------|--------------------------------------|
| 99381EP-99385EP     | Full Medical Screening               |
| 99391EP-99395EP     |                                      |
| 99381EPUC-99385EPUC | Full Medical Screening with Referral |
| 99391EPUC-99395EPUC |                                      |

A full HCY/EPSDT screen includes the following:

- A comprehensive unclothed physical examination;
- A comprehensive health and developmental history including assessment of both physical and mental health developments;
- Health education (including anticipatory guidance);
- Appropriate immunizations according to age;\*
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);\*
- Lead screening according to established guidelines;
- Hearing screening;
- Vision screening; and
- Dental screening.

It is *not* always possible to complete all components of the full medical HCY screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow their child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian with regard to the importance of these services. If the parent/guardian continues to refuse the service the child's medical record *must* document the reason the service was *not* provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work was refused. By fully documenting in the child's medical record the reason for *not* providing these services, the provider may bill a full medical HCY screening service even though all components of the full medical HCY screening service were *not* provided.

It is mandatory that the Healthy Children and Youth Screening guide be retained in the patient's medical record as documentation of the service that was provided. The Healthy Children and Youth Screening guide is *not* all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener *must* sign and date the guide and retain it in the patient's medical record.** The HCY screening guide is not the only method a provider can use to document in the patient's medical record that a service was provided. The provider can also document the screenings in an electronic medical record. If the provider uses an electronic medical record, the electronic version must contain all of the components listed on the HCY screening guide for the patient's appropriate age group.

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they make them available to appropriate state and federal officials on request. The Healthy Children and

Youth Screening guide is found at <http://manuals.momed.com/manuals/presentation/forms.jsp>. Providers *must* have a form in the medical record if billing the screening.

The MO HealthNet Division is required to record and report to the Centers for Medicare & Medicaid Services all HCY screens and referrals for treatment. Reference Sections 13 and 15 for billing instructions. *Claims for the full medical screening and/or full medical screening with referral should be submitted promptly within a maximum of 60 days from the date of screening.*

Office Visits and HCY screenings in which an abnormality or a preexisting problem are addressed in the process of performing the preventive medicine evaluation and management (E/M) service are not billable on the same date of service.

An exception would be if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service. Diagnosis codes must clearly reflect the abnormality or condition for which the additional follow-up care or treatment is indicated. In addition, the medical necessity must be clearly documented in the participant's record, and the Certificate of Medical Necessity form must be fully completed and attached to the claim when submitting for payment.

If an insignificant or trivial problem/abnormality is encountered in the process of performing the preventive medicine E/M service which does not require significant, additional work and the performance of the key components of a problem-oriented E/M service is not documented in the record, then an additional E/M service should not be reported separately.

\*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

### **9.5.A QUALIFIED PROVIDERS**

The full screen *must* be performed by a MO HealthNet enrolled physician, assistant physician, physician assistant, nurse practitioner or nurse midwife\*.

\*only infants age 0-2 months; and females age 15-20 years

### **9.6 PARTIAL HCY/EPSTD SCREENS**

Segments of the full medical screen may be provided by different providers. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial or interperiodic screening service to have a referral source to send the child for the remaining components of a full screening service.

Office visits and screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record.

The Healthy Children and Youth Screening guide provides age-specific guidelines for the screener's assistance.

### **9.6.A DEVELOPMENTAL ASSESSMENT**

#### PROCEDURE

| CODE       | DESCRIPTION  |
|------------|--|
| 99429 59   | Developmental/Mental Health partial screen               |
| 99429 59UC | Developmental/Mental Health partial screen with Referral |

This screen includes the following:

- Assessment of social and language development. Age-appropriate behaviors are identified in the HCY Screening guide.
- Assessment of fine and gross motor skill development. Age-appropriate behaviors are identified in the HCY Screening guide.
- Assessment of emotional and psychological status. Some age-appropriate behaviors are found in the HCY Screening guide.

#### **9.6.A(1) Qualified Providers**

The Developmental/Mental Health partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife\*;
- Speech/language therapist;
- Physical therapist
- Occupational therapist; or
- Professional counselors, social workers, marital and family therapists, and psychologists.

\*only infants age 0-2 months; and females age 15-20 years

### **9.6.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN**

#### PROCEDURE

| CODE | DESCRIPTION |
|------|-------------|
|------|-------------|



9938152EP-9938552EP HCY Unclothed Physical and  
 9939152EP-9939552EP History

9938152EPUC-9938552EPUC HCY Unclothed Physical and  
 9939152EPUC-9939552EPUC History with Referral

The HCY unclothed physical and history includes the following:

- Check of growth chart;
- Examination of skin, head (including otoscopy and ophthalmoscopy), neck, external genitals, extremities, chest, hips, heart, abdomen, feet, and cover test;
- Appropriate laboratory;
- Immunizations; and
- Lead screening according to established guidelines.

**9.6.B(1) Qualified Providers**

The screen may be provided by a MO HealthNet enrolled physician, nurse practitioner, assistant physician, physician assistant or nurse midwife\*.

\*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

**9.6.C VISION SCREENING**

PROCEDURE

| CODE      | DESCRIPTION                    |
|-----------|--------------------------------|
| 9942952   | Vision Screening               |
| 9942952UC | Vision Screening with Referral |

This screen can include observations for blinking, tracking, corneal light reflex, pupillary response, ocular movements. To test for visual acuity, use the Cover test for children under 3 years of age. For children over 3 years of age utilize the Snellen Vision Chart.

**9.6.C(1) Qualified Providers**

The vision partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife\*;

- Optometrist.

\* only infants age 0-2 months; and females age 15-20 years

#### **9.6.D HEARING SCREEN**

##### PROCEDURE

| CODE | DESCRIPTION |
|------|-------------|
|------|-------------|

|         |                    |
|---------|--------------------|
| 99429EP | HCY Hearing Screen |
|---------|--------------------|

|           |                                  |
|-----------|----------------------------------|
| 99429EPUC | HCY Hearing Screen with Referral |
|-----------|----------------------------------|

This screen can range from reports by parents to assessment of the child's speech development through the use of audiometry and tympanometry.

If performed, audiometry and tympanometry tests may be billed and reimbursed separately. These tests are *not* required to complete the hearing screen.

##### **9.6.D(1) Qualified Providers**

The hearing partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife\*;
- Audiologist or hearing aid dealer/fitter; or
- Speech pathologist.

\*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

#### **9.6.E DENTAL SCREEN**

##### PROCEDURE

| CODE | DESCRIPTION |
|------|-------------|
|------|-------------|

|       |                   |
|-------|-------------------|
| 99429 | HCY Dental Screen |
|-------|-------------------|

|         |                                 |
|---------|---------------------------------|
| 99429UC | HCY Dental Screen with Referral |
|---------|---------------------------------|

A dental screen is available to the HCY/EPSTDT population on a periodicity schedule that is different from that of the full HCY/EPSTDT screen.

Children may receive age-appropriate dental screens and treatment services until they become 21 years old. *A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems such as nursing caries, and educate parents in the prevention of dental disease in their child.* It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated.

When a child receives a full medical screen by a physician, nurse practitioner or nurse midwife\*, it includes an oral examination, which is *not* a full dental screen. A referral to a dental provider *must* be made where medically indicated when the child is under the age of 1 year. When the child is 1 year or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician, nurse practitioner or nurse midwife may *not* bill the dental screening procedure 99429 or 99429UC separately.

\*only infants age 0-2 months; and females age 15-20 years

#### **9.6.E(1) Qualified Providers**

A dental partial screen may only be provided by a MO HealthNet participating dentist.

#### **9.6.F ALL PARTIAL SCREENERS**

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

### **9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)**

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) has identified all children between 6 months and 72 months to be at risk for lead poisoning and has mandated they *must* receive a lead risk assessment as part of the HCY full or partial screening.

A complete lead risk assessment consists of a verbal risk assessment and blood test(s) when indicated, and at the mandatory testing ages of 12 and 24 months. Lead risk assessment is included as a component of a full HCY medical screen, 99381EP through 99385EP and 99391EP through 99395EP, or a partial HCY screen, 9938152EP through 9938552EP and 9939152EP through 9939552EP, which also includes the following components: Interval History, Unclothed Physical, Anticipatory Guidance, Lab, and Immunization. See Section 9.7.B for additional information.

CMS has also determined that there are no guidelines or policies for states or local health departments to reference in determining that an area is a lead free zone. Until there is specific information or guidance from the Centers for Disease Control (CDC) on how lead free zones are

determined, CMS will *not* recognize them in the context of screening Medicaid eligible children for lead poisoning.

### 9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

The signs and symptoms of lead exposure and toxicity may vary because of differences in individual susceptibility. A continuum of signs and symptoms exist, ranging from asymptomatic persons to those with overt toxicity.

Mild toxicity is usually associated with blood lead levels in the 35 to 50 µg/dL range for children and in the 40 to 60 µg/dL range for adults. Severe toxicity is frequently found in association with blood lead levels of 70 µg/dL or more in children and 100 µg/dL or more in adults.

The following signs and symptoms and exposure pathways are provided to assist providers in identifying children who may have lead poisoning or be at risk of being poisoned.

#### SIGNS AND SYMPTOMS

##### MILD TOXICITY

Myalgia or paresthesia  
Mild fatigue  
Irritability  
Lethargy  
Occasional abdominal discomfort

##### SEVERE TOXICITY

Paresis or paralysis  
Encephalopathy—may abruptly lead to seizures, changes in level of consciousness, coma and death  
Lead line (blue-black) on gingival tissue  
Colic (intermittent, severe abdominal cramps)

##### MODERATE TOXICITY

Arthralgia  
General fatigue  
Decrease in play activity  
Difficulty concentrating  
Muscular exhaustibility  
Tremor  
Headache  
Diffuse abdominal pain  
Vomiting  
Weight loss  
Constipation

#### EXPOSURE PATHWAYS

##### OCCUPATIONAL

Plumbers, pipe fitters  
Lead miners  
Lead smelters and refiners  
Auto repairers

##### HOBBIES AND RELATED ACTIVITIES

Glazed pottery making  
Target shooting at firing ranges  
Lead soldering (e.g., electronics)  
Painting



Glass manufacturers  
 Shipbuilders  
 Printers  
 Plastic manufacturers  
 Police Officers  
 Steel welders and cutters  
 Construction workers  
 Bridge reconstruction workers  
 Rubber products manufacturers  
 Gas station attendants  
 Battery manufacturers  
 Chemical and chemical preparation  
 Manufacturers  
 Industrial machinery and equipment operators  
 Firing Range Instructors  
 ENVIRONMENTAL  
 Lead-containing paint  
 Soil/dust near industries, roadways, lead-painted homes  
 painted homes  
 Plumbing leachate  
 Ceramic ware  
 Leaded gasoline

Preparing lead shot, fishing sinkers, bullets  
 Home remodeling  
 Stained-glass making  
 Car or boat repair

**SUBSTANCE USE**

Folk remedies  
 “Health foods”  
 Cosmetics  
 Moonshine whiskey  
 Gasoline “huffing”

Regardless of risk, all families *must* be given detailed lead poisoning prevention counseling as part of the anticipatory guidance during the HCY screening visit for children up to 72 months of age.

**9.7.B LEAD RISK ASSESSMENT**

The HCY Lead Risk Assessment Guide should be used at *each* HCY screening to assess the exposure to lead, and to determine the risk for high dose exposure. The HCY Lead Risk Assessment Guide is designed to allow the same document to follow the child for all visits from 6 months to 6 years of age. The HCY Lead Risk Assessment Guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels.

A comprehensive lead risk assessment includes both the verbal lead risk assessment and blood lead level determinations. Blood Lead Testing is mandatory at 12 and 24 months of age and if the child is deemed high risk.

The HCY Lead Risk Assessment Guide is available for provider’s use. The tool contains a list of questions that require a response from the parent. A positive response to any of the questions requires blood lead level testing by capillary or venous method.

### **9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING**

**All children between the ages of 6 months and 72 months of age MUST receive a lead risk assessment as a part of the HCY full or partial screening.** Providers are *not* required to wait until the next HCY screening interval and may complete the lead risk assessment at the next office visit if they choose.

The HCY Lead Risk Assessment Guide and results of the blood lead test *must* be in the patient's medical record even if the blood lead test was performed by someone other than the billing provider. If this information is *not* located in the medical record a full or partial HCY screen may *not* be billed.

#### **9.7.C(1) Risk Assessment**

Beginning at six months of age and at each visit thereafter up to 72 months of age, the provider *must* discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure by using the HCY Lead Risk Assessment Guide.

#### **9.7.C(2) Determining Risk**

Risk is determined from the response to the questions on the HCY Lead Risk Assessment Guide. This verbal risk assessment determines the child to be low risk or high risk.

- If the answers to all questions is no, a child is *not* considered at risk for high doses of lead exposure.
- If the answer to any question is yes, a child is considered *at risk* for high doses of lead exposure and a capillary or venous blood lead level *must* be drawn. Follow-up guidelines on the reverse side of the HCY Lead Risk Assessment Guide *must* be followed as noted depending on the blood test results.

Subsequent verbal lead risk assessments can change a child's risk category. As the result of a verbal lead risk assessment, a previously low risk child may be re-categorized as high risk.

#### **9.7.C(3) Screening Blood Tests**

The Centers for Medicare & Medicaid Services (CMS) requires mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age regardless of risk. If the answer to any question on the HCY Lead Risk Assessment Guide is positive, a venous or capillary blood test *must* be performed.

If a child is determined by the verbal risk assessment to be high risk, a blood lead level test is required, beginning at six months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ) no further action is required. Subsequent verbal lead risk assessments can change a child's risk category. A verbal risk assessment is required at every visit prescribed in the EPSDT periodicity schedule through 72 months of age and if considered to be high risk *must* receive a blood lead level test, unless the child has already received a blood lead test within the last six months of the periodic visit.

A blood lead test result equal to or greater than 10  $\mu\text{g}/\text{dL}$  obtained by capillary specimen (finger stick) *must* be confirmed using venous blood according to the time frame listed below:

- 10-19  $\mu\text{g}/\text{dL}$ - confirm within 2 months
- 20-44  $\mu\text{g}/\text{dL}$ - confirm within 2 weeks
- 45-69  $\mu\text{g}/\text{dL}$ - confirm within 2 days
- 70+  $\mu\text{g}/\text{dL}$ - IMMEDIATELY

For future reference and follow-up care, completion of the HCY Lead Risk Assessment Guide is still required at these visits to determine if a child is at risk.

#### **9.7.C(4) MO HealthNet Managed Care Health Plans**

The MO HealthNet Managed Care health plans are responsible for mandatory risk assessment for children between the ages of 6 months and 72 months. MO HealthNet Managed Care health plans are also responsible for mandatory blood testing if a child is at risk or if the child is 12 or 24 months of age. MO HealthNet Managed Care health plans *must* follow the HCY Lead Risk Assessment Guide when assessing a child for risk of lead poisoning or when treating a child found to be poisoned.

MO HealthNet Managed Care health plans are responsible for lead case management for those children with elevated blood lead levels. MO HealthNet Managed Care health plans are encouraged to work closely with the MO HealthNet Division and local public health agencies when a child with an elevated blood lead level has been identified.

Referral for an environmental investigation of the child's residence *must* be made to the local public health agency. This investigation is *not* the responsibility of the MO HealthNet Managed Care health plan, but can be reimbursed by the MO HealthNet Division on a fee-for-service basis.

### 9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

When performing a lead risk assessment in Medicaid eligible children, CMS requires the use of the blood lead level test at 12 and 24 months of age and when a child is deemed high risk. The erythrocyte protoporphyrin (EP) test is *not* acceptable as a blood lead level test for lead poisoning. The following procedure code *must* be used to bill the blood lead test:

(Capillary specimen or venous blood samples.)

#### PROCEDURE

| CODE  | DESCRIPTION              |
|-------|--------------------------|
| 83655 | Lead, quantitative blood |

This code *must* be used by MO HealthNet enrolled laboratories. Laboratories *must* be CLIA certified to perform blood lead level tests. All blood lead level tests *must* be reported to the Missouri Department of Health and Senior Services as required in 19 CSR 20-20.

### 9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

#### 9.7.E(1) Blood Lead Level <10 µg/dL

This level is *NOT* indicative of lead poisoning. No action required unless exposure sources change.

Recommended Interventions:

- The provider should refer to Section 9.8.C(3) and follow the guidelines for risk assessment blood tests.

#### 9.7.E(2) Blood Lead Level 10-19 µg/dL

Children with results in this range are in the borderline category. The effects of lead at this level are subtle and are *not* likely to be measurable or recognizable in the individual child.

Recommended Interventions:

- Provide family education and follow-up testing.
- \*Retest every 2-3 months.
- If 2 venous tests taken at least 3 months apart both result in elevations of 15 µg/dL or greater, proceed with retest intervals and follow-up guidelines as for blood lead levels of 20-44 µg/dL.

\*Retesting *must* always be completed using venous blood.

**9.7.E(3) Blood Lead Level 20-44 µg/dL**

If the blood lead results are in the 20-44 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 2 weeks. Based upon the confirmation, a complete medical evaluation *must* be conducted.

## Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- \*Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

\*Retesting *must* always be completed using venous blood.

**9.7.E(4) Blood Lead Level 45-69 µg/dL**

These children require urgent medical evaluation.

If the blood lead results are in the 45-69 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 48 hours.

Children with symptomatic lead poisoning (with or without encephalopathy) *must* be referred to a setting that encompasses the management of acute medical emergencies.

## Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.

- A child with a confirmed blood lead level greater than 44  $\mu\text{g}/\text{dL}$  should be treated promptly with appropriate chelating agents and *not* returned to an environment where lead hazard exposure may continue until it is controlled.
- \*Retest every 1-2 months until the blood lead level remains less than 15  $\mu\text{g}/\text{dL}$  for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19  $\mu\text{g}/\text{dL}$ .

\* Retesting *must* always be completed using venous blood.

#### **9.7.E(5) Blood Lead Level 70 $\mu\text{g}/\text{dL}$ or Greater**

Children with blood lead levels in this range constitute a medical emergency.

If the blood lead results are in the 70  $\mu\text{g}/\text{dL}$  range, a confirmatory venous blood lead level *must* be obtained immediately.

Recommended Interventions:

- Hospitalize child and begin medical treatment immediately.
- Begin coordination of care (case management), medical management, environmental investigation, and lead hazard control immediately.
- Blood lead levels greater than 69  $\mu\text{g}/\text{dL}$  *must* have an urgent repeat venous test, but chelation therapy should begin immediately (*not* delayed until test results are available.)
- \*Retest every 1-2 months until the blood lead level remains less than 15  $\mu\text{g}/\text{dL}$  for at least 6 months, the lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19  $\mu\text{g}/\text{dL}$ .

\* Retesting *must* always be completed using venous blood.

#### **9.7.F COORDINATION WITH OTHER AGENCIES**

Coordination with local health departments, WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, local public health agencies' Childhood Lead Poisoning Prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. Local public health agencies may have the authority and ability to investigate a lead poisoned child's environment. We

encourage providers to note referrals and coordination with other agencies in the patient's medical record.

### **9.7.G ENVIRONMENTAL LEAD INVESTIGATION**

When two consecutive lab tests performed at least three months apart measure 15 µg/dL or above, an environmental investigation *must be obtained*. Furthermore, where there is a reading above 10 µg/dL, the child *must* be re-tested in accordance to the recommended interventions listed in Section 9.8.E.

#### **9.7.G(1) Environmental Lead Investigation**

Children who have a blood lead level 20 µg/dL or greater or children who have had 2 blood lead levels greater than 15 µg/dL at least 3 months apart should have an environmental investigation performed.

The purpose of the environmental lead investigation is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels. Environmental lead investigations are to be conducted by licensed lead risk assessors who have been approved by the Missouri Department of Health and Senior Services. Approved licensed lead risk assessors shall comply with the Missouri Department of Health and Senior Services Lead Manual and applicable State laws.

All licensed lead risk assessors *must* be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children *must* also be enrolled as a MO HealthNet provider. Lead risk assessors *must* use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

The following procedure codes have been established for billing environmental lead investigations:

|           |  |
|-----------|--|
| T1029UATG | Initial Environmental Lead Investigation   |
| T1029UA   | First Environmental Lead Reinvestigation   |
| T1029UATF | Second Environmental Lead Reinvestigation  |
| T1029UATS | Subsequent Environmental Lead Reinvestigation  |
|           | Certificate of Medical Necessity <i>must</i> be attached to claim for this procedure |

Federal Medicaid regulations prohibit Medicaid coverage of environmental lead investigations of locations other than the principle residence. The Missouri



Department of Health and Senior Services recommend that all sites where the child may be exposed be assessed, e.g., day care, grandparents' home, etc.

Federal Health Care Financing policy prohibits Medicaid paying for laboratory testing of paint, soil and water samples.

Contact the local health department to arrange for environmental lead investigation services.

### **9.7.H ABATEMENT**

Medicaid *cannot* pay for abatement of lead hazards. Lead risk assessors may be able to provide information and advice on proper abatement and remediation techniques.

### **9.7.I LEAD CASE MANAGEMENT**

Children with 1 blood lead level of 20 µg/dL or greater, or who have had 2 venous tests at least 3 months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services the lead case management agency *must* be an enrolled provider with MO HealthNet Division. For additional information on Lead Case Management, go to Section 13.66.D of the Physician's Program Provider Manual.

### **9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER**

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning. The Department of Health and Senior Services, Section for Environmental Health, hotline number is (800) 392-0272.

### **9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING**

Children's Mercy Hospital  
2401 Gillham Rd.  
Kansas City, MO 64108

Kneibert Clinic, LLC PO Box  
PO Box 220  
Poplar Bluff, MO 63902

Hannibal Clinic Lab  
711 Grand Avenue  
Hannibal, MO 63401

LabCorp Holdings-Kansas City  
1706 N. Corrington  
Kansas City, MO 64120

Kansas City Health Department Lab  
2400 Troost, LL#100  
Kansas City, MO 64108

Physicians Reference Laboratory  
7800 W. 110 St.  
Overland, MO 66210

Missouri State Public Health Laboratory

Quest Diagnostics



101 Chestnut St,  
Jefferson City, MO 65101

11636 Administration  
St. Louis, MO 63146

Springfield-Greene County Public Health  
227 E. Chestnut  
Springfield, MO 65802

St. Francis Medical Center  
211 St. Francis Drive  
Cape Girardeau, MO 63703

St. Luke's Hospital Dept. of Pathology  
4401 Wornall  
Kansas City, MO

St. Louis County Environmental Health Lab  
111 S. Meramec  
Clayton, MO 63105

University of MO-Columbia Hospital & Clinics  
One Hospital Drive  
Columbia, MO 65212

**9.7.L OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES**

Arup Laboratories

Esa

500 Chipeta Way

22 Alpha Rd.

Salt Lake City, UT 84108

Chelmsford, MA 01824

Iowa Hygenic Lab

Iowa Methodist Medical Center

Wallace State Office Building

1200 Pleasant St.

Des Moines, IA 50309

Des Moines, IA 50307

Kansas Department of Health

Mayo Medical Laboratories

619 Anne Ave.

2050 Superior Dr. NW

Kansas City, KS 66101

Rochester, MN 55901

Leadcare, Inc.

Physician's Reference Laboratory

52 Court Ave.

7800 W. 110th St.

Overland Park, KS 66210

Stewart Manor, NY 11530

Quincy Medical Group

Tamarac Medical

1025 Main St.

7800 Broadway Ste. 2C

Quincy, IL 62301

Centennial, Co 80122

Specialty Laboratories

2211 Michigan Ave.

Santa Monica, CA 90404

## 9.8 HCY CASE MANAGEMENT

### PROCEDURE

| CODE      | DESCRIPTION                    |
|-----------|--------------------------------|
| T1016EP   | HCY Case Management            |
| T1016TSEP | HCY Case Management; Follow-up |

For more information regarding HCY Case Management, refer to Section 13 of the Physician's Program Provider Manual.

## 9.9 IMMUNIZATIONS

Immunizations *must* be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is *not* provided, the patient's medical record *must* document why the appropriate immunization was *not* provided. Immunization against polio, measles, mumps, rubella, pertussis, chicken pox, diphtheria, tetanus, haemophilus influenzae type b, and hepatitis B *must* be provided according to the Recommended Childhood Immunization Schedule found on the Department of Health and Senior Services' website at: <http://www.dhss.mo.gov/Immunizations/index.html>.

### 9.9.A VACCINE FOR CHILDREN (VFC)

For information on the Vaccine for Children (VFC) program, reference Section 13 of the Physician's Program Provider Manual.

## 9.10 ASSIGNMENT OF SCREENING TIMES

Participants under 21 years of age become eligible for the initial screening, as well as for the periodic screenings, at the time MO HealthNet eligibility is determined regardless of how old they are. A periodic screen should occur thereafter according to the established periodicity schedule. A notification letter is sent in the month the participant again becomes eligible for an HCY screening. The letter is to notify the participant that a screening is due.

## 9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

The periodicity schedule represents the minimum requirements for frequency of full medical screening services. Its purpose is *not* to limit the availability of needed treatment services between the established intervals of the periodicity schedule.

**Note: MO HealthNet recognizes that a full HCY screen is required for children/youth within 30 days of entering Children's Division custody. Such HCY screens are considered medically necessary even though they may occur in addition to the regular periodicity schedule.**

Children may be screened at any time the physician, nurse practitioner or nurse midwife\* feels it is medically necessary to provide additional screening services. *If it is medically necessary for a full medical screen (see Section 9.6 for procedure list) to occur more frequently than the suggested periodicity schedule, then the screen should be provided. There must, however, be documentation in the patient's medical record that indicates the medical necessity of the additional full medical screening service.*

The HCY Program makes available to MO HealthNet participants under the age of 21 a full HCY screening examination during each of the age categories in the following periodicity schedule:

|                    |             |
|--------------------|-------------|
| Newborn (2-3) days | 3 Years     |
| By 1 Month         | 4 Years     |
| 2-3 Months         | 5 Years     |
| 4-5 Months         | 6-7 Years   |
| 6-8 Months         | 8-9 Years   |
| 9-11 Months        | 10-11 Years |
| 12-14 Months       | 12-13 Years |
| 15-17 Months       | 14-15 Years |
| 18-23 Months       | 16-17 Years |
| 24 Months          | 18-19 Years |
|                    | 20 Years    |

\*only infants age 0-2 months; and females age 15-20 years

#### **9.11.A DENTAL SCREENING SCHEDULE**

- Twice a year from age 6 months to 21 years.

#### **9.11.B VISION SCREENING SCHEDULE**

- Once a year from age 3 to 21 years.

#### **9.11.C HEARING SCREENING SCHEDULE**

- Once a year from age 3 to 21 years.

### **9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING**

The full HCY screen is to serve as a complete screen and should *not* result in a referral for an additional partial screen for the component that identified a need for further assessment or treatment. A child referred as a result of a full screen should be referred for diagnostic or treatment services and *not* for additional screening except for dental (see Section 9.7.E).

Diagnostic and treatment services beyond the scope of the Medicaid state plan may require a plan of care and prior authorization (see Section 9.13.A). Additional information regarding specialized services can be found in Section 13, Benefits and Limitations.

#### **9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES)**

Medically necessary services beyond the scope of the traditional Medicaid Program may be provided when the need for these services is identified by a complete, interperiodic or partial HCY screening. When required, a Prior Authorization Request form *must* be submitted to the MO HealthNet Division. Refer to instructions found in Section 13 of the provider manual for information on services requiring prior authorization. Complete the Prior Authorization Request form in full, describing in full detail the service being requested and submit in accordance with requirements in Section 13 of the provider manual.

Section 8 of the provider manual indicates exceptions to the prior authorization requirement and gives further details regarding completion of the form. Section 14 may also include specific requirements regarding the prior authorization requirement.

### **9.13 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.

### **9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS**

Providers *must* refer to appropriate program manuals for specific information regarding cost sharing and copay requirements.

### **9.15 STATE-ONLY FUNDED PARTICIPANTS**

Children eligible under a state-only funded category of assistance are eligible for all services including those available through the HCY Program to the same degree any other person under the age of 21 years is eligible for a service. Refer to Section 1 for further information regarding state-only funded participants.

### **9.16 MO HEALTHNET MANAGED CARE**

MO HealthNet Managed Care health plans are responsible for insuring that Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.





## Dental

|                                |   |
|--------------------------------|---|
| Unclothed Physical and History | 99381 through 99385 and 99391 through 99395 |
| Developmental/Mental Health    | 9942959<br>9942959UC                        |
| Hearing Screen                 | 99429EP<br>99429EPUC                        |
| Vision Screen                  | 9942952<br>9942952UC                        |
| Dental Screen                  | 99429<br>99429UC                            |

The history and exam of a normal newborn infant and initiation of diagnostic and treatment programs may be reported by the plans with procedure code 99460. Normal newborn care in other than a hospital or birthing room setting may be reported by the plans with procedure code 99461. Both of the above newborn procedure codes are equivalent to a full HCY screening.

Plans are responsible for required immunizations and recommended laboratory tests. Lab services are *not* part of the screen and are reported separately using the appropriate CPT code. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice.

If a problem is detected during a screening examination, the child *must* be evaluated as necessary for further diagnosis and treatment services. The MO HealthNet Managed Care health plan is responsible for the treatment services.

### **9.17 ORDERING HEALTHY CHILDREN AND YOUTH SCREENING AND HCY LEAD SCREENING GUIDE**

The Healthy Children and Youth Screening and HCY Lead Screening Guide may be ordered from Wipro Infocrossing Healthcare Services, P.O. Box 5600, Jefferson City, Missouri 65102 by checking the appropriate item on the Forms Request. If a provider needs additional screening forms they can also make copies.

**END OF SECTION**

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## **SECTION 10 - FAMILY PLANNING**

Family planning services are services relating to elective sterilizations and birth control products including drugs, diaphragms, and IUDs.

Section 10, The Family Planning Section, is *not* applicable to the following manuals:

- Adult Day Care Waiver
- Adult Day Health Care (NOTE: The Adult Day Health Care Program ends June 30, 2013)
- Aged and Disabled Waiver
- AIDS Waiver
- Ambulance
- Comprehensive Day Rehabilitation
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- Hospice
- Independent Living Waiver
- Medically Fragile Adult Waiver
- Nursing Home
- Optical
- Personal Care
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy

**END OF SECTION**

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## **SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM**

MO HealthNet provides health care services to Managed Care eligibles who meet the criteria for enrollment through Managed Care arrangements, as follows:

- Under MO HealthNet's Managed Care Program certain eligible individuals are enrolled with a MO HealthNet Managed Care Health Plan. Managed Care has been implemented statewide, operating in four (4) regions of the state: Eastern (St. Louis area), Central, Southwestern, and Western (Kansas City area) regions.

### **11.1 MO HEALTHNET'S MANAGED CARE PROGRAM**

Managed Care eligibles who meet specific eligibility criteria receive services through a Managed Care Health Plan. The Managed Care Program replaces the process of direct reimbursement to individual providers by the MO HealthNet Division (MHD). Participants enroll in a Managed Care Health Plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the Managed Care Program have the opportunity to choose their own Managed Care Health Plan and primary care provider. A listing of the health plans providing services statewide for the Managed Care Program can be found on the MHD website at: <http://dss.mo.gov/mhd/participants/mc/managed-care-health-plan-options.htm>.

#### **11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS**

The Eastern Missouri Managed Care Program (St. Louis area) began providing services to members on September 1, 1995. It includes the following counties: Franklin (036), Jefferson (050), St. Charles (092), St. Louis County (096) and St. Louis City (115). On December 1, 2000, five new counties were added to this region: Lincoln (057), St. Genevieve (095), St. Francois (094), Warren (109) and Washington (110). On January 1, 2008, the following three new counties were added to the Eastern region: Madison (062), Perry (079) and Pike (082).

#### **11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS**

The central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),



Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

#### **11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS**

The Southwestern Missouri Managed Care Program began providing services to members on May 1, 2017. The southwestern Managed Care region includes the following counties: Barry (005), Barton (006), Christian (02), Dade (029), Dallas (030), Douglas (034), Greene (039), Hickory (043), Howell (046), Jasper (019), Lawrence (055), McDonald (060), Newton (073), Oregon (075), Ozark (077), Shannon (101), Stone (104), Taney (106), Texas (107), Webster (112), and Wright (114).

#### **11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS**

The Western Missouri Managed Care Program (Kansas City area) began providing services to members on November 1, 1996. The western Managed Care region includes the following counties: Cass (019), Clay (024), Jackson (048), Johnson (051), Lafayette (054), Platte (083) and Ray (089). St. Clair (093) and Henry (042) counties were incorporated into the Western region effective 2/1/99. On January 1, 2008 four new counties were added to this region: Bates (007), Cedar (020), Polk (084) and Vernon (108).

### **11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT**

The state has contracted with an independent enrollment agent to assist current and future MO HealthNet Managed Care participants to make an informed decision in the choice of a MO HealthNet Managed Care Health Plan that meets their needs.

The Managed Care enrollment agent sends mailers/letters, etc., provides MO HealthNet Managed Care Health Plan option information, and has a hot line number available to participants in order to make the selection process easy and informative.

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are *not* enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does *not* appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health



plan is *not* listed for the participant.

"OPT OUT" POPULATIONS: The Department of Social Services allows participants the option of choosing to receive services on a Fee-For-Service basis or through the MO HealthNet Managed Care Program. Participants are eligible to opt out if they are in the following classifications:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
- Described in Section 501(a)(1)(D) of the Act (children with special health care needs);
- Described in Section 1902 €(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a));
- Receiving foster care or adoption assistance under part E of Title IV of the Act;
- In foster care or otherwise in out-of-home placement; or
- Meet the SSI disability definition by the Department of Social Services.

Fee-For-Service Members or their parent/guardian should call Participant Services at 1-800-392-2161. Participant Services will provide a form to request "Opt Out". Once all information is received, a determination is made.

### **11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS**

Refer to Section 1.5.C, MO HealthNet Managed Care Participants, and 1.1.A, Description of Eligibility Categories, for more information on Managed Care Health Plan members.

Managed Care Health Plan members fall into four groups:

- Individuals with the following ME Codes fall into Group 1: 05, 06, 10, 19, 21, 24, 26, 40, 60, and 62.
- Individuals with the following ME Codes fall into Group 2: 18, 43, 44, 45, 61, 95, 96, and 98.
- Individuals with the following ME Codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 64, 66, 68, 69 and 70.
- Individuals with the following ME Codes fall into Group 5: 71, 72, 73, 74, 75 and 97.

### **11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS**

The following categories of assistance/individuals are *not* included in the MO HealthNet Managed Care Program.

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care-OAA), and 01 (Old Age Assistance-OAA);
- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State

Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);

- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;
- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
- AIDS Waiver participants (individuals twenty-one (21) years of age and over);
- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women’s health services for one year plus 60 days, regardless of income level;
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than \$250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
- Individuals with ME code 81 (Temporary Assignment Category);
- Individuals eligible under ME code 82 (MoRx);
- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and

- Individuals eligible under ME code 88 (Voluntary Placement).

### **11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS**

The MO HealthNet Managed Care Health Plans are required to provide health benefits to MO HealthNet Managed Care members for each date they are enrolled in the MO HealthNet Managed Care health plan. Managed Care members select a primary care provider (PCP) to provide routine care.

MO HealthNet enrolled providers (also called MO HealthNet Managed Care approved providers) who provide services to a Managed Care member do *not* receive direct reimbursement from the state for Managed Care health plan benefits furnished while the participant is enrolled in a MO HealthNet Managed Care health plan. MO HealthNet enrolled providers who wish to provide services for MO HealthNet Managed Care members *must* contact the Managed Care health plans for participation agreements/contracts or prior authorization.

The MO HealthNet Managed Care member *must* be told in advance of furnishing the service by the non- Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant *must* sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non- MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.

MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans *must* provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the Fee-For-Service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan's administration of health care benefits.

Some services continue to be provided outside the MO HealthNet Managed Care health plan with direct provider reimbursement by the MO HealthNet Division. Refer to Section 11.7.

