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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

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01, 04, 11, 12, 13, 14, 15, 16</td>
<td>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.</td>
</tr>
<tr>
<td>03</td>
<td>Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.</td>
</tr>
<tr>
<td>55</td>
<td>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.</td>
</tr>
<tr>
<td>18, 43, 44, 45, 61</td>
<td>Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.</td>
</tr>
<tr>
<td>10, 19, 21, 24, 26</td>
<td>Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06</td>
<td>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.</td>
</tr>
<tr>
<td>60</td>
<td>Newborns (infants under age 1 born to a MO HealthNet or managed care participant).</td>
</tr>
</tbody>
</table>

PRODUCTION : 09/06/2019
Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.

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.

Children who receive a federal adoption subsidy payment.

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.)

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.

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.

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.
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)

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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

<table>
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<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
Individuals who receive a Blind Pension check.

Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state funded foster care.

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.)

Children who receive a state only adoption subsidy payment.

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.

Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.

1.1.A(6) MO Rx

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 82      | Participants only have pharmacy Medicare Part D wrap-around benefits through the MoRx.

1.1.A(7) Women’s Health Services

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
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.

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:
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 (BCCCP) 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:

<table>
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<th>ME CODE</th>
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PRODUCTION : 09/06/2019
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 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.

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.

1.5.1 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.

1.5.1(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 is 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:

PRODUCTION : 09/06/2019
• 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;
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

PRODUCTION : 09/06/2019
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

PRODUCTION :  09/06/2019
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.
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.

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

PRODUCTION : 09/06/2019
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, 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, must complete the online 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 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.

PRODUCTION : 09/06/2019
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

The MO HealthNet Remittance Advice is available online. 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 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
the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section (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/.
3.2A 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.

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.

- 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.

3.3A 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 Area 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:
  o If frames, lens, and exam information exists and all occur on the same date.
  o Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
  o If frames, lens exist for different dates and no exam date.
  o Eye glass frames were last issued on (Frames Date).
  o Eye glass lenses were last issued on (Lens Date).
  o This participate 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.
  o Third party insurance is provided by (TPL NAME).
  o If Court Ordered, the IVR will read that this coverage is court ordered.
  o If Policy Number = ‘unknown, the IVR will read that the Policy number is unknown.
  o If Policy Number is known, the IVR will read the policy number is (Policy Number).
  o If Group Number = ‘unknown, the IVR will read that the group number is unknown.
  o 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.
  o 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:
  o The IVR reads that the claim accessed with this date of service is being processed.

• If claim is denied:
  o 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).
  o After EOB codes are read, the IVR prompts to hear EOB descriptions.
  o 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 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](http://manuals.momed.com/Application.html) and select the Apply for Internet Access link. Providers are unable to access 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. 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) 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. 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. 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. 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.

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.

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, or visit the MHD webpage at [http://dss.mo.gov/mhd/cs/](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](http://cyberaccess.xerox.com) 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. 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 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. 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.
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 if there is another liable third party.
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 cannot be assigned and it is not 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

PRODUCTION: 09/06/2019
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.
SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

MO HealthNet Division (MHD) continues to improve their billing website at 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 website found on the following website address: 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, 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. 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 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 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.
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

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Name</td>
<td>Enter last name, first name and middle initial as shown on the ID card.</td>
</tr>
<tr>
<td>2. Participant MO HealthNet ID Number</td>
<td>Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant’s ID card or letter of eligibility.</td>
</tr>
<tr>
<td>3. Procedure/Revenue Codes</td>
<td>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).</td>
</tr>
<tr>
<td>4. Description of Item/Service</td>
<td>For each procedure/revenue code listed, describe in detail the service or item being provided.</td>
</tr>
<tr>
<td>5. Reason for Service</td>
<td>For each procedure/revenue code listed, state clearly the medical necessity for this service/item.</td>
</tr>
</tbody>
</table>
6. Months Item Needed (DME only)  For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).

7. Name and Signature of Prescriber  The prescriber's signature, when required, must be an original signature. A stamp or the signature of a prescriber's employee is not acceptable. A signature is not required here if the prescriber is the provider (Fields #12 thru #14).

8. Prescriber's MO HealthNet 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 must 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 Identifier  Enter provider's NPI number.

14. Provider Signature  The provider must 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:

Service
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.

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

PRODUCTION : 09/06/2019
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.
- 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.
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.

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 - 99385</td>
<td>Preventive Screen; new patient</td>
</tr>
<tr>
<td>99391 - 99395</td>
<td>Preventive Screen; established patient</td>
</tr>
</tbody>
</table>

9.5 FULL HCY/EPSDT SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381EP-99385EP</td>
<td>Full Medical Screening</td>
</tr>
<tr>
<td>99391EP-99395EP</td>
<td></td>
</tr>
<tr>
<td>99381EPUC-99385EPUC</td>
<td>Full Medical Screening with Referral</td>
</tr>
<tr>
<td>99391EPUC-99395EPUC</td>
<td></td>
</tr>
</tbody>
</table>
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.

*Rceived 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/EPSDT 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**

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429 59</td>
<td>Developmental/Mental Health partial screen</td>
</tr>
<tr>
<td>99429 59UC</td>
<td>Developmental/Mental Health partial screen with Referral</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>

PRODUCTION: 09/06/2019
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**

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9942952</td>
<td>Vision Screening</td>
</tr>
<tr>
<td>9942952UC</td>
<td>Vision Screening with Referral</td>
</tr>
</tbody>
</table>

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/EPSDT population on a periodicity schedule that is different from that of the full HCY/EPSDT 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
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 (µg/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 µg/dL obtained by capillary specimen (finger stick) must be confirmed using venous blood according to the time frame listed below:

- 10-19 µg/dL- confirm within 2 months
- 20-44 µg/dL- confirm within 2 weeks
- 45-69 µg/dL- confirm within 2 days
- 70+ µg/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.)

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>83655</td>
<td>Lead, quantitative blood</td>
</tr>
</tbody>
</table>

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 µg/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 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(5) Blood Lead Level 70 µg/dL or Greater**

Children with blood lead levels in this range constitute a medical emergency.

If the blood lead results are in the 70 µg/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 µg/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 µg/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 µg/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 *must* 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
  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, 11636 Administration
Jefferson City, MO 65101 St. Louis, MO 63146
Springfield-Greene County Public Health St. Francis Medical Center
227 E. Chestnut 211 St. Francis Drive
Springfield, MO 65802 Cape Girardeau, MO 63703
St. Luke’s Hospital Dept. of Pathology St. Louis County Environmental Health Lab
4401 Wornall 111 S. Meramec
Kansas City, MO 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 Hygienic Lab Iowa Methodist Medical Center
Wallace State Office Building 1200 Pleasant St.
Des Moines, IA 50307 Des Moines, IA 50309
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.
Stewart Manor, NY 11530 Overland Park, KS 66210
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

PRODUCTION : 09/06/2019
9.8 HCY CASE MANAGEMENT

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1016EP</td>
<td>HCY Case Management</td>
</tr>
<tr>
<td>T1016TSEP</td>
<td>HCY Case Management; Follow-up</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn (2-3) days</td>
<td>3 Years</td>
</tr>
<tr>
<td>By 1 Month</td>
<td>4 Years</td>
</tr>
<tr>
<td>2-3 Months</td>
<td>5 Years</td>
</tr>
<tr>
<td>4-5 Months</td>
<td>6-7 Years</td>
</tr>
<tr>
<td>6-8 Months</td>
<td>8-9 Years</td>
</tr>
<tr>
<td>9-11 Months</td>
<td>10-11 Years</td>
</tr>
<tr>
<td>12-14 Months</td>
<td>12-13 Years</td>
</tr>
<tr>
<td>15-17 Months</td>
<td>14-15 Years</td>
</tr>
<tr>
<td>18-23 Months</td>
<td>16-17 Years</td>
</tr>
<tr>
<td>24 Months</td>
<td>18-19 Years</td>
</tr>
<tr>
<td></td>
<td>20 Years</td>
</tr>
</tbody>
</table>

*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.
The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or mental illness, or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid state plan. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose and may only be limited by medical necessity. According to the MO HealthNet Managed Care contracts, the MO HealthNet Managed Care health plans are responsible for providing all EPSDT/HCY services for their enrollees.

Missouri is required to provide the Centers for Medicare & Medicaid Services with screening and referral data each federal fiscal year (FFY). This information is reported to CMS on the CMS-416 report. Specific guidelines and requirements are required when completing this report. The health plans are not required to produce a CMS-416 report. Plans must report encounter data for HCY screens using the appropriate codes in order for the MO HealthNet Division to complete the CMS-416 report.

A full EPSDT/HCY screening must include the following components:

a) A comprehensive unclothed physical examination

b) A comprehensive health and developmental history including assessment of both physical and mental health development

c) Health education (including anticipatory guidance)

d) Appropriate immunizations according to age

e) Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated)

f) Lead screen according to established guidelines

g) Hearing screen

h) Vision screen

i) Dental screen

Partial screens which are segments of the full screen may be provided by appropriate providers. The purpose of this is to increase access to care to all children. Providers of partial screens are required to supply a referral source for the full screen. (For the plan enrollees this should be the primary care physician). A partial screen does not replace the need for a full medical screen which includes all of the above components. See Section 9, page 5 through 8 for specific information on partial screens.

Plans must use the following procedure codes, along with a primary diagnosis code of Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, or Z00.129 when reporting encounter data to the MO HealthNet Division on Full and Partial EPSDT/HCY Screens:

Unclothed Physical and History 99381 through 99385 and 99391 through 99395
Developmental/Mental Health 9942959
9942959UC
Hearing Screen 99429EP
99429EPUC
Vision Screen 9942952
9942952UC
Dental Screen 99429
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.
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
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
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)
• 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 MO HEALTHNET 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 frames and/or lenses when lost, broken or medically necessary, and HCY/EPSDT 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 health plan.

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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/adhcproposalpackets.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

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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.

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.
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 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; and
- 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 HEARING AIDS AND RELATED SERVICES

Reimbursement for hearing aids and related services are made on a fee-for-service basis. The MO HealthNet maximum allowable fee for a unit of service has been determined by the MO HealthNet Division to be a reasonable fee, consistent with efficiency, economy, and quality of care. MO HealthNet payment for hearing aids and related services is the lesser of the provider's usual and customary charge to the general public or the MO HealthNet allowable amount. Reimbursement for a hearing aid includes the reimbursement for the fitting fee. The hearing aid and related services must be provided to the participant before the provider bills MO HealthNet. Providers may neither request nor accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. The provider cannot bill the participant for the difference between the MO HealthNet allowable amount and the provider's usual and customary or billed charge. Accepting a portion of payment for services from a participant, except for required copayment, is in violation of 13 CSR 70-3.030 (3)(A) 9 and 15.

MO HealthNet reimbursement must be requested by the audiologist or hearing instrument specialist who actually provided the service using the hearing aid provider number currently assigned to the provider. Clinics, hearing aid companies, or company owners may not bill for hearing evaluations for the purpose of obtaining a hearing aid or hearing aid dispensing services provided by another person even if that person is employed on a salary basis. If services on the claim are provided by anyone other than the person to whom the provider number appearing on the claim is assigned, the claim may be considered to be false or fraudulent billing, and thus, subject to investigation.

12.3 ON-LINE FEE SCHEDULE

MO HealthNet fee schedules through the MO HealthNet Division are available at http://dss.mo.gov/mhd/providers/pages/cptagree.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 as 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 Hearing Aid Provider Manual for program-specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET 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.

Hearing aids and services related directly to the fitting of the hearing aid are not covered by Medicare. Medicare does reimburse for some vestibular function tests and audiologic function tests. When these tests are performed by audiologists on participants with Part B Medicare, providers should seek payment from Medicare prior to filing a claim with MO HealthNet.
12.5 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay amount. The copay amount is paid by the participant at the time services are rendered. Services of the Hearing Aid Program described in this manual are subject to a copay amount. The provider must accept in full the amounts paid by the state agency plus any copay amount required of the participant. Refer to Section 13 of the Hearing Aid Provider Manual for program specific information.

12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

One method through which MO HealthNet provides services is a Managed Health Care Delivery System. A basic package of services is offered to the participant by the health plan; however, some services are not included and are covered by MO HealthNet on a fee-for-service basis.

Hearing aid services are included as a plan benefit in MO HealthNet’s managed care program.

12.6.A MO HEALTHNET MANAGED CARE

Under a managed care health plan, a basic set of services is provided either directly or through subcontractors. Managed care health care 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.

The MO HealthNet utilizes the managed care health plans for certain included MO HealthNet eligibles. Refer to Section 1 and Section 11 of the Hearing Aid Provider Manual for a detailed description.
SECTION 13-BENEFITS AND LIMITATIONS

13.1 CONDITIONS OF PARTICIPATION

13.1.A PROVIDER PARTICIPATION

Participants shall have freedom of choice in selecting a provider of hearing aid services; however, payments under the Missouri Title XIX (MO HealthNet) Program are limited to audiologists and hearing instrument specialists who meet the following conditions:

• The audiologist or hearing instrument specialist must have a current permanent license to practice in accordance with the licensing provisions of the state in which he/she operates or practices. Temporary licenses are not acceptable.

• The audiologist or hearing instrument specialist must have a Title XIX Hearing Aid Participation Agreement in effect with the MO HealthNet Division before providing services for which MO HealthNet will be billed. If a provider's license is suspended or terminated by the State Licensing Agency, the MO HealthNet Division Participation Agreement will also be suspended or terminated effective the same date.

Additional information on provider conditions of participation can be found in Section 2 of the Hearing Aid Provider Manual.

13.2 ELIGIBILITY ON DATE OF SERVICE

The participant receiving Hearing Aid Program services must be eligible on the day the service is provided or the aid is dispensed, as explained in Section 1 of the Hearing Aid Provider Manual. Eligibility on the date of service is a requirement even if the service has been prior authorized. The only exception is explained in Section 13.12 of the Hearing Aid Provider Manual and regards participant loss of eligibility after a custom-made item has been ordered or fabricated. It is the responsibility of the provider to verify the bearer of the card is the person to whom the card was issued and the participant is eligible on the day that the service is provided or the hearing aid is dispensed. With the exception of procedure code 92557, Hearing Aid Program services are not covered for individuals covered under a limited benefit package as described in Section 1.5.A of the Hearing Aid Provider Manual.

13.3 PARTICIPANT NONLIABILITY

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

With certain specific exceptions discussed further in this section, benefits under the Hearing Aid Program are limited by the following:

- All hearing aids and dispensing fees require prior authorization.
- Services are to be delivered for the purpose of and in conjunction with the dispensing of a hearing aid.
- Routine testing and screening of individuals or groups is not a covered service.
- Hearing evaluation for the purpose of obtaining a hearing aid to be performed in a nursing home requires prior authorization.
- Stand alone TV or radio listening systems are not covered items.
- Participants are entitled to one (1) new hearing aid and related services (testing, fitting, dispensing and post-fitting evaluation) once every four (4) years.
- A replacement hearing aid or a binaural hearing aid may be covered. Refer to Section 13.11.A and Section 13.11.B of the Hearing Aid Provider Manual for guidelines.
- Repairs and post-fitting adjustments are limited to a combined total of three (3) per rolling calendar year.
- Replacement of an ear mold due to changes in the ear canals that affect the size or shape.
- The pure-tone average (PTA) for 500, 1000 and 2000 hertz (Hz) (measured with an earphone) must be 30 dB HL or greater in the better ear.
- Word recognition testing (with phonetically balanced 25 or 50 word lists) is required for participants seven (7) years of age and above. Ten word speech discrimination lists are not acceptable.
- All required services must be rendered before payment is made for any portion of the services.
- Hearing aids must be dispensed to the participant in person by the provider who requested authorization to fit the hearing aid. The hearing aid cannot be mailed to the participant.
- Additional benefits for children under the age of 21 are discussed in Section 13.10 of the Hearing Aid Provider Manual.

13.5 COVERED SERVICES

The following services are reimbursable subject to the basic limitations and criteria of MO HealthNet policy. Services and items must also have been provided in accordance with sound professional practice and the standards under which the provider is licensed.
13.5.A MEDICAL EAR EXAMINATION

Before being fitted with a hearing aid, all participants must have a medical ear examination for pathology or disease. It is preferable that this exam be performed after the hearing evaluation so that the physician can review the hearing evaluation results. The medical ear exam must be performed before the provider submits the Prior Authorization (PA) Request for the hearing aid. Hearing loss can result from a number of conditions and diseases for which a hearing aid may not be appropriate. The purpose of the exam is to ensure that all medically treatable conditions that may affect hearing are accurately identified and properly treated before a hearing aid is dispensed.

The medical ear examination must be performed by a physician (MD or DO) and preferably by an ear specialist. This examination must be performed within six (6) months prior to the date of the PA Request submission. This examination cannot be waived. If the medical ear examination is not performed or if the date of the examination is not within the specified period of time, the hearing aid and related services are not covered. Section B of the Report of Hearing Aid Evaluation (RHAE) form must be completed and signed by the physician before prior authorization to fit a hearing aid is granted.

13.5.B HEARING EVALUATION FOR THE PURPOSE OF OBTAINING A HEARING AID

Before MO HealthNet can grant prior authorization for a hearing aid and related services, a hearing evaluation for the purpose of obtaining a hearing aid (92557 or 9255722) must be performed by an audiologist or hearing instrument specialist and the results recorded in Section C of the RHAE form. The procedure must be ordered by a qualified physician and the diagnosis must be related to disease or trauma. Supporting documentation must be retained in the patient's file. Such testing, when administered for the purpose of prescribing a hearing aid, is reimbursed by the MO HealthNet Hearing Aid Program. MO HealthNet reimbursement for each test is to cover testing of both ears. The Hearing Aid Program does not pay for testing performed in relation to a medical or surgical diagnosis or treatment by a physician when a hearing aid is not being considered. Such testing can, however, be reimbursed to a physician through the Physician's Program.

The hearing tests that are required for a hearing aid must include at a minimum, air conduction thresholds, bone conduction thresholds (with masking when necessary), speech reception thresholds and word recognition testing. The results must be clear, internally consistent and must support the recommendation of which ear is to be fitted. If two (2) hearing aids are requested for participants under the age of 21, the test results must support a recommendation for binaural hearing aids. For infants and very young children word recognition testing is not possible and is not required. For children ages seven (7) and older,
word recognition is required. If a participant’s cognitive impairment precludes word recognition testing, this *must* be stated on the RHAE form.

13.5.B(1) Pure-Tone Thresholds

In most cases, the pure-tone audiogram is used to select the electro-acoustic characteristics of the hearing aid. The pure-tone audiogram is also used in the otologic diagnosis. It is assumed that the participant is alert and capable of providing results that are valid and repeatable. If this is *not* the case, the ability to specify hearing loss has been compromised and the examiner needs to indicate the problem and how it will be dealt with in Section G of the RHAE form.

Air-conduction thresholds should be obtained at 250, 500, 1000, 2000, 3000, 4000 and 6000 Hz unless there is good reason to do otherwise. Bone-conduction thresholds should be obtained at 250, 500, 1000, 2000, 3000 and 4000 Hz unless there is good reason to do otherwise. Unless it is noted otherwise, it is assumed that bone conduction is being measured from the mastoid. It is also assumed that air-and bone-conducted signals are specified in dB HL in accordance with current ANSI standards.

Masked threshold can be noted with an asterisk or superscript \( m \) (e.g., 40* or 40\( m \)).

13.5.B(2) Speech Thresholds

Thresholds are specified in dB HL for speech. If the audiometer or acoustic appraiser indicates speech level in dB sound pressure level (SPL), subtract 20 dB to convert to dB HL for speech (e.g., 75 dB SPL for speech = 55 dB HL for speech). Speech thresholds are typically tested using CID W-1 spondaically stressed words, SRT should be in agreement with the PTA of 500 Hz, 1000 Hz, 2000 Hz, by +/- 8 dB. If the SRT is much better than the PTA, it is suspected that the participant is unwilling or unable to perform pure tone tests appropriately.

13.5.B(3) Word Recognition

Word recognition *must* be tested with 25 or 50 item phonetically balanced words lists. The level at which the items are presented *must* be in dB HL *not* in dB SPL or dB sensation level. *Ten item lists are not acceptable.* This test is used to determine hearing aid candidacy for unilateral hearing aid fittings in adults. The ear with the best word recognition is the ear to be fitted. If the provider wishes to fit the ear with the worst word recognition, a written explanation *must* be in Section G of the RHAE form.

A hearing instrument specialist or audiologist *must* advise a MO HealthNet participant to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing instrument specialist or audiologist...
determines through inquiry, actual observation or review of any other available information that the MO HealthNet participant has any of the following conditions:

1. Visible congenital or traumatic deformity of the ear.
2. History of active drainage from the ear within the previous 90 days.
3. History of sudden or rapidly progressive hearing loss within the previous 90 days.
4. Acute or chronic dizziness.
5. Unilateral hearing loss of sudden or recent onset within the previous 90 days.
6. Audiometric air-bone gap equal to or greater than 15 dB at 500 Hz, 1000 Hz and 2000 Hz.
7. Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
8. Pain or discomfort in the ear.

**13.5.C BILLING FOR EVALUATION FOR THE PURPOSE OF OBTAINING A HEARING AID ONLY**

The Hearing Aid Program is intended to only provide hearing aids and related services; it does not cover routine screening or testing for hearing loss. In most cases, the RHAE form submitted with the CMS-1500 claim form should document the complete process of providing a hearing aid. If the testing process is terminated, interrupted, or if after testing a hearing aid is not recommended or a hearing aid is recommended but not dispensed the provider may bill for the testing. The provider must document in Section G of the RHAE form why they are billing only for the testing.

If the hearing test was performed on a participant age 0-20, the claim for the testing does not require the RHAE form be sent with it.

**13.6 HEARING AID AND RELATED SERVICES**

A hearing aid is purchased for eligible participants by the MO HealthNet Program when they are provided in accordance with MO HealthNet policy as defined in this manual and are medically necessary as evidenced by information on a completed RHAE form and prior authorized. Hearing measurements and hearing aid performance are specified in accordance with ANSI standards.

Only new hearing aids are purchased by MO HealthNet. Each hearing aid will be warranted by the provider for a minimum of one (1) year from the dispensing date against premature breakdown under normal use and defects in manufacture. The warranty shall cover cost of parts, labor and postage. New hearing aids will not be purchased within six (6) months of the repair of an old hearing aid.
13.6.A EAR MOLD AND IMPRESSION

The impression for the ear mold must be billed using procedure code V5275RT or V5275LT and the ear mold must be billed using procedure code V5264RT or V5264LT. An ear mold and/or impression are covered when required for the type of device being provided. If replacement of an ear mold is required due to changes in the ear canal size or shape, providers must use procedure code V5264RT or V5264LT to bill for the replacement. If these procedure codes are the only ones billed on the claim form, the RHAE form does not need to be attached.

13.6.B HEARING AID FITTING

Hearing aid fittings are covered and must include adjustment of the ear mold, tubing and vent, adjustment/programming or electroacoustic parameters, and instruction to the participant in the use and care of the hearing aid. A user's manual that explains the use and care of the hearing aid must be given to the participant at the time of the hearing aid fitting. The reimbursement for the hearing aid fitting is included in the maximum allowable reimbursement amount for the hearing aid.

13.6.C HEARING AID DISPENSING FEE

A dispensing fee is allowed to cover the provider's cost for procuring and processing the hearing aid, handling charges, postage, etc. This may also cover selection and assessment of hearing aids to achieve maximum benefit to the participant, as long as a hearing aid is actually dispensed. The hearing aid must be delivered to the participant by the provider who requested the approval to fit the hearing aid. The hearing aid cannot be mailed to the participant.

13.6.C(1) Billing for the Dispensing Fee When the Hearing Aid is not Dispensed

All reasonable attempts to correct problems and satisfy the participant must be made. If the participant, understanding that he/she may receive only one (1) hearing aid every four (4) years, still refuses to accept or wear the hearing aid, the provider should recover the hearing aid. MO HealthNet does not pay for the hearing aid in this situation, but does reimburse for the dispensing fee when the hearing aid was previously prior authorized. When billing for the dispensing fee in this situation, an explanation should be noted on the RHAE form why the provider is billing for the dispensing fee without billing for the hearing aid. The provider must use the dispensing fee procedure code that was prior authorized when billing for this type of situation.
13.6.D POST-FITTING EVALUATION

Before a provider can be paid for a hearing aid and related services, a post-fitting evaluation must be conducted and Section F of the RHAE form completed.

The post-fitting evaluation must be performed no sooner than 14 and no later than 30 days after the hearing aid was dispensed. If providers do not perform the evaluation within the specified time period, they must show good cause why they were unable to meet this requirement or the entire claim for hearing aid services will be denied. Explanation should be made on the RHAE form and it must satisfy the state audiology consultant that a reasonable attempt was made to provide the service within the time limit. If the participant loses eligibility after the hearing aid is dispensed but before the post-fitting evaluation can be conducted, the provider should still conduct the evaluation within the specified time limits.