### **11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM**

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

- Inpatient hospital services
- Outpatient hospital services
- Emergency medical, behavioral health, and post-stabilization care services
- Ambulatory surgical center, birthing center
- Asthma education and in-home environmental assessments
- Physician services (including advanced practice nurse and certified nurse midwife)



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- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME Codes 73-75, and 97
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.
- Durable medical equipment (including but *not* limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers, diabetic supplies and equipment) and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP)
- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. Personal care/advanced personal care
- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), one pair of eyeglasses every two years (during any 24 month period of time), and replacement lens(es) when there is a .50 or greater change.
- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care Health Plan or through the local public health agency and paid by the MO HealthNet Managed Care Health Plan)
  - Screening, diagnosis and treatment of sexually transmitted diseases
  - HIV screening and diagnostic services
  - Screening, diagnosis and treatment of tuberculosis
  - Childhood immunizations

- Childhood lead poisoning prevention services, including screening, diagnosis and treatment
- Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but *not* be limited to:
  - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
  - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs
    - Crisis intervention/access services
    - Alternative services that are reasonable, cost effective and related to the member's treatment plan
    - Referral for screening to receive case management services.
    - Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments.
  - Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.
- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are *not* limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing
  - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME



Codes listed for Group 4, Section 1.5.C

- Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
- Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs
- Transplant-related services. The MO HealthNet Managed Care health plan is financially responsible for any inpatient, outpatient, physician, and related support services including pre-surgery assessment/evaluation prior to the date of the actual transplant surgery. The Managed Care Health Plan is responsible for the pre-transplant and post-transplant follow-up care.

#### **11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MOHEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN**

A child is anyone less than 21 years of age. For some members the age limit may be less than 19 years of age. Some services need prior approval before they are provided. Women must be in a MO HealthNet category of assistance for pregnant women with ME codes 18, 43, 44, 45, 61 and targeted low-income pregnant women and unborn children who are eligible under Show-Me Healthy Babies with ME codes 95, 96, and 98

to receive these extra benefits.

- Comprehensive day rehabilitation, services to help with recovery from a serious head injury;
- Dental services – All preventive, diagnostic, and treatment services as outlined in the MO HealthNet State Plan;
- Diabetes self-management training for persons with gestational, Type I or Type II, diabetes;
- Hearing aids and related services;
- Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two years, replacement lens(es) when there is a .50 or greater change, and, for children under age 21, replacement framesand/or lenses when lost, broken or medically necessary, and HCY/EPST optical screen and services;
- Podiatry services;
- Services that are included in the comprehensive benefit package, medically necessary, and not identified in the IFSP or IEP.
- Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

#### **11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM**

The following services are available to MO HealthNet Managed Care members outside the MO

HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a Fee-For-Service basis by the MO HealthNet Division:

- Abortion services (subject to MO HealthNet Program benefits and limitations)
- Adult Day Care Waiver
  - Home and Community based waiver services for Adult Day Care Services include but are not limited to assistance with activities of daily living, planned group activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation.
  - The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for ADC waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the ADC waiver. Information regarding the ADC waiver services may be located on the DHSS website at: <http://health.mo.gov/seniors/hcbs/adhccproposalpackets.php>
- Physical, occupational and speech therapy services for children included in:
  - The Individual Education Plan (IEP); or
  - The Individual Family Service Plan (IFSP)
- Parents as Teachers
- Environmental lead assessments for children with elevated blood lead levels
- Community Psychiatric Rehabilitation program services
- Tobacco cessation pharmacologic and behavioral intervention services
- Applied Behavior Analysis services for children with Autism Spectrum Disorder
- Comprehensive substance treatment and rehabilitation (CSTAR) services
  - Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
  - Newborn Screening Collection Kits
  - Special Supplemental Nutrition for Women, Infants and Children (WIC) Program
  - SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
- Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions
- Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
  - Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
  - Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with

both procurement and the transplant procedure.

- The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.
- Behavioral health services for MO HealthNet Managed Care children (Group 4) in state care and custody
  - Inpatient services—patients with a dual diagnosis admission (physical and behavioral) have their hospital days covered by the MO HealthNet Managed Care Health Plan.
  - Outpatient behavioral health visits are *not* the responsibility of the MO HealthNet Managed Care Health Plan for Group 4 members when provided by a:
    - Licensed psychiatrist;
    - Licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor or provisionally licensed professional counselor ;
    - Psychiatric Clinical Nurse Specialist, Psychiatric Mental Health Nurse Practitioner state certified behavioral health or substance abuse program; or
    - A qualified behavioral health professional in the following settings:
      - Federally qualified health center (FQHC); and
      - Rural health clinic (RHC).
- Pharmacy services.
- Home birth services.
- Targeted Case Management for Behavioral Health Services.

## 11.8 QUALITY OF CARE

The state has developed quality improvement measures for the MO HealthNet Managed Care Health Plan and will monitor their performance.

## 11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are included in the MO HealthNet Managed Care Program are identified on eMOMED or the IVR system when verifying eligibility. The response received identifies the name and telephone number of the participant's selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member's primary care provider (PCP). For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan *must* have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

MO HealthNet Managed Care health plans may also issue their own individual Managed Care health plan ID cards. The individual *must* be eligible for the Managed Care Program and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

### **11.9.A NON-BILLING MO HEALTHNET PROVIDER**

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access eMOMED or the Interactive Voice Response (IVR) only if they enroll with MO HealthNet as a “Non-Billing MO HealthNet Provider.” Providers are issued an atypical provider identifier that permits access to eMOMED or the IVR; however, it is *not* valid for billing MO HealthNet on a Fee-For-Service basis. Information regarding enrollment as a “Non-Billing MO HealthNet Provider” can be obtained by contacting the Provider Enrollment Unit at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

### **11.10 EMERGENCY SERVICES**

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition for MO HealthNet Managed Care health plan members means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or; (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Post stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

### **11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates

the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

### **11.11.A ELIGIBILITY FOR PACE**

Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive service delivery system and finance model for the frail elderly. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the participant. All medical services that the participant requires, while enrolled in the program, are the financial responsibility of the PACE provider. Enrollment in a PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is the entry point for referrals to the PACE provider and assessments for PACE program eligibility. Referrals for the program may be made to DSDS by completing the PACE Referral/Assessment form and faxing to the DSDS Call Center at 314/877-2292 or by calling toll free at 866/835-3505. The PACE Referral/Assessment form can be located at <http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php>.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

### **11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE**

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

### **11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS**

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. All services are provided solely through the PACE provider. Lock-in information is available to providers through eMOMED and the IVR at (573) 751-2896. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the Fee-For-Service system at any time.

### **11.11.D PACE COVERED SERVICES**

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:

- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;
- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
- In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- Pharmaceutical services, prescribed drugs, and over the counter medications;
- Medical and surgical specialty and consultation services;
- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;



- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through Fee-For-Service.

**END OF SECTION**

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## **SECTION 12 - REIMBURSEMENT METHODOLOGY**

### **12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT**

The MO HealthNet Division is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable (10-40%), is paid from state General Revenue appropriated funds.

Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. The MO HealthNet Division then determines a maximum allowable fee for the services based upon the following information and current appropriated funds:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders;
- Medicare's allowable reasonable and customary charge payment or cost-related payment;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.

Total expenditures for MO HealthNet *must* be within the appropriation limits established by the General Assembly. If the expenditures do *not* stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

### **12.2 DENTAL SERVICES**



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Reimbursement for dental services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

### **12.3 ON-LINE FEE SCHEDULE**

MO HealthNet fee schedules through the MO HealthNet Division are available at <http://www.dss.mo.gov/mhd/providers/index.htm>. The on-line fee schedule identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The on-line fee schedule is updated quarterly and is intended as a reference *not* a guarantee for payment.

The on-line fee schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the fee schedule are set up by the service rendered and are *not* necessarily provider specific.

Refer to Section 13 of the Dental Provider Manual for program-specific benefits and limitations.

### **12.4 MEDICARE/MEDICAID REIMBURSEMENT (CROSSOVER CLAIMS)**

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider.

### **12.5 PARTICIPANT COPAY AND COINSURANCE**

Certain MO HealthNet services are subject to participant copay or coinsurance. The copay or coinsurance amount is paid by the participant at the time services are rendered. Services of the Dental Program described in this manual are subject to copay or coinsurance. The provider *must* accept in full the amounts paid by the state agency plus any copay or coinsurance amounts required of the participant. Refer to Section 13 of the Dental Provider Manual for program-specific information.

### **12.6 MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT**

One method through which MO HealthNet provides services is a MO HealthNet Managed Health Care Delivery System. A basic package of services is offered to the participant by the MO HealthNet managed care health plan; however, some services are *not* included and are covered by MO HealthNet on a fee-for-service basis.

Dental services for adult MO HealthNet managed care health plan members (age 21 and over) are the responsibility of the MO HealthNet managed care health plans when the dental services are for



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treatment of trauma to the mouth, jaw, teeth or contiguous sites as a result of injury. The MO HealthNet managed care health plans also cover services when the absence of dental treatment would adversely affect a pre-existing medical condition.

All dental services (preventive, diagnostic, and treatment) for MO HealthNet managed care health plan members age 0 through 20 are the responsibility of the MO HealthNet managed care health plans.

### **12.6.A MO HEALTHNET MANAGED HEALTH CARE**

Under a MO HealthNet managed care health plan, a basic set of services is provided either directly or through subcontractors. MO HealthNet managed care health plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage. Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month *must* provide for all needed health care to all participants in the group covered.

The health plan is at risk for staying within the *overall* budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month but many more cases cost less than the negotiated rate.

MO HealthNet utilizes the MO HealthNet managed health care delivery system for certain included MO HealthNet-eligible participants. Refer to Sections 1 and 11 of the Dental Provider Manual for a detailed description.

**END OF SECTION**

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## SECTION 13 - BENEFITS AND LIMITATIONS

### 13.1 DENTAL SERVICES

This section contains specific information regarding the benefits and limitations of the Dental Program. Dental services covered by the MO HealthNet program shall only include those which are clearly shown to be medically necessary. Children under 21 years of age and participants in a category of assistance for pregnant women, the blind or vendor nursing facility residents are eligible for the complete dental benefit. Some procedure codes in the complete dental benefit have restrictions on them, such as for age, frequency and quantities. See Section 19 of the Dental Provider Manual for specific code restrictions.

MO HealthNet covers a specific list of dental services for adults in other categories of assistance. These services along with their descriptions, requirements and limitations are limited to the following CDT codes:

| Procedure Code | Description   | Requirements/Limitations                              |
|----------------|---|---|
| D0140          | Limited oral evaluation – problem focused   | None  |
| D0220          | Intraoral – periapical – first film   | None  |
| D0230          | Intraoral – periapical – each additional film   | 4 per day   |
| D0330          | Panoramic film  | Ages 6 and over, 1 per 24 months                      |
| D7140          | Extraction, erupted tooth or exposed root (evaluation and/or forceps removal)   | None  |
| D7210          | Removal of erupted tooth requiring removal of bone and/or sectioning of tooth   | None  |
| D9110          | Palliative (emergency) treatment of dental pain – minor procedure   | None  |
| D9930          | Treatment of complications (post-surgical) – unusual circumstances, by report   | Operative report required                             |
| D7220          | Removal of impacted tooth – soft tissue   | X-ray required if <i>not</i> teeth #s 1, 16, 17 or 32 |
| D7230          | Removal of impacted tooth – partially bony  | X-ray required if <i>not</i> teeth #s 1, 16, 17 or 32 |
| D7510          | Incision and drainage of abscess – intraoral soft tissue  | None  |
| D7511          | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | None  |
| D7520          | Incision and drainage of abscess – extraoral soft tissue  | None  |

|       |   |   |
|-------|---|---|
| D7521 | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | None  |
| D7240 | Removal of impacted tooth – complete bony   | X-ray required if <i>not</i> teeth #s 1, 16, 17 or 32                       |
| D7241 | Removal of impacted tooth – complete bony, with unusual surgical complications  | X-ray required if <i>not</i> teeth #s 1, 16, 17 or 32                       |
| D7250 | Surgical removal of residual tooth roots (cutting procedure)  | X-ray required  |
| D7285 | Biopsy of oral tissue – hard (bone, tooth)  | None  |
| D7286 | Biopsy of oral tissue – soft (all others)   | None  |
| D9230 | Analgesia   | None  |
| D9243 | Intravenous conscious sedation/analgesia – each 15 minute increment   | 2 units per day   |
| D9248 | Non-intravenous conscious sedation  | None  |
| D9610 | Therapeutic drug injection  | None  |
| D9612 | Therapeutic parental drugs, 2 or more administrations, diff medication  | None  |
| D7260 | Oroantral fistula closure   | None  |
| D7261 | Primary closure of a sinus perforation  | Operative report required   |
| D0150 | Comprehensive oral evaluation   | None  |
| D1110 | Prophylaxis – Adult (Ages 13-125)   | 1 prophylaxis per 6 months, same provider, both arches                      |
| D0272 | Bitewings – 2 Films   | 1 set per 6 months, same provider   |
| D0274 | Bitewings – 4 Films   | 1 set per 6 months, same provider   |
| D4341 | Periodontal Scaling and Root Planing  | Each quadrant is limited to reimbursement one (1) time every two (2) years. |
| D4342 | Periodontal Scaling and Root Planing  | Each quadrant is limited to reimbursement one (1) time every two (2) years. |
| D4355 | Full Mouth Debridement  | None  |
| D4910 | Periodontal Maintenance   | None  |
| D2140 | Amalgam – one surface, primary or permanent   | None  |
| D2150 | Amalgam – two surfaces, primary or permanent  | None  |
| D2160 | Amalgam – three surfaces, primary or permanent  | None  |
| D2161 | Amalgam – four or more surfaces, primary or permanent   | None  |
| D2330 | Resin-based composite – one surface, anterior   | None  |
| D2331 | Resin-based composite – two surfaces, anterior  | None  |
| D2332 | Resin-based composite – three surfaces, anterior  | None  |
| D2335 | Resin-based composite – four or more surfaces,  | None  |

|       |  |      |
|-------|--|------|
|       | or involving incisal angle, anterior                     |      |
| D2390 | Resin-based composite crown, anterior                    | None |
| D2391 | Resin-based composite – one surface, posterior           | None |
| D2392 | Resin-based composite – two surfaces, posterior          | None |
| D2393 | Resin-based composite – three surfaces, posterior        | None |
| D2394 | Resin-based composite – four or more surfaces, posterior | None |
| D2940 | Protective restoration                                   | None |
| D2950 | Core build-up, including pins when required              | None |

MO HealthNet also considers additional dental services for adults with certain pre-existing medical conditions. Such services require a written referral from the participant's physician that *must* state the absence of the dental treatment would adversely affect a specific pre-existing medical condition. Using the form below as an example, the referral document *must* be maintained in the participant's record and made available to the MO HealthNet Division or its agent upon request. Referrals are effective for two (2) years from the date of the referral. Pre-existing medical conditions may include, but are *not* limited to:

- Transplants
- Chemo/radiation therapy
- Heart Valves
- Diabetes
- AIDS
- Seizure Disorder treated with Dilantin
- Any other medical condition where if the dental condition is left untreated, the dental problems would adversely affect the health of the participant resulting in a higher level of care.

Additional dental services (excluding dentures), subject to the dental consultant's review, may be provided for adults if dental care is related to traumatic injury to the jaw, mouth, teeth or other contiguous (immediately adjoining) sites (above the neck), including but *not* limited to:

- Motor vehicle accident; or
- Fracture of the jaw or any facial bone.

Dentures (full and partial) are *not* covered under the above noted pre-existing medical condition or trauma criteria. Dentures (full and partial) are only covered for pregnant patients, blind patients, and vendor nursing facility residents.

Information regarding provider participation issues such as nondiscrimination and retention of records are addressed at length in Section 2 of the Dental Provider Manual.

## Dental



Participant eligibility information is included in Section 1 of the Dental Provider Manual and participant nonliability is addressed in Section 13.3.A of the Dental Provider Manual.



**Medical Necessity Referral Form – Dental (EXAMPLE)**

*\*To be filled out by referring physician and kept on file in the dental office*

Patient Name and Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ MO HealthNet ID # \_\_\_\_\_

\_\_\_\_\_  
Patient Phone # \_\_\_\_\_

ICD-10 Diagnosis Code(s) \_\_\_\_\_ Dental Diagnosis Code(s) \_\_\_\_\_

Requested Dental Procedures Description \_\_\_\_\_

Prognosis with Treatment \_\_\_\_\_

Dentist Provider Name and Address \_\_\_\_\_ Dentist Provider NPI \_\_\_\_\_

\_\_\_\_\_  
Dentist Provider Phone # \_\_\_\_\_

Referring Provider Name and Address \_\_\_\_\_ Referring Provider NPI \_\_\_\_\_

\_\_\_\_\_  
Referring Provider Phone # \_\_\_\_\_

Referring Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## 13.2 PROVIDER PARTICIPATION

### 13.2.A DENTISTS

To participate in the MO HealthNet Dental Program, the dental provider *must* satisfy the following requirements:

- The dentist is licensed by the dental board of the state in which he/she is practicing;
- An oral surgeon or other dental specialist is currently licensed in his or her specialty area by the dental board of the state in which he/she is practicing. In those states *not* having a specialty licensure requirement, the dental specialist *must* be a graduate of and hold a valid certificate from a graduate training program in that specialty in an accredited dental school; and
- The dental specialist has signed a Title XIX Provider Participation Agreement Questionnaire, a MO HealthNet Enrollment application and the Self-Evaluation for Compliance (MOA-10).

### 13.2.B DENTAL HYGIENISTS

A dental hygienist, who has been licensed for at least three (3) consecutive years and is practicing in a public health setting, is deemed eligible to enroll as an individual provider under MO HealthNet. Dental hygienists *must* apply for and bill under his/her own provider identifier using the payment name and tax ID of the public health entity enrolled in MO HealthNet. A separate provider identifier is necessary for each public health entity at which the hygienist is employed.

In accordance with 19 CSR 10-4.040, a "public health setting" is defined as a location where dental services authorized by Section 332.311, RSMo are performed so long as the delivery of services is sponsored by a governmental health entity, which includes:

- Department of Health and Senior Services;
- A county health department;
- A city health department operating under a city charter;
- A combined city/county health department; and
- A non-profit community health center qualified as exempt from a federal taxation under Section 501(c)(3) of the Internal Revenue Code including a community health center that received funding authorized by Section 329, 330 and 340 of the United States Public Health Services Act.

Procedure codes covered under the dental hygienist program are available in Section 19 of the Dental Provider Manual.

Additional information on provider conditions of participation can be found in Section 2 of the Dental Provider Manual.

### **13.2.C SUPERVISION**

Services and supplies rendered in a private practice setting by auxiliary personnel are considered incidental to a dentist's professional services. Services and supplies rendered by auxiliary personnel *must* be under the direct personal supervision of the dentist. This rule applies to services of auxiliary personnel employed by the dentist and working under the dentist's supervision and is restricted to non-physician anesthetists, dental assistants, and certified dental assistants.

Direct personal supervision means that the dentist has examined the participant, diagnosed the condition to be treated, prepared a treatment plan, and before the dismissal of the participant, evaluated the performance of the dental auxiliary.

If auxiliary personnel other than a dental hygienist perform the services outside the office setting, the services are covered as incidental to the dental service only if there is direct personal supervision by the dentist. For example, if an assistant accompanies the dentist on a nursing home call and assists with procedures, the assistant's services are covered and billable by the dentist; if the assistant makes the calls alone and administers the service, the services are *not* covered (even when billed by the dentist) since the dentist is *not* providing direct supervision.

#### **13.2.C(1) Dental Student Supervision**

##### **13.2.C(1)(a) Supervision In An Accredited Dental/Dental Hygiene School**

Services and supplies rendered in an accredited dental school by dental students or dental hygiene students *must* be performed under the personal direction of instructors.

Personal direction of instructors means the dentist/dental hygienist has examined the participant, approved the planned procedure, and before the dismissal of the participant, evaluated the performance of the dental/dental hygiene student. The instructor *must* personally document, in the patient's record, their presence and participation in the service.

For a dental school to bill for services rendered by a student, the dental school *must* have a designated faculty member(s) enrolled as a MO HealthNet provider whose NPI number is used for billing. Dental students are *not* eligible to enroll individually as MO HealthNet providers.



### **13.2.C(1)(b) Dental Students In A Teaching/Clinical Setting Other Than An Accredited Dental/Dental Hygiene School**

To bill MO HealthNet for services performed by a dental student in a setting other than a clinic within a dental school, the teaching dentist (who is also an enrolled MO HealthNet provider) *must* be physically present during the key portion of the service. The teaching dentist *must* personally document, in the patient's record, their presence and participation in the service.

The health center/clinic using adjunct faculty, (who is also a full or part-time practicing dentist licensed in Missouri, enrolled with MO HealthNet, and trained to supervise the dental student), may bill MO HealthNet for covered services using the adjunct faculty dentist's NPI. The adjunct faculty dentist *must* document, in the patient's record, their presence and participation in the service.

### **13.2.C(1)(c) Dental Student Requirements**

Dental students providing billable patient care services *must* be enrolled in an accredited dental school that has provided appropriate training in the clinical setting.

### **13.2.C(1)(d) Teaching Dentist Requirements**

In a setting other than a clinic within a dental school, a teaching dentist may *not* supervise more than six (6) students at a time and *must* be immediately available to assist the dental student. The teaching dentist should have limited responsibilities at the time the service is being provided by the dental student.

Teaching instructors in a dental school *must* ensure the care provided was reasonable and necessary, review the care provided by the dental student during or immediately after each visit, and document approval of the treatment. The dental school has primary responsibility for patients treated by dental students.

## **13.2.D DELEGATION OF SERVICES**

MO HealthNet covered services may only be performed within the enrollment guidelines for approved MO HealthNet providers. There can be *no* delegation of services. This applies to both providing and billing for services.

The practice of one dentist supervising another and subsequently billing for those services is prohibited. Any delegation of services between two parties who can be providers is prohibited.

## **13.3 PARTICIPANT ELIGIBILITY**



The participant *must* be eligible for MO HealthNet on each date that a service is provided in order for a provider to receive MO HealthNet payment for those services. This is a requirement even when the service has been prior authorized. Additional information about participant eligibility can be found in Section 1 of the Dental Provider Manual.

It is the provider's responsibility to check the participant's eligibility status on the day services are provided through the Interactive Voice Response System (IVR) at 573-751-2896, or through the provider portal at [www.emomed.com](http://www.emomed.com).

### **13.3.A PARTICIPANT NONLIABILITY**

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

## **13.4 PRESUMPTIVE ELIGIBILITY (TEMP) PARTICIPANTS**

For information on TEMP participants, reference Section 1.5.H of the Dental Provider Manual.

## **13.5 QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM**

Section 301 of the Medicare Catastrophic Coverage Act of 1988 makes individuals who are Qualified Medicare Beneficiaries (QMB), ME code 55, a mandatory coverage group under MO HealthNet and provides payment for qualified individuals of:

- Medicare premiums; and
- Deductible and coinsurance for Medicare-covered services. This includes Medicare services from providers who by choice do *not* participate in MO HealthNet and providers whose services are *not* covered by MO HealthNet, such as chiropractors.

Dentists who do *not* participate in MO HealthNet but wish to enroll with MO HealthNet as a QMB provider *must* have a Medicare provider identifier and accept assignment by Medicare for services covered by Medicare. Refer to Section 1 of the Dental Provider Manual for additional information regarding restricted benefits for this category of assistance.

## **13.6 MANAGED HEALTH CARE DENTAL SERVICES**

MO HealthNet participants who meet specific eligibility criteria receive services through a managed care health plan known as the MO HealthNet Managed Care Program. Participants enroll in a health plan that contracts with the state to provide a specific scope of benefits. Participants who are included in the MO HealthNet Managed Care Program have the opportunity to choose their own

health plan and primary care provider. Dental services are an included benefit in the MO HealthNet Managed Care Program.

#### MO HealthNet Managed Care Children Members (Age 20 and Under)

MO HealthNet Managed Care health plans are required to provide dental screens and services for all members age 20 and under in accordance with the MO HealthNet State Plan. Dental services include, but are *not* limited to; diagnostic, preventive and restorative procedures, prosthodontic services, and medically necessary oral and maxillofacial surgeries. Expanded services, such as comprehensive orthodontics, are covered.

#### MO HealthNet Managed Care Pregnant Members with ME Codes 18, 43, 44, 45 and 61

The MO HealthNet Managed Care health plans are responsible for coverage of dentures and treatment of trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury and all other Medicaid State Plan dental services for pregnant members.

#### MO HealthNet Managed Care Adult Members (Age 21 and over)

The MO HealthNet Managed Care health plans are responsible for reimbursement of services provided for certain dental codes as well (see Section 13.1 for a list of codes). They are also responsible for reimbursement of services that treat trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. The health plans will also cover services when the absence of dental treatment would adversely affect a pre-existing medical condition (see Section 13.1 for medical conditions these may include).

Providers are advised to verify MO HealthNet eligibility prior to delivering a service because MO HealthNet eligibility can, and often does, change. If the participant is enrolled in the Managed Care program, the participant *must* receive dental care in accordance with the health plan's policies. For information on identifying Managed Care health plan enrollees, reference Section 1.3 of the Dental Provider Manual. For complete information on the MO HealthNet Managed Care programs, reference Section 11 of the Dental Provider Manual.

### **13.7 CUSTOM-MADE ITEMS**

MO HealthNet provider payment may be made for custom-made items, such as dentures, when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility *or* change of assistance category to one in which the particular service is *not* covered) or dies *after* the item is ordered or fabricated, and *prior* to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization Request form if required), and at the time of any

subsequent service, including preparatory visits prior to the actual ordering or fabrication of the device or item;

- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item *must* have been delivered or placed if the participant is living;
- The provider *must* have entered “See attachment” in the “Remarks” section of the Dental Claim Form (Field #35) and *must* have attached a *provider-signed statement* to the claim. The statement *must* explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is *not* possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimates is represented in cases where delivery or placement is *not* possible.

Payments regarding the aforementioned devices are made as follows:

- a. If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the *lesser* of the billed charge or the MO HealthNet maximum allowable amount for the total service, less any applicable coinsurance and any payments made by other insurance.
- b. If the item *cannot* be delivered or placed due to death of the participant, the payment is the *lesser* of the “net billed charge” or the MO HealthNet maximum allowable amount for the total service, less any applicable coinsurance. The “net billed charge” is the provider’s usual and customary billed charge(s) as reduced by any salvage value amount.

Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent a salvage value.

Any provider-determined retail salvage value of the unplaced or undelivered item *must* be subtracted by the provider from the charge for the item and only the net reduced charge entered on the claim form line for the item. These claims are subject to review as to salvage value adjustment represented in the billed charge.

The date of service that is shown on the claim form *for the item* (dentures, etc.) when situation a. or b. applies *must* be the last date on which service is provided to the *eligible* participant (and following receipt of an approved Prior Authorization Request form, if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided. Use of a date for which the participant is no longer eligible for MO HealthNet

coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitute the allowable MO HealthNet payment for the service. No further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility *after* the service is first initiated and *before* the custom-made item is actually ordered or fabricated, the participant *must* be immediately advised that completion of the work and delivery or placement of the item is *not* covered by MO HealthNet. It is then the participant's choice whether to request completion of the work on a private payment basis. If the participant's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does *not* reimburse the provider.

### **13.8 PARTICIPANT COPAY AND COINSURANCE**

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. This amount is referred to as copay or coinsurance. The copay or coinsurance amount is paid by the participant at the time services are rendered. Services of the Dental Program described in this manual are subject to a copay or coinsurance amount. The provider *must* accept in full the amounts paid by the state agency plus any copay or coinsurance amount required of the participant.

#### **13.8.A PROVIDER RESPONSIBILITY TO COLLECT COPAY OR COINSURANCE AMOUNTS**

Providers of service *must* charge and collect the copay or coinsurance amount. *Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged.* A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether a participant is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copay or coinsurance amounts collected and of the copay or coinsurance amount due but uncollected because the participant did *not* make payment when the service was rendered.

The copay or coinsurance amount is *not* to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay or coinsurance



amount is deducted from the MO HealthNet maximum allowable amount, as applicable, before reimbursement is made.

**13.8.B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS**

Unless otherwise exempted (refer to Section 13.8.C of the Dental Provider Manual), it is the responsibility of the participant to pay the required copay amount due. The copay is required for each procedure code according to the MO HealthNet maximum allowable amount. Whether or *not* the participant has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service.

**13.8.B(1) Copay Amounts**

Unless an exemption applies, the following copay amounts are applied to dental services with the exception of dentures (see Section 13.8.C of the Dental Provider Manual). Current Procedural Terminology physician or surgical procedures are *not* subject to copay.

| MO HEALTHNET MAXIMUM ALLOWABLE | COPAY    |
|--------------------------------|----------|
| \$10 or less.....              | \$0.50   |
| \$10.01-\$25.....              | \$1.00   |
| \$25.01-\$50.....              | \$2.00   |
| \$50.01<br>ore.....            | or\$3.00 |

**13.8.C EXEMPTIONS TO THE COPAY AMOUNT**

The following participants or conditions are exemptions to the participant’s responsibility to the copay amount as they apply to the Dental Program:

- Participants age 19 and under are exempt from copay amounts. Participants age 20 and over *must* pay the copay amount unless the participant is a foster care child or qualifies for another exemption;
- Foster Care Children up to 26 years of age with ME code 38;
- Services provided to pregnant women;
- Services provided to the blind;
- Medically-necessary services through an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen;
- Hospice participants;

- Institutionalized participants who are residing in a skilled nursing facility, an intermediate care facility, a residential care facility, a psychiatric hospital, or an adult boarding home;
- Participants who have both Medicare and MO HealthNet entitlement if Medicare covers the service and provides payment;
- Emergency services provided in an outpatient clinic or emergency room; and
- MO HealthNet Managed Care health plan enrollees for services provided by the health plan.

The exemption to the copay amount is identified by MO HealthNet when processing the claim.

### **13.8.D PARTICIPANT RESPONSIBILITY TO PAY COINSURANCE AMOUNT**

Unless an exemption applies (refer to Section 13.8.E of the Dental Provider Manual), the coinsurance amount applied to each interim, partial and full denture is 5% of the lesser of the MO HealthNet maximum allowable or the provider's billed charge. Refer to Section 19 of the Dental Provider Manual for a list of procedure codes.

### **13.8.E EXEMPTIONS TO THE COINSURANCE AMOUNT**

The following participants or conditions are exemptions to the participant's responsibility to the coinsurance amount as they apply to the Dental Program:

- Participants age 19 and under are exempt from coinsurance amounts. Participants age 20 and over *must* pay the coinsurance amount unless the participant is a foster care child or qualifies for another exemption;
- Foster Care Children up to 26 years of age with ME code 38;
- Institutionalized participants who are residing in a skilled nursing facility, an intermediate care facility, a residential care facility, a psychiatric hospital, or an adult boarding home; and
- MO HealthNet Managed Care health plan enrollees for services provided by the health plan.

The exemption to the coinsurance amount is identified by MO HealthNet when processing the claim.

## **13.9 PRIOR AUTHORIZATION**

### **13.9.A GENERAL**

The treating dentist is responsible for obtaining prior authorization as required by the MO HealthNet Division. Telephone authorization is *not* given. When completing the [Prior](#)

[Authorization \(PA\) form](#), Section IV *must* contain the NPI number and information that the claim for reimbursement of the services requested will be filed under. If the claim will be filed using a clinic NPI, Section IV of the PA form *must* reflect the clinic information and Section V *must* be completed with the performing provider's NPI number and information. If the claim for services is to be filed under the performing provider's NPI number, then Section IV *must* reflect this information and Section V can be left blank. For additional information, see Sections 8 and 14 of the Dental Provider Manual. The MO HealthNet Managed Care health plans should be contacted to request prior authorization for participants who are Managed Care health plan enrollees. Refer to Section 11 of the Dental Provider Manual for further information.

### **13.9.B EMERGENCY TREATMENT**

Emergency treatment does *not* require prior authorization. When a claim for a dental service normally requiring prior authorization is submitted without having been prior authorized because of an emergency situation, a Certificate of Medical Necessity form *must* be attached to the claim and approved by the State Dental Consultant. *The provider must state on the Certificate of Medical Necessity form, in detail, the reason for the emergency treatment.* If the Certificate of Medical Necessity form is *not* attached or the reason is *not* substantiated, the emergency service and related charges on the claim are denied.

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to pregnant woman having contractions: (a) that there is inadequate time to affect the safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

*Dentures and expanded Healthy Children and Youth (HCY) services shall not be allowed under these emergency treatment provisions.*

Palliative emergency treatment of dental pain will require a tooth number in Field #27 of the 2002, 2004 ADA claim form. A narrative of the treatment provided will need to be maintained in the patient record and made available to MO HealthNet or its agent upon request. Palliative emergency treatment is *not* allowed on the same date of service as any other dental service on the same tooth. **NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims. The tooth number receiving palliative emergency treatment will be required in Field #27 of this form.**

Emergency treatment provided in the dentist's office or the outpatient department of the hospital should be billed using one of the Office/Outpatient Evaluation and Management procedure codes in addition to the appropriate treatment code(s).

Emergency treatment provided in the hospital emergency room should be billed using one of the Emergency Department Evaluation and Management procedure codes in addition to the appropriate treatment code(s). These codes are appropriate for the emergency room only. Refer to the Section 19 of the Dental Provider Manual for the appropriate codes.

An emergency tracheostomy performed by a dentist or dental specialist is covered.

### **13.10 PLACE OF SERVICE**

Dental services may be provided in settings such as the dentist's office, the participant's home or other place of residence, the hospital or settings such as a clinical facility, ambulatory surgical care facility or school.

### **13.11 INPATIENT HOSPITAL ADMISSION CERTIFICATION**

Inpatient hospital admissions for MO HealthNet participants *must* be certified as medically necessary and appropriate for inpatient services before payment is made. All hospitals in Missouri and bordering states are subject to this admission certification requirement.

The review authority has been assigned to Conduent.

The state has given authority for Conduent to receive all the appropriate information necessary to fulfill the contract. The confidentiality of all information shall be adhered to and is included as part of the Conduent contract and policy. For additional information, please reference the Hospital Manual, Section 13.29 at [http://manuals.momed.com/collections/collection\\_hsp/print.pdf](http://manuals.momed.com/collections/collection_hsp/print.pdf). Inpatient certification requests for dental procedures may be denied if inpatient criteria is *not* met.

Most dental/surgical procedures can safely be performed in an outpatient setting, i.e., office, outpatient department or ambulatory surgical center, unless the participant exhibits other medical risks that justify inpatient admission for performance of the procedure.

### **13.11.A PHYSICIAN/HOSPITAL REVIEW RESPONSIBILITIES**

Even though the participant's physician is responsible for securing certification through Conduent prior to inpatient admission, the dentist should be aware of this requirement and assist in providing documentation of the medical need for inpatient/outpatient provision of the service, as indicated.

Conduent *must* be contacted by the physician or the hospital to provide participant/provider identifying information and medical information regarding the participant's condition and planned services.

Certification requests may be submitted to Conduent by the physician in the following manner:

- Phone (800) 766-0686
- Fax (866) 629-0737
- Mail Conduent  
P.O. Box 105110  
Jefferson City, MO 65110-5110

### **13.12 NON-ALLOWABLE SERVICES**

The following services are considered to be included in the procedure/surgery and are *not* separately allowable, billable to the participant or to the MO HealthNet agency as office/outpatient visits or in any other manner:

- Routine visits necessary in the steps required for full or partial dentures (e.g., impressions, try-ins, etc.);
- Office visit to obtain a prescription, the need of which had already been ascertained;
- Subsequent hospital visits for the same participant, same date of service, as another medical procedure (non-visit type of service) billed by that dentist;
- Routine check-ups and follow-up care associated with placement of orthodontic appliances if orthodontic treatment has been approved as an HCY (EPSDT) exception, as this service is included in the reimbursement amount approved by the orthodontic consultant;
- Administration of medication/injection (if the participant is examined/treated, the service is included in the office/outpatient visit or other procedure performed);
- Replacement crowns within six (6) months of the previous placement by the same provider;
- Adjustments of full and partial dentures by the originating dentist within six (6) months following initial placement of full or partial dentures;

- Relines and rebases within 12 months of placement of replacement dentures. It is the responsibility of the dentist who placed the dentures to assure correct fit of dentures within this initial period;
- Palliative emergency treatment on the same date of service as any other dental care on the same tooth of the participant;
- Routine post-operative care as a result of an oral surgery/procedure;
- Removal or placement of sutures by the operating oral surgeon/dentist;
- Services or supplies furnished free of charge by any governmental body;
- Sterilization of instruments;
- Postage;
- Telephone calls;
- Filing of MO HealthNet, Medicare or private health insurance claims; and
- Canceled or “no show” dental appointments.