A post-fitting evaluation requires face-to-face contact between the provider and the participant. The purpose of the post-fitting evaluation is to determine that the patient is receiving reasonable and optimal benefit from the hearing aid, that the hearing aid is functioning properly and that the patient is actually wearing the hearing aid. Services to be provided at the time of the evaluation include some or all of the following:

- Checking if the patient's ear is sore and modifying the ear mold or custom shell;
- Adjusting frequency or gain of the hearing aid;
- Reprogramming the hearing aid;
- Checking the ear mold and tubing;
- Venting adjustment on ear mold or custom shell;
- Reinstructing the patient in the use or care of the hearing aid;
- Electroacoustic evaluation of the hearing aid and/or real ear measurements; and
- Other adjustments or services.

If at the time of the post-fitting evaluation, it is determined that the hearing aid is unsuitable, other hearing aids should be tried for trial periods but in the end billing can be made for only one (1) mold, one (1) fitting, one (1) dispensing fee, one (1) hearing aid and one (1) post-fitting evaluation.

13.6.D(1) Billing for Post-Fitting Evaluation When the Hearing Aid is Not Dispensed

All reasonable attempts to correct problems and satisfy the participant must be made. If the participant, understanding that he/she may receive only one (1) hearing aid every four (4) years, still refuses to accept or wear the hearing aid, the provider should recover the hearing aid. MO HealthNet does not pay for the hearing aid in this
situation, but does reimburse for the post-fitting evaluation if it was performed, when the hearing aid was previously prior authorized. When billing for the post-fitting evaluation when the hearing aid was *not* dispensed, an explanation should be noted on the RHAE form.

13.6.D(2) Billing for Post-Fitting Evaluation When Patient No Longer Eligible For MO HealthNet

If the patient becomes ineligible for MO HealthNet prior to performing the post-fitting evaluation, MO HealthNet pays for the post-fitting evaluation if it was performed according to the guidelines stated in Section 13.6.D of the Hearing Aid Provider Manual. When billing for this service, the date of service entered on the claim form must be no later than the last date of MO HealthNet eligibility. On the RHAE form, the actual date of service must be shown for the post-fitting evaluation along with the explanation as to why the dates on the claim and the RHAE form are different.

13.6.E POST-FITTING ADJUSTMENTS

Post-fitting adjustments are covered for dates of service after *the post-fitting evaluation*. The evaluation should cover any adjustment necessary on that day. A post-fitting adjustment requires face-to-face contact between provider and participant and must be at the request of the participant. Examples of services covered under the code for post-fitting adjustment are:

- Checking if the patient's ear is sore and modifying the ear mold or custom shell;
- Adjusting frequency or gain of the hearing aid;
- Reprogramming the hearing aid;
- Checking the ear mold and tubing;
- Venting adjustment on ear mold or custom shell;
- Reinstructing the patient in the use and care of the hearing aid;
- Minor hearing aid repairs if aid hearing is *not* under warranty such as changing microphone screens, replacing tubing, replacing domes;
- Hearing re-tests;
- Electroacoustic evaluation of the hearing aid and/or real ear measurements;
- Removal of cerumen from the ear mold and tubing; and
- Other adjustments and services.

Post-fitting adjustments do *not* include replacing batteries or deodorizing the hearing aid.
A claim for a post-fitting adjustment only does not require a RHAE form. A maximum of three (3) post-fitting adjustments or three (3) hearing aid repairs or any combinations totaling three (3) are covered in a 12-month period. Complete explanation of actions taken during post-fitting adjustments, for each date the participant is seen must be kept in the clinic record.

13.7 REPAIR OF HEARING AID OR HEARING ASSISTIVE WIRELESS TECHNOLOGY

Repairs within the scope of the warranty for the hearing aid or hearing assistive wireless technology such as FM/Bluetooth personal listening systems and repairs for premature breakdown under normal use are not covered for one (1) year following the dispensing date. Repairs resulting from participant abuse or neglect are not covered. All repairs for hearing aids or hearing assistive wireless technology must include a six (6)-month warranty. Repairs to a hearing aid or hearing assistive wireless technology that is five (5) years of age or older are noncovered. New hearing aids will not be purchased within six (6) months of the repair of an old hearing aid. During a hearing aid's warranty period, repairs that cannot be covered by the warranty are considered on a prior authorization basis. The PA Request must give the procedure code, date of purchase, describe the nature of the repairs and explain why the repairs are beyond the scope of the warranty.

MO HealthNet covers necessary repairs to the participant’s hearing aid that is no longer under warranty. The methods of reimbursement for repairs are as follows.

13.7.A OUT-OF-SHOP REPAIRS

Necessary repairs made out of shop, when the aid must be sent out to the manufacturer or repair lab are reimbursed at twenty dollars ($20.00) plus the invoiced cost of the repair. The $20.00 covers the provider's cost for postage for returning the aid to the provider or any insurance fee charged. A copy of the repair invoice must be attached to the claim. The RHAE form is not required.

13.8 SPECIAL TESTS

The following special tests are covered when requested by the examining physician to rule out retrocochlear involvement or middle ear disease before recommending a hearing aid.

Procedure codes used to rule out retrocochlear involvement or middle ear disease:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92550</td>
<td>Tympanometry and reflex threshold</td>
</tr>
<tr>
<td>92567</td>
<td>Tympanometry (impedance testing)</td>
</tr>
<tr>
<td>92570</td>
<td>Acoustic Immittance; includes tympanometry, acoustic reflex threshold and reflex decay</td>
</tr>
</tbody>
</table>
13.9 SERVICES PROVIDED IN A NURSING HOME OR INSTITUTION

Requests for hearing evaluation for the purpose of obtaining a hearing aid and hearing aids must originate with the participant and must proceed with the participant’s full knowledge and consent. It is not the intent of the MO HealthNet Program for large groups of participants residing in nursing homes to be screened to determine the need for hearing aids.

Except for post-fitting evaluations, post-fitting adjustments and repairs to hearing aids no longer under warranty, all hearing evaluations, hearing aids and dispensing fees performed or provided in a nursing home or institution require prior authorization.

The following procedure code must be used for requesting hearing evaluation which is to be provided in a nursing home or institution:

9255722 Comprehensive audiometry threshold evaluation and speech recognition, Nursing Home

Hearing evaluations performed in a residential care center or an adult boarding home do not require prior authorization.

13.9.A HEARING EVALUATION, NURSING HOME

• If hearing evaluation is to be performed in a nursing home or institution, the provider must first request prior authorization to perform the evaluation.

• A RHAE form with Sections A and D completed must accompany the PA Request form.

• The provider receives a MO HealthNet Authorization Determination advising whether the request has been approved or denied.

• In the event that a PA Request is denied for the hearing aid, the provider may submit a claim for the prior authorized 9255722.

13.9.B HEARING AIDS AND RELATED SERVICES, NURSING HOME

• If the hearing evaluation results indicate a hearing aid would be beneficial to the participant, the provider must submit a second PA Request form for the hearing aid and related services.

• The second PA Request form must be accompanied by the original RHAE form with Sections B and C completed in addition to Sections A and D.

• The provider receives a MO HealthNet Authorization Determination advising whether the request has been approved or denied.

13.9.C CLAIM SUBMISSION—NURSING HOME

• Nursing facility level of care must be indicated on the MO HealthNet eligibility file.
• Upon receipt of an approved PA Request form for the hearing aid, the provider may proceed with the fitting and dispensing of the hearing aid.

• After the post-fitting and evaluation has been performed, the claim may be submitted to the fiscal agent.

• The post-fitting evaluation—V5011RT22 or V5011LT22 must be billed on the same claim with the appropriate hearing aid, dispensing fee, ear mold and ear mold impression procedure codes.

• In the event that a PA Request form for a hearing aid is returned to the provider marked denied, the provider may submit a claim for the prior approved hearing evaluation.

13.10 HEALTHY CHILDREN AND YOUTH (HCY) EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, hearing instrument specialist, audiologist or other health care professional visit or exam (interperiodic screen) may be covered for persons under 21 years of age on a prior authorization basis by the MO HealthNet Division. Additional benefits through the HCY Program include:

• Hearing assistive wireless technology such as FM/Bluetooth personal listening systems (hearing assistive wireless technology such as FM/Bluetooth personal listening systems are not covered for participants 21 years of age or older), prior authorization is required.

• Two (2) new hearing aids (binaural hearing aid fitting) and related services (testing, fitting, dispensing, and post-fitting evaluation) every four (4) years (for binaural hearing aid users only), and one (1) hearing assistive wireless technology, such as FM/Bluetooth personal listening systems every four (4) years.

• For participants under 21 years of age, the following audiometric threshold criteria (measured by earphone, sound field, or auditory brainstem response testing or auditory steady-state response testing) must be met:
  • Pure-tone threshold average for the frequencies 500, 1000, and 2000 Hz of 20 dB HL or greater;
  • Pure-tone threshold of 25 dB HL at two (2) consecutive high frequencies for 2000, 3000, 4000 Hz; and
  • Pure-tone threshold of 25 dB HL at three (3) consecutive high frequencies for 3000, 4000, and 6000 Hz.

It is important to note that every MO HealthNet eligible child should have a complete HCY (EPSDT) screen. If the child has not had a full screen, the provider should refer the child for a full
screen to be done at a later date. Refer to Section 9 of the Hearing Aid Provider Manual for information about screening providers.

The following guidelines must be used to request prior authorization:

- PA Requests for coverage of non-covered items/services, non-covered testing, etc., must be sent to Wipro Infocrossing, P.O. Box 5700, Jefferson City, MO 65102.

- The PA Request form should be clearly marked as an HCY request. The procedure code to use is V5299 if there is not a specific code. Please refer to Section 19.2 of the Hearing Aid Provider Manual for a list of HCY codes and their billing requirements.

- The following documentation must be included on, or submitted with, the PA Request form for procedure code V5299:
  - The nature of the item or service to be provided, the duration of time the item is needed and the projected outcome; and
  - An invoice showing the provider's cost if the request is for a special type of hearing aid or some type of instrument.

Upon receipt of the request, a decision is made regarding medical necessity and approval of each service. A MO HealthNet Authorization Determination is sent to the provider after a decision to approve or deny has been made. Prior authorization must be obtained before the services are provided in order for MO HealthNet payment to be made.

Prior authorization approves the medical necessity of the item or service requested. Prior authorization does not establish MO HealthNet eligibility. The participant must be MO HealthNet eligible on the date of service.

13.10.A HEARING AID BATTERIES

Hearing aid batteries are covered for participants under age 21 only. A manufacturer's invoice of the provider's cost for the batteries must be attached to each claim submitted for batteries. The invoice must indicate the number of batteries in a package. Field #24g of the CMS-1500 claim form must indicate the specific number of batteries being dispensed, not the number of packages. The participant must be eligible on the date the batteries are dispensed.

13.10.B HEARING ASSISTIVE WIRELESS TECHNOLOGY

Hearing assistive wireless technology such as FM/Bluetooth personal listening systems are covered for participants under age 21 for coupling to hearing aids, bone anchored hearing aids (BAHA) and cochlear implant speech processors. Covered items include any necessary hearing aid boots/shoes, cords, microphones, rechargeable batteries and battery chargers.

Hearing assistive wireless technology such as FM/Bluetooth personal listening systems may be covered for participants under age 21 with normal hearing sensitivity, who have an
auditory processing disorder or auditory dyssynchrony confirmed by appropriate testing. Neurologic conditions that may cause compromise to the auditory neural system include, but are not limited to, auditory neuropathy, traumatic brain injury, kernicterus and certain developmental disorders. MO HealthNet does not automatically cover wireless personal listening systems for children with autism, language impairment, dyslexia, ADHD, developmental delay or listening difficulties.

Tests for auditory processing disorder must include at least one (1) measure for each of the following auditory skill areas, and test materials must be commercially pre-recorded and calibrated:

1. Temporal processing, such as Gaps in Noise or Frequency Pattern test.
2. Dichotic listening, such as Staggered Spondaic Word Test, Dichotic Digits, competing words.
3. Speech understanding in noise, such as Auditory Figure Ground subtest, or Katz’s W22’s in Noise, Masking Level Difference testing.
4. Understanding of distorted speech, such as words that are filtered, compressed, and/or in reverberation.

Auditory processing testing must be performed by a licensed audiologist with expertise in the area of auditory processing evaluation. A comprehensive written report regarding auditory processing test results and interpretation must be attached to the PA Request for review by the state audiology consultant. Hearing assistive wireless technology, such as FM/Bluetooth personal listening systems, for the purposes of treating auditory processing disorders are not covered for children under seven (7) years of age, since there are very limited valid test materials for younger children. It is suggested instead that children under seven (7) years of age, suspected of auditory processing disorder, undergo a comprehensive receptive/expressive language evaluation. Hearing assistive wireless technology such as FM/Bluetooth personal listening systems must be prior authorized. See Section 19.1 of the Hearing Aid Provider Manual for the appropriate procedure code to use.