### **13.13 NON-COVERED SERVICES**

The following are non-covered services:

- Routine check-ups and follow-up care associated with placement of orthodontic appliances, which are non-covered. (If orthodontic treatment is approved as an HCY [EPSDT] exception, follow-up care is *non-allowable*, as it is included in the reimbursement for the specific treatment and is *not* separately billable as office/outpatient visits);
- Cosmetic oral surgeries;
- Other preventive services, such as dietary planning, oral hygiene instruction and training in preventive dental care; and
- Preparation of special reports sent to insurance companies.

### **13.14 EVALUATION AND MANAGEMENT**

Evaluation and Management (E/M) services include examinations, evaluations, treatments, conferences with or concerning participants, preventive pediatric and adult dental health supervision and similar dental services.

The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical/dental knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of (covered) E/M services may be used by all dentists.



The E/M services recognize seven (7) components, six (6) of which are used in defining the levels of E/M services. These components are history, examination, medical decision making, counseling, coordination of care and nature of presenting problem. Time associated with the various encounters is based on averages and is *not* to be used as an absolute component in defining levels of E/M services.

History, examination and medical decision making are considered the *key* components in selecting a level of E/M services. Counseling, coordination of care and the nature of the presenting problem are considered *contributory* factors in the majority of encounters. The nature of the presenting problem and time are provided in some levels to assist the physician/dentist in determining the appropriate level of E/M service.

#### **13.14.A INSTRUCTIONS FOR SELECTING A LEVEL OF EVALUATION/ MANAGEMENT (E/M) SERVICE**

- a. Identify the category and subcategory of service provided, e.g., office service, new patient (99201-99203);
- b. Review Current Procedural Terminology or the Dental Provider Manual for any special guidelines or instructions applicable to that category or subcategory;
- c. Review the level of E/M service descriptions and examples in the selected category or subcategory;
- d. Determine the extent of *history* obtained based on these types of history:
  - Problem Focused—chief complaint; brief history of present dental problem;
  - Expanded Problem Focused—chief complaint; brief history of present dental problem; problem pertinent review as a result of patient’s medical problem(s);
  - Detailed—chief complaint; extended history of present dental problem; expanded system review as a result of patient’s medical problem(s);
- e. Determine the extent of the *examination* performed based on the types of examinations defined below:
  - Problem Focused Examination—one that is limited to the affected dental area;
  - Expanded Problem Focused Examination—an examination of the affected dental area, with expanded involvement as a result of required x-rays (including cephalometric, as applicable); study models, if appropriate; detailed long-range plans and treatment goals; and conferences with others in relation to coordination of care/treatment and/or symptomatic or related organ system(s) problems;
- f. Determine the complexity of *medical decision making*, referring to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:
  - The number of diagnoses or the number of management options to be considered;

- The amount and/or complexity of medical/dental records, diagnostic tests and/or other information that *must* be obtained, reviewed and analyzed; and
- The risk of significant complications associated with the patient’s presenting problems, diagnostic procedure(s) and/or possible management options.

MO HealthNet recognizes straightforward and low complexity dental decision making; and

- g. Select the appropriate level of E/M service based on the number of key components (e.g., history, examination and medical decision making), which *must* be met or exceeded.

### 13.15 OFFICE VISIT LIMITATIONS

Office visits are limited to one (1) visit per participant per provider on any given day and may *not* be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. Additional medically necessary visits may be covered if a properly completed Certificate of Medical Necessity form is attached to the claim and approved by the Dental Consultant. See Section 7 of the Dental Provider Manual for instructions on completion of the Certificate of Medical Necessity form.

An office visit may be billed on the same date of service as a hospital admission.

An office visit for observations *must not* be billed in conjunction with any other dental-related procedure code on the same date of service by the same provider for the same participant.

“New patient” office visits are limited to one (1) per provider for each participant. Visits subsequent to the “new patient” office visit *must* be coded as “established patient” office visits.

Any provisions as mandated by the Occupational Safety and Health Administration (OSHA) are also included in the reimbursement for the specific procedure or service being provided.

An office visit includes, but is *not* limited to, the following:

- Oral examination of the participant for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written participant record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist’s private practice; and
- Local anesthesia.

An office visit may be billed for a dental HCY/EPSTDT examination that falls outside the periodicity schedule for a dental screen.

An office visit is included and may *not* be billed for the same date of service as any of the identified *office* surgeries. The fee for these services includes the dentist's service and all ancillary and overhead costs associated with performing the procedure in an office setting.

Billing for an office visit is expected *only* for the first session in a series of treatments.

### **13.16 HOSPITAL DISCHARGE DAY MANAGEMENT**

Hospital discharge day management is *not* a covered service for the dentist. This procedure is billed by the physician to report final hospital care and preparation of discharge records prior to discharge of a participant.

The services provided by the dentist on the date of discharge of the participant, i.e., examination, discussion of the hospital stay, instructions for continuing care and any other records documentation should be billed as a subsequent hospital visit at the appropriate level.

### **13.17 CONSULTATIONS**

A consultation is a type of service provided by a physician or dentist whose opinion or advice regarding evaluation and/or management of a specific problem *is requested by another physician or dentist* or other appropriate source.

The request for a consultation from the attending physician or dentist (or other appropriate source) and the need for consultation *must* be documented in the participant's medical/dental record. The consultant's opinion and any services that were ordered or performed *must* also be documented in the participant's medical record and communicated to the requesting physician or dentist (or appropriate source).

"Consultations" initiated by a participant and/or family (*not* requested by a physician or dentist) are considered requests for a second (or third) opinion and are reported using the codes for confirmatory consultations or office visits, as appropriate.

After completion of a consultation, if the consultant subsequently assumes responsibility for management of a portion or all of the participant's condition, the follow-up consultation codes should *not* be used. Instead, if the participant is hospitalized, subsequent hospital visits should be used. In the office setting, the appropriate established patient code should be used.

Telephone calls for consultation are *not* covered.

A consultation may *not* be billed on the same date of service as a nursing home visit (NF, RCF-I or RCF-II), an office or outpatient visit, hospital visit or another type of consultation based on the place of service.

## 13.18 EMERGENCY DEPARTMENT SERVICES

### 13.18.A LIMITATIONS ON EMERGENCY DEPARTMENT SERVICES

Emergency department procedure codes are to be used only if the services provided are of an emergency nature and require both the use of the hospital's emergency room facility and the services of emergency room professional staff.

## 13.19 NURSING FACILITY SERVICES

When billing for nursing facility services use Current Procedural Terminology evaluation and management codes specific to patients in nursing facilities (formerly known as Skilled Nursing Facilities [SNFs], Intermediate Care Facilities [ICFs] or Long Term Care Facilities [LTCFs]).

Two subcategories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Note that there is *no* distinction between “*new*” and “*established*” patients in a nursing facility.

A nursing facility visit may *not* be billed on the same date of service as another nursing home visit (NF, RCF-I or RCF-II), an office or other outpatient visit, hospital visit, dental screening or consultation.

## 13.20 SCALING AND ROOT PLANING SERVICES

To make sure claims for scaling and root planing services (CDT Codes D4341 and D4342) will be paid, check for the following:

- For D4341, each quadrant *must* have three (3) teeth each with at least one (1) five (5)-millimeter pocket and signs of sub-gingival calculus on x-ray, or four (4) teeth each with at least one (1) five (5)-millimeter pocket.
- For D4342, at least one (1) tooth in a quadrant with one (1) five (5)-millimeter pocket *must* be present.
- MO HealthNet (MHD) will only reimburse each quadrant one (1) time every two (2) years.

Adequate documentation must be kept in the patient's medical record. This includes periodontal charting and/or x-rays. If MHD or MHD's authorized agent requests to see the documentation, it must be provided.

## 13.21 ANTIMICROBIAL AGENTS



The localized delivery of antimicrobial agents may only be billed in conjunction with scaling and root planing. The following CDT codes for scaling and root planing *must* be billed on the same date of service as D4381.

- D4341 periodontal scaling and root planing-four (4) or more teeth per quadrant
- D4342 periodontal scaling and root planing-one (1) to three (3) teeth per quadrant

The participant's record *must* document the specific agent administered. A chlorhexidine rinse is *not* covered under D4381. The antimicrobial agent *must* be reported in Field #30 on the ADA claim form.

The use of CDT code D4381 is limited to eight (8) sites per date of service; one (1) site per tooth, per six (6) months.

**13.22 ALVEOLOPLASTIES—SURGICAL PREPARATION OF RIDGE FOR DENTURES**

In order to prevent alveoloplasties from being denied as duplicates when more than one (1) quadrant is done, the following oral cavity code *must* be shown in the appropriate space on the claim form for procedure codes D7310 and D7320. A maximum of four (4) of any combination of alveoloplasties is allowed per participant, either in conjunction with extractions (D7310) or *not* in conjunction with extractions (D7320).

| ORAL CAVITY CODE | QUADRANT    |
|------------------|-------------|
| 10.....          | Upper Right |
| 20.....          | Upper Left  |
| 30.....          | Lower Left  |
| 40.....          | Lower Right |

**13.23 GINGIVECTOMY/GINGIVOPLASTY**

In order to prevent gingivectomies or gingivoplasties from being denied as duplicates when more than one (1) quadrant is done, the following oral cavity code *must* be shown in the appropriate space on the claim form for procedure code D4210.

| ORAL CAVITY CODE | QUADRANT    |
|------------------|-------------|
| 10.....          | Upper Right |
| 20.....          | Upper Left  |



## Dental

30.....Lower Left

40.....Lower Right

A gingivectomy or gingivoplasty is allowed for participants' age five (5) and over. Limited occlusal adjustment is covered under emergency treatment only.

### **13.24 ANESTHESIA**

General anesthesia administered in the office is a covered service.

General anesthesia administered in the hospital or an ambulatory surgical center by a participating certified anesthesiologist or CRNA is a covered service under the Physician Program and *must* be billed by the physician or CRNA on the CMS-1500 claim form.

Local anesthesia is *not* payable under a separate code. It is included in the fees for:

- Oral prophylaxis;
- Restoration or treatment of either permanent or primary teeth;
- Placement of all types of crowns; and
- Extractions—routine extractions and impacted teeth (including supernumerary teeth), either permanent or primary.

A Trigeminal Division Block (D9212) is an extraoral injection for diagnostic purposes only. It is *not* to be used for a second Division Block.

### **13.25 INTRAVENOUS (IV) SEDATION**

Intravenous sedation administered in the office is a covered service. The reimbursement amount includes the medication.

### **13.26 CROWNS**

A fixed crown of chrome, porcelain/ceramic or stainless steel is covered.

A fixed polycarbonate crown is covered for an anterior tooth. A fixed polycarbonate crown for a posterior tooth is *not* covered.

Procedure code D2740 (crown-porcelain/ceramic substrate) on both anterior and posterior teeth is covered.

The fee for a fixed crown includes all prior preparations.

Provisional crowns are a covered service if procedure code D2799 is used. A crown utilized as an interim restoration of at least six (6) months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is *not* limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is *not* to be used as a temporary crown for a routine restoration.

Bridges, bridge pontics and bridge retainers are covered for participants age 20 and under, but *must* be prior authorized.

Recementation of a bridge, crown or inlay is a covered service.

Replacement of a broken acrylic or porcelain facing where the post backing is intact is covered.

Replacement of a broken acrylic or porcelain facing where the post backing is broken is covered.

Replacement crowns are *not* allowed within six (6) months of the previous placement by the same provider.

See Section 19 of the Dental Provider Manual for specific age restrictions related to crown codes.

### **13.27 DENTURES, FULL**

A full denture *must* be constructed of an acrylic type of material in order to be covered under the MO HealthNet Program and all dentures *must* meet the following criteria:

- Full arch impression;
- Bite registration;
- Each tooth set individually in wax;
- Try-in of teeth set individually in wax before denture processing;
- Insertion of the processed denture; and
- Six (6)-month follow-up adjustments.

Dentures *must* be dispensed to the participant before the provider bills MO HealthNet. Holding dentures until MO HealthNet payment is received constitutes a payment for a service *not* provided and is in violation of 13 CSR 70-3.030(3)(A)9. The participant's MO HealthNet eligibility *must* be verified for the date the dentures are dispensed and/or services rendered. Refer to Section 13.7 of the Dental Provider Manual for more information on custom-made items.

Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of 13 CSR 70-3.030(3)(A)9. Temporary full dentures are *not* covered.

Full overdentures are *not* covered.

Dentures, full or partial, are covered only for children under 21 or for persons under a category of assistance for pregnant women, the blind or vendor nursing facility residents.

### **13.27.A TORUS**

Removal of torus procedures (D7471-removal of lateral exostosis [maxilla or mandible], D7472-removal of torus palatinus, and D7473-removal of torus mandibularis) is limited to those instances when the removal of excess bone is required for fitting a removable prosthetic (full or partial dentures). The removal of a torus *must* be based on dental necessity due to other treatments *not* being effective and *must* be consistent with clinical practice. The participant's record *must* include the treatment plan and dental necessity for performing the torus procedure.

### **13.28 DENTURES, PARTIAL**

A partial denture *must* replace permanent teeth.

Partial dentures are *not* covered after full dentures.

In the case of any partial denture, service is *not* completed until the partial denture has been permanently delivered to the participant (placement). A claim *must not* be submitted before the participant receives the denture. The placement date is the date of service. (See explanation under Section 13.27 of the Dental Provider Manual – Dentures, Full.) When billing for partial dentures, the tooth section of Field #27 on the Dental Claim Form *must* contain the tooth number of one of the missing teeth. In addition, the specific tooth numbers applicable to the partial denture *must* be entered in the “Description” section of Field #30.

A partial denture without clasps replacing one (1) *permanent anterior* tooth is covered.

A partial denture without clasps *must* replace more than one (1) *permanent posterior* tooth.

A partial denture without clasps is limited to a maximum of four (4) teeth.

A partial denture with clasps *must* replace a minimum of three (3) permanent teeth, excluding third molars. (Procedure codes D5211 and D5212.)

A partial denture involving third molars (wisdom teeth) is *not* covered.

Bent-wire, cast gold or cast chrome clasps are covered.

Adding a tooth or teeth to an existing partial denture, where possible, is a covered service.

Partial dentures with lingual or palatal bars are *not* covered.

Partial overdentures are *not* covered.

X-rays involving partial dentures should *not* be submitted, unless specifically requested.

Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of 13 CSR 70-030.(3)(A)9. (This does *not* apply to the coinsurance requirement. Refer to Section 13.8 of the Dental Provider Manual.)

### **13.28.A TORUS**

Removal of torus procedures (D7471-removal of lateral exostosis [maxilla or mandible], D7472-removal of torus palatinus, and D7473-removal of torus mandibularis) is limited to those instances when the removal of excess bone is required for fitting a removable prosthetic (full or partial dentures). The removal of a torus *must* be based on dental necessity due to other treatments *not* being effective and *must* be consistent with clinical practice. The participant's record *must* include the treatment plan and dental necessity for performing the torus procedure.

### **13.28.B MAXILLARY AND MANDIBULAR PARTIAL DENTURES – FLEXIBLE BASE**

Maxillary and mandibular partial dentures are covered for participants meeting the denture criteria.

## **13.29 REPLACEMENT DENTURES**

Replacement dentures are covered in cases when dentures no longer fit properly due to significant weight loss as a result of illness or a loss of bone or tissue due to some form of neoplasm and/or surgical procedure or when the dentures no longer fit or function properly due to normal wear and/or deterioration resulting from use over an extended period of time.

## **13.30 DENTURE ADJUSTMENTS AND REPAIRS**

Denture adjustments are covered, but *not* for the originating dentist of a new denture until six (6) months after the date of its placement. Repair of a broken denture, where necessary, may be accomplished on the same date of service as denture duplication or reline.

Broken denture repair involving no broken teeth is covered.

Broken denture repair involving broken teeth is covered.

Replacing a broken tooth or teeth only on a denture is covered.

Reattaching an intact clasp for a partial denture is covered.

Replacing a broken bent-wire clasp on a partial denture with a new bent-wire clasp is covered.

Replacing a broken cast gold or cast chrome clasp on a partial denture with a new cast gold or cast chrome clasp is covered.

### **13.31 DENTURE REBASES AND RELINES**

One (1) reline or rebase is allowed during the 12 months following the placement of immediate dentures. The next reline is allowed 12 months following the first reline. A denture reline or rebase is *not* covered until 12 months after the placement of replacement dentures. Any additional denture relining or rebasing is further limited to three (3) years from the date of the last preceding reline or rebase.

Reline of a partial or full denture, laboratory or chairside (office), is covered.

Denture rebase or reline, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any partial or full denture *must* include a new impression of the old denture, check bite and full-process procedure.

Laboratory reline of any partial or full denture *must* include a new impression of the old denture, check bite and full-process procedure.

Chairside (office) reline of any partial or full denture for tissue conditioning purposes only before a new denture is made is covered.

Tissue conditioning (D5850 or D5851) is *not* covered for the same date of service as a reline and/or rebase.

### **13.32 EXTRACTIONS**

The following policies apply to extraction services.

- Enter an alpha letter *A through T* (primary teeth) in Field #27 of the Dental Claim Form to identify teeth extracted. Alpha letter *AS through TS* are used in the case of a supernumerary primary tooth.
- Enter a tooth number *1 through 32* in Field #27 of the Dental Claim Form to identify permanent teeth. Tooth numbers *51 through 82* are used in case of a supernumerary permanent tooth.
- The location of a supernumerary tooth *must* be provided on the claim.
- Pre-operative x-rays involving extractions are *not* to be submitted unless requested by the State Dental Consultant.
- Post-operative x-rays of extractions are *not* covered.

- Extraction fees for routine extractions and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and routine post-operative treatment.
- Surgical extraction of impacted teeth is a covered service. Claims submitted for removal of impacted teeth other than third molars *must* include x-rays.

The following criteria applies to third molar extractions.

- Surgical extraction of impacted and erupted third molar teeth is a covered service. Indications of removal and criteria or conditions allowable for reimbursement are to include erupted, partially erupted, and unerupted/impacted third molars. One or more of the following conditions *must* be present and documented in the participant dental record:
  1. Pain;
  2. Pericoronitis;
  3. Carious lesion;
  4. Facilitation of the management of or limitation of progression of periodontal disease;
  5. Nontreatable pulpal or periapical lesion;
  6. Acute and/or chronic infection;
  7. Ectopic position;
  8. Elective therapeutic removal;
  9. Abnormalities of tooth size or shape precluding normal function;
  10. Facilitation of orthodontic tooth movement and promotion of dental stability;
  11. Tooth impeding the normal eruption of an adjacent tooth;
  12. Tooth in line of fracture;
  13. Impacted tooth;
  14. Pathology associated with tooth;
  15. Pathology associated with impacted tooth (odontogenic cysts, neoplasms);
  16. Tooth involved in tumor resection;
  17. Preventive or prophylactic removal, when indicated, for patients with medical or surgical conditions or treatments;
  18. Clinical findings of fractured tooth or teeth;
  19. Internal or external resorption of tooth or adjacent teeth;
  20. Anatomical position causing potential damage to adjacent teeth; and/or
  21. Patient's informed refusal of nonsurgical treatment options.

### **13.33 FLUORIDE TREATMENT (PREVENTIVE)**

#### **13.33.A TOPICAL FLUORIDE TREATMENT**

Topical fluoride treatment is a covered service for participants age 20 and under.

Fluoride treatment for participants age 21 and over is limited to the following participants and conditions or criteria:

- Participants with rampant or severe caries (decay);
- Participants who are undergoing radiation therapy to the head and neck;
- Participants with diminished salivary flow;
- Intellectually disabled participants who *cannot* perform their own hygiene maintenance; or
- Participants with cemental or root surface caries secondary to gingival recession.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per calendar year for all eligible participants. Providers may bill this code one (1) time for dates of service that occur between the months of January and June and one (1) time for dates of service that occur between the months of July and December.

Sodium fluoride series treatments are *not* covered.

Each allowable fluoride treatment *must* include both the upper and lower arch.

Fluoride treatment *must* be a separate service from prophylaxis (reference Section 13.36 of the Dental Provider Manual).

#### **13.33.B FLUORIDE VARNISH**

Fluoride varnish is covered for participants age 20 and under when applied in a dental office.

Fluoride varnish is covered for participants age five (5) and under, when the need is identified through an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visit. Fluoride varnish may be applied by physicians and nurse practitioners along with other medical professionals (RN, LPN, Physician Assistant, Medical Assistant, Nursing Assistant) working in a physician's office or clinic.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per calendar year for all eligible participants. Providers may bill this code one (1) time for dates of service that occur between the months of January and June and one (1) time for dates of service that occur between the months of July and December.

##### **13.33.B(1) Fluoride Varnish Training For Medical Offices**

Training in the application of fluoride varnish is required in order for providers to bill MO HealthNet. Documentation to support their completed training *must* be retained by the medical office. This completed training documentation *must* be made available upon request by the MO HealthNet Division. Training is available on-line through the [Department of Health and Senior Services, Division of Community and Public Health](#).

### **13.33.B(2) Billing Fluoride Varnish In A Medical Office**

Application of fluoride varnish should be billed on the CMS-1500 claim form or the appropriate electronic claim form. To bill MO HealthNet for fluoride varnish, enter the procedure code D1206 in Field 24.D on the CMS-1500 or the appropriate field on an electronic claim form.

## **13.34 INJECTIONS**

The procedure codes in Section 19 include injections covered in the Dental Program. Use the appropriate code and the amount injected (based on the unit value shown in Section 19 of the Dental Provider Manual) when billing.

## **13.35 DIAGNOSTIC EXAMS**

Comprehensive oral evaluations (CDT D0150) are reimbursed one (1) time per dental provider for all eligible participants.

Eligible participants include children under 21 years of age and participants in a category of assistance for pregnant women, the blind, vendor nursing facility residents and adults who receive limited dental benefits. *See Section 13.1 of the Dental Manual for a list of all services covered under the adult limited dental benefit.*

Periodic oral examinations (CDT D0120) may only be reimbursed two (2) times per calendar year for all eligible participants. Providers may bill this code one (1) time for dates of service that occur between the months of January and June and one (1) time for dates of service that occur between the months of July and December.

Eligible participants include children under 21 years of age and participants in a category of assistance for pregnant women, the blind or vendor nursing facility residents. CDT D0120 is *not* a covered code for all other adult participants who receive limited dental benefits.

Limited oral evaluations – problem focused (CDT D0140) may only be reimbursed one (1) time every two (2) years for all eligible participants.

Eligible participants include children under 21 years of age, participants in a category of assistance for pregnant women, the blind, vendor nursing facility residents and adults who receive limited

dental benefits. *See Section 13.1 of the Dental Manual for a list of all services covered under the adult limited dental benefit.*

### **13.36 PROPHYLAXIS (PREVENTIVE)**

Prophylaxis of either the upper or lower arch or both arches is covered two (2) times per calendar year by the same provider for all eligible participants. Prophylaxis *must* include scaling and polishing teeth. Providers may bill this code one (1) time for dates of service that occur between the months of January and June and one (1) time for dates of service that occur between the months of July and December.

Eligible participants include children under 21 years of age, participants in a category of assistance for pregnant women, the blind, vendor nursing facility residents and adults who receive limited dental benefits. *See Section 13.1 of the Dental Manual for a list of all services covered under the adult limited dental benefit.*

Prophylaxis *must* be a separate service from fluoride treatment (reference Section 13.33 of the Dental Provider Manual).

Other preventive services, such as dietary planning, oral hygiene instruction and training in preventive dental care are *not* allowable, as they are included in the reimbursement for other services provided, i.e., preventive, restorative, etc.

### **13.37 PULP TREATMENT (ENDODONTIC)**

A pulpotomy may only be performed on primary teeth.

A pulpotomy *must* include the complete amputation of the vital coronal pulp and the placement of a drug (approved by the ADA Council of Scientific Affairs) over the remaining exposed tissue.

The fee for a pulpotomy excludes the fee for final restoration.

Pulp vitality tests are covered.

Pulp caps are covered.

Root canal therapy is a covered service for permanent teeth only (reference Section 13.39 of the Dental Provider Manual).

- Apicoectomy, periradicular surgery of bicuspid—first root (D3421) is a covered service.
- Apicoectomy, periradicular surgery of molar—first root (D3425) is a covered service.

An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has *not* been successful.



An apicoectomy and root canal may *not* be allowed on the same tooth for the same participant on the same date of service.

Other endodontic procedures are *not* covered.

### **13.38 RESTORATIONS**

When billing for any of the amalgam, composite or resin restorations, the tooth number *and* tooth surface code(s) *must* be entered in the appropriate fields under #27 and #28 on the Dental Claim Form.

Amalgam and resin restorations on posterior teeth are covered.

Fees for amalgam fillings include polishing.

Resin restorations on anterior teeth are covered.

A restoration of any material other than those named above is *not* covered.

Pin retention, exclusive of amalgam or composite resin, is a covered item.

Same restoration on same tooth in less than a six (6)-month interval is *not* allowed.

Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.

X-rays involving restorations are *not* to be submitted unless specifically requested.

#### **13.38.A MULTI-SURFACE RESTORATIONS**

Reimbursement for restorative dental services will be based on the number of unique surfaces per tooth, per date of service. A surface may only be counted once per tooth, per date of service for purposes of billing the appropriate Code on Dental Procedures and Nomenclature (CDT) code. A restoration is considered a “two or more surface restoration” only when two or more actual tooth surfaces are involved. Restoration services for multiple surfaces on the same tooth with different materials (i.e., amalgam and composite) will be reimbursed at the least costly multiple surface codes. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite liners, bases and curing are included as part of the restoration and *cannot* be billed separately.

#### **CDT CODES TO USE**

The appropriate CDT codes and descriptions for billing restorative dental services are as follows:

D2140 Amalgam – one surface, primary and permanent

D2150 Amalgam – two surfaces, primary or permanent

D2160 Amalgam – three surfaces, primary or permanent

D2161 Amalgam – four or more surfaces, primary or permanent

D2330 Resin-based composite – one surface, anterior

D2331 Resin-based composite – two surfaces, anterior

D2332 Resin-based composite – three surfaces, anterior

D2335 Resin-based composite – four or more surfaces or involving incisal angle, anterior

D2391 Resin-based composite – one surface, posterior

D2392 Resin-based composite – two surfaces, posterior

D2393 Resin-based composite – three surfaces, posterior

D2394 Resin-based composite – four or more surfaces, posterior

Claims for restorative services for an individual tooth will reimburse no more than once in a thirty (30) day period. Dental claims submitted by the same provider for the same participant with a restoration procedure code that has the same tooth number as a claim for a restoration procedure code that has been paid within the last 30 days will be denied.

### **13.39 ROOT CANAL THERAPY (ENDODONTIC)**

Root canal therapy is restricted to permanent teeth.

Root canal therapy fees include all in-treatment x-rays.

Root canal therapy fees exclude final restoration fees.

An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has *not* been successful. Other endodontic procedures are *not* covered.

X-rays involving root canal therapy are *not* to be submitted unless specifically requested.

### **13.40 SEALANTS**

MO HealthNet covers pit and fissure sealants for all Healthy Children and Youth (HCY) MO HealthNet eligible participants ages five (5) through 20.

Sealants may be applied only on healthy (without occlusal restorations) first and second permanent molars (tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31). No payment is made for sealants applied to third molars. Sealants will *not* be a covered service if applied to primary teeth.

Sealants may only be applied every three (3) years per provider, per participant, per tooth.

Permanent first and second molars may be sealed as they erupt or, for older or newly-approved MO HealthNet participants (ages five (5) through 20) whose teeth have never been sealed, all eight (8) molars may be sealed in one (1) setting.

### **13.41 X-RAYS**

No x-rays are to be submitted for interpretation by the State Dental Consultant. All other x-rays are immediately returned.

X-rays that are of no diagnostic value for interpretation are *not* covered.

All x-rays *must* be of the intraoral type, excluding a panoramic type of film.

Panoramic types of film and sialograph survey films are the only extraoral x-rays that are covered for a dentist. Procedure code D0330 (panoramic film) will only be reimbursed for participants age six (6) and older. If medically necessary for children under age six (6), a panoramic film may be reimbursed if billed using procedure code D0999 and a narrative report describing the situation is attached to the claim.

A maximum of four (4) additional periapical x-rays (D0230) is covered after the first (D0220) on any given date of service.

A pre-operative full-mouth x-ray survey of permanent or primary teeth or of mixed dentition is covered once in a 24-month interval.

A pre-operative full-mouth x-ray survey of permanent teeth is defined as 14 periapical films plus two (2) bitewing films (one [1] each right and left) or a total of 16 single films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A pre-operative full-mouth x-ray survey of primary teeth is defined as four (4) periapical films plus two (2) bitewing films (one [1] each right and left) or a total of six (6) films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A pre-operative full-mouth x-ray survey of mixed dentition is defined as six (6) periapical films (one (1) each upper and lower anterior teeth, one (1) each upper and lower right teeth, one (1) each upper and lower left teeth) plus two (2) bitewing films (one [1] each right and left) or a total of eight (8) films—OR—one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A maximum of two (2) pre-operative bitewing x-rays are covered two (2) times per calendar year for all eligible participants. Providers may bill this code two (2) times for dates of service that occur between the months of January and June and two (2) times for dates of service that occur between the months of July and December.

Refer to Section 13.44.H of the Dental Provider Manual for x-rays that are required as part of the orthodontic records submitted for approval of orthodontic treatment.

Post-operative x-rays of extractions are *not* covered.

### **13.42 ORTHODONTIC TREATMENT/SPACE MANAGEMENT THERAPY**

Orthodontic braces and treatment are *not* covered unless they are found to be medically necessary as a result of a full or partial HCY (EPSDT) screening and approved by the State Orthodontic Consultant (reference Section 13.44 of the Dental Provider Manual).

Pre-orthodontic care, such as extractions and restorations, is covered.

Minor orthodontic appliances for interceptive and oral development, as listed in Section 19 of the Dental Provider Manual, are covered.

Fixed space-maintainers, unilateral and bilateral, are provided for the premature loss of primary teeth only.

Removable space maintainers are *not* covered.

Recementation of a space maintainer is covered.

Treatment of malocclusion is *not* covered unless prior authorized as an expanded HCY service.

Placement of device to facilitate eruption of impacted tooth (i.e., an orthodontic bracket, band or other device) is a covered service only when the participant has been authorized to receive orthodontia services.

Comprehensive orthodontic treatment is available only for participants who meet the criteria in Section 13.44, transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the participant.

### **13.43 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM**

The purpose of the Healthy Children and Youth Program (HCY), also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT), is to insure a comprehensive, preventative health care program for MO HealthNet eligible children who are age 20 and under. HCY is designed to link the child and family to an ongoing health care delivery system. The HCY Program provides early and

periodic medical/dental/vision/hearing screening, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening.

### **13.43.A EPSDT/HCY FULL MEDICAL SCREEN**

Missouri has adopted the American Academy of Pediatrics' (AAP) July 1991 schedule for Preventive Pediatric Health Care as a *minimum* standard for frequency of providing full HCY screens for MO HealthNet eligible children and youth between the ages of birth and 21 years. The periodicity schedule for dental screens is more frequent than the AAP recommendation.

### **13.43.B DENTAL SCREEN**

Ageappropriate dental screens are available to children from birth until they become 21 years of age.

A child's first visit to the dentist should occur twice a year beginning with the eruption of the first tooth and no later than 12 months of age so that the dentist can evaluate the infant's oral health and intercept potential problems such as dental disease in the child. It is recommended that preventive dental services and oral treatment for children begin at age 6(six)-12 months, or with the eruption of the first tooth, and be repeated every six (6) months or as medically indicated.

When a child receives a full medical screen by a physician or nurse practitioner, it includes an oral examination that is *not* a full dental screen. A referral to a dental provider *must* be made when medically indicated when the child is under the age of one (1) year. When the child is one (1) year of age or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician or nurse practitioner may *not* bill the dental screening procedure code 99429 separately.

#### **13.43.B(1) EPSDT/HCY Dental Screening With Referral (99429UC)**

When the dentist completes a dental screening and determines the need for the services of another provider, i.e., oral surgeon or orthodontist, a referral should be made for follow-up care. Procedure code 99429UC *must* be billed in this situation. Field #1 of the Dental Claim Form *must* be marked EPSDT.

#### **13.43.B(2) EPSDT/HCY Dental Screening Without Referral (99429)**

If the dentist completes a dental screening and (1) no abnormalities are noted or (2) the same dentist provides the necessary dental treatment services, a referral is unnecessary and procedure code 99429, which designates "without referral," should be used. Field #1 of the Dental Claim Form *must* be marked EPSDT, even though a referral is *not* made.

Age appropriate screening guides (Healthy Children & Youth Screening) are available and are to be used when the provider completes the screening. The completed form should be filed in the participant's chart as documentation of the screening service.

The dentist may *not* bill for a dental screening and office visit on the same date of service.

### **13.43.C EXPANDED HCY SERVICES**

The Omnibus Reconciliation Act of 1989 (OBRA 89) mandated that Medicaid-covered services be provided for participants *under the age of 21* when the service is medically necessary, regardless of whether the service is covered by the State Medicaid Plan.

## **13.44 ORTHODONTICS**

When an eligible participant is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the participant to a qualified dentist or orthodontist for preliminary examination to determine if the treatment will be approved. The fact that the participant has moderate or even severe orthodontic problems, or has been advised by a dentist or orthodontist to have treatment is *not*, by itself, a guarantee that the participant will qualify for orthodontia services through MO HealthNet. Coverage is determined solely by meeting the criteria listed below in Subsections 13.44.A and 13.44.B or 13.44.C.

### **13.44.A GENERAL REQUIREMENTS**

To be eligible for orthodontia services, the participant *must* meet all of the following general requirements:

1. Be under 21 years of age; and
2. Have good oral hygiene documented in the child's treatment plan; and
3. Have all dental work complete; and
4. Have permanent dentition. Exceptions to having permanent dentition are as follows:
  - a. Participant has a primary tooth retained due to ectopic or missing permanent tooth; or
  - b. Participant may have primary teeth present if they have cleft palate, severe traumatic deviations, or an impacted maxillary central incisor; or
  - c. Participant may have primary teeth if they are thirteen (13) years of age or older; or

- d. The orthodontia provider has provided to the Division written documentation which proves that orthodontic treatment is medically necessary under one (1) of the criteria in Subsection 13.44.C.

#### **13.44.B HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX**

The determination whether or *not* a participant will be approved for orthodontic services shall be initially screened using the [Handicapping Labio-Lingual Deviation \(HLD\) Index](#). The HLD Index *must* be fully completed in accordance with the instructions and ***must be submitted*** with the Prior Authorization (PA) form. MO HealthNet will approve orthodontic services when the participant meets all the criteria in Subsection 13.44.A above and one (1) of the criteria listed below.

1. Has a cleft palate;
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is *not* sufficient);
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present;
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine millimeter (9mm) or reverse over-jet of greater than three and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores 28 points or greater on the HLD Index.

#### **13.44.C MEDICAL NECESSITY**

If the participant does *not* meet any of the criteria in Subsection 13.44.B, MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary.