### 13.11 EXCEPTIONS TO THE BASIC LIMITATIONS

Exceptions to the basic limitations as set forth earlier in this section may be prior authorized by the state audiology consultant. Detailed justification must be provided for overriding the limitations.

The items and services that are to be provided and the charge for each must be listed in the III. SERVICE INFORMATION field on the PA Request form. The explanation for the exception to the basic limitation must be written in Field #24 on the PA Request form. If authorization is granted, the provider must bill the procedure codes that have been prior authorized, along with the procedure codes for the hearing evaluation, ear molds and ear mold impressions. The date of service entered on
the claim form for the hearing aid, dispensing fee, ear mold and ear impression must be the date the hearing aid is dispensed.

Prior authorization must be requested for the following exceptions to the basic limitations.

**13.11.A  SECOND HEARING AID IN FOUR (4) YEARS: REPLACEMENT**

For replacement of a hearing aid within four (4) years of its purchase, the provider must request prior authorization. The request must contain, in Field #24 of the PA Request form, the date the original hearing aid was purchased and detailed information of the circumstances under which it was lost, destroyed or ceased to function effectively. The information needs to make clear why the original hearing aid cannot be repaired. If authorization is granted, a medical ear examination and audiometric testing must be performed, if none has been done within the previous six (6) months. Replacement resulting from participant abuse or neglect is not covered. When requesting prior authorization, use the appropriate hearing aid procedure code and dispensing fee procedure code found in Section 19 of the Hearing Aid Provider Manual.

**13.11.B  SECOND HEARING AID IN FOUR (4) YEARS: BINAURAL FITTING**

Any hearing aid for the purpose of binaural amplification must be prescribed by an Otolaryngologist, Otologist or Otorhinolaryngologist; however, backup or spare hearing aids are noncovered. It is not the intent of the MO HealthNet Program to routinely pay for two (2) hearing aids for eligible participants 21 years of age and older. MO HealthNet pays for a second hearing aid only when special justification is documented for binaural aids, such as: educational purposes, learning of language for children and legally blind. Any hearing aid for the purpose of binaural amplification for participants 21 years of age and older is a covered service only in cases of blindness. Physicians must enter their specialty, the prescription and a detailed description of the medical necessity for fitting binaural aids in Part B, Field #11 of the RHAE form.

- If two (2) hearing aids are to be fitted simultaneously, the provider must request authorization for both hearing aid procedure codes and both dispensing fee procedure codes on the same PA Request form. The RHAE form must accompany the PA Request form. If authorization is granted, both hearing aid procedure codes and dispensing fee procedure codes must be billed on the same claim form with one (1) unit of each along with the hearing evaluation and post-fitting evaluation. Additional reimbursement for the testing and post-fitting evaluation is not allowed. The completed RHAE form is required for claim submission. The date of service for both codes must be the day the hearing aids were dispensed.
• If the second hearing aid is not to be fitted at the same time as the first, the provider should wait at least until the first hearing aid has been evaluated and found satisfactory before requesting authorization for the second hearing aid.

A copy of the RHAE form for the first hearing aid must accompany the PA Request form for the second hearing aid.

If more than six (6) months has elapsed between the original medical examination and the fitting of the second hearing aid, another medical examination is required and must be recorded on a second RHAE form. In addition, hearing evaluation for the purpose of obtaining a hearing aid must be performed if more than six (6) months elapses from the original date of testing. The hearing evaluation for the purpose of obtaining a hearing aid results must be entered on a second RHAE form and submitted with the PA Request form. Testing (when applicable), the hearing aid, ear mold, ear impression, dispensing fee and a post-fitting evaluation are covered for the second hearing aid if the second hearing aid is not fitted simultaneously with the first hearing aid.

Use the binaural hearing aid procedure codes found in Section 19 of the Hearing Aid Provider Manual on the PA Request.

13.12 EXCEPTION FOR COVERAGE DUE TO PARTICIPANT LOSS OF ELIGIBILITY

The participant must be eligible on the date a service is provided or the aid is dispensed. This is a requirement even if the service has been prior authorized. It is the responsibility of the provider to verify the participant’s eligibility on the date that the hearing aid is dispensed to ascertain that the participant is eligible on that date.

However, MO HealthNet payment may be made for the hearing aid when the participant becomes ineligible for the service or dies after the aid is ordered and before the aid can be fitted or the post-fitting evaluation can be conducted.

The following prerequisites apply to all such payments:

• There must have been a commitment by the provider to provide the service and to accept the MO HealthNet payment based upon verified MO HealthNet eligibility at the initiation of the service;

• There must have been reason to believe that the participant’s MO HealthNet eligibility would continue;

• The participant must have been eligible when the service was first initiated and following receipt of an approved PA Request, if required. The participant must also have been eligible when the ear mold impression was made and the hearing aid was ordered;
Hearing Aid

• The medical examination and hearing evaluation must have been conducted and results must have met the policy requirements set forth in this section;

• The hearing aid or ear mold must have been ordered and fabricated to the specific medical needs of the participant; and

• The hearing aid must have been fitted and dispensed and a post-fitting evaluation conducted within the time period specified by policy if the participant is living.

Payments under this exception are made as follows:

• If the hearing aid is dispensed to the participant following loss of eligibility and all the prerequisites listed above have been met, payment may be made for those services rendered during the participant’s eligibility and also for the hearing aid, the fitting, the dispensing fee and the post-fitting evaluation. Likewise, if the participant loses eligibility after the hearing aid is dispensed but before the post-fitting evaluation is conducted, payment may be made for the post fitting evaluation. Payments under this exception are subject to applicable copay requirements.

• If the hearing aid cannot be dispensed due to the death of the participant, payment is made not only for those services actually rendered during the participant’s eligibility but also for any restocking fee (less applicable copay) charged by the manufacturer to return the hearing aid. If the aid is not returnable, MO HealthNet pays the provider's cost. Such payments as provided under the conditions of this paragraph will not exceed the MO HealthNet maximum allowable fee for a hearing aid less applicable copay amounts.

This policy does not apply to a situation in which:

• The hearing aid cannot be dispensed because the participant refuses to accept it or it is determined that a hearing aid will not benefit the participant.

Procedures for submitting a claim under this exception are as follows:

• All dates of service entered on the CMS-1500 claim form must be no later than the last date on which service was provided to the eligible participant. Entering a date of service for which the participant is ineligible causes that line of the claim to be denied.

• The amount billed for the hearing aid must not exceed the fee charged by the manufacturer to restock or remake it. Alternately, the amount billed must not exceed the invoice cost of the aid less its salvage value.

• The provider must enter the phrase "loss of eligibility exception," in Field #10d of the CMS-1500 claim form.

The provider must complete:

• The RHAE as usual, entering the actual dates of service in the required fields. In the Comments section of the RHAE, however, the provider must explain the circumstances,
including the date of the participant’s death if the hearing aid was not dispensed due to that reason. The provider must also justify the amount billed for the hearing aid, showing both invoice cost and salvage value, or declaring the amount of the restocking fee. This statement must be signed and dated. Further documentation may be required if needed for review by the state audiology consultant.

13.13 NON-COVERED ITEMS/SERVICES

- Hearing aid batteries for participants 21 years old and over;
- Hearing aids for participants with medical contraindications;
- Eyeglass hearing aid models;
- Hearing aids provided on a rental or loan basis;
- Postage for mailing a hearing aid to a participant;
- Hearing aids determined to be ineffective or unsatisfactory by the provider or participant during or before the post-fitting evaluation;
- Back-up or spare hearing aids;
- Routine testing and screening of individuals or groups; and
- Custom in-the-ear hearing aids for participants age 12 or younger.

13.14 PARTICIPANT COPAY

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. The copay amount is paid by the participant at the time services are rendered. Services of the Hearing Aid Program described in this manual are subject to a copay amount. The provider must accept in full the amounts paid by the state agency plus any copay amount required of the participant.

13.14.A PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS

Providers of service must charge and collect the copay 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 an individual 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 amounts collected and of the copay amount due but uncollected because the participant did not make payment when the service was rendered.

The copay amount is not to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay amount is deducted from the MO HealthNet maximum allowable amount, as applicable, before reimbursement is made.

13.14.B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS

Unless otherwise exempted (refer to Section 13.14.B(2)), it is the responsibility of the participant to pay the required copay amount due. 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.


Unless an exemption applies, the following copay amounts are applied to all Hearing Aid Program services:

<table>
<thead>
<tr>
<th>MO HEALTHNET MAXIMUM ALLOWABLE</th>
<th>COPAY AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.99 or less</td>
<td>$0.50</td>
</tr>
<tr>
<td>$11.00 to $25.99</td>
<td>$1.00</td>
</tr>
<tr>
<td>$26.00 to $50.99</td>
<td>$2.00</td>
</tr>
<tr>
<td>$51.00 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

13.14.B(2) 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 Hearing Aid Program:

Participants ages 17 and under are exempt from copay amounts. Participants age 18 and over must pay the copay amount unless the individual is a foster care child or meets another exemption:

- Foster care children up to 21 years of age (ME codes 07 and 08);
- Hospice participants;
- Institutionalized participants who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility or an adult boarding home;
• MO HealthNet Managed Care health plan enrollees are exempt from copay amounts for services provided by the health plan, except MO HealthNet Managed Care enrollees must pay the shared pharmacy dispensing fee. MO HealthNet Managed Care enrollees whose services are outside of the plan benefit must pay the copay amount when applicable.

The exemption to the copay amount is identified by MO HealthNet when processing the claim. Services related to an EPSDT are exempt from a copay amount. (EPS diagnosis or EPSDT condition code must appear on the claim form).

NOTE: The EPSDT exemption only applies to those participants under age 18. Participants age 18 and over must pay the copay amount for EPSDT-related services unless another exemption applies.

13.15 MO HEALTHNET MANAGED CARE HEARING AID PROGRAM BENEFITS

Health plans are required to provide all hearing testing, auditory evoked potentials testing, cochlear implant testing, BAHA testing and hearing aid services for all MO HealthNet Managed Care enrolled individuals under 21 years of age. This includes binaural hearing aids for participants under age 21. This includes all medically necessary hearing aid services including HCY screens, treatment, personal wireless listening systems such as FM and Bluetooth, aural habilitation, post cochlear implant training, special hearing aid accessories needed for coupling to listening systems, accessories needed for cleaning and care, battery chargers and hearing aid batteries, etc. For participants age 21 and over who are eligible for hearing aids and related services, these services are covered by the health plans.

Hearing aids that have been prior approved by MO HealthNet for enrollees prior to enrollment in a health plan are reimbursed fee-for-service by the state agency.

Hearing aids that have been prior approved by the MO HealthNet Managed Care health plans prior to the participant becoming fee-for-service are reimbursed by the MO HealthNet Managed Care health plan.
SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS

14.1 THE REPORT OF HEARING AID EVALUATION (RHAE)

A completed RHAE form must be attached to all claims for hearing aid services except post-fitting hearing aid adjustments, hearing aid repairs, replacement of ear molds for children (due to growth) and HCY services or items not related to a hearing aid. This form must also accompany all requests for prior authorization, except for repairs beyond the scope of the warranty.

The RHAE form should be completed to the extent possible in each case. The hearing aid consultant reviews each report before authorizing services or payment. Incomplete or inconsistent information causes the claim for payment or the request for prior authorization to be denied. In the following instructions, the fields marked with an asterisk (*) are required to be completed in all cases.

FIELD NUMBER & NAME

INSTRUCTIONS FOR COMPLETION

Section A. Patient Identification

*1. Participant’s Name
Enter participant’s full name exactly as it appears on the ID card.

*2. Date of Birth
Enter the participant’s date of birth—month, day and year.

*3. Family Support Division Identification Number
Enter the participant’s MO HealthNet identification number exactly as it appears on the ID card.

Section B. Physician’s Examination and Certification

This section must be completed and signed by the physician who performed the medical ear examination. Items 6 to 12 in this section may not be completed by the hearing aid provider unless the provider is also the physician who performed the examination.

*1. Physician’s Name
Enter the name of the physician who performed the medical ear examination.

*2. M.D., D.O., Otolaryngologist
Check the appropriate degree and/or specialty. (Must be an otolaryngologist otologist or otorhinolaryngologist if bilateral hearing aids are prescribed.)

3. Physician’s NPI
Enter the NPI number of the physician.

*4. Physician’s Address
Enter the physician’s complete address.

*5. Physician’s Telephone
Enter the physician’s telephone number.