1. MO HealthNet shall consider additional information of a substantial nature about the presence of severe deviations affecting craniofacial health. Other deviations shall be considered to be severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures, resulting in disease-related bone and tooth loss, or craniofacial deformities associated with developmental disabilities in chewing or speaking.
2. Other evidence shall include information of a substantial nature about the presence of a medical condition which is directly affected by the condition of the mouth or underlying structures. Orthodontic treatment shall be considered to be medically necessary if, without the orthodontic treatment, the medical

- condition would be adversely affected and would result in pain, infection, illness or significant and immediate impact on the normal function of the body and the individual's ability to function. In addition, such orthodontic treatment *must* be demonstrated to be 1) of clear clinical benefit to the eligible participant; 2) appropriate for the injury or illness in question; and 3) conform to the standards of generally accepted orthodontic practice as supported by applicable medical and scientific literature. In addition to documentation from an orthodontist or dentist, a recommendation for orthodontic treatment in relation to a medical condition *must* also be supported by documented evidence of the medical condition from a licensed medical doctor, board certified to diagnose the medical condition.
3. In addition, the Division may consider information of a substantial nature about the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions, as defined in the most current edition of the *Diagnostic Statistical Manual* of the American Psychiatric Association, and which may be caused by the participant's daily functioning as it relates to a dentofacial deformity. The MO HealthNet Division will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation *must* clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavioral problems and *must* clearly and substantially document that orthodontic treatment is medically necessary and will significantly ameliorate the problems.
4. Orthodontic treatment shall *not* be considered to be medically necessary when:
- A. The orthodontic treatment is for aesthetic or cosmetic reasons only; or
  - B. The orthodontic treatment is to correct crowded teeth only, if the child can adequately protect the periodontium with reasonable oral hygiene measures; or
  - C. The child has demonstrated a lack of motivation to maintain reasonable standards of oral hygiene and oral hygiene is deficient.

#### **13.44.C(1) Medical Necessity Documentation**

If the participant does *not* meet the HLD Index requirements and the treating orthodontist/dentist feels the orthodontia services are medically necessary, a written, detailed explanation of the medical necessity of the orthodontia services *must* be submitted along with the completed HLD Index, study models and the prior authorization request form. All documentation *must* be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical

condition, which left untreated, the medical condition would be adversely affected and would result in pain, infection, illness or significant and immediate impact on the normal function of the body and the individual's ability to function. Additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services *must* be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions, additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services *must* be submitted along with the required documentation from the treating orthodontist/dentist. The evaluation *must* clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional and/or behavioral problems and *must* clearly and substantially document that orthodontic treatment is medically necessary and will significantly ameliorate the problems.

#### **13.44.D DENTISTS/ORTHODONTISTS PROVIDING SERVICES *MUST* BE MO HEALTHNET PROVIDERS**

In order to receive payment from MO HealthNet for any dental/orthodontic services performed, providers *must* be enrolled as MO HealthNet dental/orthodontic providers. Each dental provider *must* sign the necessary Provider Enrollment Agreement forms provided by the Missouri Department of Social Services, Missouri Medicaid Audit & Compliance (MMAC), Provider Enrollment Unit.

Dentists who make referrals to dentists/orthodontists who are *not* MO HealthNet participating providers should make those providers aware of this requirement and/or refer them to the Provider Enrollment Unit at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

Failure to abide by the regulations of the Missouri Department of Social Services, MO HealthNet Division's Dental Services Provider Agreement shall be considered a breach of contract and may result in the imposition of sanctions, as outlined in 13 CSR 70-3.030. These sanctions include suspension from the MO HealthNet Program, withholding of future payments or recoupment from future provider payments.

#### **13.44.E COMPREHENSIVE ORTHODONTIC TREATMENT**

Comprehensive orthodontic treatment includes, but is *not* limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances);
- All necessary adjustments;



- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques; and
- Adjustment of the retainers and observation of the participant for a proper period of time (approximately 18 to 24 months).

For severe skeletal cases, extended treatment times are considered by the State Orthodontic Consultant.

#### **13.44.F REGULAR DENTAL CARE/ORAL HYGIENE**

The participant *must* be a good candidate for comprehensive orthodontic treatment in that the participant has exhibited a history of good oral hygiene. The participant should also be under the care of a dentist for routine care and all necessary dentistry, i.e., prophylaxis, fillings, etc., *must* be completed prior to submission of the Prior Authorization Request form.

The participant *must* also make the necessary arrangements for such services as extractions. Extractions are *not* included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

#### **13.44.G PRIOR AUTHORIZATION FOR ORTHODONTICS**

When requesting prior authorization for orthodontic services, the provider *must* complete and submit the HLD Index, the Prior Authorization Request form, study models and a written treatment plan. This information *must* be mailed to:

|                          |              |
|--------------------------|--------------|
| Wipro                    | Infocrossing |
| P.O.                     | Box          |
| Jefferson City, MO 65102 | 5700         |

Photographs and cephalometric radiographs will only be required if requested by the state orthodontic consultant after review of the study models and when necessary, the panoramic radiograph.

See Section 14 of the Dental Provider Manual for detailed information.

#### **13.44.H ORTHODONTIC (DIAGNOSTIC) RECORDS**

Orthodontic records consist of a cephalometric x-ray; panoramic x-ray or full-mouth survey; external facial photographs (both frontal and profile); intraoral photographs (both sides of the dental arches in occlusion and a frontal view in occlusion); and dental study models (if submitting plaster or plastic molds they *must* be properly occluded and trimmed so that the models simulate centric occlusion of the patient when the models are placed on their heels.

If the models and/or x-rays are unusable, they are rejected and new records *must* be submitted prior to authorization of treatment.



The orthodontic examination and preparation of orthodontic records are *not* separately reimbursable. They are considered to be a part of the comprehensive treatment fee. No reimbursement will be paid for diagnostic photographs or cephalometric x-rays unless specifically requested by the State Orthodontic Consultant after review of the study models and panoramic radiograph.

#### **13.44.I PARTICIPANT ELIGIBILITY FOR ORTHODONTIC TREATMENT**

Upon receipt of an approved Prior Authorization Request form, the dentist *must* verify the participant's MO HealthNet eligibility prior to beginning orthodontic treatment. It is important for the dentist to verify eligibility through the Interactive Voice Response (IVR) system at (573) 751-2896 or through the Internet at [www.emomed.com](http://www.emomed.com) each time a treatment/service is rendered. Even though a service is prior authorized, the participant *MUST* be eligible on the date the treatment begins and at the time of each subsequent visit. If eligible, the dentist should proceed to treat the orthodontic condition as soon as possible, in accordance with the prior authorized treatment plan.

#### **13.44.J INTERCEPTIVE ORTHODONTIC TREATMENT**

Interceptive orthodontic treatment is only reimbursed when it is *not* part of an ongoing comprehensive treatment plan.

##### **13.44.J(1) Palatal Expansion**

The State Orthodontic Consultant may approve palatal expansion when it is the only treatment necessary. If the palatal expansion is necessary as a part of a larger orthodontic treatment plan, it should be considered as part of the comprehensive orthodontic treatment.

##### **13.44.J(2) Functional Appliances (i.e., Frankels, Saggitals, etc.)**

When a malocclusion exists and the treatment of the malocclusion is completed using only a functional appliance and is *not* the "first step" or "first phase" of a comprehensive orthodontic treatment plan, the State Orthodontic Consultant may approve this service as a separate treatment plan.

#### **13.44.K RETENTION OF RECORDS**

Providers are required to retain copies of the participant history, cephalometric x-rays, panoramic x-rays, facial photographs and study models for a minimum of five (5) years.

#### **13.44.L TRANSFER OF PARTICIPANTS**

A participant who becomes MO HealthNet eligible and is already receiving orthodontic treatment through an entity other than a State Medicaid Agency *must* demonstrate that the need

for service requirements specified in Subsections 13.43.A, 13.43.B and 13.43.C were met before orthodontic treatment commenced.

A participant who becomes MO HealthNet eligible and is already receiving orthodontic treatment through a Medicaid agency in another state may continue to receive covered orthodontic treatment services. The amount of payment for the remaining treatment will be based on the MO HealthNet orthodontic fee schedule and prorated based on the time left in treatment as evaluated by the State Orthodontic Consultant.

#### **13.44.M ORTHODONTIC EXAMINATION AND TREATMENT PLAN**

The Orthodontic Examination and Treatment Plan includes the diagnosis; a written treatment plan; cephalometric x-ray; panoramic x-rays or full-mouth survey; external facial photographs (frontal and profile); intraoral photographs (both sides in occlusion and frontal view in occlusion); and study models. As stated previously, these services are included in the comprehensive treatment fee and are *not* separately payable.

#### **13.44.N BILLING INSTRUCTIONS/REIMBURSEMENT FOR THE INITIAL PHASE OF TREATMENT—FIXED APPLIANCE THERAPY**

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth (1/4) of the total approved amount (as indicated on the Prior Authorization Request form), and includes the orthodontic examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances.

A Dental Claim Form may be submitted to Wipro Infocrossing, P.O. Box 5600, Jefferson City, MO 65102, using the appropriate procedure code for the service performed. The date of service is the date the appliances were placed. The billed charge should be one-fourth (1/4) of the total approved amount. For example, if \$2,200 is the approved amount, the billed charge (and reimbursement) is \$550.

#### **13.44.O SUBSEQUENT PAYMENTS—ADJUSTMENTS**

Reimbursement for adjustments is made on a quarterly basis using the Dental Claim Form with the same procedure code that was authorized on the Prior Authorization form.

Providers *must* bill for each quarterly payment. The date of service for the first quarterly payment is the last day of the third month following placement (*counting the month of placement as the first month*).

For example, the placement date was any date in July 2017. The date of service for the first quarterly payment is September 30, 2017. Subsequent quarterly payments are based on dates of



service December 31, 2017; March 31, 2018; June 30, 2018; September 30, 2018; December 31, 2018, etc.

The amount of the quarterly payment is determined by the balance due after the initial payment (one-fourth  $1/4$ ) has been deducted from the prior authorized amount. The remainder is divided by the total number of months of treatment and that result is multiplied by three (3), which then represents the amount of all future quarterly payments.

For example, to continue with the previous example, the approved amount was \$2,200 less \$550 (the initial payment) leaving \$1,650 to be divided by 24 months (the total expected treatment time), at \$68.75 per month, multiplied by three (3) or \$206.25 per quarter.

At such time as there is any change in the length of treatment or discontinuation of the service, e.g., the participant moves from the area, please contact the Department of Social Services, MO HealthNet Division, Clinical Services Unit immediately at (573) 751-6963.

#### **13.44.P PARTICIPANT LOSES ELIGIBILITY DURING PAYMENT QUARTER**

When a participant loses eligibility during a portion of the payment quarter, the claim is manually processed.

The following circumstances require manual processing:

- The participant is only eligible for one (1) or two (2) months of the quarter.
- The participant's eligibility ends prior to the last day of the quarter but after the participant is seen in the third month of the quarter.

Under the first circumstance, the provider *must* bill the exact dates the participant was seen in the office for the one (1) or two (2) months the participant was eligible. Each month *must* be billed on a separate line. The allowed amount for each month is one-third ( $1/3$ ) of the quarterly payment.

Under the second circumstance, the provider should show the last date of eligibility during the third month of the quarter as the date of service.

The completed claim form should be mailed to:

Wipro Infocrossing  
P.O. Box 5600  
Jefferson City, MO 65102

#### **13.45 OCCLUSAL GUARD**

An occlusal guard for participants under the age of 21 is a covered item when a report detailing the condition accompanies the claim when billing for this service. Documentation *must* indicate the occlusal guard will minimize the effects of bruxism or other occlusal factors.

### **13.46 SUTURES**

Suture procedure codes D7910, D7911, and D7912 *cannot* be billed with the following procedure codes:

D3410 through D4999-Endodontics and Periodontics

D6010 through D6100-Implant Services and Prosthodontics

D7000 through D7999-Oral and Maxillofacial Surgery

### **13.47 MULTIPLE SURGICAL PROCEDURES**

When multiple surgical procedures are performed for the same body system through the same incision, the major procedure is considered for payment at 100% of the allowable fee for the procedure. (No reimbursement is made for incidental procedures.)

Multiple surgical procedures (*not* bilateral) performed on the same participant, on the same date of service, by the same provider, through separate incisions, are to be billed and are considered in accordance with the following guidelines:

- The major, secondary and tertiary procedures should be indicated on the claim form using appropriate HCPCS codes.
- A copy of the operative report *must* be attached to all claims for multiple surgeries.

Claims for multiple surgeries are allowed according to the following:

- 100% of the allowable fee for the major procedure.
- 50% of the allowable fee for the secondary procedure.
- 25% of the allowable fee for the tertiary procedure.

### **13.48 POSTOPERATIVE CARE**

Postoperative care includes 30 days of routine follow-up care for those surgical or diagnostic procedures having a MO HealthNet reimbursement amount of \$75.00 or more. For counting purposes, the date of surgery is the first day. This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home,



nursing home, etc.). Pain management is considered part of postoperative care. Visits for the purpose of postoperative pain control are *not* separately reimbursable.

Follow-up care provided by the assistant dental surgeon is subject to the 30-day postoperative policy. Supplies necessary for providing the follow-up care in the office, such as surgical dressings in connection with covered surgical procedures that are subject to the postoperative care policy, may be billed under procedure code D9999. When using procedure D9999 for supplies provided during the postoperative period, an invoice of cost for the supplies used and a written description of the supplies *must* be included with the claim form.

### **13.48.A DENTAL SERVICES SUBJECT TO POSTOPERATIVE RESTRICTION**

The following procedures are subject to the postoperative editing when billed within 30 days after the date of a surgical procedure. These services are included in the postoperative care and are *not* billable as separate services.

#### Office or Other Outpatient Services

|       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|
| 99201 | 99202 | 99203 | 99204 | 99205 | 99211 |
| 99212 | 99213 | 99214 | 99215 |       |       |

#### Hospital Inpatient Services

|       |       |       |
|-------|-------|-------|
| 99231 | 99232 | 99233 |
|-------|-------|-------|

#### Emergency Department Services

|       |       |       |       |
|-------|-------|-------|-------|
| 99281 | 99282 | 99283 | 99284 |
|-------|-------|-------|-------|

### **13.48.B EXCEPTIONS**

Exceptions to the postoperative care policy may be reimbursed for complications or extenuating circumstances that have been documented and determined to be exempt by the State Medical Consultant. In addition, the following services are exempted from the postoperative policy limitations:

- Initial hospital visits to allow payment for dental services when a participant is admitted to the hospital on the same date of service as a surgery;
- Consultations;
- Dental services provided prior to the date of surgery;
- All surgeries or procedures billed having a reimbursement amount of less than \$75.00; and
- Suture removal:

- If the sutures are removed by the same physician who performed the surgery, the charge is included in the surgical fee and is *not* paid separately. Only dressings, x-rays, etc., are payable.

### **13.48.C POSTOPERATIVE CARE—OTHER THAN THE SURGEON**

- Postoperative care is noncovered when rendered by another member of a group or corporation to which the operating surgeon belongs when the second dentist's specialty is the same as the operating surgeon.
- Postoperative care by another member of a group or corporation whose specialty is different from the surgeon is payable.
- Postoperative care by a dentist other than the surgeon is payable if:
  - The diagnosis treated is *not* related to the surgery;
  - The illness requires hospitalization in its own right; or
  - The surgeon is *not* expected to handle the condition.

### **13.49 DENTAL SERVICES—AMBULATORY SURGICAL CENTERS**

Certain dental procedures are covered in a free-standing ambulatory surgical care facility for those participants unable to cooperate in the conventional dental setting due to age, handicap or psychological problems.

The following are examples of participants 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 handicapped participants;
- Accident participants; and
- Dental phobic participants.

Covered dental services in an ambulatory surgical center (for participants meeting the above criteria only) include the following:

- Tooth extraction;
- Wisdom tooth/impacted tooth extraction;
- Pedodontic restoration. (This may include one (1) or more of the following procedures: complete clinical examination, prophylaxis, fluoride treatment, composite/amalgam restorations, extractions, removal of wisdom/impacted teeth, primary teeth, pulpotomies on primary teeth, root canals on permanent teeth and crowns); and
- Local and general anesthesia (see Section 13.24 of the Dental Provider Manual).

### **13.49.A REIMBURSEMENT OF DENTAL SERVICES IN AN AMBULATORY SURGICAL CENTER**

All dental services that are to be billed to MO HealthNet *must* be MO HealthNet covered and *must* be performed by dentists who are currently enrolled as MO HealthNet providers.

Ambulatory surgical center facilities are *not* required to be MO HealthNet enrolled providers as a condition of coverage of the dentist's service. However, they *must* be enrolled in order to receive direct MO HealthNet payment for facility charges.

Dentists *must* use only dental (CDT) procedure codes found in Section 19 of the Dental Provider Manual for the dental procedure(s) performed. Dentists *must* use the Dental Claim Form when billing for these services.

The current fee payable to the dentist includes an allowance for all dental materials necessary for crowns, restorations, etc.

Procedure code 99201, 99202 or 99203 may be used for the initial history and physical workup prior to outpatient surgery in the ambulatory surgical center.

### **13.50 DENTAL SERVICES FOR TRANSPLANT CANDIDATES**

MO HealthNet assures coverage of medically necessary dental services for MO HealthNet transplant participants. This assurance is given to eliminate any risk factors posed to the transplant candidate that may result from poor dental health and would jeopardize the transplant candidate's health or impede an opportunity for transplant if the services were *not* provided. "Medically necessary" is defined as any services required to reduce the possibility of infection and any other complications that may be incurred by the transplant candidate.

Dental services that are *not* identified as medically necessary for the transplant candidate's health *must* meet the guidelines applicable to all MO HealthNet participants as set forth in this manual.

- Participants *must* be on file in the MO HealthNet Divisions' Clinical Services Unit as a potential MO HealthNet transplant candidate in order for coverage of the transplant participant's dental services to be considered.
- The transplant facility *must* have notified the MO HealthNet Division of the need for a transplant.
- The need for dental services *must* have been determined during the transplant evaluation.
- The transplant candidate *must* have the dental work completed in order to be approved by the facility as a transplant candidate.

### **13.51 POISON CONTROL HOTLINE TELEPHONE NUMBER**



The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning.

### **13.52 REPORTING CHILD ABUSE CASES**

State statute at 210.115 RSMo requires physicians and other medical professionals, dentists and other specified personnel to report possible child abuse cases to the Children's Division Child Abuse Hot Line at (800) 392-3738.

**END OF SECTION**

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## **SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS**

Program limits may require prior authorization. Refer to Section 14.2 of the Dental Provider Manual for special dental instructions for requesting prior authorization.

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

Please be aware that when a specific procedure requires an attachment and a modifier (such as “50” bilateral) is used, the attachment remains a positive requirement and *must* also be attached to the procedure that has the modifier.

### **14.1 OPERATIVE REPORT**

An operative or special descriptive report (as indicated by the procedure) may be requested by the State Dental/Orthodontic Consultant to assist in determining the exact procedure(s) performed and subsequent reimbursement. Certain procedure codes always require a report with each claim submission.

#### **14.1.A PROCEDURES REQUIRING A REPORT**

Refer to Section 19 of the Dental Provider Manual for codes that always require a report.

### **14.2 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 efficient and appropriate use of available services. See Section 8 of the Dental Provider Manual, Prior Authorization, for general information about requesting prior authorization and using the Prior Authorization Request form. For dental prior authorization guidelines, reference Section 13.9.A of the Dental Provider Manual.

When requesting prior authorization of a currently noncovered service through the Healthy Children and Youth (HCY) Program, indicate “HCY REQUEST” in the description Field #21.

Approval or denial is indicated line by line on the Prior Authorization Request form in the box to the right of Section III. Also in this box the consultant indicates the allowed amount if applicable, or if the procedure requires manual pricing.

When completing the Prior Authorization Request form, Section IV *must* contain the NPI number and information that the claim for reimbursement of the services requested will be filed under. If the claim will be filed using a clinic NPI, Section IV of the form *must* reflect the clinic information and Section V *must* be completed with the performing provider’s NPI number and information. If the claim for services



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is to be filed under the performing provider's NPI number, then Section IV *must* reflect this information and Section V can be left blank.

At the bottom of the form, the consultant explains any denials or makes notations as needed, referencing specific procedure codes and descriptions, or the specific line number (1 through 12).

The consultant also indicates the date the services are authorized to begin (this is normally the date the consultant review is completed). Finally, the consultant initials the form.

**Claims are *not* reimbursed unless prior authorization was obtained *before* the date of service.**

### **14.2.A PROCEDURES REQUIRING PRIOR AUTHORIZATION**

Orthodontics is an example of a procedure that always requires prior authorization, regardless of the participant's place of residence, or where the services are to be provided. Procedure codes that require prior authorization are listed in Section 19 of the Dental Provider Manual.

### **14.2.B PRIOR AUTHORIZATION FOR ORTHODONTICS**

When requesting prior approval for the provision of extended orthodontic treatment, providers should pay particular attention to Fields #19 "From" and #20 "Through" on the Prior Authorization Request form. These fields should reflect the anticipated orthodontic treatment time required. If the service is approved, this information is reflected on the prior authorization file.

The approved amount is authorized on the Prior Authorization Request form when requesting orthodontics, and when the procedure requires manual pricing this amount is also reflected on the prior authorization file.

## **14.3 THE HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX**

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandates that Medicaid-covered services be provided for individuals under the age of 21 when service is medically necessary, regardless of whether the service is covered by the State Medicaid Plan. Individuals under age 21 with Medical Eligibility (ME) codes 80 and 89 are *not* able to access expanded HCY services.

Orthodontic procedures are covered as expanded HCY services but require prior approval. Orthodontic procedures are approved for the most severe malocclusions and in cases of medical necessity as determined by the state orthodontic consultant when the treating orthodontist/dentist submits documentation supporting medical necessity.

### **14.3.A GUIDELINES AND RULES FOR APPLYING THE HLD INDEX**

1. Orthodontic benefits are available to eligible beneficiaries under the age of 21 with severe malocclusions and in cases of medical necessity as determined by the state orthodontic consultant when the treating orthodontist/dentist submits documentation supporting medical

necessity. Benefits are for participants with permanent dentition except in cleft palate cases, severe traumatic deviations, an impacted maxillary central incisor or when medical necessity criteria are met, or with mixed dentition when the beneficiary has reached the age of 13.

2. Study models *must* be of diagnostic quality. To meet diagnostic requirements when submitting hard/plaster study models, the models *must* be properly poured and adequately trimmed with no large voids or positive bubbles present. Hard/plaster dental study models should simulate centric occlusion of the patient when models are placed on their heels. Study models that do *not* meet the diagnostic requirements described above are *not* accepted.
3. Only teeth that have erupted and are visible on the study models should be considered, measured, counted and recorded.
4. In cases submitted for deep impinging bite with tissue damage, the lower teeth *must* be clearly touching the palate and tissue indentations or other evidence of soft tissue damage *must* be visible on the study models.
5. Either of the upper central incisors *must* be used to measure overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. Do *not* use the upper lateral incisors or cuspids for these measurements.
6. The following definitions and instructions apply when using the HLD Index to identify ectopic eruptions:
  - Examples of ectopic eruption (and ectopic development) of teeth include:
    - When a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar;
    - Transposed teeth;
    - Teeth in the maxillary sinus;
    - Teeth in the ascending ramus of the mandible; and
    - Situations where teeth have developed in locations other than the dental arches.
  - In all other situations, teeth deemed to be ectopic *must* be more than 50% blocked out and clearly out of the dental arch.
  - In cases of mutually blocked-out teeth, only one (1) is counted.

### **14.3.B INSTRUCTIONS FOR THE HLD INDEX MEASUREMENTS**

Procedure:

1. Indicate by checkmark next to A, B and/or C which criteria is being submitted for review.
2. Position the patient's teeth in centric occlusion.

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3. Record all measurements in the order given and round off to the nearest millimeter.
4. Enter the score “0” if condition is absent.
5. The use of a recorder (assistant or hygienist) is recommended.

### Conditions:

Conditions 1 through 6 are considered automatic qualifiers under the MO HealthNet Division orthodontic program.

1. Cleft palate deformities—the deformity *must* be demonstrated on the study model, if the deformity *cannot* be demonstrated on the study model, the condition *must* be diagnosed by properly credentialed experts and the diagnosis *must* be supported by documentation. If present, enter an “X”.
2. Deep impinging overbite—tissue damage of the palate *must* be clearly visible in the mouth. On study models, the lower teeth *must* be clearly touching the palate and the tissue indentations or evidence of soft tissue damage *must* be clearly visible. If present, enter an “X”.
3. Crossbite of individual anterior teeth—damage of soft tissue *must* be clearly visible in the mouth and reproducible and visible on the study models. Gingival recession *must* be at least 1½ mm deeper than the adjacent teeth. If present, enter an “X”. In the case of a canine, the amount of gingival recession should be compared to the opposite canine.
4. Severe traumatic deviations—these might include, for example, loss of a premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. If present, enter an “X”.
5. Overjet—this is recorded with the patient’s teeth in centric occlusion and is measured from the labial surface of the most labial lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do *not* use the upper lateral incisors or cuspids. The measurement may apply to only one (1) tooth if it is severely protrusive. Reverse overjet may be measured in the same manner. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. If the overjet is greater than 9 mm or reverse overjet is greater than 3.5 mm enter an “X”.
6. Impacted Maxillary Central Incisor—if present, enter an “X”.
7. Overjet—this is recorded with the patient’s teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do *not* use the upper lateral incisors or cuspids. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter the measurement in millimeters.
8. Overbite—a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking

and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. “Reverse” overbite may exist and should be measured on an upper central incisor – from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter the measurement in millimeters.

9. Mandibular (dental) protrusion or reverse overjet—measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).
10. Open bite—measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).
11. Ectopic eruption—count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3).

If condition No. 12a and/or 12b, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **DO NOT SCORE BOTH CONDITIONS.**

- 12a. Anterior crowding of maxilla—anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and one (1) point for a mandibular arch with anterior crowding and multiply by five (5).
- 12b. Anterior crowding of mandible— anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).

If condition No. 11, ectopic eruption, is also present in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **DO NOT SCORE BOTH CONDITIONS.**

13. Labio-lingual spread—use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be



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measured for labio-lingual spread but only the most severe individual measurement should be entered on the on the score sheet. Enter the measurement in mm.

14. Posterior crossbite—this condition involves one (1) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment. Upon completion of the HLD Index score sheet, review all measurements and calculations for accuracy.

**END OF SECTION**

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## SECTION 15-BILLING INSTRUCTIONS

### 15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at [www.wpc-edi.com](http://www.wpc-edi.com). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12N Version 5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12N Version 5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide

### 15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is [www.emomed.com](http://www.emomed.com). Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference <http://dss.mo.gov/mhd/providers/> and click on the [Apply for Internet Access link](#). Providers are unable to access [www.emomed.com](http://www.emomed.com) without proper authorization. An authorization is required for each individual user.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (2002, 2004 American Dental Association), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission. **NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.**

### 15.3 DENTAL CLAIM FORM

The Dental Claim Form, American Dental Association (ADA), 2002, 2004 is used to bill MO HealthNet for dental services unless a provider bills those services electronically. Instructions on how to complete the Dental Claim Form are on the following pages. **NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.**



## 15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of the Dental Provider Manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

## 15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit electronically or on a Dental Claim Form. An example of a correctable error is the use of an invalid procedure code.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, if the dental provider received \$2.00 instead of \$20.00, that claim *cannot* be resubmitted. It will deny as a suspect duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of the Dental Provider Manual explains the adjustment request process.

## 15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payor. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, a claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice attached indicating the denial. For submission of claims to MO HealthNet, reference Section 16 of the Dental Provider Manual for instructions.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), a crossover claim *must* be submitted to MO HealthNet. For billing instructions, reference Section 16 of the Dental Provider Manual.



## 15.7 DENTAL CLAIM FILING INSTRUCTIONS

The American Dental Association, 2002, 2004, Dental Claim Form should be typed or legibly printed. **NOTE: Effective November 1, 2020 MHD will begin accepting the 2019 ADA form for dental claims. The claim filing instructions in this section will be revised at that time to reflect any applicable changes.** It may be duplicated if the copy is legible. MO HealthNet claims should be submitted electronically to [www.emomed.com](http://www.emomed.com) or mailed to:

Wipro Infocrossing  
P.O. Box 5600  
Jefferson City, MO 65102

NOTE: An asterisk (\*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (\*\*) beside the field number indicate a field is required in specific situations.

| FIELD NUMBER & NAME                  | INSTRUCTIONS FOR COMPLETION  |
|--------------------------------------|--|
| 1-2.                                 | Not required.  |
| *3. Primary Payer Information        | Enter name, address, city, state and zip code for the insurance company or third-party payer.  |
| **4-11. Other Coverage               | Required only if participant has second dental policy. Leave blank if there is <i>not</i> other dental coverage.(1)  |
| **12-17. Primary Insured Information | When verifying the participant's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, address, and policy number.<br><br>If the other insurance pays, the amount paid should be entered in field #32, section : "Other Fees." Leave blank if there are no other dental coverage. |
| 18-19.                               | Not required.  |
| *20. Patient Name                    | Enter the participant's last name, first name and middle initial as shown on the participant's ID card. (Optional: Enter the participant's street address, city of residence and state.)   |



- 21. Date of Birth Not required.
- 22. Sex Not required.
- \*23. Patient ID# Enter the MO HealthNet number exactly as shown on the participant's ID card.
- \*24. Date Enter the actual date services were rendered in month/day/year numeric format.
- \*\*25. Oral Cavity Report the area of the oral cavity. In any of the following instances, leave this field blank.
  - a. The procedure identified in #29 requires the identification of a tooth or a range of teeth.
  - b. The procedure identified in #29 incorporates a specific area of the oral cavity in its nomenclature.
  - c. The procedure identified in #29 does *not* relate to any portion of the oral cavity.
- 26. Tooth System Not required.
- \*\*27. Tooth Number or Letter Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does *not* apply, this field may be left blank. The valid fields are:
  - A-T — Deciduous teeth
  - 1-32 —Permanent teeth
  - AS-TS — Deciduous supernumerary teeth
  - 51-82 —Permanent supernumerary teeth

When billing for partial dentures, enter the tooth number for one of the teeth being replaced in this field. Alveoplasties should be billed using the correct oral cavity code 10 for upper right quadrant, 20 for upper left quadrant, 30 for lower left quadrant and 40 for lower right quadrant.



|                            |   |
|----------------------------|---|
| **28. Tooth Surface        | Enter the appropriate surface code, if applicable, otherwise leave blank. The valid values are:<br>M — Mesial<br>D — Distal<br>O — Occlusal<br>L — Lingual<br>I — Incisal<br>F — Facial<br>B — Buccal                                     |
| *29. Procedure Code        | Enter the five-digit code for the service performed, as well as any applicable modifiers.   |
| 30. Description            | Only required in specific situations as described in Section 13.  |
| *31. Fee                   | Enter the usual and customary fee for the procedures(s) performed. Do <i>not</i> subtract the copay or coinsurance amounts from the charge.   |
| 32. Other fees             | When other charges are applicable to dental services provided, this field <i>must</i> be reported. Enter the amount here.   |
| *33. Total Fee             | Enter the total of the charges shown.   |
| 34. Missing Teeth          | Not required.   |
| **35. Remarks              | For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely. |
| 36-38.                     | Not required.   |
| **39. Number of Enclosures | Complete whether or not radiographs, oral images, or study models are submitted with  |

- the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no possible attachments are missing.
40. Is Treatment For Orthodontics    If no, skip to #43. If yes, answer #41 and 42.
41. Date Appliance Placed    Enter the date orthodontic appliance was placed if the answer to #40 is yes, otherwise leave blank.
42. Months of Treatment Remaining    Enter the months of orthodontic treatment remaining if the answer to #40 is yes, otherwise leave blank.
43. Replacement of Prosthesis    This item applies to crowns and all fixed or removable prostheses.
- a. If claim does *not* involve a prosthetic restoration, check "no" and proceed to #45.
- b. If claim is for the initial placement of a crown or fixed or removable prosthesis, check "no" and go to #45.
- c. The patient has previously had these teeth replaced by a crown, check "yes" and go to #44.
44. Date of Prior Placement    Enter the date of the initial placement of the prosthesis if the answer to #43 is yes, otherwise leave blank.
45. Treatment Resulting From    If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box and proceed to items #46 & 47. If services are *not* the result of an accident, skip to field #48. The valid values are:
- AA — Auto Accident
- EM — Employment Related
- OA — Other Accident

|   |   |
|---|---|
| 46. Accident Date                           | Enter the date on which the accident in #45 occurred, otherwise leave blank.  |
| 47. Auto Accident State                     | Enter the state in which the auto accident in #45 occurred, otherwise leave blank.  |
| 48. Name, Address, City, State              | Enter the name and complete address of dentist or dental entity.  |
| 49. Provider ID#                            | This number is the NPI number assigned to the billing dentist or dental entity.   |
| 50. Dentist License #                       | Not required.   |
| 51. Dentist SS# or T.I.N                    | Not required.   |
| 52. Phone Number                            | Enter provider's phone number.  |
| 53. Signature & Date                        | Not required.   |
| **54. Provider ID#<br>(Performing Provider) | This number is the NPI number assigned to the treating dentist.<br><br>This field is required for a clinic/group practice only. |
| 55. License #                               | Not required.   |
| *56. Address, City, State, MO               | Enter the name and complete address of dentist or dental entity.  |
| 57. Phone Number                            | Enter treating dentist phone number.  |
| 58. Treating Provider Specialty             | Not required.   |

\* These fields are mandatory on *all* Dental Claim Forms.

\*\* These fields are mandatory only in specific situations as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the Dental Provider Manual for further TPL information.

## 15.8 THIRD PARTY LIABILITY (TPL) INFORMATION

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Division's participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896 or the Internet at [www.emomed.com](http://www.emomed.com).



Both systems allow the provider to inquire on third party resources. Reference Sections 1 and 3 of the Dental Provider Manual for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PARTICIPANT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5, Third Party Liability, of the Dental Provider Manual for additional information.

**END OF SECTION**

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## **SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS**

### **16.1 GENERAL INFORMATION**

This section includes general information about the Medicare and MO HealthNet Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and MO HealthNet are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.

- MO HealthNet is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. MO HealthNet is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Mo HealthNet benefits by completing an application form at a Family Support Division (FSD) office.

In Missouri, MO HealthNet claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the MO HealthNet Division within the Department of Social Services, which is the single state agency for the administration of the MO HealthNet Program.

- For participants having both Medicare and MO HealthNet eligibility, the MO HealthNet Program pays the cost-sharing amounts indicated by Medicare due on the Medicare allowed amount. These payments are referred to as “Crossovers.”
- “Cost-sharing” amounts include the participant’s co-insurance, deductible, and any co-pays that are due for any Medicare-covered service.



## 16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS)

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first. After making payment, the Medicare contractor forwards the claim information to MO HealthNet for payment of cost-sharing amounts. (Reference Section 16.3 for instructions to bill MO HealthNet when Medicare denies a service.)

The MO HealthNet payment of the cost-sharing appears on the provider's MO HealthNet Remittance Advice (RA).

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The Medicare contractor does *not* send crossovers to MO HealthNet
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for MO HealthNet.
- The MO HealthNet participant information on the crossover claim does *not* match the fiscal agent's participant file.
- The provider's National Provider Identifier (NPI) number is *not* on file in the MO HealthNet Division's provider files.

MO HealthNet no longer accepts paper crossover claims. Medicare/MO HealthNet (crossover) claims that do not cross automatically from Medicare to MO HealthNet must be filed through the MO HealthNet billing web portal at [www.emomed.com](http://www.emomed.com) or through the 837 electronic claims transaction. Before filing an electronic crossover claim, providers should wait 30 days from the date of Medicare payment to avoid duplication. The following tips are provided to make filing a claim at the MO HealthNet billing web portal successful:

- 1) Through the MO HealthNet billing web portal at [www.emomed.com](http://www.emomed.com), choose the claim form that corresponds with the claim form used to bill Medicare. Enter all appropriate information from that form.
- 2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.
- 3) There must be an "Other Payer" header form completed for every crossover claim type. This provides information that pertains to the whole claim.
- 4) Part A crossover claims need only the "Other Payer" header form completed and not the "Other Payer" detail form.

- 5) Part B and B of A crossover claims need the “Other Payer” header form completed. An “Other Payer” detail form is required for each claim line detail with the group code, reason code and adjustment amount information.
- 6) Choose the appropriate codes that can be entered in the “Group Code” field on the “Other Payer” header and detail forms from the dropdown box. For example, the “PR” code (Patient Responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare EOMB.
- 7) The codes to enter in the “Reason Code” field on the “Other Payer” header and detail forms are also found on the Medicare EOMB. If not listed there, choose the most appropriate code from the list of “Claim Adjustment Reason Codes”. These HIPAA mandated codes can be found at [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes). For example, on the “Claim Adjustment Reason Codes” list the code for “deductible amount” is 1 and for “coinsurance amount” it is 2. Therefore, choose a “Reason Code” of “1” for deductible amounts due and a “Reason Code” of “2” for coinsurance amounts due.
- 8) The “Adjust Amount” should reflect any amount not paid by Medicare including any cost-sharing amounts and any non-allowed amounts.
- 9) If there is a commercial insurance payment or denial to report on the crossover claim, complete an additional “Other Payer” header form. Complete an additional “Other Payer” detail form(s) as appropriate.

Note: For further assistance on how to bill crossover claims, please contact Provider Education at (573) 751-6683.

### **16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE**

Not all services covered under the MO HealthNet Program are covered by Medicare. (Examples are: eyeglasses, most dental services, hearing aids, adult day health care, personal care or most eye exams performed by an optometrist.) In addition, some benefits that are provided under Medicare coverage may be subject to certain limitations. The provider will receive a Medicare Remittance Advice that indicates if a service has been denied by Medicare. The provider may submit a Medicare denied claim to MO HealthNet electronically using the proper claim form for consideration of reimbursement through the 837 electronic claims transaction or through the MO HealthNet web portal at [www.emomed.com](http://www.emomed.com). If the 837 electronic claims transaction is used, providers should refer to the implementation guide for assistance. The following are tips to assist in successfully filing Medicare denied claims through the MO HealthNet web portal at [www.emomed.com](http://www.emomed.com):



- 1) To bill through the MO HealthNet web portal, providers should select the appropriate claim type (CMS 1500, UB-04, Nursing Home, etc.) Do *not* select the Medicare crossover claim form. Complete all pertinent data for the MO HealthNet claim.
- 2) Some fields are required for Medicare and not for Third Party Liability (TPL). The code entered in the “Filing Indicator” field will determine if the attachment is linked to TPL or Medicare coverage.

## **16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS**

Medicare Advantage/Part C plans do not forward electronic crossover claims to MHD. Therefore, providers must submit Medicare Advantage/Part C crossover claims through the MHD Web portal at [www.emomed.com](http://www.emomed.com). The following are tips to assist in successfully filing Medicare Advantage/Part C crossover claim through the MO HealthNet web portal at [www.emomed.com](http://www.emomed.com):

- 1) Access the MHD web portal at [www.emomed.com](http://www.emomed.com). Choose the appropriate Part C crossover claim format. Enter all appropriate information from the Medicare Advantage/Part C plan claim. Do not use the Medicare Part A or Part B crossover claim format.
- 2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the “Other Payer” header and “Other Payer” detail screens. The HELP screens are identified by a “?” and is located in the upper right-hand corner.
- 3) The filing indicator for Medicare Advantage/Part C crossover claims is 16 followed by the appropriate claim type.
- 4) There must be an “Other Payer” header detail screen completed for every crossover claim format. This provides information that pertains to the whole claim.
- 5) Medicare Advantage/Part C institutional claims need only the “Other Payer” header detail screen completed and not the “Other Payer” line detail screen.
- 6) Medicare Advantage/Part C outpatient and professional crossover claims need the “Other Payer” header detail screen completed. An “Other Payer” line detail screen is required to be completed for each claim detail line with group code, reason code and adjustment amount information.
- 7) The appropriate code from the codes available in the “Group Code” drop down box on the “Other Payer” header and detail screens *must* be selected. For example, the “PR” code (patient responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare Advantage/Part C explanation of benefits.



- 8) The codes to enter in the “Reason Code” field on the “Other Payer” header and detail screens are found on the Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, choose the most appropriate code from the list of “Claim Adjustment Reason Codes” that can be accessed at <http://www.wpc-edi.com/codes/Codes.asp>. For example, enter “Reason Code” of “1” for deductible amounts, “2” for coinsurance amounts and “3” for co-payment amounts.

#### **16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS**

For non-QMB MO HealthNet participants enrolled with a Medicare Advantage/Part C Plan, MO HealthNet will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet provider manual at <http://manuals/momed.com>. In accordance with this policy, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e., CMS-1500, UB-04). ***Do not use a crossover claim.***

### **16.5 TIMELY FILING**

Claims that have been initially filed with Medicare within the Medicare timely filing requirements, and which are submitted as a crossover through an 837 electronic claim transaction or through the MO HealthNet Web portal at [www.emomed.com](http://www.emomed.com) meet the timely filing requirement by being submitted by the provider and received by the MO HealthNet Division within six months of the date of the allowed Medicare RA/EOMB or one (1) year from the date of service. Refer to Section 4 for further instructions on timely filing.

### **16.6 REIMBURSEMENT**

The MO HealthNet Division reimburses the cost-sharing amount as determined by the Medicare contractor and reflected on the Medicare RA/EOMB. MHD prorates the reimbursement amount allowing a prorated amount for each date the individual was MO HealthNet eligible. Days on which the participant was not MO HealthNet eligible are not reimbursed.

#### **16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS**

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A and deductible, coinsurance and copayment amounts for Medicare Advantage/Part C crossover claims only when the MO HealthNet applicable payment schedule exceeds the amount paid by Medicare plus calculated pass-through costs. In those situations where MO HealthNet has an obligation to pay a crossover claim, the amount of MO HealthNet’s



payment is limited to the lower of the actual crossover amount or the amount the MO HealthNet fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participant to be considered a Medicare/Medicaid crossover claim. For further information, please see 12.4 of the Hospital Program Manual.

#### **16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS**

MO HealthNet reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services is seventy-five percent (75%) of the allowable cost sharing amount. The cost sharing amount includes the coinsurance, deductible and/or copayment amounts reflected on the Medicare RA/EOMB from the Medicare carrier or fiscal intermediary. The crossover claims for Medicare Advantage/Part C outpatient hospital services must have been provided to QMB or QMB Plus participant to be reimbursed at seventy-five percent (75%) of the allowable cost sharing amount. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

**END OF SECTION**

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## SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at <http://manuals.momed.com/Application.html>. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

### 17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at [www.emomed.com](http://www.emomed.com) or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.



## 17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

## 17.3 ON-LINE HELP

All Internet screens at [www.emomed.com](http://www.emomed.com) offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

## 17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

- Crossovers
- Inpatient
- Outpatient (Includes Rural Health Clinic and Hospice)
- Medical
- Nursing Home
- Home Health
- Dental
- Drug
- Capitation
- Credits

Claims in each category are listed alphabetically by participant's last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

| FIELD NAME          | FIELD DESCRIPTION  |
|---------------------|--|
| PAGE                | The remittance advice page number.   |
| CLAIM TYPE          | The type of claim(s) processed.  |
| RUN DATE            | The financial cycle date.  |
| PROVIDER IDENTIFIER | The provider's NPI number.   |
| RA #                | The remittance advice number.  |
| PROVIDER NAME       | The name of the provider.  |
| PROVIDER ADDR       | The provider's address.  |
| PARTICIPANT NAME    | The participant's last name and first name.  |
|                     | NOTE: If the participant's name and identification number are <i>not</i> on file, only the first two letters of the last name and the first letter of the first name appear.   |
| MO HEALTHNET ID     | The participant's current 8-digit MO HealthNet identification number.  |
| ICN                 | The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: <ul style="list-style-type: none"> <li>11— Paper Drug</li> <li>13— Inpatient</li> <li>14— Dental</li> <li>15— Paper Medical</li> <li>16— Outpatient</li> <li>17— Part A Crossover</li> <li>18— Paper Medicare/MO HealthNet Part B Crossover Claim</li> <li>21— Nursing Home</li> <li>40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.</li> <li>41— Direct Electronic MO HealthNet Information (DEMI)</li> <li>43— MTB/DEMI</li> <li>44— Direct Electronic File Transfer (DEFT)</li> <li>45— Accelerated Submission and Processing (ASAP)</li> <li>46— Adjudicated Point of Service (POS)</li> <li>47— Captured Point of Service (POS)</li> </ul> |



- 49— Internet
- 50— Individual Adjustment Request
- 55— Mass Adjustment

The third and fourth digits indicate the year the claim was received.

The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from “001” (January 1) to “365” (December 31) (“366” in a leap year).

The last digits of an ICN are for internal processing.

For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.

|                    |   |
|--------------------|---|
| SERVICE DATES FROM | The initial date of service in MMDDYY format for the claim.   |
| SERVICE DATES TO   | The final date of service in MMDDYY format for the claim.   |
| PAT ACCT           | The provider’s own patient account name or number. On drug claims this field is populated with the prescription number.   |
| CLAIM: ST          | This field reflects the status of the claim. Valid values are: <ul style="list-style-type: none"> <li>1 — Processed as Primary</li> <li>3 — Processed as Tertiary</li> <li>4 — Denied</li> <li>22 — Reversal of Previous Payment</li> </ul> |
| TOT BILLED         | The total claim amount submitted.   |
| TOT PAID           | The total amount MO HealthNet paid on the claim.  |
| TOT OTHER          | The combined totals for patient liability (surplus), participant copay and spenddown total withheld.  |
| LN                 | The line number of the billed service.  |
| SERVICE DATES      | The date of service(s) for the specific detail line in MMDDYY.  |
| REV/PROC/NDC       | The submitted procedure code, NDC, or revenue code for the specific detail line.<br><br>NOTE: The revenue code only appears in this field if a procedure code is <i>not</i> present.  |
| MOD                | The submitted modifier(s) for the specific detail line.   |
| REV CODE           | The submitted revenue code for the specific detail line.<br><br>NOTE: The revenue code only appears in this field if a procedure code has also been submitted.  |



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|                          |   |
|--------------------------|---|
| QTY                      | The units of service submitted.   |
| BILLED AMOUNT            | The submitted billed amount for the specific detail line.   |
| ALLOWED AMOUNT           | The MO HealthNet maximum allowed amount for the procedure/service.  |
| PAID AMOUNT              | The amount MO HealthNet paid on the claim.  |
| PERF PROV                | The NPI number for the performing provider submitted at the detail.   |
| SUBMITTER LN ITM<br>CNTL | The submitted line item control number.   |
| GROUP CODE               | The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are:<br>CO—Contractual Obligation<br>CR—Correction and Reversals<br>OA—Other Adjustment<br>PI—Payer Initiated Reductions<br>PR—Patient Responsibility   |
| RSN                      | The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at <a href="http://www.wpc-edi.com/codes/claimadjustment">http://www.wpc-edi.com/codes/claimadjustment</a> .   |
| AMT                      | The dollar amount adjusted for the corresponding reason code.   |
| QTY                      | The adjustment to the submitted units of service. This field is <i>not</i> printed if the value is zero.  |
| REMARK CODES             | The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are:<br>HE—Claim Payment Remark Codes<br>RX—National Council for Prescription Drug Programs Reject/Payment Codes<br><br>The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at <a href="http://www.wpc-edi.com/codes/remittanceadvice">http://www.wpc-edi.com/codes/remittanceadvice</a> . |
| CATEGORY TOTALS          | Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.  |
| CHECK AMOUNT             | The total check amount for the provider.  |

## EARNINGS REPORT

PROVIDER IDENTIFIER The provider's NPI number.

RA # The remittance advice number.

## EARNINGS DATA

NO. OF CLAIMS PROCESSED The total number of claims processed for the provider.

DOLLAR AMOUNT PROCESSED The total dollar amount processed for the provider.

CHECK AMOUNT The total check amount for the provider.

**17.5 CLAIM STATUS MESSAGE CODES**

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at <http://www.wpc-edi.com/content/view/180/223/>. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

**17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS**

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

| Claim Payment Reduction/Cutback           | Claim Group Code | Description            | Claim Adjustment Reason Code | Description   |
|---|------------------|------------------------|------------------------------|---|
| Payment reimbursed at the maximum allowed | CO               | Contractual Obligation | 45                           | Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement. |
| Payment reduced by other insurance amount | OA               | Other Adjustment       | 23                           | Payment adjusted because charges have been paid by another payer                                |



|   |    |                        |     |   |
|---|----|------------------------|-----|---|
| Medicare Part A Repricing                                     | OA | Other Adjustment       | 45  | Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement. |
| Payment cut back to federal percentage (IEP therapy services) | OA | Other Adjustment       | A2  | Contractual adjustment  |
| Payment reduced by co-payment amount                          | PR | Patient Responsibility | 3   | Co-Payment amount   |
| Payment reduced by patient spenddown amount                   | PR | Patient Responsibility | 178 | Payment adjusted because patient has <i>not</i> met the required spenddown                      |
| Payment reduced by patient liability amount                   | PR | Patient Responsibility | 142 | Claim adjusted by monthly MO HealthNet patient liability amount                                 |

## 17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

## 17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.

## 17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at [www.emomed.com](http://www.emomed.com). The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

## 17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at [www.emomed.com](http://www.emomed.com). Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.



## **17.10 PRIOR AUTHORIZATION STATUS**

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at [www.emomed.com](http://www.emomed.com). PA status queries are restricted to the provider who submitted the Prior Authorization Request.

**END OF SECTION**

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## **SECTION 18—DIAGNOSIS CODES**

### **18.1 GENERAL INFORMATION**

The diagnosis code is *not* required on the Dental Claim Form.

### **18.2 TOOTH NUMBER/LETTER CODES**

The following codes are used in the “Tooth Number” column of Field #27 on the Dental Claim Form.

- A-T Primary teeth as shown on chart on claim form
- 1-32 Permanent teeth as shown on chart on claim form
- 51-82 Permanent supernumerary tooth
- AS-TS Primary supernumerary tooth

### **18.3 TOOTH SURFACE CODES**

The following codes are used in the “Surface Code” column of Field #28 on the Dental Claim Form.

- M Mesial
- D Distal
- O Occlusal
- L Lingual
- I Incisal
- F Facial
- B Buccal

**END OF SECTION**

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## SECTION 19—PROCEDURE CODES

The MO HealthNet Division uses the procedure coding systems found in the Current Dental Terminology (CDT) and Current Procedural Terminology (CPT) coding book. Both the CDT and CPT may be purchased at your local bookstore or medical resource supplier of your choice.

The following guide should be used throughout Section 19 of this manual for those codes that have reference marks beside them.

- \* Coverable for children under 21 or for persons under a category of assistance for pregnant women, the blind or nursing facility residents.
- \*\* Dental services procedure codes considered for trauma or medical condition.
- PA=Prior Authorization Request; MP=Manually Priced; IOC=Invoice of Cost
- § Dental services procedure codes considered support (billable only in conjunction with a trauma or medical code).
- + Covered under the Dental Hygienist Program.
- ¥ Assistant surgeon is also covered. CPT modifier 80 must be added to the code when billing as an assistant surgeon.

### 19.1 CDT AND INJECTION PROCEDURE CODES

The following CDT and injection procedure codes are covered for eligible needy children under the age of 21 or persons receiving MO HealthNet under a category of assistance for pregnant women, the blind, or participants residing in a nursing facility. For eligibility determination refer to Section 1 of the Dental Provider Manual.

| PROC CODE                            | DESCRIPTION  | AGE LIMIT | MAXIMUM ALLOWED AMOUNT |
|--------------------------------------|--|-----------|------------------------|
| <b>19.1.A DIAGNOSTIC</b>             |  |           |                        |
| <b>19.1.A(1) Clinical Oral Exams</b> |  |           |                        |
| <b>D0120</b>                         | Periodic oral evaluation   | *None     | \$24.73                |
| <b>**D0140</b>                       | Limited oral evaluation - problem focused  | *None     | \$23.95                |
| <b>D0145</b>                         | Oral evaluation for a patient under 3 years of age and counseling with primary caregiver | 0-2       | \$29.62                |
| <b>**D0150</b>                       | Comprehensive oral evaluation - new or established patient                               | *None     | \$39.67                |
| <b>**D0160</b>                       | Detailed and extensive oral evaluation - problem focused, by report                      | *None     | \$49.91                |

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|   |   |             |         |
|---|---|-------------|---------|
| <b>**D0170</b>                                  | Re-evaluation—limited, problem focused (Established patient; not post-operative visit)  | *None       | \$24.73 |
| <b>**D0171</b>                                  | Re-evaluation - post-operative office visit   | *None       | \$23.95 |
| <b>19.1.A(2) Diagnostic Imaging</b>             |   |             |         |
| <b>**D0210</b>                                  | Intraoral - complete series of radiographic images (one in 24 months, may not bill D0330 during same 24 month period.)  | *None       | \$40.72 |
| <b>**D0220</b>                                  | Intraoral - periapical first radiographic image (one on a date of service)  | *None       | \$9.58  |
| <b>**D0230</b>                                  | Intraoral - periapical each additional radiographic image (maximum of 4 same date of service as D0220)  | *None       | \$7.99  |
| <b>**D0240</b>                                  | Intraoral - occlusal radiographic image (one on a date of service)  | *None       | \$13.97 |
| <b>**D0250</b>                                  | Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector (one on a date of service)  | *None       | \$19.97 |
| <b>**D0251</b>                                  | Extra-oral posterior dental radiographic image  | *None       | \$16.66 |
| <b>**D0270</b>                                  | Bitewing - single radiographic image (maximum quantity of 4-single, or combination of D0270 (qty 2) and D0272 (qty 1) in 6 months) (not covered during same six months as D0274 or D0277) | *None       | \$9.18  |
| <b>**D0272</b>                                  | Bitewings - two radiographic images (not covered during same six months as D0274 or D0277)  | *None       | \$14.78 |
| <b>**D0273</b>                                  | Bitewings - three radiographic images (not covered during same six months as D0272, D0274 or D0277)   | *None       | \$18.37 |
| <b>**D0274</b>                                  | Bitewings - four radiographic images (not covered during same six months as D0272 or D0277)   | *None       | \$21.64 |
| <b>**D0277</b>                                  | Vertical bitewings - 7 to 8 radiographic images (not covered during same six months as D0272 or D0274) (cannot bill on the same date of service as regular bitewings)                     | *None       | \$34.00 |
| <b>**D0290</b>                                  | Posterior-anterior or lateral skull and facial bone survey radiographic image   | *None       | \$40.31 |
| <b>**D0310</b>                                  | Sialography (includes injectable material)  | *None       | \$99.41 |
| <b>**D0330</b>                                  | Panoramic radiographic image (one in 24 months, may not bill D0210 during same 24 month period) (See also D0999)  | *6 and over | \$36.72 |
| <b>D0340</b>                                    | 2D cephalometric radiographic image - acquisition, measurement and analysis (orthodontic treatment)   | 0-20        | \$41.51 |
| <b>D0350</b>                                    | 2D oral/facial photographic image <u>obtained intra-orally or extra-orally</u>  | 0-20        | \$22.36 |
| <b>D0351</b>                                    | 3D photographic image   | 0-20        | \$26.57 |
| <b>19.1.B TESTS AND LABORATORY EXAMINATIONS</b> |   |             |         |
| <b>D0415</b>                                    | Bacteriologic studies for determination of pathologic agents.   | 0-20        | \$53.89 |
| <b>D0460</b>                                    | Pulp vitality tests   | 0-20        | \$18.76 |
| <b>D0470</b>                                    | Diagnostic casts (orthodontic treatment only)   | 0-20        | \$36.06 |
| <b>§D0999</b>                                   | Unspecified diagnostic procedure, by report (for panorex more than 1 in 24 months, include office notes and reason for the medical necessity of second panorex)                           | *None       | MP/OR   |

| <b>19.1.C PREVENTATIVE/DENTAL PROPHYLAXIS</b>                  |  |        |          |
|--|--|--------|----------|
|  | Includes scaling and polishing of teeth.   |        |          |
| <b>+§D1110</b>   | Prophylaxis—adult—both arches (One per participant in 6-month intervals) (See also D9999)                                    | 13-125 | \$29.14  |
| <b>+§D1120</b>   | Prophylaxis—child—both arches (One per participant in 6-month intervals) (See also D9999)                                    | *1-12  | \$21.95  |
| <b>19.1.C(1) Fluoride Treatments</b>                           |  |        |          |
| <b>+§D1206</b>   | Topical application of fluoride varnish (one per participant in 6-month intervals)   | 0-20   | \$13.97  |
| <b>+§D1208</b>   | Topical application of fluoride - excluding varnish  | *None  | \$11.98  |
| <b>19.1.C(2) Other Preventative Services</b>                   |  |        |          |
| <b>+D1351</b>  | Dental sealants. Permanent 1st & 2nd molars (applied to unrestored occlusal surface) must bill each tooth on a separate line | 5-20   | \$19.58  |
| <b>+D1353</b>  | Sealant repair – per tooth   | 5-20   | \$9.28   |
| <b>+D1354</b>  | Int Caries Med App Per Tooth   | 1-5    | \$2.75   |
| <b>19.1.C(3) EPSDT/HCY Dental Screen</b>                       |  |        |          |
| <b>99201 EP</b>  | Office/Other Outpatient Visit; Requires 3 Key Components Problem Focused Hx, Exam, & Medical Decision Making                 | 0-20   | \$24.41  |
| <b>99202 EP</b>  | Office/Other Outpatient Visit; Requires 3 Key Components Problem Focused Hx, Exam, & Medical Decision Making                 | 0-20   | \$40.33  |
| <b>99203 EP</b>  | Office/Other Outpatient Visit; Requires 3 Key Components; Detailed Hx; Exam; & Med Dec Low Complexity                        | 0-20   | \$58.77  |
| <b>99204 EP</b>  | Office/Other Outpatient Visit; Requires 3 Key Components; Comprehensive Hx, Exam; & Med Dec Moderate Complexity              | 0-20   | \$89.81  |
| <b>99205 EP</b>  | Office/Other Outpatient Visit; Requires 3 Key Components; Comprehensive Hx, Exam; & Med Dec High Complexity                  | 0-20   | \$112.88 |
| <b>99211 EP</b>  | Office/Other Outpatient Visit, May Not Require Presence Of Physician - Presenting Problem(s) Minimal                         | 0-20   | \$15.92  |
| <b>99212 EP</b>  | Office/Other Outpatient Visit; Requires 2 Of 3 Component Problem Focused Hx, Exam, Medical Decision Making                   | 0-20   | \$26.53  |
| <b>99213 EP</b>  | Office/Other Outpatient Visit; Requires 2 Of 3 Components - Expanded Problem Focused Hx; Exam; Low Complexity                | 0-20   | \$38.60  |
| <b>99214 EP</b>  | Office/Other Outpatient Visit; Requires 2 Of 3 Component - Detail Hx; Exam; Med Dec Moderate Complexity                      | 0-20   | \$58.09  |
| <b>99215 EP</b>  | Office/Other Outpatient Visit; Requires 2 Of 3 Components - Comprehensive Hx; Exam; Med Dec High Complexity                  | 0-20   | \$76.35  |
| <b>99429</b>   | Unlisted preventative (Dental)   | 0-20   | \$20.60  |
| <b>19.1.C(4) Space Management Therapy (Passive Appliances)</b> |  |        |          |
| <b>D1510</b>   | Space maintainer - fixed - unilateral - per quadrant   | 0-20   | \$103.40 |
|  |  |        |          |
| <b>D1516</b>   | Fixed Bilat Space Maint, Max   | 0-20   | \$143.32 |
| <b>D1517</b>   | Fixed Bilat Space Maint, Man   | 0-20   | \$143.32 |

## Dental



|                                       |   |       |          |
|---------------------------------------|---|-------|----------|
| <b>D1526</b>                          | Remove Bilat Space Main, Max  | 0-20  | \$15.23  |
| <b>D1527</b>                          | Remove Bilat Space Main, Man  | 0-20  | \$15.23  |
| <b>D1551</b>                          | Re-cement or re-bond bilateral space maintainer –maxillary                          | 0-20  | \$25.95  |
| <b>D1552</b>                          | Re-cement or re-bond bilateral space maintainer – mandibular                        | 0-20  | \$25.95  |
| <b>D1553</b>                          | Re-cement or re-bond unilateral space maintainer – per quadrant                     | 0-20  | \$25.95  |
| <b>D1556</b>                          | Removal of fixed unilateral space maintainer – per quadrant                         | 0-20  | \$25.95  |
| <b>D1557</b>                          | Removal of fixed bilateral space maintainer – maxillary                             | 0-20  | \$25.95  |
| <b>D1558</b>                          | Removal of fixed bilateral space maintainer – mandibular                            | 0-20  | \$25.95  |
| <b>D1575</b>                          | Distal shoe space maintainer – fixed – unilateral – per quadrant                    | 0-20  | \$113.32 |
| <b>D1999</b>                          | Unspecified preventive procedure, by report   | *None | MP/PA    |
| <b>19.1.D RESTORATIVE</b>             |   |       |          |
| <b>19.1.D(1) Amalgam Restorations</b> |   |       |          |
| <b>§D2140</b>                         | Amalgam-one surface, primary or permanent   | *None | \$43.12  |
| <b>§D2150</b>                         | Amalgam-two surfaces, primary or permanent  | *None | \$55.09  |
| <b>§D2160</b>                         | Amalgam-three surfaces, primary or permanent  | *None | \$65.07  |
| <b>§D2161</b>                         | Amalgam-four or more surfaces, primary or permanent                                 | *None | \$77.45  |
| <b>19.1.D(2) Resin Restorations</b>   |   |       |          |
| <b>§D2330</b>                         | Resin-based composite - one surface, anterior                                       | *None | \$51.50  |
| <b>§D2331</b>                         | Resin-based composite - two surfaces, anterior                                      | *None | \$63.87  |
| <b>§D2332</b>                         | Resin-based composite - three surfaces, anterior                                    | *None | \$75.85  |
| <b>§D2335</b>                         | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | *None | \$95.01  |
| <b>§D2390</b>                         | Resin-based composite crown, anterior   | *None | \$139.72 |
| <b>§D2391</b>                         | Resin-based composite - one surface, posterior                                      | *None | \$55.09  |
| <b>§D2392</b>                         | Resin-based composite - two surfaces, posterior                                     | *None | \$71.86  |
| <b>§D2393</b>                         | Resin-based composite - three surfaces, posterior                                   | *None | \$92.62  |
| <b>§D2394</b>                         | Resin-based composite - four or more surfaces, posterior                            | *None | \$111.26 |

| <b>19.1.D(3) Crowns-Single Restorations Only</b> |  |       |             |
|--|--|-------|-------------|
| Includes all prior preparation.                  |  |       |             |
| <b>D2710</b>                                     | Crown - resin-based composite (indirect)   | 0-20  | \$279.45/PA |
| <b>D2720</b>                                     | Crown - resin with high noble metal  | 0-20  | \$343.32/PA |
| <b>D2721</b>                                     | Crown - resin with predominantly base metal  | 0-20  | \$317.78/PA |
| <b>D2722</b>                                     | Crown - resin with noble metal   | 0-20  | \$329.36/PA |
| <b>D2740</b>                                     | Crown - porcelain/ceramic substrate  | 0-20  | \$327.36/PA |
| <b>D2750</b>                                     | Crown - porcelain fused to high noble metal  | 0-20  | \$355.43/PA |
| <b>D2751</b>                                     | Crown - porcelain fused to predominantly base metal  | 0-20  | \$327.36/PA |
| <b>D2752</b>                                     | Crown - porcelain fused to noble metal   | 0-20  | \$341.32/PA |
| <b>D2753</b>                                     | Crown – porcelain fused to titanium and titanium alloys  | 0-20  | \$25.95/PA  |
| <b>D2780</b>                                     | Crown - 3/4 cast high noble  | 0-20  | \$358.52/PA |
| <b>D2781</b>                                     | Crown - 3/4 cast predominately base metal  | 0-20  | \$328.48/PA |
| <b>D2782</b>                                     | Crown - 3/4 cast noble metal   | 0-20  | \$339.233PA |
| <b>D2783</b>                                     | Crown - 3/4 porcelain/ceramic  | 0-20  | \$359.29/PA |
| <b>D2790</b>                                     | Crown - full cast high noble metal   | 0-20  | \$353.71/PA |
| <b>D2791</b>                                     | Crown - full cast predominantly base metal   | 0-20  | \$318.58/PA |
| <b>D2792</b>                                     | Crown - full cast noble metal  | 0-20  | \$341.32/PA |
| <b>§D2799</b>                                    | Provisional crown – further treatment or completion of diagnosis necessary prior to final impression | *None | \$131.75    |
| <b>19.1.D(4) Other Restorative Services</b>      |  |       |             |
| <b>§D2910</b>                                    | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration                            | *None | \$34.73     |
| <b>§D2915</b>                                    | Re-cement or re-bond indirectly fabricated or prefabricated post and core                            | *None | \$36.33     |
| <b>§D2920</b>                                    | Re-cement or re-bond crown   | *None | \$35.54     |
| <b>§D2921</b>                                    | Reattachment of tooth fragment, incisal edge or cusp   | *None | \$51.50     |
| <b>D2929</b>                                     | Prefabricated porcelain/ceramic crown - primary tooth  | 0-20  | \$115.38    |
| <b>§D2930</b>                                    | Prefabricated stainless steel crown - primary tooth (replacement within 6 months is not covered)     | *None | \$89.42     |
| <b>§D2931</b>                                    | Prefabricated stainless steel crown - permanent tooth (replacement within 6 months is not covered)   | *None | \$103.40    |
| <b>§D2932</b>                                    | Prefabricated resin crown - anterior tooth only (replacement within 6 months is not covered)         | *None | \$111.78    |
| <b>§D2933</b>                                    | Prefabricated stainless steel crown with resin window (replacement within 6 months is not covered)   | *None | \$115.38    |
| <b>§D2934</b>                                    | Prefabricated esthetic coated stainless steel crown - primary tooth                                  | *None | \$122.55    |

## Dental



|                                     |   |       |             |
|-------------------------------------|---|-------|-------------|
| §D2940                              | Protective restoration  | *None | \$36.72     |
| D2941                               | Interim therapeutic restoration - primary dentition   | 0-20  | \$36.72     |
| §D2949                              | Restorative foundation for an indirect restoration  | *None | \$43.12     |
| §D2950                              | Core buildup, including any pins when required  | *None | \$89.83     |
| §D2951                              | Pin retention - per tooth, in addition to restoration   | *None | \$35.03     |
| §D2952                              | Cast post and core in addition to crown   | *None | \$137.74    |
| §D2953                              | Each additional cast post - same tooth (to be used with D2952)  | *None | \$94.21     |
| §D2954                              | Prefabricated post and core in addition to crown  | *None | \$109.39    |
| §D2955                              | Post removal - (not in conjunction with endodontic therapy)   | *None | \$94.21     |
| §D2957                              | Each additional prefabricated post - same tooth (to be used with D2954)   | *None | \$61.81     |
| D2960                               | Labial veneer (resin laminate) - chairside  | 0-20  | \$192.82/PA |
| D2961                               | Labial veneer (resin laminate) - laboratory   | 0-20  | \$299.41/PA |
| D2962                               | Labial veneer (porcelain laminate) - laboratory   | 0-20  | \$350.51/PA |
| D2971                               | Additional procedures to construct new crown under existing partial denture framework   | 0-20  | MP/OR       |
| D2980                               | Crown repair necessitated by restorative material failure   | 0-20  | MP/OR       |
| D2981                               | Inlay repair necessitated by restorative material failure   | 0-20  | MP/PA       |
| D2982                               | Only repair necessitated by restorative material failure  | 0-20  | MP/PA       |
| §D2999                              | Unspecified restorative procedure, by report  | *None | MP/OR       |
| <b>19.1.E ENDODONTICS</b>           |   |       |             |
| <b>19.1.E(1) Pulp Capping</b>       |   |       |             |
| §D3110                              | Pulp cap - direct (excluding final restoration)   | *None | \$26.79     |
| §D3120                              | Pulp cap - indirect (excluding final restoration)   | *None | \$26.35     |
| <b>19.1.E(2) Pulpotomy</b>          |   |       |             |
| §D3220                              | Therapeutic pulpotomy, (excluding final restoration) (including complete amputation of vital coronal pulp and placement of suitable drug over remaining exposed tissue) | *None | \$61.87     |
| §D3221                              | Pulpal debridement primary and permanent teeth  | *None | \$80.36     |
| <b>19.1.E(3) Endodontic Therapy</b> |   |       |             |
| §D3230                              | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)   | *None | \$85.83     |
| §D3240                              | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)  | *None | \$99.41     |

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| <b>19.1.E(4) Root Canal Therapy - Permanent Teeth Only</b>      |  |       |              |
|---|--|-------|--------------|
| Includes all in-treatment films but excludes final restoration. |  |       |              |
| <b>§D3310</b>   | Anterior (excluding final restoration)   | *None | \$231.54     |
| <b>§D3320</b>   | Bicuspid (excluding final restoration)   | *None | \$274.25     |
| <b>§D3330</b>   | Molar (excluding final restoration)  | *None | \$330.15     |
| <b>§D3331</b>   | Treatment of root canal obstruction; non-surgical access (report required, office notes sent with claim)   | *None | \$151.528/OR |
| <b>§D3332</b>   | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth (report required, office notes sent with claim)   | *None | \$131.69/OR  |
| <b>§D3333</b>   | Internal root repair of perforation defects (report required, office notes sent with claim)  | *None | \$91.23/OR   |
| <b>19.1.E(5) Endodontic Retreatment</b>                         |  |       |              |
| <b>§D3346</b>   | Retreatment of previous root canal therapy - anterior, permanent teeth only, must be 2 years between first root canal and retreatment of the tooth   | *None | \$266.28     |
| <b>§D3347</b>   | Retreatment of previous root canal therapy - bicuspid, permanent teeth only, must be 2 years between first root canal and retreatment of the tooth   | *None | \$307.40     |
| <b>§D3348</b>   | Retreatment of previous root canal therapy - molar, permanent teeth only, must be 2 years between first root canal and retreatment of the tooth  | *None | \$363.68     |
| <b>§D3351</b>   | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.), permanent teeth only  | *None | \$111.78     |
| <b>§D3352</b>   | Apexification/recalcification - interim medication replacement, permanent teeth only   | *None | \$81.44      |
| <b>§D3353</b>   | Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.), permanent teeth only            | *None | \$165.67     |
| <b>19.1.E(6) Apicoectomy/Periradicular Services</b>             |  |       |              |
| <b>§D3410</b>   | Apicoectomy/periradicular surgery - anterior - performed as separate surgical procedure (per tooth first root), permanent teeth only, (when conventional root canal therapy is unsuccessful) | *None | \$212.78     |
| <b>§D3421</b>   | Apicoectomy/periradicular surgery - bicuspid (first root), permanent teeth only, (when conventional root canal therapy is unsuccessful)  | *None | \$239.93     |
| <b>§D3425</b>   | Apicoectomy/periradicular surgery - molar (first root), permanent teeth only, (when conventional root canal therapy is unsuccessful)   | *None | \$279.45     |
| <b>§D3426</b>   | Apicoectomy (each additional root), permanent teeth only, (when conventional root canal therapy is unsuccessful)   | *None | \$114.97     |
| <b>D3427</b>  | Periradicular surgery without apicoectomy  | *None | \$212.78     |
| <b>D3428</b>  | Bone graft in conjunction with periradicular surgery – per tooth, single site  | *None | \$80.88      |
| <b>D3429</b>  | Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site  | *None | \$61.81      |
| <b>§D3430</b>   | Retrograde filling - per root  | *None | \$87.83      |

|                                     |   |       |             |
|-------------------------------------|---|-------|-------------|
| <b>§D3431</b>                       | Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery   | *None | MP/IOC      |
| <b>D3432</b>                        | Guided tissue regeneration resorbable barrier, per site, in conjunction with periradicular surgery  | *None | \$61.81     |
| <b>§D3450</b>                       | Root amputation - per root. Permanent teeth only.   | *None | \$153.70    |
| <b>§D3910</b>                       | Surgical procedures for isolation of tooth with rubber dam  | *None | \$66.67     |
| <b>§D3999</b>                       | Unspecified endodontic procedure, by report (pre-treatment x-rays required with PA request)   | *None |             |
| <b>19.1.F PERIODONTICS</b>          |   |       |             |
| <b>19.1.F(1) Surgical Service</b>   |   |       |             |
| Includes usual post-operative care. |   |       |             |
| <b>§D4210</b>                       | Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant (requires office notes if billed on same date of service as D7310 or D7320)  | *None | \$199.61    |
| <b>§D4211</b>                       | Gingivectomy or gingivoplasty - one to three contiguous teeth, or bounded teeth spaces per quadrant (requires office notes if billed on same date of service as D7310 or D7320) | *None | \$76.25     |
| <b>D4212</b>                        | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth  | *None | \$76.25     |
| <b>**D4230</b>                      | Anatomical crown exposure - four or more contiguous teeth per quadrant  | *None | \$206.25    |
| <b>**D4231</b>                      | Anatomical crown exposure - one to three teeth per quadrant   | *None | \$181.65    |
| <b>**D4240</b>                      | Gingival flap procedure, including root planning - four or more contiguous teeth or bounded teeth spaces per quadrant.  | *None | \$236.33    |
| <b>**D4241</b>                      | Gingival flap procedure, including root planning - one to three contiguous teeth, or bounded teeth spaces per quadrant.   | *None | \$198.01    |
| <b>§D4245</b>                       | Apically positional flap (office notes or operative report sent with claim)   | *None | \$274.08/OR |
| <b>D4249</b>                        | Clinical crown lengthening - hard tissue  | 0-20  | \$241.12    |
| <b>§D4260</b>                       | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.                                | *None | \$339.33    |
| <b>§D4261</b>                       | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth tooth bounded spaces per quadrant                                    | *None | \$279.45    |
| <b>D4263</b>                        | Bone replacement graft - first site in quadrant   | 0-20  | \$210.79/PA |
| <b>D4264</b>                        | Bone replacement graft - each additional site in quadrant (use if performed on date of service as D4263)  | 0-20  | \$159.69/PA |
| <b>§D4265</b>                       | Biologic materials to aid in soft and osseous tissue regeneration   | None  | \$235.93/PA |
| <b>D4266</b>                        | Guided tissue regeneration - resorbable barrier, per site (includes membrane removal)   | 0-20  | \$283.32    |
| <b>D4267</b>                        | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)  | 0-20  | \$386.34    |
| <b>D4268</b>                        | Surgical revision procedure, per tooth (office notes or operative report sent with claim)   | 0-20  | \$264.16/OR |
| <b>D4270</b>                        | Pedicle soft tissue graft procedure   | 0-20  | \$266.67    |