*6. Date of Examination
Enter the date of the medical ear examination. This date preferably follows the hearing evaluation. This date must
*7. Diagnosis
Enter the patient’s diagnosis.

*8. Physical & Mental Condition
Answer the question “yes” or “no,” as it pertains to the patient’s physical or mental condition, noting comments in the Comments field as appropriate.

*9. Otologic Symptoms or Problems
Since the condition of the ears and auditory system bears directly on the decision to aid an ear, the otologic diagnoses and treatments (if any) must be specified. This is of greatest importance if there is evidence of active ear disease.

*10. Recommendation for a Hearing Aid
Answer the question “yes” or “no.” If a hearing aid is recommended, specify which ear is recommended.

*11. Comments
If there are special circumstances that affect the use of a hearing aid, the physician can help greatly by describing them (e.g., preschool child with developmental delay; recent stroke victim with speech, language and hearing problems; participant has slight to mild loss but is also legally blind, etc.). Comments help to justify prior authorizations; they provide a basis for making an exception to established rules.

*12. Signature and Date
The physician must sign the certification in this field after making a final recommendation. A signature stamp or facsimile is not acceptable. The date in Field #12 must be the date the physician signs the RHAE form. This date may be different from the date in Field #6.

Section C. Hearing Evaluation and Certification
This section must be completed by the person who actually performs the tests.

*1. Provider’s Name
Enter the name of the person who performed the hearing evaluation for the purpose of obtaining a hearing aid.

*2. Type of Provider
Check the appropriate provider type.
*3. Provider’s Telephone Number
Enter the telephone number of the provider.

*4. Provider’s NPI
Enter the provider NPI of the person who performed the hearing evaluation, if appropriate. Providers must enter their number if MO HealthNet is to be billed for the tests.

*5. Pure-Tone Thresholds
Enter the indicated test results. Note masked thresholds with an asterisk or superscript $m$.

*6. Speech Reception Thresholds
Enter the indicated test results, name of test and how obtained. Note masked thresholds with an asterisk or superscript $m$.

*7. Speech Discrimination
Enter the indicated speech discrimination (word recognition) results, name of test and how obtained. Note masked thresholds with an asterisk or superscript $m$.

*8. Date of Tests
Enter the date the hearing evaluation testing was performed.

9. Recommendation
Enter any recommendations. For example: Ear(s) to be aided; special considerations related to selection and fitting of the aid.

*10. Certification
The person who performed the hearing evaluation must sign and date either Field #10a or #10b. If the MO HealthNet Hearing Aid Program is to be billed for the tests recorded in Section C, Field #10a must be signed, certifying that the tests were performed for the purpose of prescribing a hearing aid.

Section D. Institutionalized/Nursing Home Participants Only
This section must be completed when requesting prior authorization for any Hearing Aid Program service provided to participants in nursing homes.

1. Signature of Participant
Institutionalized nursing home participants must sign and date this field, indicating that they requested the hearing aid services and that authorization is given to render services to them. If participants are unable to sign the form, the Prior Authorization Request form
must contain detailed information as to why they are unable to sign.

2. Signature of Institution Administrator

The institution’s administrator must sign and date this field certifying that the patient initiated the request for the hearing aid and that the provider has secured the patient’s approval to render the service.

Section E. Hearing Aid Fitting and Certification

This section must be completed by the person who fits the hearing aid.

*1. Provider’s Name
Enter the name of the person who fitted the hearing aid.

*2. Provider’s NPI
Enter the provider NPI of the person who fitted the hearing aid.

*3. Date of Fitting
Enter the date the hearing aid was fitted.

*4. Ear Fitted
Check the appropriate box or boxes.

*5. Approximate Gain
Enter the gain in dB.

*6. Aid Fitted
Enter the style, make, model and serial number of the aid that was fitted.

*7. Certification
Signature of the person who fit the hearing aid and the date.

Section F. Post-Fitting Hearing Aid Evaluation

*1. Provider’s Name
Enter the name of the person who performed the post-fitting evaluation.

*2. Provider’s NPI
Enter the provider NPI of the person who performed the post-fitting evaluation.

*3. Date of Evaluation
Enter the date the post-fitting evaluation was performed (14 to 30 days after the date it was fitted or provide explanation in Section G).

*4. Select and Complete a, b, or c
a. Check this field if performance was satisfactory using free-running speech.

b. Check this field and complete indicated items if sound field measurements were used to evaluate performance.

c. Check this field if continued use of the dispensed hearing aid is no longer
Section G. Comments

Use this section to note any problems or unusual conditions associated with the testing, fitting and acceptance of the hearing aid. If there were difficulties in testing, fitting or training the participant in the use of the aid, they must be described.

* Completion of these fields are mandatory.

14.2 INSTRUCTIONS FOR REQUESTING PRIOR AUTHORIZATION

All hearing aids and related services require prior authorization except for hearing evaluation for the purpose of obtaining a hearing aid, post-fitting evaluation, post-fitting adjustment and repairs to hearing aids no longer under warranty. Reference Section 8 of the Hearing Aid Provider Manual for complete instructions.

Following are the procedures that must be followed in order to secure prior authorization for a hearing aid:

14.2.A REQUESTING PRIOR AUTHORIZATION

1. The hearing aid provider must have performed the hearing evaluation prior to submitting a Prior Authorization Request form. The participant must also receive a medical ear examination for pathology or disease by a physician. The medical ear examination must be performed no more than six (6) months before the hearing aid is dispensed. (It is preferable that this exam be performed after the hearing evaluation so that the physician can review the results.)

2. The RHAE form with Sections A, B and C completed must accompany the Prior Authorization Request form.

3. Providers must request prior authorization for hearing aid procedure codes and dispensing fee procedure codes using type of service "V." The amount being charged for procedure code V5200 (hearing service, miscellaneous) and any manually priced hearing aids and dispensing fees shown in Field #23 on the Prior Authorization Request form must be the provider's usual and customary charge to the general public. All hearing aid procedure codes which are not manually priced do not require an amount in Field #23 on the Prior Authorization Request form.

14.2.B MO HEALTHNET AUTHORIZATION DETERMINATION

1. Refer to Section 8.7 of the Hearing Aid Provider Manual for an explanation regarding approved and denied prior authorizations.

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2. Upon receipt of a MO HealthNet Authorization Determination that has a denied status, the provider may submit a claim for the hearing evaluation, 92577. A copy of the RHAE form must accompany the claim form.

3. Upon receipt of a MO HealthNet Authorization Determination that has an incomplete status, the provider should submit a new Prior Authorization Request form with a copy of the completed RHAE form, which explains in detail the information needed to document the hearing evaluation findings. Section G of the RHAE may be used for further comments. If necessary, attach additional supporting documentation, such as a letter from the physician, to document the findings.

**14.2.C REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST**

1. Refer to Section 8.8 and Section 8.8.A of Hearing Aid Provider Manual for an explanation on how to request prior authorization changes.

**14.2.D HCY PROGRAM**

1. A medically necessary item that is normally noncovered, but that is identified as a result of a physician's or health care professional's (such as a hearing instrument specialist or audiologist) visit or exam may be covered for persons under 21 years of age on a prior authorization basis. The Prior Authorization Request should be clearly marked as an "HCY Request." The procedure code to be used for non-covered items/services is V5299, type of service V.

2. For more information on the HCY Program, including screening guidelines, reference Section 9 of the Hearing Aid Provider Manual.

END OF SECTION

TOP OF SECTION
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. 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. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.mo.gov/mhd/providers for further information. Providers are unable to access 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 (ADA 2002, Version 2004), 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.

15.3 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for hearing aid services unless a provider chooses to bill those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.
15.4 PROVIDER RELATIONS COMMUNICATION UNIT

It is the responsibility of the Provider Relations Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of the Hearing Aid Provider Manual has a detailed explanation of this unit.

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 an error that can be corrected. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider must resubmit on a CMS-1500 claim form. An example of a correctable error is the use of an invalid procedure code or an incorrect type of service code.

If a line item on a claim paid, but the payment was incorrect, do not resubmit that line item. For instance, if the amount billed was inaccurate, that claim cannot be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider must submit an Individual Adjustment Request. Section 6 of the Hearing Aid Provider Manual explains the adjustment request process.

15.6 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be 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 (2) asterisks (**) beside the field number indicate a field is required in specific situations.

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of Health Insurance Coverage</td>
<td>Indicate in the appropriate box the type of health insurance coverage applicable to this claim by checking the appropriate box, i.e., if a Medicare claim is being filed, check the Medicare box; if a MO HealthNet claim is being filed, check the MO HealthNet box; and if the patient has both Medicare and MO HealthNet, check both boxes.</td>
</tr>
<tr>
<td>*1a. Insured’s ID Number</td>
<td>Enter the patient’s eight (8)-digit MO HealthNet or MO HealthNet Managed Care Plan ID number (DCN) as shown on the patient’s ID card.</td>
</tr>
<tr>
<td>*2. Patient’s Name</td>
<td>Enter last name, first name, middle initial in that</td>
</tr>
</tbody>
</table>
3. **Patient’s Birth Date**
   - Enter month, day, and year of birth. (Not required.)
   - **Sex**
   - Mark appropriate box. (Not required.)

4. **Insured’s Name**
   - If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13.

5. **Patient’s Address**
   - Enter address and telephone number if available. (Not required.)

6. **Patient’s Relationship to Insured**
   - Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.

7. **Insured’s Address**
   - Enter the primary policyholder’s address; enter policyholder’s telephone number, if available. If no private insurance is involved, leave blank.

8. **Reserved for NUCC Use**
   - Leave Blank.

9. **Other Insured’s Name**
   - Enter other insured’s full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. (See Note)(1)

9a. **Other Insured’s Policy or Group Number**
   - Enter the secondary policyholder’s insurance group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)

9b. **Reserved for NUCC Use**
   - Leave Blank.

9c. **Reserved for NUCC use**
   - Leave blank.

9d. **Insurance Plan Name or Program Name**
   - Enter the secondary policyholder’s insurance plan or program name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)

10a-10c. **Is Condition Related to:**
   - If services on the claim are related to patient’s employment, auto accident or other accident, mark the appropriate box. **If the services are not related to an accident, leave blank.**

10d. **Claim Codes (Designated by NUCC)**
   - Leave Blank.

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**11. Insured’s Group Policy or FECA Number**
Enter the primary policyholder’s insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)

**11a. Insured’s Date of Birth**
Enter primary policyholder’s date of birth and mark the appropriate box reflecting the sex of the policyholder. If no private insurance is involved, leave blank. (See Note)(1)

**11b. Other Claim ID (Designated by NUCC)**
Enter the “Other Claim ID.” Applicable claim identifiers are designated by the NUCC.

**11c. Insurance Plan Name or Program Name**
Enter the primary policyholder’s insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)

**11d. Other Health Benefit Plan**
Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9, 9a and 9d with the secondary insurance information. If no private insurance is involved, leave blank. (See Note)(1)

12. **Patient’s or Authorized Person’s Signature**
Leave Blank.

**13. Insured’s or Authorized Person’s Signature**
This field should be completed only when the patient has another health insurance policy. Obtain the policyholder’s or authorized person’s signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the MO HealthNet provider. Otherwise payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.

14. **Date of Current Illness, Injury or Pregnancy**
Not required.

15. **Other Date**
Leave Blank.

16. **Dates Patient Unable to Work**
Leave Blank.

17. **Name of Referring Provider**
Enter the name of the referring physician or other
or Other Source

source. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

17a. Other ID Number

The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

0B  State License Number
1G  Provider UPIN Number
G2  Provider Commercial Number
LU  Location Number (this qualifier is used for Supervising Provider only.)

17b. NPI

Enter the NPI number of the referring, ordering, or supervising provider.

18. Hospitalization Dates

Not required.

19. Additional Claim Information (Designated by NUCC)

Providers may use this field for additional remarks/descriptions, such as time spent for labor for in-shop repairs.

20. Outside Lab

Leave blank.

*21. Diagnosis

Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Enter the diagnosis in the same order on all pages of claims with multiple lines. The ICD indicator is not used.

**22. Resubmission Code

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.

23. Prior Authorization Number

Leave Blank.

*24a. Date(s) of Service

Enter the date of service under “from” in month/day/year format, using the six (6)-digit format in the unshaded area of the field. All line items must
have a “from” date. A “to” date is never used when billing hearing aid services. The date of service for hearing aids and related services must be the date items were dispensed.

*24b. Place of Service
Enter the appropriate place of service code in the unshaded area of the field. For a list with descriptions see Section 15.7 of the Hearing Aid Provider Manual.

24c. EMG-Emergency
Leave blank.

*24d. Procedure Code
Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. A description of the service must be listed on the claim form when billing for repairs and HCY services. Use the space after the procedure code or use a separate line to list the description. Reference Section 19 of the Hearing Aid Provider Manual for applicable procedure codes.