Dental



|   |   |       |             |
|---|---|-------|-------------|
| <b>D4273</b>                                      | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft                                     | 0-20  | \$391.49    |
| <b>D4274</b>                                      | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the anatomical area).   | 0-20  | \$221.56    |
| <b>§D4275</b>                                     | Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft                                 | *None | \$317.72/PA |
| <b>§D4276</b>                                     | Combined connective tissue and double pedicle graft, per tooth  | *None | \$356.98/PA |
| <b>D4277</b>                                      | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft   | 0-20  | \$284.24    |
| <b>D4278</b>                                      | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site                  | 0-20  | \$142.12    |
| <b>D4283</b>                                      | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site     | 0-20  | \$391.49    |
| <b>D4285</b>                                      | Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site | 0-20  | \$317.72    |
| <b>19.1.F(2) Non-Surgical Periodontal Service</b> |   |       |             |
| <b>§D4320</b>                                     | Provisional splinting - intracoronal  | *None | \$162.88    |
| <b>§D4321</b>                                     | Provisional splinting - extracoronal  | *None | \$147.71    |
| <b>**D4341</b>                                    | Periodontal scaling and root planing four or more contiguous teeth or bounded teeth spaces per quadrant. Each quadrant is limited to reimbursement one (1) time every two (2) years.        | *None | \$83.62     |
| <b>**D4342</b>                                    | Periodontal scaling and root planing, one to three teeth per quadrant. Each quadrant is limited to reimbursement one (1) time every two (2) years.  | None  | \$56.02     |
| <b>§D4355</b>                                     | Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.  | *None | \$62.19     |
| <b>§D4381</b>                                     | Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth  | *None | \$68.51     |
| <b>19.1.F(3) Other Periodontal Services</b>       |   |       |             |
| <b>§D4910</b>                                     | Periodontal maintenance, office visit non-covered on the date of service  | *None | \$43.92     |
| <b>**D4920</b>                                    | Unscheduled dressing change - by someone other than treating dentist or their staff   | *None | \$32.74     |
| <b>§D4921</b>                                     | Gingival irrigation – per quadrant  | *None | \$10.30     |
| <b>§D4999</b>                                     | Unspecified periodontal procedure, by report  | *None | MP/PA       |

| <b>19.1.G PROSTHODONTICS (REMOVABLE)</b>  |  |           |          |
|---|--|-----------|----------|
| <b>19.1.G(1) Complete Dentures</b>  |  |           |          |
| <b>D5110</b>  | Complete upper (placed after absorption or replacement)  | *None     | \$518.98 |
| <b>D5120</b>  | Complete lower (placed after absorption or replacement)  | *None     | \$519.78 |
| <b>D5130</b>  | Immediate denture - maxillary (once per lifetime)  | *None     | \$566.48 |
| <b>D5140</b>  | Immediate denture - mandibular (once per lifetime)   | *None     | \$566.88 |
| <b>19.1.G(2) Partial Dentures</b>   |  |           |          |
| Replace permanent teeth only.   |  |           |          |
| <b>D5211</b>  | Upper partial - resin base - with two bent-wire clasps and rests (minimum three teeth excluding third molars)                    | *8 & over | \$389.23 |
| <b>D5212</b>  | Lower partial - resin base - with two bent-wire clasps and rests (minimum three teeth excluding third molars)                    | *8 & over | \$391.23 |
| <b>D5213</b>  | Upper partial denture - cast metal framework with resin denture bases. (including retentive/clasping materials, rests and teeth) | *8 & over | \$558.90 |
| <b>D5214</b>  | Lower partial denture - cast metal framework with resin denture bases.(including retentive/clasping materials, rests and teeth)  | *8 & over | \$558.90 |
| <b>D5225</b>  | Maxillary partial denture – flexible base  | *8 & over | \$480.25 |
| <b>D5226</b>  | Mandibular partial denture – flexible base   | *8 & over | \$481.46 |
| <b>D5282</b>  | Remove Unit Part Denture, Max  | *None     | \$482.13 |
| <b>D5283</b>  | Remove Unit Part Denture, Man  | *None     | \$482.13 |
| <b>D5284</b>  | Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant                       | *None     | \$25.95  |
| <b>D5286</b>  | Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant                               | *None     | \$25.95  |
| <b>19.1.G(3) Adjustments to Dentures</b>  |  |           |          |
| By other than originating dentist; originating dentist six months after insertion of new denture. |  |           |          |
| <b>D5410</b>  | Adjust complete denture - upper  | *None     | \$29.55  |
| <b>D5411</b>  | Adjust complete denture - lower  | *None     | \$29.55  |
| <b>D5421</b>  | Adjust partial denture - upper   | *None     | \$29.55  |
| <b>D5422</b>  | Adjust partial denture - lower   | *None     | \$29.55  |
| <b>19.1.G(4) Repairs to Complete Dentures</b>   |  |           |          |
| <b>D5511</b>  | Rep Broke Comp Dent Base Man   | *None     | \$64.90  |
| <b>D5512</b>  | Rep Broke Comp Dent Base Max   | *None     | \$64.90  |
| <b>D5520</b>  | Replace missing or broken teeth - complete denture (each tooth)  | *None     | \$59.08  |

| <b>19.1.G(5) Repairs to Partial Dentures</b> |   |           |          |
|--|---|-----------|----------|
| <b>D5611</b>                                 | Rep Resin Part Dent Base Man  | *None     | \$66.47  |
| <b>D5612</b>                                 | Rep Resin Part Dent Base Max  | *None     | \$66.47  |
| <b>D5621</b>                                 | Rep Cast Part Frame Man   | *8 & over | \$93.00  |
| <b>D5622</b>                                 | Rep Cast Part Frame Max   | *8 & Over | \$93.00  |
| <b>D5630</b>                                 | Repair or replace broken clasp - per tooth  | *None     | \$86.23  |
| <b>D5640</b>                                 | Replace broken teeth - per tooth  | *None     | \$59.89  |
| <b>D5650</b>                                 | Add tooth to existing partial denture - per tooth   | *None     | \$72.66  |
| <b>D5660</b>                                 | Add clasp to existing partial denture - maximum two clasps  | *None     | \$89.83  |
| <b>19.1.G(6) Denture Rebase Procedures</b>   |   |           |          |
| Includes adjustment for six months.          |   |           |          |
| <b>D5710</b>                                 | Rebase complete upper denture   | *None     | \$187.63 |
| <b>D5711</b>                                 | Rebase complete lower denture   | *None     | \$188.42 |
| <b>D5720</b>                                 | Rebase upper partial denture  | *None     | \$188.54 |
| <b>D5721</b>                                 | Rebase lower partial denture  | *None     | \$180.04 |
| <b>19.1.G(7) Denture Reline Procedures</b>   |   |           |          |
| <b>D5730</b>                                 | Reline complete upper denture (chairside)   | *None     | \$119.76 |
| <b>D5731</b>                                 | Reline complete lower denture (chairside)   | *None     | \$119.76 |
| <b>D5740</b>                                 | Reline upper partial denture (chairside)  | *None     | \$118.17 |
| <b>D5741</b>                                 | Reline lower partial denture (chairside)  | *None     | \$119.36 |
| <b>D5750</b>                                 | Reline complete upper denture (laboratory) (includes new impression in old denture, check bite, and full-process procedure) | *None     | \$151.70 |
| <b>D5751</b>                                 | Reline complete lower denture (laboratory) (includes new impression in old denture, check bite, and full-process procedure) | *None     | \$152.50 |
| <b>D5760</b>                                 | Reline upper partial denture (laboratory) (includes new impression in old denture, check bite, and full-process procedure)  | *None     | \$150.50 |
| <b>D5761</b>                                 | Reline lower partial denture (laboratory) (includes new impression in old denture, check bite, and full-process procedure)  | *None     | \$150.50 |
| <b>19.1.G(8) Interim Prosthesis</b>          |   |           |          |
| <b>D5820</b>                                 | Interim partial denture upper - includes all clasps and rests, resin, up to four teeth, anterior only (once per lifetime)   | *None     | \$294.64 |
| <b>D5821</b>                                 | Interim partial denture lower - includes all clasps and rests, resin, up to four teeth, anterior only (once per lifetime)   | *None     | \$294.64 |
| <b>D5867</b>                                 | Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)                        | 0-20      | \$105.11 |
| <b>D5876</b>                                 | Add Metal Sub to Acrylic Dent   | *None     | \$177.63 |

| <b>19.1.G(9) Other Removable Prosthetic Services</b> |  |       |             |
|--|--|-------|-------------|
| <b>D5850</b>   | Tissue conditioning, maxillary - per denture unit (not covered for the same date of service as a reline and/or rebase)   | *None | \$65.47     |
| <b>D5851</b>   | Tissue conditioning, mandibular - per denture unit (not covered for the same date of service as a reline and/or rebase)  | *None | \$65.47     |
| <b>D5862</b>   | Precision attachment (office notes explaining the reason needed, the type of precision attachment used and invoice (if appropriate) must be sent with the claim)   | 0-20  | \$218.15/OR |
| <b>D5863</b>   | Overdenture - complete maxillary   | *None | \$640.74/PA |
| <b>D5864</b>   | Overdenture - partial maxillary  | *None | \$467.00/PA |
| <b>D5865</b>   | Overdenture - complete mandibular  | *None | \$640.74/PA |
| <b>D5866</b>   | Overdenture - partial mandibular   | *None | \$467.00/PA |
| <b>D5867</b>   | Replacement of replaceable part of semi-precision or precision attachment (male or female component) (office notes which explain the repairs made, the time spent and what parts were used must be submitted with the claim) | 0-20  | \$105.11/OR |
| <b>§D5899</b>  | Unspecified removable prosthodontic procedure  | *None | MP/PA       |
| <b>19.1.H MAXILLOFACIAL PROSTHETICS</b>              |  |       |             |
| <b>**D5913</b>                                       | Nasal prosthesis   | *None | \$735.88    |
| <b>**D5914</b>                                       | Auricular prosthesis   | *None | \$781.55    |
| <b>**D5919</b>                                       | Facial prosthesis (operative report sent with claim)   | *None | MP/OR       |
| <b>**D5922</b>                                       | Nasal septal prosthesis  | *None | \$735.88    |
| <b>**D5926</b>                                       | Nasal prosthesis, replacement  | *None | \$735.88    |
| <b>**D5927</b>                                       | Auricular prosthesis, replacement  | *None | \$781.55    |
| <b>**D5932</b>                                       | Obturator prosthesis, definitive - for surgically excised palatal tissue complete procedure  | *None | \$786.63    |
| <b>**D5934</b>                                       | Mandibular resection prosthesis with guide flange  | *None | \$715.58    |
| <b>**D5935</b>                                       | Mandibular resection prosthesis without guide flange   | *None | \$715.58    |
| <b>**D5936</b>                                       | Obturator prosthesis, interim  | *None | \$700.35    |
| <b>**D5952</b>                                       | Speech aid prosthesis, pediatric (temporary or interim prosthesis, when growth is still possible)  | *None | \$743.55    |
| <b>**D5953</b>                                       | Speech aid prosthesis, adult (when no further growth is anticipated)   | *None | \$705.43    |
| <b>**D5954</b>                                       | Palatal augmentation prosthesis  | *None | \$614.08    |
| <b>**D5955</b>                                       | Palatal lift prosthesis, definitive  | *None | \$603.93    |
| <b>**D5958</b>                                       | Palatal lift prosthesis, interim   | *None | \$603.93    |
| <b>**D5959</b>                                       | Palatal lift prosthesis, modification  | *None | \$603.93    |
| <b>**D5960</b>                                       | Speech aid prosthesis, modification  | *None | \$705.43    |

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|   |  |       |             |
|---|--|-------|-------------|
| <b>**D5988</b>                          | Surgical stent   | *None | \$263.90    |
| <b>**D5992</b>                          | Adjust maxillofacial prosthetic appliance  | *None | MP/PA       |
| <b>**D5993</b>                          | Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report | *None | MP/PA       |
| <b>D5994</b>                            | Periodontal medicament carrier with peripheral seal – laboratory processed   | *None | MP/PA       |
| <b>**D5999</b>                          | Unspecified maxillofacial prosthesis, by report (operative report sent with claim)                                       | *None | MP/OR       |
| <b>19.1.I IMPLANT SERVICES</b>          |  |       |             |
| <b>**D6010</b>                          | Surgical placement of implant body: endosteal implant  | *None | \$373.11/PA |
| <b>**D6011</b>                          | Second stage implant surgery   | *None | \$117.99    |
| <b>**D6040</b>                          | Surgical placement: eposteal implant   | *None | \$471.98    |
| <b>**D6050</b>                          | Surgical placement: transosteal implant  | *None | \$466.90    |
| <b>D6052</b>                            | Semi-precision attachment abutment   | *None | \$276.47    |
| <b>D6056</b>                            | Prefabricated abutment - includes modification and placement   | *None | \$276.47    |
| <b>D6057</b>                            | Custom fabricated abutment - includes placement  | *None | \$276.47    |
| <b>19.1.I(1) Other Implant Services</b> |  |       |             |
| <b>D6082</b>                            | Implant supported crown – porcelain fused to predominantly base alloys   | 0-20  | \$522.00/PA |
| <b>D6083</b>                            | Implant supported crown – porcelain fused to noble alloys  | 0-20  | \$509.82/PA |
| <b>D6084</b>                            | Implant supported crown – porcelain fused to titanium and titanium alloys  | 0-20  | \$552.34/PA |
| <b>D6086</b>                            | Implant supported crown – predominantly base alloys  | 0-20  | \$456.18/PA |
| <b>D6087</b>                            | Implant supported crown – noble alloys   | 0-20  | \$560.60/PA |
| <b>D6088</b>                            | Implant supported crown – titanium and titanium alloys   | 0-20  | \$528.00/PA |
| <b>**D6090</b>                          | Repair implant supported prosthesis, by report (operative report sent with claim)  | *None | \$234.47/OR |
| <b>**D6092</b>                          | Re-cement or re-bond implant/abutment supported crown  | *None | \$50.80     |
| <b>**D6093</b>                          | Re-cement or re-bond implant/abutment supported fixed partial denture  | *None | \$55.49     |
| <b>**D6095</b>                          | Repair implant abutment, by report (operative report sent with claim)  | *None | \$233.30/OR |
| <b>D6097</b>                            | Abutment supported crown – porcelain fused to titanium and titanium alloys   | 0-20  | \$565.20/PA |
| <b>D6098</b>                            | Implant supported retainer – porcelain fused to predominantly base alloys  | 0-20  | \$545.20/PA |
| <b>D6099</b>                            | Implant supported retainer for FPD – porcelain fused to noble alloys   | 0-20  | \$540.12/PA |
| <b>**D6100</b>                          | Implant removal, by report (operative report sent with claim)  | *None | \$259.49/OR |
| <b>D6120</b>                            | Implant supported retainer – porcelain fused to titanium and titanium alloys   | 0-20  | \$545.20/PA |
| <b>D6121</b>                            | Implant supported retainer for metal FPD – predominantly base alloys   | 0-20  | \$550.40/PA |

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|  |   |      |              |
|--|---|------|--------------|
| <b>D6122</b>   | Implant supported retainer for metal FPD – noble alloys                       | 0-20 | \$560.60/PA  |
| <b>D6123</b>   | Implant supported retainer for metal FPD – titanium and titanium alloys       | 0-20 | \$522.00/PA  |
| <b>D6195</b>   | Abutment supported retainer – porcelain fused to titanium and titanium alloys | 0-20 | \$565.20/PA  |
| <b>19.1.J PROSTHODONTICS/BRIDGE PONTICS</b>                                  |   |      |              |
| Each retainer and each pontic constitutes a unit in a fixed partial denture. |   |      |              |
| <b>19.1.J(1) Fixed Partial Denture Pontics</b>                               |   |      |              |
| <b>D6210</b>   | Pontic - cast high noble metal  | 0-20 | \$349.31/PA  |
| <b>D6211</b>   | Pontic - cast predominantly base metal  | 0-20 | \$320.17/ PA |
| <b>D6212</b>   | Pontic - cast noble metal   | 0-20 | \$337.34/ PA |
| <b>D6240</b>   | Pontic - porcelain fused to high noble metal                                  | 0-20 | \$354.90/ PA |
| <b>D6241</b>   | Pontic - porcelain fused to predominantly base metal                          | 0-20 | \$329.36/ PA |
| <b>D6242</b>   | Pontic - porcelain fused to noble metal                                       | 0-20 | \$339.33/ PA |
| <b>D6243</b>   | Pontic – porcelain fused to titanium and titanium alloys                      | 0-20 | \$565.20/PA  |
| <b>D6245</b>   | Pontic - porcelain/ceramic  | 0-20 | \$359.29/ PA |
| <b>D6250</b>   | Pontic - resin with high noble metal  | 0-20 | \$347.70/ PA |
| <b>D6251</b>   | Pontic - resin with predominantly base metal                                  | 0-20 | \$327.75/ PA |
| <b>D6252</b>   | Pontic - resin with noble metal   | 0-20 | \$334.83/ PA |
| <b>19.1.J(2) Fixed Partial Denture Retainers - Inlays/Onlays</b>             |   |      |              |
| <b>D6545</b>   | Retainer - cast metal for resin bonded fixed prosthesis                       | 0-20 | \$247.51/ PA |
| <b>D6548</b>   | Retainer - porcelain/ceramic for resin bonded fixed prosthesis                | 0-20 | \$313.38/PA  |
| <b>D6549</b>   | Resin retainer - for resin bonded fixed prosthesis                            | 0-20 | \$211.35/PA  |
| <b>D6600</b>   | Retainer inlay - porcelain/ceramic, two surfaces                              | 0-20 | \$319.30/PA  |
| <b>D6601</b>   | Retainer inlay - porcelain/ceramic, three or more surfaces                    | 0-20 | \$377.57/PA  |
| <b>D6602</b>   | Retainer inlay - cast noble metal, two surfaces                               | 0-20 | \$329.61/PA  |
| <b>D6603</b>   | Retainer inlay - cast noble metal, three or more surfaces                     | 0-20 | \$350.24/PA  |
| <b>D6604</b>   | Retainer inlay - cast predominantly base metal, two surfaces                  | 0-20 | \$313.75/PA  |
| <b>D6605</b>   | Retainer inlay - cast predominantly base metal, three or more surfaces        | 0-20 | \$339.52PA   |
| <b>D6606</b>   | Retainer inlay - cast noble metal, two surfaces                               | 0-20 | \$318.51/PA  |
| <b>D6607</b>   | Retainer inlay - cast noble metal, three or more surfaces                     | 0-20 | \$343.89/PA  |

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|   |  |       |              |
|---|--|-------|--------------|
| <b>D6608</b>  | Retainer onlay - porcelain/ceramic, two surfaces                       | 0-20  | \$347.04/PA  |
| <b>D6609</b>  | Retainer onlay - porcelain/ceramic, three or more surfaces             | 0-20  | \$372.05/PA  |
| <b>D6610</b>  | Retainer onlay - cast high noble metal, two surfaces                   | 0-20  | \$356.98/PA  |
| <b>D6611</b>  | Retainer onlay - cast high noble metal, three or more surfaces         | 0-20  | \$376.81/PA  |
| <b>D6612</b>  | Retainer onlay - cast predominantly base metal, two surfaces           | 0-20  | \$339.13/PA  |
| <b>D6613</b>  | Retainer onlay - cast predominantly base metal, three or more surfaces | 0-20  | \$369.66/PA  |
| <b>D6614</b>  | Retainer onlay - cast noble metal, two surfaces                        | 0-20  | \$355.00/PA  |
| <b>D6615</b>  | Retainer onlay - cast noble metal, three or more surfaces              | 0-20  | \$397.73/PA  |
| <b>19.1.J(3) Fixed Partial Denture Retainers - Crowns</b> |  |       |              |
| <b>D6720</b>  | Retainer crown - resin with high noble metal                           | 0-20  | \$347.32/ PA |
| <b>D6721</b>  | Retainer crown - resin with predominantly base metal                   | 0-20  | \$329.36/ PA |
| <b>D6722</b>  | Retainer crown - resin with noble metal                                | 0-20  | \$339.33/ PA |
| <b>D6740</b>  | Retainer crown - porcelain/ceramic                                     | 0-20  | \$364.08/ PA |
| <b>D6750</b>  | Retainer crown - porcelain fused to high noble metal                   | 0-20  | \$357.29/ PA |
| <b>D6751</b>  | Retainer crown - porcelain fused to predominantly base metal           | 0-20  | \$327.36/ PA |
| <b>D6752</b>  | Retainer crown - porcelain fused to noble metal                        | 0-20  | \$340.13/ PA |
| <b>D6753</b>  | Retainer crown – porcelain fused to titanium and titanium alloys       | 0-20  | \$565.20/PA  |
| <b>D6780</b>  | Retainer crown - 3/4 cast high noble metal                             | 0-20  | \$349.71/ PA |
| <b>D6781</b>  | Retainer crown - 3/4 cast predominately base metal                     | 0-20  | \$346.16/ PA |
| <b>D6782</b>  | Retainer crown - 3/4 cast noble metal                                  | 0-20  | \$349.25/ PA |
| <b>D6783</b>  | Retainer crown - 3/4 cast porcelain/ceramic                            | 0-20  | \$359.29/ PA |
| <b>D6790</b>  | Retainer crown - full cast high noble metal                            | 0-20  | \$355.43/ PA |
| <b>D6791</b>  | Retainer crown - full cast predominately base metal                    | 0-20  | \$334.83/ PA |
| <b>D6792</b>  | Retainer crown - full cast noble metal                                 | 0-20  | \$339.33/ PA |
| <b>19.1.J(4) Other Fixed Partial Denture Services</b>     |  |       |              |
| <b>D6920</b>  | Connector Bar  | 0-20  | \$318.10/OR  |
| <b>§D6930</b>   | Re-cement or re-bond fixed partial denture                             | *None | \$53.50      |
| <b>D6940</b>  | Stress breaker   | 0-20  | \$135.74/ PA |
| <b>D6950</b>  | Precision attachment   | 0-20  | \$209.19/ PA |
| <b>D6971</b>  | Cast post as part of bridge retainer                                   | 0-20  | \$35.03/ PA  |

|   |  |       |             |
|---|--|-------|-------------|
| <b>D6980</b>  | Fixed partial denture repair necessitated by restorative material failure  | *None | \$122.96/OR |
| <b>§D6999</b>   | Unspecified, fixed prosthodontic procedure (a report describing the prosthesis must be sent in with the PA)  | *None | MP/PA/OR    |
| <b>19.1.K ORAL AND MAXILLOFACIAL SURGERY</b>            |  |       |             |
| <b>19.1.K(1) Extractions</b>                            |  |       |             |
| Includes local anesthesia and post-operative treatment. |  |       |             |
| <b>§D7111</b>   | Extraction, coronal Remnants - deciduous tooth   | *None | \$43.12     |
| <b>§D7140</b>   | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)   | *None | \$52.29     |
| <b>19.1.K(2) Surgical Extractions</b>                   |  |       |             |
| Includes local anesthesia and post-operative treatment. |  |       |             |
| <b>§D7210</b>   | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.<br>Permanent teeth only  | *None | \$89.83     |
| <b>§D7220</b>   | Removal of impacted tooth - soft tissue. Pre-treatment x-rays required for tooth numbers other than third molars.  | *None | \$101.79    |
| <b>§D7230</b>   | Removal of impacted tooth - partially bony. Pre-treatment x-rays required for tooth numbers other than third molars.   | *None | \$130.14    |
| <b>§D7240</b>   | Removal of impacted tooth - completely bony. Pre-treatment x-rays required for tooth numbers other than third molars.  | *None | \$159.69    |
| <b>§D7241</b>   | Removal of impacted tooth - completely bony, with unusual surgical complications. Pre-treatment x-rays required for tooth numbers other than third molars.   | *None | \$189.62    |
| <b>§D7250</b>   | Surgical removal of residual tooth roots (cutting procedure). Pre-treatment x-rays and office notes or operative report sent with claim (cannot be billed on same date of service as an extraction of the same tooth). | *None | \$97.57/OR  |
| <b>D7251</b>  | Coronectomy - intentional partial tooth removal  | *None | MP/PA       |
| <b>19.1.K(3) Other Surgical Procedures</b>              |  |       |             |
| <b>**D7260</b>  | Oroantral fistula closure  | *None | \$320.95    |
| <b>D7261</b>  | Primary Closure of a Sinus Perforation (office notes or operative report sent with claim)  | *None | \$213.97/OR |
| <b>**D7270</b>  | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus   | *None | \$256.76    |
| <b>D7280</b>  | Surgical exposure of impacted or unerupted tooth - for orthodontic reasons   | 0-20  | \$153.30    |
| <b>D7283</b>  | Placement of device to facilitate eruption of impacted tooth   | 0-20  | \$135.99    |
| <b>**D7285</b>  | Incisional biopsy of oral tissue - hard (bone, tooth)  | *None | \$128.93    |
| <b>**D7286</b>  | Incisional biopsy of oral tissue - soft  | *None | \$102.81    |
| <b>D7287</b>  | Exfoliative cytology sample collection (office notes or operative report sent with claim)  | 0-20  | \$49.24/OR  |
| <b>D7290</b>  | Surgical repositioning of teeth (pre-treatment x-rays must be sent with the claim)   | *None | \$152.71/OR |
| <b>D7291</b>  | Transsepral fiberotome/supra crestal fiberotomy  | 0-125 | \$96.78/PA  |

Dental



|   |  |       |             |
|---|--|-------|-------------|
| <b>D7295</b>  | Harvest of bone for use in autogenous grafting procedure   | *None | MP/PA       |
| <b>D7296</b>  | Corticotomy, 1-3 Teeth   | *None | \$88.50     |
| <b>D7297</b>  | Corticotomy, 4 or More Teeth   | *None | \$177.00    |
| <b>D7310</b>  | Alveoloplasty in conjunction with extractions - per quadrant (requires office notes if billed on same date of service as D4210 or D4211)   | *None | \$92.21     |
| <b>D7320</b>  | Alveoloplasty not in conjunction with extractions - per quadrant (requires office notes if billed on same date of service as D4210 or D4211)   | *None | \$135.74    |
| <b>19.1.K(4) Vestibuloplasty</b>                                    |  |       |             |
| <b>**D7340</b>  | Vestibuloplasty - ridge extension (secondary epithelialization) (operative report sent with claim)   | *None | \$327.04/OR |
| <b>**D7350</b>  | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (operative report sent with claim) | *None | \$629.54/OR |
| <b>19.1.K(5) Surgical Excision of Reactive Inflammatory Lesions</b> |  |       |             |
| Scar tissue of localized congenital lesions.                        |  |       |             |
| <b>**D7410</b>  | Radical excision - lesion diameter up to 1.25 cm   | *None | \$160.48    |
| <b>**D7411</b>  | Excision of benign lesion greater than 1.25 cm   | *None | \$213.97    |
| <b>**D7412</b>  | Excision of benign lesion, complicated (office notes/operative report and pathology report sent with claim)  | *None | \$255.79/OR |
| <b>**D7413</b>  | Excision of benign lesion up to 1.25 cm (office notes/operative report and pathology report sent with claim)   | *None | \$204.11/OR |
| <b>**D7414</b>  | Excision of malignant lesion greater than 1.25 cm (office notes/operative report and pathology report sent with claim)   | *None | \$307.69/OR |
| <b>**D7415</b>  | Excision of malignant lesion, complicated (office notes/operative report and pathology report sent with claim)   | *None | \$401.59/OR |
| <b>19.1.K(6) Removal of Tumors, Cysts and Neoplasms</b>             |  |       |             |
| <b>**D7440</b>  | Excision of malignant tumor - lesion diameter up to 1.25 cm  | *None | \$203.00    |
| <b>**D7441</b>  | Excision of malignant tumor - lesion diameter greater than 1.25 cm   | *None | \$273.54    |
| <b>**D7450</b>  | Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm   | *None | \$213.97    |
| <b>**D7451</b>  | Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm  | *None | \$240.72    |
| <b>**D7460</b>  | Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm  | *None | \$213.97    |
| <b>**D7461</b>  | Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm   | *None | \$240.72    |
| <b>D7465</b>  | Destruction of lesion(s) by physical or chemical method, by report   | *None | \$58.84     |
| <b>19.1.K(7) Excision of Bone Tissue</b>                            |  |       |             |
| <b>**D7471</b>  | Removal of exostosis - per site (indicate right/left and upper/lower on the claim)   | *None | \$207.28    |
| <b>**D7472</b>  | Removal of Torus Palatinus (office notes or operative report sent with claim)  | *None | \$245.01/OR |

Dental



|   |  |       |             |
|---|--|-------|-------------|
| <b>**D7473</b>                                      | Removal of Torus Mandibularis (office notes or operative report sent with claim)                                 | *None | \$238.79/OR |
| <b>**D7485</b>                                      | Surgical Reduction of Osseous Tuberosity (office notes or operative report sent with claim)                      | *None | \$219.13/OR |
| <b>**D7490</b>                                      | Radical resection of mandible with bone graft  | *None | \$507.50    |
| <b>19.1.K(8) Surgical Incision</b>                  |  |       |             |
| <b>**D7510</b>                                      | Incision and drainage of abscess - intraoral soft tissue   | *None | \$75.46     |
| <b>**D7511</b>                                      | Incision and Drainage of Abscess – Intraoral Soft Tissue – Complicated   | *None | \$95.56     |
| <b>**D7520</b>                                      | Incision and drainage of abscess - extraoral soft tissue   | *None | \$128.93    |
| <b>**D7530</b>                                      | Removal of foreign body, skin, or subcutaneous alveolar tissue   | *None | \$116.49    |
| <b>**D7540</b>                                      | Removal of reaction - producing foreign bodies, musculoskeletal system   | *None | \$205.94    |
| <b>**D7550</b>                                      | Sequestrectomy for osteomyelitis   | *None | \$401.19    |
| <b>**D7560</b>                                      | Maxillary sinusotomy for removal of tooth fragment or foreign body   | *None | \$279.13    |
| <b>19.1.K(9) Treatment of Fractures - Simple</b>    |  |       |             |
| <b>**D7610</b>                                      | Maxilla - open reduction (teeth immobilized, if present)   | *None | \$319.73    |
| <b>**D7620</b>                                      | Maxilla - closed reduction (teeth immobilized, if present)   | *None | \$267.96    |
| <b>**D7630</b>                                      | Mandible - open reduction (teeth immobilized, if present)  | *None | \$1,261.04  |
| <b>**D7640</b>                                      | Mandible - closed reduction (teeth immobilized, if present)  | *None | \$1,091.14  |
| <b>**D7650</b>                                      | Malar and/or zygomatic arch - open reduction   | *None | \$427.93    |
| <b>**D7660</b>                                      | Malar and/or zygomatic arch - closed reduction   | *None | \$96.43     |
| <b>**D7670</b>                                      | Alveolus - stabilization of teeth, closed reduction splinting  | *None | \$424.38    |
| <b>**D7671</b>                                      | Alveolus - open reduction, may include stabilization of teeth (office notes or operative report sent with claim) | *None | \$264.95/OR |
| <b>**D7680</b>                                      | Facial bones - complicated reduction with fixation and multiple surgical approaches                              | *None | \$2,024.45  |
| <b>19.1.K(10) Treatment of Fractures - Compound</b> |  |       |             |
| <b>**D7710</b>                                      | Maxilla - open reduction   | *None | \$1,396.65  |
| <b>**D7720</b>                                      | Maxilla - closed reduction   | *None | \$1,043.86  |
| <b>**D7730</b>                                      | Mandible - open reduction  | *None | \$1,559.60  |
| <b>**D7740</b>                                      | Mandible - closed reduction  | *None | \$1,174.88  |
| <b>**D7750</b>                                      | Malar and/or zygomatic arch - open reduction   | *None | \$1,342.37  |
| <b>**D7760</b>                                      | Malar and/or zygomatic arch - closed reduction   | *None | \$96.43     |
| <b>**D7770</b>                                      | Alveolus - stabilization of teeth, open reduction splinting  | *None | \$243.60    |