*24e. Diagnosis Pointer
Enter A, B, C, D from Field #21 in the unshaded area of the field. Do not enter the actual diagnosis code.

*24f. Charges
Enter the provider’s usual and customary charge to the general public for each line item in the unshaded area of the field. This should be the total charge if multiple units are shown. Do not subtract the copay amount from the charge.

*24g. Days or Units
Enter the number of units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a “1” if the field is left blank.

**24h. EPSDT/Family Planning
If the service is an HCY/EPSDT screening service or referral, enter “E.”

24i. ID Qualifier
Enter the Provider Taxonomy qualifier ZZ in the shaded area of 24i if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet.

24j. Rendering Provider ID
If the Provider Taxonomy qualifier was reported in
24i, enter the 10-digit Provider Taxonomy Code in the shaded area.

Enter the NPI number of the provider in the unshaded area of the field.

This field is required for a clinic, teaching institution, or a group practice only.

<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>25. Federal Tax ID Number</td>
<td>Leave Blank.</td>
</tr>
<tr>
<td>26. Patient Account Number</td>
<td>For the provider’s information, a maximum of 12 alpha and/or numeric characters may be entered here. The patient account number is printed on the remittance advice.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Accept Assignment</td>
<td>Leave Blank.</td>
</tr>
<tr>
<td>28. Total Charge</td>
<td>Enter the sum of the line item charges.</td>
</tr>
<tr>
<td>29. Amount Paid</td>
<td>Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, and copay amounts are not to be entered in this field.</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Reserved for NUCC Use</td>
<td>Leave Blank.</td>
</tr>
<tr>
<td>31. Provider Signature</td>
<td>Leave Blank.</td>
</tr>
<tr>
<td>32. Service Facility Location Information</td>
<td>Not required.</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>32a. NPI Number</td>
<td>Not required.</td>
</tr>
<tr>
<td>32b. Other ID Number</td>
<td>Not required.</td>
</tr>
<tr>
<td>33. Provider Name/Number/Address</td>
<td>Enter the provider’s name and address.</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>33a. NPI Number</td>
<td>Enter the NPI number of the billing provider listed in Field #33.</td>
</tr>
<tr>
<td>33b. Other ID Number</td>
<td>Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in #33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. A Provider Taxonomy Code must be reported if the provider has a one to many provider NPI’s.</td>
</tr>
</tbody>
</table>
* These fields are mandatory on all CMS-1500 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 Hearing Aid Provider Manual for further TPL information.

### 15.6.A CLAIM SUBMISSION

1. Upon receipt of an approved Prior Authorization Request form, the provider should proceed with the fitting and dispensing of the hearing aid. The provider must verify the participant’s eligibility to ensure that the participant is eligible on each date a service is performed.

2. The post-fitting evaluation must not be performed earlier than 14 days or later than 30 days after the hearing aid is dispensed. If post-fitting evaluation is performed earlier than 14 days or later than 30 days after the hearing aid is dispensed, the Report of Hearing Aid Evaluation (RHAЕ) form must be sent in with the claim. Explain in Section G of the RHAЕ form why the post-fitting evaluation was not performed during the specified time period.

3. Providers may bill for the hearing evaluation for the purpose of obtaining a hearing aid (92557 or 9255722) for individuals 21 and over, as soon as it is performed or they may wait until all other services have been approved, performed and dispensed. The procedure must be ordered by a qualified physician and the diagnosis must be related to disease or trauma. Supporting documentation must be retained in the patient's file. Testing that is performed in relation to a medical or surgical diagnosis or treatment when a hearing aid is not being considered is not covered through the MO HealthNet Hearing Aid Program.

4. After the post-fitting evaluation is performed, a claim may be submitted to the fiscal agent for the hearing evaluation, the hearing aid(s) and related services, and the post fitting evaluation. The date of service entered on the claim form for the hearing aid must be the date the hearing aid was dispensed.

### 15.7 PLACE OF SERVICE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
</tbody>
</table>

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
<table>
<thead>
<tr>
<th>Code</th>
<th>Facility Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Home</td>
<td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under the supervision of, physicians to patients admitted for a variety of medical conditions.</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
<td>The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services and does not provide the level of care or treatment available in a hospital.</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or on a regular basis health-related care services above the level of custodial care to other than mentally retarded individuals.</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>A facility that provides room, board and other personal assistance services, generally on a long-term basis and that does not include a medical component.</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Clinic (FQHC)</td>
<td>A facility approved by the federal government to provide health care services in generally low income areas.</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Developmentally Disabled</td>
<td>A facility that primarily provides health-related care and services above the level of custodial care to developmentally disabled individuals but does not provide the level of care or treatment available in a hospital or nursing facility.</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social or psychological services and orthotics and prosthetics services.</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient</td>
<td>A facility that provides comprehensive rehabilitation services.</td>
</tr>
</tbody>
</table>

PRODUCTION : 09/06/2019
Rehabilitation Facility services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy and speech pathology services.

71 State or Local Public Health Clinic A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic A certified facility that is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

97 Non-Public School A parochial or private school supported by private funds and governed by a private body.

98 Public School A school open to any child in the community, supported by tax dollars and governed by a local school district.

99 Other Unlisted Facility Other service facilities not identified above.

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 Divisions’ participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 of the Hearing Aid 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, AND THE POLICY NUMBER. Reference Section 5, Third Party Liability, of the Hearing Aid Provider Manual.

END OF SECTION

TOP OF SECTION
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 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, 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. 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. 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:
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. 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:

1) Access the MHD web portal at 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.

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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 copayment 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 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.
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 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 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.

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>FIELD DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAGE</td>
<td>The remittance advice page number.</td>
</tr>
<tr>
<td>CLAIM TYPE</td>
<td>The type of claim(s) processed.</td>
</tr>
<tr>
<td>RUN DATE</td>
<td>The financial cycle date.</td>
</tr>
<tr>
<td>PROVIDER IDENTIFIER</td>
<td>The provider’s NPI number.</td>
</tr>
<tr>
<td>RA #</td>
<td>The remittance advice number.</td>
</tr>
<tr>
<td>PROVIDER NAME</td>
<td>The name of the provider.</td>
</tr>
<tr>
<td>PROVIDER ADDR</td>
<td>The provider’s address.</td>
</tr>
<tr>
<td>PARTICIPANT NAME</td>
<td>The participant’s last name and first name.</td>
</tr>
</tbody>
</table>

NOTE: If the participant’s name and identification number are not 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: |

11—Paper Drug
13—Inpatient
14—Dental
15—Paper Medical
16—Outpatient
17—Part A Crossover
18—Paper Medicare/MO HealthNet Part B Crossover Claim
21—Nursing Home
40—Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.
41—Direct Electronic MO HealthNet Information (DEMI)
43—MTB/DEMI
44—Direct Electronic File Transfer (DEFT)
45—Accelerated Submission and Processing (ASAP)
46—Adjudicated Point of Service (POS)
47—Captured Point of Service (POS)
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:

   1 — Processed as Primary
   3 — Processed as Tertiary
   4 — Denied
   22 — Reversal of Previous Payment

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.

NOTE: The revenue code only appears in this field if a procedure code is not present.

MOD
The submitted modifier(s) for the specific detail line.

REV CODE
The submitted revenue code for the specific detail line.

NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

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<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QTY</td>
<td>The units of service submitted.</td>
</tr>
<tr>
<td>BILLED AMOUNT</td>
<td>The submitted billed amount for the specific detail line.</td>
</tr>
<tr>
<td>ALLOWED AMOUNT</td>
<td>The MO HealthNet maximum allowed amount for the procedure/service.</td>
</tr>
<tr>
<td>PAID AMOUNT</td>
<td>The amount MO HealthNet paid on the claim.</td>
</tr>
<tr>
<td>PERF PROV</td>
<td>The NPI number for the performing provider submitted at the detail.</td>
</tr>
<tr>
<td>SUBMITTER LN ITM CNTL</td>
<td>The submitted line item control number.</td>
</tr>
<tr>
<td>GROUP CODE</td>
<td>The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>CO—Contractual Obligation</td>
</tr>
<tr>
<td></td>
<td>CR—Correction and Reversals</td>
</tr>
<tr>
<td></td>
<td>OA—Other Adjustment</td>
</tr>
<tr>
<td></td>
<td>PI—Payer Initiated Reductions</td>
</tr>
<tr>
<td></td>
<td>PR—Patient Responsibility</td>
</tr>
<tr>
<td>RSN</td>
<td>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>.</td>
</tr>
<tr>
<td>AMT</td>
<td>The dollar amount adjusted for the corresponding reason code.</td>
</tr>
<tr>
<td>QTY</td>
<td>The adjustment to the submitted units of service. This field is <em>not</em> printed if the value is zero.</td>
</tr>
<tr>
<td>REMARK CODES</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>HE—Claim Payment Remark Codes</td>
</tr>
<tr>
<td></td>
<td>RX—National Council for Prescription Drug Programs Reject/Payment Codes</td>
</tr>
<tr>
<td></td>
<td>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>.</td>
</tr>
<tr>
<td>CATEGORY TOTALS</td>
<td>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.</td>
</tr>
<tr>
<td>CHECK AMOUNT</td>
<td>The total check amount for the provider.</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Claim Payment Reduction/Cutback</th>
<th>Claim Group Code</th>
<th>Description</th>
<th>Claim Adjustment Reason Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment reimbursed at the maximum allowed</td>
<td>CO</td>
<td>Contractual Obligation</td>
<td>45</td>
<td>Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.</td>
</tr>
<tr>
<td>Payment reduced by other insurance amount</td>
<td>OA</td>
<td>Other Adjustment</td>
<td>23</td>
<td>Payment adjusted because charges have been paid by another payer</td>
</tr>
</tbody>
</table>

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### 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. 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. 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. PA status queries are restricted to the provider who submitted the Prior Authorization Request.
SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field and the accuracy of the code that describes the patient's condition is important.

The diagnosis code must be entered on the claim form exactly as it appears in the applicable version of ICD. Note that the appropriate code(s) may be up to seven (7) characters, depending upon the patient’s diagnosis and applicable ICD code version.

Diagnosis codes are not included in this section. Claims may be denied if the applicable version of ICD diagnosis code is not used. The ICD-9-CM (Volume I) and ICD-10-CM should be used as a guide in the selection of the appropriate diagnosis code. Additional information regarding the ICD-9-CM and ICD-10-CM may be found at www.cdc.gov/nchs/icd.htm.
SECTION 19-PROCEDURE CODES

Procedure codes used by MO HealthNet are identified as HCPCS codes (Health Care Procedure Coding System). The HCPCS is divided into three subsystems, referred to as level I and level II. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes.

Reference materials regarding the HCPCS and CPT codes may be obtained through the American Medical Association at:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
Telephone Number: (800) 621-8335
AMA Members: (800) 262-3211
Fax Orders: (312) 464-5600

https://catalog.ama-assn.org/Catalog/home.jsp

19.1 PROCEDURE CODES

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>AGE LIMIT</th>
<th>REQUIRED ATTACHMENTS</th>
<th>MAXIMUM ALLOWED AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92557</td>
<td>Basic comprehensive audiometry hearing exam, including the measuring of hearing acuity and tests relating to air conduction, bone conduction, speech reception threshold, and speech discrimination. (The procedure must be ordered by a qualified physician and the diagnosis must be related to disease or trauma. Supporting documentation must be retained in the patient's file.)</td>
<td>None</td>
<td>RHAE</td>
<td>$20.00</td>
</tr>
</tbody>
</table>
Basic comprehensive audiometry hearing exam, including the measuring of hearing acuity and tests relating to air conduction, bone conduction, speech reception threshold, and speech discrimination (in a nursing home). (The procedure must be ordered by a qualified physician and the diagnosis must be related to disease or trauma. Supporting documentation must be retained in the patient's file.)