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|   |  |       |             |
|---|--|-------|-------------|
| **D7771   | Alveolus, closed reduction stabilization of teeth (office notes or operative report sent with claim) | *None | \$519.35/OR |
| **D7780   | Facial bones - complicated reduction with fixation and multiple surgical approaches                  | *None | \$437.47    |
| <b>19.1.K(11) Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions</b> |  |       |             |
| **D7810   | Open reduction of dislocation  | *None | \$60.90     |
| **D7820   | Closed reduction of dislocation  | *None | \$25.38     |
| **D7830   | Manipulation under anesthesia  | *None | \$26.75     |
| **D7840   | Condylectomy   | *None | \$279.13    |
| **D7850   | Surgical discectomy, with/without implant  | *None | \$380.63    |
| **D7860   | Arthrotomy   | *None | \$152.25    |
| **D7865   | Arthroplasty   | *None | \$598.85    |
| **D7870   | Arthrocentesis   | *None | \$18.27     |
| **D7871   | Non-arthroscopic lysis and lavage (office notes or operative report sent with claim)                 | *None | MP/OR       |
| **D7872   | Arthroscopy - diagnosis, with or without biopsy  | *None | \$145.15    |
| **D7873   | Arthroscopy - surgical: lavage and lysis of adhesions  | *None | \$145.15    |
| **D7874   | Arthroscopy - surgical: disc repositioning and stabilization   | *None | \$297.40    |
| **D7875   | Arthroscopy - surgical: synovectomy  | *None | \$297.40    |
| **D7876   | Arthroscopy - surgical: discectomy   | *None | \$297.40    |
| **D7877   | Arthroscopy - surgical: debridement  | *None | \$297.40    |
| **D7880   | Occlusal orthotic device, by report (operative report sent with claim)                               | *None | \$293.08/OR |
| <b>19.1.K(12) Repair of Traumatic Wounds</b>  |  |       |             |
| **D7910   | Suture of recent small wounds up to 5 cm   | *None | \$213.97    |
| <b>19.1.K(13) Complicated Suturing</b>  |  |       |             |
| **D7911   | Complicated suture - up to 5 cm  | *None | \$213.97    |
| **D7912   | Complicated suture - greater than 5 cm   | *None | \$294.21    |
| <b>19.1.K(14) Complicated Suturing</b>  |  |       |             |
|   | Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.   |       |             |
| **D7920   | Skin graft (identify defect covered, location and type of graft)                                     | *None | \$325.82    |
| D7922   | Placement of intra-socket biological dressing to aid I hemostasis or clot stabilization, per site    | *None | \$10.00     |
| **D7940   | Osteoplasty - for orthognathic deformities   | *None | \$427.93    |

Dental



|                                    |  |       |             |
|------------------------------------|--|-------|-------------|
| <b>**D7941</b>                     | Osteotomy - mandibular rami  | *None | \$2,754.58  |
| <b>**D7942</b>                     | Osteotomy – Ramus, Open  | *None | \$539.98    |
| <b>**D7943</b>                     | Osteotomy - mandibular rami with bone graft; includes obtaining the graft  | *None | \$406.00    |
| <b>**D7944</b>                     | Osteotomy - segmented or subapical - per sextant or quadrant   | *None | \$2,167.54  |
| <b>**D7945</b>                     | Osteotomy - body of mandible   | *None | \$406.00    |
| <b>**D7946</b>                     | LeFort I (maxilla-total)   | *None | MP/OR       |
| <b>**D7947</b>                     | LeFort I (maxilla-segmented)   | *None | \$406.00/OR |
| <b>**D7948</b>                     | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft   | *None | \$406.00/OR |
| <b>D7949</b>                       | LeFort II or LeFort III - with bone graft  | *None | MP/OR       |
| <b>**D7950</b>                     | Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones-autogenous or nonautogenous, by report (operative report sent with claim) | *None | MP/OR       |
| <b>**D7953</b>                     | Bone replacement graft for ridge preservatoin per site (operative report sent with claim)  | *None | MP/OR       |
| <b>**D7955</b>                     | Repair of maxillofacial soft and/or hard tissue defect (operative report sent with claim)  | *None | MP/OR       |
| <b>**D7960</b>                     | Frenulectomy (frenectomy or frenotomy) - separate procedure  | *None | \$147.16    |
| <b>**D7970</b>                     | Excision of hyperplastic tissue - per arch   | *None | \$165.83    |
| <b>**D7971</b>                     | Excision of pericoronal gingiva  | *None | \$77.53     |
| <b>**D7972</b>                     | Surgical reduction of fibrous tuberosity (office notes or operative report sent with claim)  | *None | \$239.72/OR |
| <b>**D7980</b>                     | Sialolithotomy   | *None | \$152.25    |
| <b>**D7981</b>                     | Excision of salivary gland, by report (operative report sent with claim)   | *None | MP/OR       |
| <b>**D7982</b>                     | Sialodochoplasty   | *None | \$177.63    |
| <b>**D7983</b>                     | Closure of salivary fistula  | *None | \$203.00    |
| <b>**D7990</b>                     | Emergency tracheotomy  | *None | \$101.50    |
| <b>**D7991</b>                     | Coronoidectomy   | *None | \$329.88    |
| <b>**D7995</b>                     | Synthetic graft - mandible or facial bones (operative report sent with claim)  | *None | MP/OR       |
| <b>**D7996</b>                     | Implant - mandible for augmentation purposes (excluding alveolar ridge) (operative report sent with claim)   | *None | \$227.36/OR |
| <b>**D7997</b>                     | Appliance removal (not by dentist who placed appliance), includes removal of archbar   | *None | \$94.10     |
| <b>**D7998</b>                     | Intraoral placement of a fixation device not in conjunction with a fracture  | *None | \$678.39    |
| <b>**D7999</b>                     | Unspecified oral surgery procedure (operative report sent with claim)  | *None | MP/OR       |
| <b>19.1.L Orthodontic Services</b> |  |       |             |
| <b>D8010</b>                       | Limited orthodontic treatment of the primary dentition   | 0-20  | MP/PA       |
| <b>D8020</b>                       | Limited orthodontic treatment of the transitional dentition  | 0-20  | MP/PA       |

Dental



|   |   |       |              |
|---|---|-------|--------------|
| <b>D8030</b>                              | Limited orthodontic treatment of the adolescent dentition   | 0-20  | MP/PA        |
| <b>D8040</b>                              | Limited orthodontic treatment of the adult dentition  | 0-20  | MP/PA        |
| <b>D8050</b>                              | Interceptive orthodontic treatment of the primary dentition   | 0-20  | MP/PA        |
| <b>D8060</b>                              | Interceptive orthodontic treatment of the transitional dentition                                      | 0-20  | MP/PA        |
| <b>D8070</b>                              | Comprehensive orthodontic treatment of the transitional dentition                                     | 0-20  | MP/PA        |
| <b>D8080</b>                              | Comprehensive orthodontic treatment of the adolescent dentition                                       | 0-20  | MP/PA        |
| <b>D8090</b>                              | Comprehensive orthodontic treatment of the adult dentition  | 0-20  | MP/PA        |
| <b>D8210</b>                              | Removable appliance therapy   | *None | MP/PA        |
| <b>D8220</b>                              | Fixed appliance therapy   | *None | MP/PA        |
| <b>D8680</b>                              | Orthodontic retention (removal of appliances, construction and placement of retainer(s))              | 0-20  | \$247.25/ PA |
|   |   |       |              |
|   |   |       |              |
|   |   |       |              |
| <b>D8695</b>                              | Remove Fixed Ortho Appliance  | 0-20  | \$329.88     |
| <b>D8696</b>                              | Repair of orthodontic appliance – maxillary   | 0-20  | \$60.00/OR   |
| <b>D8697</b>                              | Repair of orthodontic appliance – mandibular  | 0-20  | \$60.00/OR   |
| <b>D8698</b>                              | Re-cement or re-bond fixed retainer – maxillary   | 0-20  | \$75.75      |
| <b>D8699</b>                              | Re-cement or re-bond fixed retainer – mandibular  | 0-20  | \$75.75      |
| <b>D8701</b>                              | Repair of fixed retainer, includes reattachment – maxillary   | 0-20  | \$75.75      |
| <b>D8702</b>                              | Repair of fixed retainer, includes reattachment – mandibular  | 0-20  | \$75.75      |
| <b>D8703</b>                              | Replacement of lost or broken retainer – maxillary  | 0-20  | \$123.63     |
| <b>D8704</b>                              | Replacement of lost or broken retainer – mandibular   | 0-20  | \$123.63     |
| <b>D8999</b>                              | Unspecified orthodontic procedure (office notes or operative report sent with claim)                  | 0-20  | MP/PA/OR     |
| <b>19.1.M ADJUNCTIVE GENERAL SERVICES</b> |   |       |              |
| <b>D9110</b>                              | Palliative (emergency) treatment of dental pain - minor procedure (report in patient record)          | *None | \$37.92      |
| <b>**D9120</b>                            | Fixed partial denture sectioning  | *None | \$77.74      |
| <b>**D9212</b>                            | Trigeminal division block (for diagnostic purposes only; not to be used for a Second Division Block.) | *None | \$91.62      |
| <b>**D9219</b>                            | Evaluation for deep sedation or general anesthesia  | *None | \$23.60      |
| <b>**D9222</b>                            | Deep Anesthesia, first 15 min   | *None | \$115.03     |



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|                               |   |        |            |
|-------------------------------|---|--------|------------|
| <b>**D9223</b>                | Deep sedation/general anesthesia - each 15 minute increment   | *None  | \$86.28    |
| <b>**D9230</b>                | Analgesia, anxiolysis, inhalation of nitrous oxide  | *None  | \$23.21    |
| <b>**D9239</b>                | IV Mod Sedation, first 15 Min   | *None  | \$115.03   |
| <b>**D9243</b>                | Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment  | *None  | \$86.28    |
| <b>**D9248</b>                | Non-intravenous conscious sedation  | *None  | \$103.65   |
| <b>**D9310</b>                | Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)  | *None  | \$39.38    |
| <b>**D9410</b>                | House/extended care facility call   | *None  | \$69.86    |
| <b>**D9420</b>                | Hospital call   | *None  | \$82.92    |
| <b>D9430</b>                  | Office visit for observation (during regularly scheduled hours) - no other services performed   | *None  | \$31.94    |
| <b>**D9440</b>                | Office visit - after regularly scheduled hours  | *None  | \$53.89    |
| <b>D9610</b>                  | Therapeutic drug injection Includes antibiotic or injection of sedative. To be used if the injection is not on the injection list. Must write in description field on claim form the name of the drug and amount of drug given.   | *None  | \$31.73    |
| <b>D9612</b>                  | Therapeutic parenteral drugs, two or more administrations, different medications  | *None  | \$56.32    |
| <b>D9910</b>                  | Application of desensitizing medicaments. Emergency treatment   | *None  | \$19.56    |
| <b>D9911</b>                  | Application of desensitizing resin for cervical and/or root surface, per tooth  | *None  | \$24.76    |
| <b>D9930</b>                  | Treatment of complications - unusual circumstances (office notes or operative report sent with claim)   | *None  | \$43.12/OR |
| <b>D9942</b>                  | Repair and /or reline of occlusal guard. Operative report is required with claim.   | 0-20   | \$77.35/OR |
| <b>D9944</b>                  | Occ Guard, Hard, Full Arch  | 0-20   | \$192.24   |
| <b>D9945</b>                  | Occ Guard, Soft, Full Arch  | 0-20   | \$55.83    |
| <b>D9946</b>                  | Occ Guard, Hard Part Arch   | 0-20   | \$96.12    |
| <b>D9995</b>                  | Teledentistry Real – Time   | *None  | \$14.82    |
| <b>D9996</b>                  | Teledentistry Dent Review   | *None  | \$14.82    |
| <b>D9997</b>                  | Dental case management – patients with special health care needs  | *None  | \$12.36    |
| <b>+D9999</b>                 | Unspecified adjunctive procedure. Office notes, invoice of costs or operative report is required with claim. For prophylaxis more often than every six months, or panorex more than 24 months, requires office notes with claim, explaining medical necessity or emergency nature of the service. | *None  | MP/OR      |
| <b>19.1.N INJECTION CODES</b> |   |        |            |
| <b>§J0120</b>                 | Tetracycline (Achromycin)   | 250 mg | \$4.26     |
| <b>§J0290</b>                 | Ampicillin sodium   | 500 mg | \$4.57     |
| <b>§J0692</b>                 | Cefepime hydrochloride  | 500 mg | \$7.71     |
| <b>§J0702</b>                 | Betamethasone acetate and betamethasone sodium phosphate (Celestone Soluspan)   | 3 mg   | \$2.73     |

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|        |  |               |        |
|--------|--|---------------|--------|
| §J1100 | Dexamethasone sodium phosphate   | 4 mg/ml       | \$3.25 |
| §J1720 | Hydrocortisone sodium succinate (Solu-Cortef, A-Hydrocort)   | 100 mg        | \$4.79 |
| §J2175 | Meperidine (Demerol HCL)   | 50 mg         | \$1.19 |
| §J2250 | Midazolam Hcl (Versed )  | per mg        | \$2.74 |
| §J2270 | Morphine sulfate   | 10 mg         | \$1.19 |
| §J2510 | Penicillin G procaine, aqueous (Wycillin, Duracillin A.S., Pfizerpen A.S., Crysticillin 300 A.S., Crysticillin 600 A.S.)               | 600,000 units | \$2.98 |
| §J2550 | Promethazine HCl (Phenergan, Anergan 25, Anergan 50, Phenazine 25, Phenazine 50, Prorex-25, Prorex-50, Prothazine, V-Gan 25, V-Gan 50) | 50 mg         | \$1.44 |
| §J3000 | Streptomycin (Streptomycin Sulfate)  | 1 g           | \$1.96 |
| §J3070 | Pentazocine HCl (Talwin)   | 30 mg         | \$1.19 |
| §J3360 | Diazepam (Valium, Zetran)  | 5 mg          | \$1.96 |
| §J3410 | Hydroxyzine HCl (Vistaril, Vistaject-25, Hyzine-50)  | 25 mg         | \$1.19 |

**19.2 CPT PROCEDURE CODES**

Providers may bill CPT codes for surgical procedures. CPT anesthesia procedure codes (00100-01999) are invalid Medicaid codes. Reference the CDT codes when billing for anesthesia services. Modifiers may be added to CPT codes to bill for: postoperative management; postoperative management only; or assistant surgery services.

The following CPT procedure codes are covered for eligible needy children under the age of 21 or persons receiving Medicaid under a category of assistance for pregnant women, the blind, or participants residing in a nursing facility or when the absence of dental treatment would adversely affect the participants pre-existing medical condition or as related to trauma of the mouth, jaw, teeth or other contiguous sites. For eligibility determination refer to Section 1 of the Dental Provider Manual.

**19.2.A INTEGUMENTARY SYSTEM - SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES**

**19.2.A(1) Incision and Drainage**

|         |   |          |  |
|---------|---|----------|--|
| **10060 | Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single        | \$62.45  |  |
| **10061 | Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple | \$107.70 |  |
| **10120 | Incision and removal of foreign body, subcutaneous tissues; simple  | \$80.03  |  |
| **10121 | Incision and removal of foreign body, subcutaneous tissues; complicated   | \$153.57 |  |

| <b>19.2.A(2) Excision - Debridement</b>       |   |          |  |
|---|---|----------|--|
| <b>**11044</b>                                | Debridement; skin, subcutaneous tissue, muscle and bone   | \$214.82 |  |
| <b>19.2.A(3) Biopsy</b>                       |   |          |  |
| <b>**11102</b>                                | Tangential biopsy of skin; single lesion  | \$62.20  |  |
| <b>**11103</b>                                | Each separate/additional lesion   | \$33.58  |  |
| <b>19.2.A(4) Excision - Benign Lesions</b>    |   |          |  |
| <b>**11440</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less | \$75.39  |  |
| <b>**11441</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm  | \$93.60  |  |
| <b>**11442</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm  | \$105.26 |  |
| <b>**11443</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm  | \$126.95 |  |
| <b>**11444</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm  | \$160.10 |  |
| <b>**11446</b>                                | Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm    | \$215.16 |  |
| <b>19.2.A(5) Excision - Malignant Lesions</b> |   |          |  |
| <b>**11640</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 or less  | \$107.90 |  |
| <b>**11641</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.6 to 1.0 cm  | \$131.68 |  |
| <b>**11642</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 1.1 to 2.0 cm  | \$151.73 |  |
| <b>**11643</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm  | \$179.29 |  |
| <b>**11644</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 3.1 to 4.0 cm  | \$222.89 |  |
| <b>**11646</b>                                | Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter over 4.0 cm  | \$294.86 |  |
| <b>19.2.A(6) Repair - Simple</b>              |   |          |  |
| <b>**12011</b>                                | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less                            | \$92.58  |  |
| <b>**12013</b>                                | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm                          | \$101.77 |  |
| <b>**12014</b>                                | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm                          | \$119.74 |  |
| <b>**12015</b>                                | Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm                         | \$150.54 |  |

| <b>19.2.A(7) Repair - Intermediate</b>                     |   |          |  |
|--|---|----------|--|
| <b>**12051</b>   | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less  | \$149.49 |  |
| <b>**12052</b>   | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm  | \$164.27 |  |
| <b>**12053</b>   | Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm  | \$180.15 |  |
| <b>19.2.A(8) Repair - Complex</b>                          |   |          |  |
| <b>**13131</b>   | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm   | \$204.57 |  |
| <b>**13132</b>   | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm   | \$319.29 |  |
| <b>**13133</b>   | Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 5 cm or less. (List separately in addition to code for primary procedure.) <i>This is an add-on code.</i>   | \$96.24  |  |
| <b>**13151</b>   | Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm  | \$231.91 |  |
| <b>**13152</b>   | Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm  | \$315.37 |  |
| <b>**13153</b>   | Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure.) <i>This is an add-on code.</i>  | \$107.39 |  |
| <b>19.2.A(9) Adjacent Tissue Transfer or Rearrangement</b> |   |          |  |
| <b>14040</b>   | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less  | \$433.17 |  |
| <b>14041</b>   | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm  | \$593.17 |  |
| <b>14060</b>   | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less   | \$442.71 |  |
| <b>14061</b>   | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm   | \$642.99 |  |
| <b>14301</b>   | Skin tissue rearrangement   | \$521.50 |  |
| <b>19.2.A(10) Free Skin Grafts</b>                         |   |          |  |
| <b>**15004</b>   | Wound prep (face, forehead, neck)   | \$235.63 |  |
| <b>**15120</b>   | Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children   | \$540.47 |  |
| <b>**15240</b>   | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less   | \$518.18 |  |
| <b>**15241</b>   | Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (list separately in addition to code for primary procedure). <i>This is an add-on code.</i> | \$107.43 |  |
| <b>**15260</b>   | Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less  | \$552.09 |  |
| <b>**15261</b>   | Skin full graft, add-on   | \$123.47 |  |

| <b>19.2.A(11) Destruction, Benign or Premalignant Lesions</b> |  |          |  |
|---|--|----------|--|
| <b>**17000</b>  | Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions or premalignant lesions in any location, or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; one lesion | \$43.35  |  |
| <b>19.2.A(12) Destruction, Malignant Lesions, Any Method</b>  |  |          |  |
| <b>**17280</b>  | Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less  | \$75.81  |  |
| <b>**17281</b>  | Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm   | \$96.47  |  |
| <b>**17282</b>  | Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm   | \$111.78 |  |
| <b>**17283</b>  | Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm   | \$135.64 |  |
| <b>19.2.B MUSCULOSKELETAL SYSTEM - GENERAL</b>                |  |          |  |
| <b>19.2.(B)(1) Excision</b>                                   |  |          |  |
| <b>**20200</b>  | Biopsy, muscle; superficial  | \$112.21 |  |
| <b>**20205</b>  | Biopsy, muscle; deep   | \$153.83 |  |
| <b>**20206</b>  | Biopsy, muscle, percutaneous needle  | \$164.67 |  |
| <b>**20220</b>  | Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)   | \$117.74 |  |
| <b>**20225</b>  | Biopsy, bone, trocar, or needle; deep (vertebral body, femur)  | \$500.13 |  |
| <b>**20240</b>  | Biopsy, bone, excisional; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)   | \$139.04 |  |
| <b>**20245</b>  | Biopsy, bone, excisional; deep (e.g., humerus, ischium, femur)   | \$367.05 |  |
| <b>19.2.(B)(2) Introduction or Removal</b>                    |  |          |  |
| <b>**20520</b>  | Removal of foreign body in muscle or tendon sheath; simple   | \$113.66 |  |
| <b>**20525</b>  | Removal of foreign body in muscle or tendon sheath; deep or complicated  | \$286.94 |  |
| <b>**20605</b>  | Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)   | \$35.33  |  |
| <b>**<del>Y</del>20650</b>                                    | Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)   | \$116.21 |  |
| <b>**20670</b>  | Removal of implant; superficial,(e.g., buried wire, pin or rod) (separate procedure)   | \$264.67 |  |
| <b>**20680</b>  | Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)   | \$350.11 |  |
| <b>**20690</b>  | Application of a uniplane (pins or wires in one plane), unilateral, external fixation system   | \$298.20 |  |
| <b>**<del>Y</del>20692</b>                                    | Application of multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g. Ilizarov, Monticelli type)  | \$548.66 |  |

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| **20693  | Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s)) | \$278.30 |  |
| **20694  | Removal, under anesthesia, of external fixation system   | \$261.94 |  |
| <b>19.2.(B)(3) Grafts (or Implants)</b>          |  |          |  |
| **¥20900   | Bone graft, any donor area; minor or small (e.g., dowel or button)   | \$359.45 |  |
| **¥20902   | Bone graft, any donor area; major or large   | \$319.36 |  |
| **20910  | Cartilage graft; costochondral   | \$372.47 |  |
| **20926  | Tissue grafts, other (e.g., paratenon, fat, dermis)  | \$260.98 |  |
| <b>19.2.C MUSCULOSKELETAL SYSTEM - HEAD</b>      |  |          |  |
| Skull, facial bones and temporomandibular joint. |  |          |  |
| <b>19.2.C(1) Incision</b>                        |  |          |  |
| **21010  | Arthrotomy, temporomandibular joint  | \$433.44 |  |
| 2101050  | Arthrotomy, temporomandibular joint (bilateral)  | \$650.17 |  |
| <b>19.2.C(2) Excision</b>                        |  |          |  |
| **21015  | Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp  | \$255.05 |  |
| **21025  | Excision of bone (e.g., for osteomyelitis or bone abscess); mandible   | \$579.74 |  |
| **21026  | Excision of bone (e.g., for osteomyelitis or bone abscess); facial bone(s)   | \$441.31 |  |
| **21029  | Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)   | \$436.53 |  |
| **21030  | Excision of benign tumor or cyst of facial bone other than mandible  | \$283.84 |  |
| **21031  | Excision of torus mandibularis   | \$218.37 |  |
| **21032  | Excision of maxillary torus palatinus  | \$222.47 |  |
| ** ¥21034  | Excision of malignant tumor of facial bone other than mandible   | \$787.81 |  |
| **21040  | Excision of benign cyst or tumor of mandible; simple   | \$284.79 |  |
| ** ¥21044  | Excision of malignant tumor of mandible  | \$521.13 |  |
| ** ¥21045  | Excision of malignant tumor of mandible; radical resection   | \$723.56 |  |
| **21050  | Condylectomy, temporomandibular joint (separate procedure)   | \$508.27 |  |
| **2105050  | Condylectomy, temporomandibular joint (separate procedure) - bilateral   | \$762.42 |  |
| ** ¥21060  | Meniscectomy, partial or complete, temporomandibular joint (separate procedure)  | \$469.64 |  |
| **¥2106050                                       | Meniscectomy, partial or complete, temporomandibular joint (separate procedure) - bilateral  | \$704.46 |  |
| **21070  | Coronoidectomy (separate procedure)  | \$383.78 |  |

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| <b>**210750</b>   | Coronoidectomy (separate procedure) - bilateral   | \$575.69      |  |
| <b>19.2.C(3) Introduction or Removal</b>                |   |               |  |
| <b>**21079</b>  | Impression and custom preparation; interim obturator prosthesis   | \$1,007.82    |  |
| <b>**21080</b>  | Impression and custom preparation; definitive obturator prosthesis  | \$1,145.89    |  |
| <b>**21081</b>  | Impression and custom preparation; mandibular resection prosthesis  | \$1,042.60    |  |
| <b>**21082</b>  | Impression and custom preparation; palatal augmentation prosthesis  | \$958.24      |  |
| <b>**21083</b>  | Impression and custom preparation; palatal lift prosthesis  | \$910.75      |  |
| <b>**21084</b>  | Impression and custom preparation; speech aid prosthesis  | \$1,031.98    |  |
| <b>**21085</b>  | Impression and custom preparation; oral surgical splint   | \$416.83      |  |
| <b>**21086</b>  | Impression and custom preparation; auricular prosthesis   | \$1,093.26/PA |  |
| <b>**21087</b>  | Impression and custom preparation; nasal prosthesis   | \$1082.29/PA  |  |
| <b>**21088</b>  | Impression and custom preparation; facial prosthesis  | MP/PA         |  |
| <b>**21089</b>  | Unlisted maxillofacial prosthetic procedure   | MP            |  |
| <b>19.2.C(4) Repair, Revision and/or Reconstruction</b> |   |               |  |
| <b>**Y21120</b>   | Genioplasty; augmentation (autograft, allograft, prosthetic material)   | \$370.14/PA   |  |
| <b>**Y21121</b>   | Genioplasty; sliding osteotomy, single piece  | \$440.33/PA   |  |
| <b>**Y21122</b>   | Genioplasty; sliding osteotomies, two or more osteotomies (e.g. wedge excision or bone wedge reversal for asymmetrical chin)  | \$424.90/PA   |  |
| <b>**Y21123</b>   | Genioplasty; sliding augmentation with interpositional bone grafts (includes obtaining autografts)  | \$501.52/PA   |  |
| <b>**Y21125</b>   | Augmentation, mandibular body or angle; prosthetic material   | \$1,691.57/PA |  |
| <b>**Y21127</b>   | Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)  | \$1,848.59/PA |  |
| <b>**Y21141</b>   | Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft  | \$798.78      |  |
| <b>**Y21142</b>   | Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft   | \$784.11      |  |
| <b>**Y21143</b>   | Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft   | \$821.25      |  |
| <b>**Y21145</b>   | Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)  | \$925.64      |  |
| <b>**Y21146</b>   | Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)                                  | \$923.80      |  |
| <b>**Y21147</b>   | Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies) | \$985.96      |  |
| <b>**Y21150</b>   | Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)   | \$1,048.02    |  |
| <b>**Y21151</b>   | Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)   | \$1,120.98    |  |

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| **¥21154 | Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I   | \$1,252.54  |  |
| **¥21155 | Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I  | \$1,459.46  |  |
| **¥21159 | Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I | \$1,702.41  |  |
| **¥21160 | Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I    | \$1,767.61  |  |
| ¥21188   | Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)   | \$973.28/PA |  |
| **¥21193 | Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft   | \$745.21    |  |
| **¥21194 | Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; with bone graft (includes obtaining graft)   | \$845.86    |  |
| **¥21195 | Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation   | \$800.34    |  |
| **¥21196 | Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation  | \$870.13    |  |
| **¥21198 | Osteotomy, mandible, segmental   | \$679.22    |  |
| **¥21206 | Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)  | \$661.14    |  |
| **21208  | Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)   | \$944.45    |  |
| **¥21209 | Osteoplasty, facial bones; reduction   | \$535.46    |  |
| **21210  | Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)  | \$1,109.92  |  |
| **21215  | Graft, bone; mandible (includes obtaining graft)   | \$1,844.13  |  |
| **21230  | Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)  | \$461.77/PA |  |
| **21235  | Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)  | \$419.23/PA |  |
| **¥21240 | Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)  | \$694.56    |  |
| ¥2124050 | Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft) - bilateral  | \$1,041.85  |  |
| **¥21242 | Arthroplasty, temporomandibular joint, with allograft  | \$613.41    |  |
| **¥21243 | Arthroplasty, temporomandibular joint, with prosthetic joint replacement   | \$1,001.43  |  |
| **¥21244 | Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)  | \$614.98    |  |
| **¥21245 | Reconstruction of mandible or maxilla subperiosteal implant; partial   | \$662.80    |  |
| **¥21246 | Reconstruction of mandible or maxilla subperiosteal implant; complete  | \$547.23    |  |
| **¥21247 | Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)  | \$972.75    |  |
| **21248  | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial  | \$617.97    |  |
| **21249  | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete   | \$869.88    |  |
| **¥21255 | Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)   | \$830.27    |  |
| **¥21256 | Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., microphthalmia)  | \$685.87    |  |

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| ¥21267                                       | Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach  | \$932.62   |  |
| ¥21268                                       | Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extra-cranial approach   | \$1,094.39 |  |
| **¥21270                                     | Malar augmentation, prosthetic material  | \$528.80   |  |
| **¥21275                                     | Secondary revision of orbitocraniofacial reconstruction  | \$478.14   |  |
| **21295                                      | Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach   | \$259.76   |  |
| **21296                                      | Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach   | \$294.21   |  |
| <b>19.2.C(5) Other Procedures</b>            |  |            |  |
| **¥21299                                     | Unlisted craniofacial and maxillofacial procedure, by report   | MP/OR      |  |
| <b>19.2.C(6) Fracture and/or Dislocation</b> |  |            |  |
| **21310                                      | Closed treatment of nasal bone fracture; without manipulation  | \$65.66    |  |
| **21315                                      | Closed treatment of nasal bone fracture; without stabilization   | \$151.14   |  |
| **21320                                      | Closed treatment of nasal bone fracture; with stabilization  | \$145.06   |  |
| **21325                                      | Open treatment of nasal fracture; uncomplicated  | \$286.40   |  |
| **21330                                      | Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation   | \$349.83   |  |
| **21335                                      | Open treatment of nasal fracture; with concomitant open treatment of fractured septum  | \$436.13   |  |
| **21336                                      | Open treatment of nasal septal fracture, with or without stabilization   | \$380.72   |  |
| **21337                                      | Closed treatment of nasal septal fracture, with or without stabilization   | \$227.68   |  |
| 21338  | Open treatment of nasoethmoid fracture; without external fixation  | \$460.13   |  |
| **¥21339                                     | Open treatment of nasoethmoid fracture; with external fixation   | \$497.74   |  |
| **21340                                      | Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus | \$471.52   |  |
| **¥21343                                     | Open treatment of depressed frontal sinus fracture   | \$693.61   |  |
| **¥21344                                     | Open treatment of complicated (e.g., comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches                                | \$895.75   |  |
| **21345                                      | Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint                                   | \$466.24   |  |
| **21346                                      | Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation   | \$560.65   |  |
| **¥21347                                     | Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches  | \$672.71   |  |
| **¥21348                                     | Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)   | \$718.48   |  |
| **21355                                      | Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation   | \$251.21   |  |
| **21356                                      | Open treatment of depressed zygomatic arch fracture (e.g., Gilles approach)  | \$286.47   |  |

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| **¥21360 | Open treatment of depressed malar fracture, including zygomatic arch and malar tripod  | \$312.67   |  |
| **¥21365 | Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches | \$653.31   |  |
| **¥21366 | Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)           | \$739.56   |  |
| **¥21385 | Open treatment of orbital floor “blowout” fracture; transantral approach (Caldwell-Luc type operation)   | \$422.06   |  |
| **¥21386 | Open treatment of orbital floor “blowout” fracture; periorbital approach   | \$393.93   |  |
| **¥21387 | Open treatment of orbital floor “blowout” fracture; combined approach  | \$449.06   |  |
| **¥21390 | Open treatment of orbital floor “blowout” fracture; periorbital approach, with alloplastic or other implant  | \$449.21   |  |
| **¥21395 | Open treatment of orbital floor “blowout” fracture; periorbital approach with bone graft (includes obtaining graft)  | \$573.16   |  |
| **21400  | Closed treatment of fracture of orbit, except “blowout”; without manipulation  | \$123.57   |  |
| **¥21401 | Closed treatment of fracture of orbit, except “blowout”; with manipulation   | \$270.25   |  |
| **¥21406 | Open treatment of fracture of orbit, except “blowout”; without implant   | \$353.05   |  |
| **¥21407 | Open treatment of fracture of orbit, except “blowout”; with implant  | \$411.89   |  |
| **¥21408 | Open treatment of fracture of orbit, except “blowout”; with bone grafting (includes obtaining graft)   | \$517.13   |  |
| **21421  | Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint   | \$410.51   |  |
| **¥21422 | Open treatment of palatal or maxillary fracture (LeFort I type)  | \$400.09   |  |
| **¥21423 | Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches   | \$473.55   |  |
| **¥21431 | Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint   | \$436.25   |  |
| **¥21432 | Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation  | \$395.68   |  |
| **¥21433 | Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches  | \$1,000.06 |  |
| **¥21435 | Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (e.g., head cap, halo device, and/or intermaxillary fixation)                     | \$785.49   |  |
| **¥21436 | Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)   | \$1,128.92 |  |
| **21440  | Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)   | \$289.59   |  |
| **¥21445 | Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)   | \$420.02   |  |
| **21450  | Closed treatment of mandibular fracture; without manipulation  | \$303.07   |  |
| **21451  | Closed treatment of mandibular fracture; with manipulation   | \$406.81   |  |
| **21452  | Percutaneous treatment of mandibular fracture, with external fixation  | \$359.48   |  |
| **21453  | Closed treatment of mandibular fracture with interdental fixation  | \$469.42   |  |

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| **21454  | Open treatment of mandibular fracture with external fixation  | \$325.69   |  |
| **¥21461   | Open treatment of mandibular fracture; without interdental fixation   | \$1,023.37 |  |
| **¥21462   | Open treatment of mandibular fracture; with interdental fixation  | \$1,122.03 |  |
| **¥21465   | Open treatment of mandibular condylar fracture  | \$542.46   |  |
| **¥21470   | Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints | \$703.38   |  |
| **21480  | Closed treatment of temporomandibular dislocation; initial or subsequent  | \$54.91    |  |
| **21485  | Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent                      | \$359.62   |  |
| **¥21490   | Open treatment of temporomandibular dislocation   | \$549.18   |  |
| **21497  | Interdental wiring, for condition other than fracture   | \$360.90   |  |
| <b>19.2.C(7) Other Procedures</b>                    |   |            |  |
| **¥21499   | Unlisted musculoskeletal procedure, head, by report   | MP/OR      |  |
| <b>19.2.D MUSCULOSKELETAL SYSTEM - ARTHROSCOPY</b>   |   |            |  |
| **29800  | Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)  | \$315.54   |  |
| **¥29804   | Arthroscopy, temporomandibular joint, surgical  | \$390.45   |  |
| <b>19.2.E RESPIRATORY SYSTEM - NOSE</b>              |   |            |  |
| **30580  | Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)  | \$365.39   |  |
| **30600  | Repair fistula; oronasal  | \$336.60   |  |
| <b>19.2.F RESPIRATORY SYSTEM - ACCESSORY SINUSES</b> |   |            |  |
| <b>19.2.F(1) Incision</b>                            |   |            |  |
| **31020  | Sinusotomy, maxillary (antrotomy); intranasal   | \$280.18   |  |
| 3102050  | Sinusotomy, maxillary (antrotomy); intranasal - bilateral   | \$368.21   |  |
| **31030  | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps  | \$411.96   |  |
| 3103050  | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps (bilateral)  | \$551.53   |  |
| **31032  | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps   | \$382.47   |  |
| 3103250  | Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps (bilateral)   | \$573.71   |  |

| <b>19.2.G RESPIRATORY SYSTEM - TRACHEA AND BRONCHI</b>   |  |          |  |
|--|--|----------|--|
| <b>19.2.G(1) Incision</b>  |  |          |  |
| <b>**31600</b>   | Tracheostomy, planned (separate procedure)   | \$246.90 |  |
| <b>**31603</b>   | Tracheostomy, emergency procedure; transtracheal                                   | \$138.99 |  |
| <b>**31605</b>   | Tracheostomy, emergency procedure; cricothyroid membrane                           | \$117.68 |  |
| <b>19.2.H DIGESTIVE SYSTEM - LIPS</b>  |  |          |  |
| <b>19.2.H(1) Excision</b>  |  |          |  |
| <b>**40490</b>   | Biopsy of lip  | \$72.95  |  |
| <b>**40500</b>   | Vermilionectomy (lip shave), with mucosal advancement                              | \$284.94 |  |
| <b>**40510</b>   | Excision of lip; transverse wedge excision with primary closure                    | \$279.11 |  |
| <b>**40520</b>   | Excision of lip; V-excision with primary direct linear closure                     | \$293.55 |  |
| <b>**40530</b>   | Resection of lip, more than one-fourth, without reconstruction                     | \$321.18 |  |
| <b>19.2.H(2) Repair (Cheiloplasty)</b>   |  |          |  |
| <b>**40650</b>   | Repair lip, full thickness; vermilion only   | \$245.91 |  |
| <b>19.2.I DIGESTIVE SYSTEM - VESTIBULE OF MOUTH</b>  |  |          |  |
| The vestibule is the part of the oral cavity outside the dentoalveolar structures; it includes the mucosal and submucosal tissue of lips and cheeks. |  |          |  |
| <b>19.2.I(1) Incision</b>  |  |          |  |
| <b>**40800</b>   | Drainage of abscess, cyst, hematoma, vestibule of mouth; simple                    | \$111.70 |  |
| <b>**40801</b>   | Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated               | \$172.33 |  |
| <b>**40804</b>   | Removal of embedded foreign body, vestibule of mouth; simple                       | \$117.28 |  |
| <b>**40805</b>   | Removal of embedded foreign body, vestibule of mouth; complicated                  | \$184.79 |  |
| <b>**40806</b>   | Incision of labial frenum (frenotomy)  | \$59.04  |  |
| <b>19.2.I(2) Excision, Destruction</b>   |  |          |  |
| <b>**40808</b>   | Biopsy, vestibule of mouth   | \$99.61  |  |
| <b>**40810</b>   | Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair     | \$112.12 |  |
| <b>**40812</b>   | Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair | \$158.53 |  |