Evaluation of central auditory function with report 1st 60 minutes
Evaluation of central auditory function with report each additional 15 minutes
Evaluation of auditory rehabilitation status; first hour
Evaluation of auditory rehabilitation status; add on
Auditory rehabilitation; pre-lingual hearing loss
Auditory rehabilitation; post-lingual hearing loss
Unlisted preventive (hearing)
Speech therapy, re-evaluation

Hearing Aids/Services

Fitting/orientation/checking of hearing aid, right ear
Fitting/orientation/checking of hearing aid, left ear
Post fitting evaluation, right ear (used to bill for the post fitting evaluation). (Refer to Section 13.6.D(1) and Section 13.6.D(2) of the Hearing Aid Provider Manual for special billing instructions.)
Post fitting evaluation, left ear (used to bill for the post fitting evaluation). (Refer to

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Section 13.6.D(1) and Section 13.6.D(2) of the Hearing Aid Provider Manual for special billing instructions.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Additional Info</th>
<th>Payment</th>
<th>Unit Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5030RT</td>
<td>Hearing aid, monaural; body worn, air conduction, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5030LT</td>
<td>Hearing aid, monaural; body worn, air conduction, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5040RT</td>
<td>Hearing aid, monaural; body worn, bone conduction, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5040LT</td>
<td>Hearing aid, monaural; body worn, bone conduction, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5050RT</td>
<td>Hearing aid, monaural; in the ear, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5050LT</td>
<td>Hearing aid, monaural; in the ear, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5060RT</td>
<td>Hearing aid, monaural; behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5060LT</td>
<td>Hearing aid, monaural; behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5090RT</td>
<td>Dispensing fee, unspecified hearing aid, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5090LT</td>
<td>Dispensing fee, unspecified hearing aid, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5100RT</td>
<td>Hearing aid, bilateral, body worn, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5100LT</td>
<td>Hearing aid, bilateral, body worn, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5110RT</td>
<td>Dispensing fee, bilateral, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5110LT</td>
<td>Dispensing fee, bilateral, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5120RT</td>
<td>Binaural; body, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5120LT</td>
<td>Binaural; body, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5130RT</td>
<td>Binaural; in the ear, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5130LT</td>
<td>Binaural; in the ear, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5140RT</td>
<td>Binaural; behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5140LT</td>
<td>Binaural; behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Dispensing Fee</td>
<td>Insurance Plan</td>
<td>Amount</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------</td>
<td>----------------</td>
<td>----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>V5160RT</td>
<td>Dispensing fee, binaural, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5160LT</td>
<td>Dispensing fee, binaural, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5170RT</td>
<td>Hearing aid, CROS; in the ear, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5170LT</td>
<td>Hearing aid, CROS; in the ear, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5180RT</td>
<td>Hearing aid, CROS; behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5180LT</td>
<td>Hearing aid, CROS; behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5200RT</td>
<td>Dispensing fee, CROS, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5200LT</td>
<td>Dispensing fee, CROS, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5210RT</td>
<td>Hearing aid, bicros; in the ear, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5210LT</td>
<td>Hearing aid, bicros; in the ear, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5220RT</td>
<td>Hearing aid, bicros; behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5220LT</td>
<td>Hearing aid, bicros; behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5240RT</td>
<td>Dispensing fee, bicros, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5240LT</td>
<td>Dispensing fee, bicros, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5241RT</td>
<td>Dispensing fee, monaural hearing aid, any type, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5241LT</td>
<td>Dispensing fee, monaural hearing aid, any type, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$95.00</td>
</tr>
<tr>
<td>V5242RT</td>
<td>Hearing aid, analog, monaural, completely in the ear canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5242LT</td>
<td>Hearing aid, analog, monaural, completely in the ear canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5243RT</td>
<td>Hearing aid, analog, monaural, in the canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5243LT</td>
<td>Hearing aid, analog, monaural, in the canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5244RT</td>
<td>Hearing aid, digitally programmable analog, monaural, completely in the ear canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5244LT</td>
<td>Hearing aid, digitally programmable analog, monaural, completely in the ear canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5244RTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, completely in the ear canal, right</td>
<td>0-20*</td>
<td>PA/RHAE/IofC</td>
<td>MP</td>
</tr>
<tr>
<td>Model</td>
<td>Description</td>
<td>Degree</td>
<td>Insertion</td>
<td>Brand</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>V5244LTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, completely in the ear canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5245RT</td>
<td>Hearing aid, digitally programmable analog, monaural, in the canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5245LT</td>
<td>Hearing aid, digitally programmable analog, monaural, in the canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5245RTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, in the canal, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5245LTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, in the canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5246RT</td>
<td>Hearing aid, digitally programmable analog, monaural, in the ear, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5246LT</td>
<td>Hearing aid, digitally programmable analog, monaural, in the ear, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5246RTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, in the ear, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5246LTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, in the ear, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5247RT</td>
<td>Hearing aid, digitally programmable analog, monaural, behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5247LT</td>
<td>Hearing aid, digitally programmable analog, monaural, behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5247RTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, behind the ear, right ear</td>
<td>0-20</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5247LTEP</td>
<td>Hearing aid, digitally programmable analog, monaural, behind the ear, left ear</td>
<td>0-20</td>
<td>RHAE</td>
<td>MP</td>
</tr>
</tbody>
</table>

PRODUCTION: 09/06/2019
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5248RT</td>
<td>Hearing aid, analog, binaural, completely in the ear canal, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5248LT</td>
<td>Hearing aid, analog, binaural, completely in the ear canal, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5249RT</td>
<td>Hearing aid, analog, binaural, in the canal, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5249LT</td>
<td>Hearing aid, analog, binaural, in the canal, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5250RT</td>
<td>Hearing aid, digitally programmable analog, binaural, completely in the ear canal, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5250LT</td>
<td>Hearing aid, digitally programmable analog, binaural, completely in the ear canal, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5250RTEP</td>
<td>Hearing aid, digitally programmable analog, binaural, completely in the ear canal, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
</tr>
<tr>
<td>V5250LTEP</td>
<td>Hearing aid, digitally programmable analog, binaural, completely in the ear canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
</tr>
<tr>
<td>V5251RT</td>
<td>Hearing aid, digitally programmable analog, binaural, in the canal, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5251LT</td>
<td>Hearing aid, digitally programmable analog, binaural, in the canal, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5251RTEP</td>
<td>Hearing aid, digitally programmable analog, binaural, in the canal, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
</tr>
<tr>
<td>V5251LTEP</td>
<td>Hearing aid, digitally programmable analog, binaural, in the canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
</tr>
<tr>
<td>V5252RT</td>
<td>Hearing aid, digitally programmable, binaural, in the ear, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5252LT</td>
<td>Hearing aid, digitally programmable, binaural, in the ear, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5252RTEP</td>
<td>Hearing aid, digitally programmable, binaural, in the ear, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
</tr>
</tbody>
</table>

* Invoice of cost required with PA
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
<th>MIC</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5252LTEP</td>
<td>Hearing aid, digitally programmable, binaural, in the ear, left ear</td>
<td>0-20*</td>
<td>PA/RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5253RT</td>
<td>Hearing aid, digitally programmable, binaural, behind the ear, right ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5253LT</td>
<td>Hearing aid, digitally programmable, binaural, behind the ear, left ear</td>
<td>None</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5253RTEP</td>
<td>Hearing aid, digitally programmable, binaural, behind the ear, right ear</td>
<td>0-20</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V5253LTEP</td>
<td>Hearing aid, digitally programmable, binaural, behind the ear, left ear</td>
<td>0-20</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V5254RT</td>
<td>Hearing aid, digital, monaural, completely in the ear canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5254LT</td>
<td>Hearing aid, digital, monaural, completely in the ear canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5254RTEP</td>
<td>Hearing aid, digital, monaural, completely in the ear canal, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
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<tr>
<td>V5254LTEP</td>
<td>Hearing aid, digital, monaural, completely in the ear canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
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</tr>
<tr>
<td>V5255RT</td>
<td>Hearing aid, digital, monaural, in the canal, right ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5255LT</td>
<td>Hearing aid, digital, monaural, in the canal, left ear</td>
<td>None*</td>
<td>PA/RHAE</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5255RTEP</td>
<td>Hearing aid, digital, monaural, in the canal, right ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>V5255LTEP</td>
<td>Hearing aid, digital, monaural, in the canal, left ear</td>
<td>0-20*</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td></td>
<td>Invoice of cost required with PA</td>
<td></td>
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<td></td>
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</tbody>
</table>
## Hearing Aid

<table>
<thead>
<tr>
<th>Part Number</th>
<th>Description</th>
<th>Price</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5256RT</td>
<td>Hearing aid, digital, monaural, in the ear, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5256LT</td>
<td>Hearing aid, digital, monaural, in the ear, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5256RTEP</td>
<td>Hearing aid, digital, monaural, in the ear, right ear</td>
<td></td>
<td>RHAЕ MP</td>
</tr>
<tr>
<td>V5256LTEP</td>
<td>Hearing aid, digital, monaural, in the ear, left ear</td>
<td></td>
<td>RHAЕ MP</td>
</tr>
<tr>
<td>V5257RT</td>
<td>Hearing aid, digital, binaural, behind the ear, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5257LT</td>
<td>Hearing aid, digital, binaural, behind the ear, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5257RTEP</td>
<td>Hearing aid, digital, binaural, behind the ear, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5257LTEP</td>
<td>Hearing aid, digital, binaural, behind the ear, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5258RT</td>
<td>Hearing aid, digital, binaural, completely in the ear canal, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5258LT</td>
<td>Hearing aid, digital, binaural, completely in the ear canal, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5258RTEP</td>
<td>Hearing aid, digital, binaural, completely in the ear canal, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5258LTEP</td>
<td>Hearing aid, digital, binaural, completely in the ear canal, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5259RT</td>
<td>Hearing aid, digital, binaural, in the canal, right ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>V5259LT</td>
<td>Hearing aid, digital, binaural, in the canal, left ear</td>
<td>$385.00</td>
<td>PA/RHAЕ</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Category</td>
<td>Fee</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>V5259RTEP</td>
<td>Hearing aid, digital, binaural, in the canal, right ear</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5259LTEP</td>
<td>Hearing aid, digital, binaural, in the canal, left ear</td>
<td>RHAE</td>
<td>MP</td>
</tr>
<tr>
<td>V5260RT</td>
<td>Hearing aid, digital, binaural, in the ear, right ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5260LT</td>
<td>Hearing aid, digital, binaural, in the ear, left ear</td>
<td>None*</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5260RTEP</td>
<td>Hearing aid, digital, binaural, in the ear, right ear</td>
<td>0-20*</td>
<td>MP</td>
</tr>
<tr>
<td>V5260LTEP</td>
<td>Hearing aid, digital, binaural, in the ear, left ear</td>
<td>0-20*</td>
<td>MP</td>
</tr>
<tr>
<td>V5261RT</td>
<td>Hearing aid, digital, binaural, behind the ear, right ear</td>
<td>None</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5261LT</td>
<td>Hearing aid, digital, binaural, behind the ear, left ear</td>
<td>None</td>
<td>$385.00</td>
</tr>
<tr>
<td>V5261RTEP</td>
<td>Hearing aid, digital, binaural, behind the ear, right ear</td>
<td>0-20</td>
<td>MP</td>
</tr>
<tr>
<td>V5261LTEP</td>
<td>Hearing aid, digital, binaural, behind the ear, left ear</td>
<td>0-20</td>
<td>MP</td>
</tr>
<tr>
<td>V5264RT</td>
<td>Ear mold/insert, not disposable, any type, right ear (a maximum of 4 may be billed on the same date of service)</td>
<td>None</td>
<td>$25.00</td>
</tr>
<tr>
<td>V5264LT</td>
<td>Ear mold/insert, not disposable, any type, left ear (a maximum of 4 may be billed on the same date of service)</td>
<td>None</td>
<td>$25.00</td>
</tr>
<tr>
<td>V5267</td>
<td>Hearing aid supplies/accessories</td>
<td>0-20</td>
<td>Invoice of cost required with claim MP</td>
</tr>
</tbody>
</table>

PRODUCTION: 09/06/2019
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5275RT</td>
<td>Ear impression, right ear (a maximum of 4 may be billed on the same date of service)</td>
<td>None</td>
<td>$5.00</td>
</tr>
<tr>
<td>V5275LT</td>
<td>Ear impression, left ear (a maximum of 4 may be billed on the same date of service)</td>
<td>None</td>
<td>$5.00</td>
</tr>
<tr>
<td>V5281RTEP</td>
<td>Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5281LTEP</td>
<td>Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5282</td>
<td>Assistive listening device, personal fm/dm system, binaural, (2 receivers, transmitter, microphone), any type</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5283RTEP</td>
<td>Assistive learning device, personal fm/dm neck, loop induction receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5283LTEP</td>
<td>Assistive learning device, personal fm/dm neck, loop induction receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5284RTEP</td>
<td>Assistive learning device, personal fm/dm, ear level receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5284LTEP</td>
<td>Assistive learning device, personal fm/dm, ear level receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5285RTEP</td>
<td>Assistive listening device, personal fm/dm, direct audio input receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5285LTEP</td>
<td>Assistive listening device, personal fm/dm, direct audio input receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5286RTEP</td>
<td>Assistive listening device, personal blue tooth fm/dm receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
<tr>
<td>V5286LTEP</td>
<td>Assistive listening device, personal blue tooth fm/dm receiver</td>
<td>0-20 RHAE/Invoice of cost required with PA</td>
<td></td>
</tr>
</tbody>
</table>
### Hearing Aid