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| **40814  | Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair   | \$215.64 |  |
| **40816  | Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle                 | \$226.26 |  |
| **40818  | Excision of mucosa of vestibule of mouth as donor graft   | \$286.26 |  |
| **40819  | Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)   | \$170.71 |  |
| **40820  | Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)                | \$142.79 |  |
| <b>19.2.I(3) Repair</b>                                    |   |          |  |
| **40830  | Closure of laceration, vestibule of mouth; 2.5 cm or less   | \$138.00 |  |
| **40831  | Closure of laceration, vestibule of mouth; over 2.5 cm or complex   | \$182.55 |  |
| **40840  | Vestibuloplasty; anterior   | MP/OR    |  |
| **40842  | Vestibuloplasty; posterior, unilateral  | MP/OR    |  |
| **40843  | Vestibuloplasty; posterior, bilateral   | MP/OR    |  |
| **40844  | Vestibuloplasty; entire arch  | MP/OR    |  |
| **40845  | Vestibuloplasty; complex (including ridge extension, muscle repositioning)  | MP/OR    |  |
| <b>19.2.I(4) Other Procedures</b>                          |   |          |  |
| **40899  | Unlisted procedure, vestibule of mouth, by report   | MP/OR    |  |
| <b>19.2.J DIGESTIVE SYSTEM - TONGUE AND FLOOR OF MOUTH</b> |   |          |  |
| <b>19.2.J(1) Incision</b>                                  |   |          |  |
| **41000  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual                          | \$91.20  |  |
| **41005  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial          | \$123.81 |  |
| **41006  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid | \$205.24 |  |
| **41007  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space                  | \$204.29 |  |
| **41008  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space              | \$209.38 |  |
| **41009  | Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space                 | \$223.16 |  |
| **41010  | Incision of lingual frenum (frenotomy)  | \$113.87 |  |
| **41015  | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual                                 | \$241.86 |  |
| **41016  | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental                                  | \$247.87 |  |
| **41017  | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular                              | \$250.04 |  |
| **41018  | Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space                           | \$287.61 |  |

| <b>19.2.J(2) Excision</b>                                 |  |            |  |
|---|--|------------|--|
| **41100   | Biopsy of tongue; anterior two-thirds  | \$96.14    |  |
| **41105   | Biopsy of tongue; posterior one-third  | \$95.46    |  |
| **41108   | Biopsy of floor of mouth   | \$81.73    |  |
| **41110   | Excision of lesion of tongue without closure   | \$117.43   |  |
| **41112   | Excision of lesion of tongue with closure; anterior two-thirds   | \$186.24   |  |
| **41113   | Excision of lesion of tongue with closure; posterior one-third   | \$204.19   |  |
| **41114   | Excision of lesion of tongue with closure; with local tongue flap (list code 41114 in addition to code 41112 or 41113)   | \$378.60   |  |
| **41115   | Excision of lingual frenum (frenectomy)  | \$133.88   |  |
| **41116   | Excision, lesion of floor of mouth   | \$180.50   |  |
| ** <del>Y</del> 41120                                     | Glossectomy; less than one-half tongue   | \$621.03   |  |
| ** <del>Y</del> 41130                                     | Glossectomy; hemiglossectomy   | \$757.04   |  |
| ** <del>Y</del> 41150                                     | Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection | \$1,285.58 |  |
| ** <del>Y</del> 41153                                     | Glossectomy; composite procedure with resection floor of mouth, with suprahyoid neck dissection                          | \$1,385.82 |  |
| <b>19.2.J(3) Repair</b>                                   |  |            |  |
| **41250   | Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue                                 | \$127.13   |  |
| **41251   | Repair of laceration 2.5 cm or less; posterior one-third of tongue   | \$138.22   |  |
| **41252   | Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex   | \$235.37   |  |
| <b>19.2.J(4) Other Procedures</b>                         |  |            |  |
| **41510   | Suture of tongue to lip for micrognathia (Douglas type procedure)  | \$255.67   |  |
| **41520   | Frenoplasty (surgical revision of frenum, eg, with Z-plasty)   | \$235.37   |  |
| ** <del>Y</del> 41599                                     | Unlisted procedure, tongue, floor of mouth   | MP/OR      |  |
| <b>19.2.K DIGESTIVE SYSTEM - DENTOALVEOLAR STRUCTURES</b> |  |            |  |
| <b>19.2.K(1) Incision</b>                                 |  |            |  |
| **41800   | Drainage of abscess, cyst, hematoma from dentoalveolar structures  | \$119.17   |  |
| **41805   | Removal of embedded foreign body from dentoalveolar structures; soft tissues   | \$119.99   |  |
| **41806   | Removal of embedded foreign body from dentoalveolar structures; bone   | \$183.67   |  |

| <b>19.2.K(2) Excision, Destruction</b>            |   |          |  |
|---|---|----------|--|
| **41821   | Operculectomy, excision pericoronal tissues   | MP/OR    |  |
| **41822   | Excision of fibrous tuberosities, dentoalveolar structures  | MP/OR    |  |
| **41825   | Excision of lesion or tumor(except listed above), dentoalveolar structures; without repair                                  | \$115.30 |  |
| **41826   | Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair                             | \$150.67 |  |
| **41827   | Excision of lesion or tumor(except listed above), dentoalveolar structures; with complex repair                             | \$238.46 |  |
| **41828   | Excision of hyperplastic alveolar mucosa, each quadrant (specify)   | \$175.86 |  |
| <b>19.2.L DIGESTIVE SYSTEM - PALATE AND UVULA</b> |   |          |  |
| <b>19.2.L(1) Incision</b>                         |   |          |  |
| **42000   | Drainage of abscess of palate, uvula  | \$91.52  |  |
| <b>19.2.L(2) Excision, Destruction</b>            |   |          |  |
| **42100   | Biopsy of palate, uvula   | \$85.47  |  |
| **42104   | Excision, lesion of palate, uvula; without closure  | \$114.76 |  |
| **42106   | Excision, lesion of palate, uvula; with simple primary closure  | \$146.22 |  |
| **42107   | Excision, lesion of palate, uvula; with local flap closure  | \$259.02 |  |
| ** ¥42120   | Resection of palate or extensive resection of lesion  | \$564.47 |  |
| **42140   | Uvulectomy, excision of uvula   | \$139.91 |  |
| **42145   | Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)   | \$412.40 |  |
| **42160   | Destruction of lesion, palate or uvula (thermal, cryo or chemical)  | \$141.38 |  |
| <b>19.2.L(3) Repair</b>                           |   |          |  |
| **42180   | Repair, laceration of palate; up to 2 cm  | \$139.22 |  |
| **42182   | Repair, laceration of palate; over 2 cm or complex  | \$190.66 |  |
| **¥42200  | Palatoplasty for cleft palate, soft and/or hard palate only   | \$536.96 |  |
| **¥42205  | Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only   | \$554.03 |  |
| **¥42210  | Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft) | \$650.51 |  |
| **¥42215  | Palatoplasty for cleft palate; major revision   | \$430.67 |  |
| **¥42220  | Palatoplasty for cleft palate; secondary lengthening procedure  | \$411.89 |  |
| **¥42225  | Palatoplasty for cleft palate; attachment pharyngeal flap   | \$590.72 |  |

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| ** <del>Y</del> 42226                                     | Lengthening of palate, and pharyngeal flap   | \$575.11 |  |
| ** <del>Y</del> 42227                                     | Lengthening of palate, with island flap  | \$566.58 |  |
| ** <del>Y</del> 42235                                     | Repair of anterior palate, including vomer flap  | \$462.67 |  |
| ** <del>Y</del> 42260                                     | Repair of nasolabial fistula   | \$497.95 |  |
| **42280   | Maxillary impression for palatal prosthesis  | \$90.16  |  |
| **42281   | Insertion of pin-retained palatal prosthesis   | \$116.01 |  |
| <b>19.2.L(4) Other Procedures</b>                         |  |          |  |
| ** <del>Y</del> 42299                                     | Unlisted procedure, palate uvula, by report  | MP/OR    |  |
| <b>19.2.M DIGESTIVE SYSTEM - SALIVARY GLAND AND DUCTS</b> |  |          |  |
| <b>19.2.M(1) Incision</b>                                 |  |          |  |
| **42300   | Drainage of abscess; parotid, simple   | \$119.45 |  |
| **42305   | Drainage of abscess; parotid, complicated  | \$257.53 |  |
| **42310   | Drainage of abscess; submaxillary or sublingual, intraoral   | \$93.47  |  |
| **42320   | Drainage of abscess; submaxillary, external  | \$142.87 |  |
| **42330   | Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral                    | \$133.52 |  |
| **42335   | Sialolithotomy; submandibular (submaxillary), complicated, intraoral   | \$210.76 |  |
| **42340   | Sialolithotomy; parotid, extraoral or complicated intraoral  | \$268.08 |  |
| <b>19.2.M(2) Excision</b>                                 |  |          |  |
| **42400   | Biopsy of salivary gland; needle   | \$62.81  |  |
| **42405   | Biopsy of salivary gland; incisional   | \$176.82 |  |
| **42408   | Excision of sublingual salivary cyst (ranula)  | \$262.29 |  |
| ** <del>Y</del> 42409                                     | Marsupialization of sublingual salivary cyst (ranula) (For fistulization of sublingual salivary cyst, see 42325) | \$188.96 |  |
| ** <del>Y</del> 42410                                     | Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection                               | \$374.63 |  |
| ** <del>Y</del> 42415                                     | Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve       | \$674.00 |  |
| ** <del>Y</del> 42420                                     | Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve              | \$773.84 |  |
| ** <del>Y</del> 42425                                     | Excision of parotid tumor or parotid gland; total, en bloc removal with sacrifice of facial nerve                | \$510.64 |  |
| ** <del>Y</del> 42426                                     | Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection                       | \$828.32 |  |
| ** <del>Y</del> 42440                                     | Excision of submandibular (submaxillary) gland   | \$277.18 |  |
| **42450   | Excision of sublingual gland   | \$262.57 |  |

| <b>19.2.M(3) Repair</b>  |  |          |  |
|--|--|----------|--|
| **42500  | Plastic repair of salivary duct, sialodochoplasty; primary or simple   | \$249.43 |  |
| **42505  | Plastic repair of salivary duct, sialodochoplasty; secondary or complicated  | \$326.74 |  |
| **42507  | Parotid duct diversion, bilateral (Wilke type procedure)   | \$305.18 |  |
| **42509  | Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands               | \$514.58 |  |
| **42510  | Parotid duct diversion, bilateral (Wilke type procedure); with ligation of both sub mandibular (Wharton's) ducts   | \$378.49 |  |
| <b>19.2.M(4) Other Procedures</b>  |  |          |  |
| **42550  | Injection procedure for sialography  | \$95.84  |  |
| **42600  | Closure salivary fistula   | \$277.98 |  |
| **42650  | Dilation salivary duct   | \$47.68  |  |
| **42660  | Dilation and catheterization of salivary duct, with or without injection   | \$61.39  |  |
| **42665  | Ligation salivary duct, intraoral  | \$205.94 |  |
| **42699  | Unlisted procedure, salivary glands or ducts, by report  | MP/OR    |  |
| <b>19.2.N DIGESTIVE SYSTEM - PHARYNX, ADENOIDS AND TONSILS</b>                                       |  |          |  |
| <b>19.2.N(1) Incision</b>  |  |          |  |
| **42700  | Incision and drainage abscess; peritonsillar   | \$107.48 |  |
| **42720  | Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach                               | \$267.13 |  |
| **42725  | Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach                                | \$482.22 |  |
| <b>19.2.N(2) Excision, Destruction</b>   |  |          |  |
| **42800  | Biopsy; oropharynx   | \$90.34  |  |
| <b>19.2.O NERVOUS SYSTEM - EXTRACRANIAL NERVES, PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM</b>   |  |          |  |
| <b>19.2.O(1) Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical, Radiofrequency)</b> |  |          |  |
| **64600  | Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch | \$263.81 |  |
| <b>19.2.O(2) Transection or Avulsion</b>   |  |          |  |
| **64732  | Transection or avulsion of; supraorbital nerve   | \$235.37 |  |

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| **64734   | Transection or avulsion of; infraorbital nerve  | \$246.75 |  |
| ** <del>Y</del> 64736   | Transection or avulsion of; mental nerve  | \$221.31 |  |
| ** <del>Y</del> 64738   | Transection or avulsion of; inferior alveolar nerve by osteotomy  | \$279.04 |  |
| ** <del>Y</del> 64740   | Transection or avulsion of; lingual nerve   | \$276.14 |  |
| <b>19.2.O(3) Excision - Somatic Nerves</b>                        |   |          |  |
| **64795   | Biopsy of nerve   | \$116.53 |  |
| <b>19.2.P SPECIAL SERVICES, PROCEDURES AND REPORTS</b>            |   |          |  |
| <b>19.2.P(1) After Hours Services</b>                             |   |          |  |
| **99050   | Services Requested After Posted Office Hours In Addition To Basic Service   | \$5.16   |  |
| **99058   | Office Services Provided On An Emergency Basis  | \$11.34  |  |
| <b>19.2.Q OFFICE OR OTHER OUTPATIENT SERVICES</b>                 |   |          |  |
| <b>19.2.Q(1) New Patient</b>                                      |   |          |  |
| **99201   | Office/Other Outpatient Visit; Requires 3 Key Components Problem Focused Hx, Exam, & Medical Decision Making      | \$23.70  |  |
| **99202   | Office/Other Outpatient Visit; Requires 3 Key Components Problem Focused Hx, Exam, & Medical Decision Making      | \$39.15  |  |
| **99203   | Office/Other Outpatient Visit; Requires 3 Key Components; Detailed Hx; Exam; & Med Dec Low Complexity             | \$57.05  |  |
| **99204   | Office/Other Outpatient Visit; Requires 3 Key Components; Comprehensive Hx, Exam; & Med Dec Moderate Complexity   | \$87.19  |  |
| **99205   | Office/Other Outpatient Visit; Requires 3 Key Components; Comprehensive Hx, Exam; & Med Dec High Complexity       | \$109.60 |  |
| <b>19.2.Q(2) Established Patient</b>                              |   |          |  |
| **99211   | Office/Other Outpatient Visit, May Not Require Presence Of Physician - Presenting Problem(s) Minimal              | \$15.46  |  |
| **99212   | Office/Other Outpatient Visit; Requires 2 Of 3 Component Problem Focused Hx, Exam, Medical Decision Making        | \$25.76  |  |
| **99213   | Office/Other Outpatient Visit; Requires 2 Of 3 Components - Expanded Problem Focused Hx; Exam; Low Complexity     | \$37.48  |  |
| **99214   | Office/Other Outpatient Visit; Requires 2 Of 3 Component - Detail Hx; Exam; Med Dec Moderate Complexity           | \$56.39  |  |
| **99215   | Office/Other Outpatient Visit; Requires 2 Of 3 Components - Comprehensive Hx; Exam; Med Dec High Complexity       | \$76.35  |  |
| <b>19.2.R HOSPITAL INPATIENT SERVICES</b>                         |   |          |  |
| <b>19.2.R(1) Initial Hospital Care New or Established Patient</b> |   |          |  |
| **99221   | Initial Hosp Care, Per Day, For Evaluation & Management Of Patient Which Requires These 3 Key Components(See CPT) | \$54.00  |  |

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| **99222  | Initial Hosp Care - Per Day - Requires 3 Key Components - Comprehensive Hx; Exam; & Med Dec Moderate Complexity                  | \$74.29  |  |
| **99223  | Initial Hosp Care - Per Day - Requires 3 Key Components - Comprehensive Hx; Exam; & Med Dec High Complexity                      | \$109.14 |  |
| <b>19.2.R(2) Subsequent Hospital Care</b>              |  |          |  |
| **99231  | Subsequent Hosp Care - Per Day - 2 Of 3 Components - Problem Focused Interval Hx; Exam; Low Complexity                           | \$37.09  |  |
| **99232  | Subsequent Hosp Care - Per Day - 2 Of 3 Components - Int Evaluation Hx; Exam; Med Dec Moderate Complexity                        | \$40.15  |  |
| **99233  | Subsequent Hosp Care - Per Day - 2 Of 3 Components - Detailed Interval Hx; Exam; Med Dec High Complexity                         | \$37.09  |  |
| <b>19.2.S OFFICE OR OTHER OUTPATIENT CONSULTATIONS</b> |  |          |  |
| <b>19.2.S(1) New or Established Patient</b>            |  |          |  |
| **99241  | Office Consultation - New/Established - 3 Key Components - Problem Focused Hx; Exam. & Straightforward Med Decision              | \$37.09  |  |
| **99242  | Office Consultation - New/Established - 3 Key Components - Expanded Focused Hx; Exam; & Straightforward Med Dec                  | \$55.91  |  |
| **99244  | Office Consultation - New/Established - 3 Key Components - Comprehensive Hx; Exam; & Med Dec Moderate Complexity                 | \$28.85  |  |
| **99245  | Office Consultation - New/Established - 3 Key Components - Comprehensive Hx; Exam & Med Dec High Complexity                      | \$51.51  |  |
| <b>19.2.T INITIAL INPATIENT CONSULTATIONS</b>          |  |          |  |
| <b>19.2.T(1) New or Established Patient</b>            |  |          |  |
| **99251  | Initial Inpatient Consultation - New/Established - 3 Key Components - Problem Focused Hx; Exam; & Straightforward Med Dec        | \$29.05  |  |
| **99252  | Initial Inpatient Consultation - New/Established - 3 Key Components - Expand Problem Focused Hx; Exam; & Straightforward Med Dec | \$46.14  |  |
| <b>19.2.U EMERGENCY DEPARTMENT SERVICES</b>            |  |          |  |
| <b>19.2.U(1) New or Established Patient</b>            |  |          |  |
| **99281  | Emergency Dept Visit - 3 Key Components - Problem Focused Hx; Exam; & Straightforward Med Decision                               | \$36.54  |  |
| **99282  | Emergency Dept Visit - 3 Key Components - Expanded Problem Focused Hx; Exam; & Med Dec Low Complexity                            | \$37.09  |  |
| **99283  | Emergency Dept Visit For Evaluation & Management Of Patient Which Requires These Three Components (Refer To CPT)                 | \$37.63  |  |
| **99284  | Emergency Dept Visit - 3 Key Components - Detailed Hx; Exam; & Medical Decision Moderate Complexity                              | \$69.48  |  |

|                              |   |         |  |
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| <b>19.2.V HOME SERVICES</b>  |   |         |  |
| <b>19.2.V(1) New Patient</b> |   |         |  |
| <b>**99342</b>               | Home Visit/Evaluation & Management/New Patient/Requires 3 Key Components - Moderate Severity/30 Minutes | \$25.76 |  |
| <b>**99343</b>               | Home Visit/Evaluation & Management/New Patient/Requires 3 Key Components - High Severity/45 Mins        | \$30.91 |  |

### 19.3 ADD-ON PROCEDURE CODES

Procedure codes 11101, 13133, 13153, 15241 and 15261 are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as “add-on” codes with a “+” symbol in the CPT book. Add-on codes can be readily identified by specific descriptor terminology which includes phrases such as “each additional: or “(List separately in addition to primary procedure).” The “add-on” code concept in CPT applies only to add-on procedures/services performed by the same practitioner. These codes describe additional intra-service work associated with the primary procedure. Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. In addition to payment for the primary service/procedure, the add-on codes are also paid at 100% of the Maximum Allowable Amount or the provider’s billed amount, whichever is lower.

## SECTION 20-EXCEPTION PROCESS

### 20.1 EXCEPTION PRINCIPLE

Under certain conditions of medical need, the MO HealthNet Division may authorize payment for a MO HealthNet eligible participant to receive an *essential* medical service or item of equipment that otherwise exceeds the benefits and limitations of any one of the various medical service programs administered by the Division. Under specific criteria and on a case-by-case basis, an administrative exception may be made to limitations and restrictions set by agency policy. No exception can be made where requested items or services are restricted or specifically prohibited by state or federal law or regulation, or excluded under the restrictions section of this rule. The director of the MO HealthNet Division has the final authority to approve payment on a request made to the exception process. These decisions are made with appropriate medical or pharmaceutical advice and consultation.

With the exception of group 2 and group 3 pressure reducing support surfaces, mattress rentals, all services for individuals under age 21 determined to be medically necessary, may be considered for coverage under the EPSDT/HCY Program. Reference Section 9 for more information. Group 2 and group 3 pressure reducing support surface, mattress rentals, *must* be approved through the Exception Process prior to being dispensed, regardless of the participant's age.

Exception requests are only accepted from authorized health care prescribers licensed as a physician or advanced practice nurse.

### 20.2 REQUIREMENTS

Requirements for consideration and provision of a service as an exception to the normal limitations of MO HealthNet coverage are as follows:

- A prescriber *must* certify that MO HealthNet covered treatment or items of services appropriate to the illness or condition have been determined to be medically inappropriate or have been used and found to be ineffective in treatment of the participant for whom the exception is being requested;
- While requests may be approved, documentation verifying that all third party resource benefits have been exhausted *must* accompany claims for payment before the MO HealthNet Program pays for any item or service; for example,
  - Medicare
  - Private Insurance
  - The American Diabetes Society
  - The Veterans Administration
  - The American Cancer Society
  - A United Way Agency;

Except in the case of retroactive MO HealthNet eligibility determination, requests *must* be submitted prior to delivery of the service. Do *not* wait until after receipt of documentation of noncoverage from an alternative payor to submit the completed Exception Request form.

- Any requested medical, surgical or diagnostic service which is to be provided under the authority of the treating prescriber, *must* be listed in the most recent publication of *A Comprehensive Guide to Current Procedural Terminology*, (CPT) or the CMS-approved list of HCPCS codes. The CPT and HCPCS books may be purchased at any medical bookstore;
- Any individual for whom an exception request is made *must* be eligible for MO HealthNet on the date the item or service is provided. If requested, approval may be granted in the case of retroactive MO HealthNet eligibility determinations.
- The provider of the service *must* be an enrolled provider in the MO HealthNet Program on the date the item or service is provided;
- The item or service for which an exception is requested *must* be of a type and nature that falls within the broad scope of a medical discipline included in the MO HealthNet Program and does *not* represent a departure from the accepted standards and precepts of good medical practice. *No* consideration can be given to requests for experimental therapies or services;
- All requests for exception consideration *must* be initiated by the treating prescriber of an eligible participant and *must* be submitted as prescribed by policy of the MO HealthNet Division, 13 CSR 70-2.100;
- Requests for exception consideration *must* support and demonstrate that one (1) or more of the following conditions is met:
  1. The item or service is required to sustain the participant's life;
  2. The item or service would substantially improve the quality of life for a terminally ill patient;
  3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or
  4. The item or service is necessary to prevent a higher level of care.
- All requests *must* be made and approval granted before the requested item or service is provided. An exception to that requirement may be granted in cases in which the participant's eligibility for MO HealthNet is retroactively established or when emergency circumstances preclude the use of the established procedures for submitting a request, and a request is received *not* more than one (1) state working day following the provision of the service.

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

- All exception requests *must* represent cost-effective utilization of MO HealthNet funds. When an exception item or service is presented as an alternative, lesser level-of-care than the level otherwise necessary, the exception *must* be less program costly; and
- Reimbursement of services and items approved under this exception procedure shall be made in accordance with the MO HealthNet established fee schedules or rates for the same or comparable services. For those services for which no MO HealthNet-established fee schedule or rate is applicable, reimbursement is determined by the state agency considering costs and charges.

### 20.3 RESTRICTIONS

The following are examples of types of requests that are *not* considered for approval as an exception. This is *not* an all-inclusive list:

- Requests for restricted program areas. Refer to Section 1 for a list of restricted program areas.
- Requests for expanded HCY/EPSTDT services (individuals under age 21). These should be directed to the HCY/EPSTDT coordinator. (Reference manual Section 9).
- Requests for orthodontic services;
- Requests for inpatient hospital services;



- Requests for alternative services (Personal Care, Adult Day Health Care, AIDS Waiver, Aged and Disabled Waiver, Hospice, and Respite Care) regardless of authorization by the Missouri Department of Health and Senior Services;
- Requests for chiropractic services;
- Requests for services that are provided by individuals whose specialty is *not* covered by the MO HealthNet Program;
- Requests for psychological testing or counseling *not* otherwise covered by the MO HealthNet Program;
- Requests for waiver of program requirements for documentation, applicable to services requiring a second surgical opinion, hysterectomy, voluntary sterilizations, and legal abortions;
- Requests for drug products excluded from coverage by the MO HealthNet Program;
- Requests relating to the failure to obtain prior authorization or pre-certification as required for a service otherwise covered by MO HealthNet;
- Requests for payment of dentures and/or partials placed after the participant is ineligible when fabrication occurred prior to that time;
- Requests for delivery or placement of any custom-made items following the participant's death or loss of eligibility for the service;
- Requests for removal from the Lock-In or Prepaid Health Programs;
- Requests for additional reimbursement for items or services otherwise covered by the MO HealthNet Program;
- Requests for air ambulance transportation;
- Requests for Qualified Medicare Beneficiary (QMB) services;
- Requests for MO HealthNet Waiver services such as AIDS Waiver;
- Requests for services exceeding the limits of the Transplant Program;
- Requests for services exceeding the limits of the regular MO HealthNet Program.

## 20.4 REQUESTING AN EXCEPTION

All Exception Request forms *must* be signed by the treating prescriber of an eligible participant. The requests are to be submitted to the Exceptions Unit. This unit processes the request, obtains a decision from the appropriate medical or pharmaceutical consultant and/or administrative official, and informs the treating prescriber, provider of service, and participant of all approved decisions. In the event of a denial, only the prescriber and participant are notified.

There are two categories of exception request—emergency and nonemergency, each of which are processed differently.



#### **20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS**

Requests for life-threatening emergencies may be submitted by the treating prescriber by calling the toll-free number (800) 392-8030. The office hours for the Exceptions Unit are from 8:00 A.M. to 5:00 P.M. Monday through Friday, except on observed holidays. All other provider inquiries regarding covered program benefits *must* be directed the Provider Communications Unit at (573) 751-2896.

The treating prescriber *must* provide Exceptions Unit personnel with information consistent with that required on the Exception Request form. The request is processed within one (1) state working day with notification of approval communicated by fax to the provider of service. If the request is denied, the prescriber is notified within one (1) state working day.

#### **20.4.B NON-EMERGENCY EXCEPTION REQUESTS**

In order to ensure access to the Exceptions Unit for life-threatening emergency requests, all non-emergency requests *must* be submitted on an Exception Request form. Requests may be faxed to (573) 522-3061.

Non-emergency requests may also be submitted by mailing to:

MO HealthNet Division  
Exceptions Unit  
P.O. Box 6500  
Jefferson City, MO 65102-6500

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.

**END OF SECTION**

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Dental

## **SECTION 21- ADVANCE HEALTH CARE DIRECTIVES**

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

- Adult Day Health Care
- Aged and Disabled Waiver
- Ambulance
- Ambulatory Surgical Centers
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- MRDD Waiver
- Nurse Midwife
- Optical
- Pharmacy
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy

**END OF SECTION**

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## SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

### 22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

### 22.2 DEFINITIONS

The following definitions apply for this program:

|                    |   |
|--------------------|---|
| Action             | The denial, termination, suspension, or reduction of an NEMT service.   |
| Ancillary Services | Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child. |
| Appeal             | The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.   |
| Attendant          | An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant   |



*cannot* travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.

|                                |   |
|--------------------------------|---|
| Basic/Urban/<br>Rural Counties | As defined in 20 CSR, the following counties are categorized as: <ul style="list-style-type: none"> <li>• Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;</li> <li>• Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;</li> <li>• Rural – All other counties.</li> </ul> |
| Broker                         | Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.  |
| Call<br>Abandonment            | Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.   |
| Call Wait Time                 | Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.  |
| Clean Claim                    | A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.  |
| Complaint                      | A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.   |
| DCN                            | Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.   |
| Denial Reason                  | The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: <ul style="list-style-type: none"> <li>• Non-covered Service</li> <li>• Lack of Day's Notice</li> </ul>   |

- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

### Emergency

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

### Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.



|   |  |
|---|--|
| Free<br>Transportation                    | Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.   |
| Grievance<br>(Participant)                | A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are <i>not</i> limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker's personnel, or failure to respect the participant's rights.   |
| Grievance<br>(Transportation<br>Provider) | A written request for further review of a transportation provider's complaint that remains unresolved after completion of the complaint process.   |
| Inquiry                                   | A request from a transportation provider regarding information that would clarify broker's policies and procedures, or any aspect of broker function that may be in question.  |
| Most<br>Appropriate                       | The mode of transportation that accommodates the participant's physical, mental, or medical condition.   |
| MO HealthNet<br>Covered<br>Services       | Covered services under the MO HealthNet program.   |
| Medically<br>Necessary                    | Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could <i>not</i> have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services <i>must</i> be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. |
| Medical Service<br>Provider               | An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.   |

|                         |  |
|-------------------------|--|
| NEMT Services           | Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does <i>not</i> include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times. |
| No Vehicle Available    | Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All “no vehicle available” trips shall be reported as denials in the category of no vehicle available.  |
| Participant             | A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.  |
| Pick-up Time            | The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.   |
| Public Entity           | State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.  |
| Transportation Leg      | From pick up point to destination.   |
| Transportation Provider | Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.   |
| Urgent                  | A serious, but <i>not</i> life threatening illness/injury. Examples include, but are <i>not</i> limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do <i>not</i> require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant’s medical provider.  |
| Will Call               | An unscheduled pick-up time when the participant calls the broker or   |



transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

## 22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.



If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

## **22.4 PARTICIPANT ELIGIBILITY**

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

## **22.5 NON-COVERED PARTICIPANTS**

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
  - a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

## **22.6 TRAVEL STANDARDS**

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards

are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. Urban-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. Basic-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. Rural-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

#### **TRAVEL STANDARDS: MAXIMUM MILEAGE**

| <b>Provider/Service Type</b> | <b>Urban<br/>Access<br/>County</b> | <b>Basic<br/>Access<br/>County</b> | <b>Rural<br/>Access<br/>County</b> |
|------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <b>Physicians</b>            |                                    |                                    |                                    |
| PCPs                         | 10                                 | 20                                 | 30                                 |
| Obstetrics/Gynecology        | 15                                 | 30                                 | 60                                 |
| Neurology                    | 25                                 | 50                                 | 100                                |
| Dermatology                  | 25                                 | 50                                 | 100                                |
| Physical Medicine/Rehab      | 25                                 | 50                                 | 100                                |
| Podiatry                     | 25                                 | 50                                 | 100                                |
| Vision Care/Primary Eye Care | 15                                 | 30                                 | 60                                 |
| Allergy                      | 25                                 | 50                                 | 100                                |
| Cardiology                   | 25                                 | 50                                 | 100                                |
| Endocrinology                | 25                                 | 50                                 | 100                                |
| Gastroenterology             | 25                                 | 50                                 | 100                                |
| Hematology/Oncology          | 25                                 | 50                                 | 100                                |
| Infectious Disease           | 25                                 | 50                                 | 100                                |
| Nephrology                   | 25                                 | 50                                 | 100                                |



Dental

|                                |    |    |     |
|--------------------------------|----|----|-----|
| Ophthalmology                  | 25 | 50 | 100 |
| Orthopedics                    | 25 | 50 | 100 |
| Otolaryngology                 | 25 | 50 | 100 |
| Pediatric                      | 25 | 50 | 100 |
| Pulmonary Disease              | 25 | 50 | 100 |
| Rheumatology                   | 25 | 50 | 100 |
| Urology                        | 25 | 50 | 100 |
| General surgery                | 15 | 30 | 60  |
| Psychiatrist-Adult/General     | 15 | 40 | 80  |
| Psychiatrist-Child/Adolescent  | 22 | 45 | 90  |
| Psychologists/Other Therapists | 10 | 20 | 40  |
| Chiropractor                   | 15 | 30 | 60  |

**Hospitals**

|                    |    |    |    |
|--------------------|----|----|----|
| Basic Hospital     | 30 | 30 | 30 |
| Secondary Hospital | 50 | 50 | 50 |

**Tertiary Services**

|                                 |     |     |     |
|---------------------------------|-----|-----|-----|
| Level I or Level II trauma unit | 100 | 100 | 100 |
| Neonatal intensive care unit    | 100 | 100 | 100 |
| Perinatology services           | 100 | 100 | 100 |
| Comprehensive cancer services   | 100 | 100 | 100 |
| Comprehensive cardiac services  | 100 | 100 | 100 |
| Pediatric subspecialty care     | 100 | 100 | 100 |

**Mental Health Facilities**

|  |    |    |    |
|--|----|----|----|
| Inpatient mental health treatment facility   | 25 | 40 | 75 |
| Ambulatory mental health treatment providers | 15 | 25 | 45 |

|   |    |    |    |
|---|----|----|----|
| Residential mental health treatment providers | 20 | 30 | 50 |
|---|----|----|----|

**Ancillary Services**

|                  |    |    |    |
|------------------|----|----|----|
| Physical Therapy | 30 | 30 | 30 |
|------------------|----|----|----|

|                      |    |    |    |
|----------------------|----|----|----|
| Occupational Therapy | 30 | 30 | 30 |
|----------------------|----|----|----|

|                |    |    |    |
|----------------|----|----|----|
| Speech Therapy | 50 | 50 | 50 |
|----------------|----|----|----|

|           |    |    |    |
|-----------|----|----|----|
| Audiology | 50 | 50 | 50 |
|-----------|----|----|----|

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
  - Participant eligibility; and
  - MO HealthNet covered service.

## 22.7 COPAYMENTS

The participant is required to pay a \$2.00 copayment for transportation services. The \$2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
  - 03 - Aid to the blind;
  - 12 - MO HealthNet-Aid to the blind; and
  - 15 - Supplemental Nursing Care-Aid to the blind;
  - 18 - MO HealthNet for pregnant women;
  - 43 - Pregnant women-60 day assistance;
  - 44 - Pregnant women-60 day assistance-poverty;
  - 45 - Pregnant women-poverty; and
  - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

## 22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).



## 22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

## 22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

## 22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

## 22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

## 22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the

NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

## **22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS**

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC  
1807 Park 270 Drive, Suite 518  
St. Louis, MO 63146  
866-269-5944

## **22.15 PARTICIPANT RIGHTS**

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.

2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

## **22.16 DENIALS**

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

## **22.17 PARTICIPANT GRIEVANCE PROCESS**

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC  
1807 Park 270 Drive, Suite 518  
St. Louis, MO 63146

## **22.18 STANDING ORDERS**

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.



1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

## **22.19 ANCILLARY SERVICES**

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.



### **22.19.A ANCILLARY SERVICES REQUEST PROCEDURE**

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.
5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for



reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

## **22.20 WHERE'S MY RIDE? (WMR)**

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

## **22.21 QUALITY ASSURANCE (QA) PROCEDURE**

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare

representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

## 22.22 FREQUENTLY ASKED QUESTIONS

- A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

- B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

- C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

- D. Who do I contact for reoccurring issues?



All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

**END OF SECTION**

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## SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

### 23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Certificate of Medical Necessity (**only for the Durable Medical Equipment Program**)

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

Wipro Infocrossing  
P.O. Box 5900  
Jefferson City, MO 65102

These attachments may also be submitted to Wipro Infocrossing via the Internet when additional documentation is *not* required. The web site address for these submissions is [www.emomed.com](http://www.emomed.com).

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

## **23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY**

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

**END OF SECTION**

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