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
<th>Provider</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5287RTEP</td>
<td>Assistive listening device, personal fm/dm receiver, not otherwise specified</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5287LTEP</td>
<td>Assistive listening device, personal fm/dm receiver, not otherwise specified</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5288RTEP</td>
<td>Assistive listening device, personal fm/dm transmitter assistive listening device</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5288LTEP</td>
<td>Assistive listening device, personal fm/dm transmitter assistive listening device</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5289RTEP</td>
<td>Assistive listening device, personal fm/dm adapter/boot coupling device for receiver, any type</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5289LTEP</td>
<td>Assistive listening device, personal fm/dm adapter/boot coupling device for receiver, any type</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5290RTEP</td>
<td>Assistive listening device, transmitter microphone, any type</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
<tr>
<td>V5290LTEP</td>
<td>Assistive listening device, transmitter microphone, any type</td>
<td>0-20</td>
<td>PA</td>
<td>RHAE/Invoice of cost required with PA</td>
</tr>
</tbody>
</table>

### Repairs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
<th>Provider</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L7510</td>
<td>Repair of prosthetic device, repair or replace minor parts</td>
<td>None</td>
<td>PA</td>
<td>Invoice of cost required with claim</td>
</tr>
<tr>
<td>L8615</td>
<td>Replacement headset/piece for cochlear implant</td>
<td>None</td>
<td>PA</td>
<td>Invoice of cost required with claim</td>
</tr>
<tr>
<td>L8616</td>
<td>Replacement microphone for cochlear implant</td>
<td>None</td>
<td>PA</td>
<td>Invoice of cost required with claim</td>
</tr>
<tr>
<td>L8617</td>
<td>Replacement transmitting coil for cochlear implant</td>
<td>None</td>
<td>PA</td>
<td>Invoice of cost required with claim</td>
</tr>
<tr>
<td>L8618</td>
<td>Replacement transmitter cable for cochlear</td>
<td>None</td>
<td>PA</td>
<td>Invoice of cost required with claim</td>
</tr>
</tbody>
</table>

**PRODUCTION:** 09/06/2019
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>None</th>
<th>Invoice of cost required with claim</th>
<th>PA/RHAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8619</td>
<td>Cochlear implant external speech processor, replacement</td>
<td>None</td>
<td>Invoice of cost required with PA</td>
<td>MP</td>
</tr>
<tr>
<td>L8621</td>
<td>Replacement zinc air battery for cochlear implant each</td>
<td>None</td>
<td>Invoice of cost required with claim</td>
<td>MP</td>
</tr>
<tr>
<td>L8622</td>
<td>Alkaline battery for use with cochlear implant, any size, replacement, each</td>
<td>None</td>
<td>Invoice of cost required with PA</td>
<td>MP</td>
</tr>
<tr>
<td>L8623</td>
<td>Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement each</td>
<td>None</td>
<td>Invoice of cost required with claim</td>
<td>MP</td>
</tr>
<tr>
<td>L8624</td>
<td>Lithium ion battery for use with cochlear implant device speech processor; ear level, replacement each</td>
<td>None</td>
<td>Invoice of cost required with claim</td>
<td>MP</td>
</tr>
<tr>
<td>L8692</td>
<td>Non-Osseointegrated sound processor</td>
<td>None</td>
<td>PA/RHAE</td>
<td>MP</td>
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</tbody>
</table>

**Special Otorhinolaryngologic Services**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>None</th>
<th>Invoice of cost required with claim</th>
<th>PA/RHAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory disorder includes aural rehabilitation; individual. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.)</td>
<td>None</td>
<td>None</td>
<td>$10.50</td>
</tr>
<tr>
<td>92601</td>
<td>Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.)</td>
<td>None</td>
<td>None</td>
<td>$10.50</td>
</tr>
</tbody>
</table>

**Diagnostic Analysis of Cochlear Implant**

92602 Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.) $10.50
patient under 7 years of age; subsequent reprogramming. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.) Do not report in addition to 92601 on the same date of service.

92603 Diagnostic analysis of cochlear implant, patient 7 years or older; with programming. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.)

92604 Diagnostic analysis of cochlear implant, patient 7 years or older; subsequent reprogramming. Maximum quantity per day is 16 units. (A unit is up to 15 minutes.) Do not report 92604 in addition to 92603 on the same date of service.

**Special Tests (Covered Only When Prescribed by a Physician)**

The physician must indicate in Section "B" on the RHAE form, why the tests are being ordered.

92562 Loudness balance test, alternate binaural or monaural (retrocochlear vs. cochlear) None None $3.30

92563 Tone Decay Test None None $3.30

92564 Short Increment Sensitivity Index (SISI) None None $3.30

92567 Tympanometry (impedance testing) None None $5.00

92568 Acoustic Reflex Testing None None $5.00

92570 Acoustic Immittance Testing None None $15.03

**Healthy Children and Youth (HCY)—For Participants 20 and Under Only**

V5266 Battery for use in hearing device (When billing for batteries, list the number of batteries dispensed in Field #24 of the CMS - 1500 claim form.) 0-20 None $1.56

V5298RT Hearing aid, not otherwise classified, right ear 0-20 Invoice of cost required with PA

V5298LT Hearing aid, not otherwise classified, left ear 0-20 Invoice of cost required with PA

V5299 Hearing service, miscellaneous (Includes FM 0-20 Invoice of cost required
Hearing Aid

Systems, noncovered testing, repair to hearing equipment other than hearing aids, etc. Not to be used for hearing aids.)

RHAE, Report of Hearing Aid Evaluation; PA, Prior Authorization; MP, Manually priced;
* Not covered for participants under the age of 13 except for medically necessary reasons, e.g., no external ear, psychological reasons, etc.

### 19.2 HCY PROCEDURE CODES FOR PARTICIPANTS 20 YEARS OLD AND UNDER

Many of the HCY procedure codes require a Certificate of Medical Necessity form. Reference Section 7, Medical Necessity, of the Hearing Aid Provider Manual for a sample Certificate of Medical Necessity form.

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>AGE LIMIT</th>
<th>REQUIRED ATTACHMENTS</th>
<th>MAXIMUM ALLOWED AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Evaluation of speech, language, voice communication, auditory processing and/or aural rehabilitation status. Maximum quantity per day is 16 units (A unit is up to 15 minutes.)</td>
<td>0-20</td>
<td>—</td>
<td>$10.50</td>
</tr>
<tr>
<td>92531</td>
<td>Spontaneous nystagmus, including gaze</td>
<td>0-20</td>
<td>MNF</td>
<td>$18.85</td>
</tr>
<tr>
<td>92532</td>
<td>Positional nystagmus</td>
<td>0-20</td>
<td>MNF</td>
<td>$21.90</td>
</tr>
<tr>
<td>92533</td>
<td>Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)</td>
<td>0-20</td>
<td>MNF</td>
<td>$24.45</td>
</tr>
<tr>
<td>92534</td>
<td>Optokinetic nystagmus</td>
<td>0-20</td>
<td>MNF</td>
<td>$27.10</td>
</tr>
<tr>
<td>92541</td>
<td>Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording</td>
<td>0-20</td>
<td>MNF</td>
<td>$20.00</td>
</tr>
<tr>
<td>92542</td>
<td>Positional nystagmus test, minimum of 4 positions, with recording</td>
<td>0-20</td>
<td>MNF</td>
<td>$20.00</td>
</tr>
<tr>
<td>92543</td>
<td>Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording</td>
<td>0-20</td>
<td>MNF</td>
<td>$23.28</td>
</tr>
<tr>
<td>92544</td>
<td>Optokinetic nystagmus test, bidirectional foveal or peripheral stimulation, with recording</td>
<td>0-20</td>
<td>MNF</td>
<td>$10.00</td>
</tr>
<tr>
<td>92545</td>
<td>Oscillating tracking test, with recording</td>
<td>0-20</td>
<td>MNF</td>
<td>$10.00</td>
</tr>
<tr>
<td>92546</td>
<td>Sinusoidal vertical axis rotational testing</td>
<td>0-20</td>
<td>MNF</td>
<td>$15.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Range</td>
<td>Type</td>
<td>Amount</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>92547</td>
<td>Use of vertical electrodes in any or all of above tests counts as one additional test</td>
<td>0-20</td>
<td>MNF</td>
<td>$5.11</td>
</tr>
<tr>
<td>92551</td>
<td>Screening test, pure tone, air only</td>
<td>0-20</td>
<td>—</td>
<td>$5.00</td>
</tr>
<tr>
<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
<td>0-20</td>
<td>—</td>
<td>$8.00</td>
</tr>
<tr>
<td>92553</td>
<td>Pure tone audiometry (threshold); air and bone</td>
<td>0-20</td>
<td>—</td>
<td>$11.00</td>
</tr>
<tr>
<td>92555</td>
<td>Speech audiometry threshold</td>
<td>0-20</td>
<td>—</td>
<td>$5.00</td>
</tr>
<tr>
<td>92556</td>
<td>Speech audiometry threshold; with speech recognition</td>
<td>0-20</td>
<td>—</td>
<td>$5.00</td>
</tr>
<tr>
<td>92557</td>
<td>Stenger test, pure tone</td>
<td>0-20</td>
<td>—</td>
<td>$10.76</td>
</tr>
<tr>
<td>92572</td>
<td>Staggered spondaic word test</td>
<td>0-20</td>
<td>—</td>
<td>$14.25</td>
</tr>
<tr>
<td>92577</td>
<td>Stenger test, speech</td>
<td>0-20</td>
<td>—</td>
<td>$14.83</td>
</tr>
<tr>
<td>92579</td>
<td>Visual reinforcement audiometry (VRA)</td>
<td>0-20</td>
<td>—</td>
<td>$20.00</td>
</tr>
<tr>
<td>92582</td>
<td>Conditioning play audiometry</td>
<td>0-20</td>
<td>—</td>
<td>$20.00</td>
</tr>
<tr>
<td>92583</td>
<td>Select picture audiometry</td>
<td>0-20</td>
<td>—</td>
<td>$5.00</td>
</tr>
<tr>
<td>92584</td>
<td>Electrocochleography</td>
<td>0-20</td>
<td>PA</td>
<td>$57.20</td>
</tr>
<tr>
<td>92585</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
<td>0-20</td>
<td>—</td>
<td>$85.32</td>
</tr>
<tr>
<td>92586</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited.</td>
<td>0-20</td>
<td>—</td>
<td>$35.43</td>
</tr>
<tr>
<td>92587</td>
<td>Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)</td>
<td>0-20</td>
<td>—</td>
<td>$27.11</td>
</tr>
<tr>
<td>92588</td>
<td>Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)</td>
<td>0-20</td>
<td>—</td>
<td>$38.08</td>
</tr>
</tbody>
</table>

SECTION 20 - EXCEPTION PROCESS

The Exception Process is a formal process under which the MO HealthNet Division may grant an exception and authorize an essential medical service or item of equipment that otherwise exceeds the benefits and limitations set in policy.

Section 20, Exception Process, is not applicable to the following manuals, because services cannot be approved in accordance with the exception process regulation.

- Adult Day Health Care
- Aged and Disabled Waiver
- AIDS Waiver
- Ambulance
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Environmental Lead Assessment
- Hearing Aid
- Hospice
- MRDD Waiver
- Nurse Midwife
- Optical
- Personal Care
- Private Duty Nursing
- Psychology/Counseling
- Therapy

END OF SECTION

TOP OF PAGE

PRODUCTION: 09/06/2019
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
TOP OF PAGE
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:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>The denial, termination, suspension, or reduction of an NEMT service.</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>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.</td>
</tr>
<tr>
<td>Appeal</td>
<td>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.</td>
</tr>
<tr>
<td>Attendant</td>
<td>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</td>
</tr>
</tbody>
</table>
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/Rural Counties

As defined in 20 CSR, the following counties are categorized as:

- **Urban** – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
- **Basic** – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
- **Rural** – All other counties.

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 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:

- Non-covered Service
- Lack of Day’s Notice
Hearing Aid

- 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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Transportation</td>
<td>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.</td>
</tr>
<tr>
<td>Grievance (Participant)</td>
<td>A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are not 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.</td>
</tr>
<tr>
<td>Grievance (Transportation Provider)</td>
<td>A written request for further review of a transportation provider’s complaint that remains unresolved after completion of the complaint process.</td>
</tr>
<tr>
<td>Inquiry</td>
<td>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.</td>
</tr>
<tr>
<td>Most Appropriate</td>
<td>The mode of transportation that accommodates the participant’s physical, mental, or medical condition.</td>
</tr>
<tr>
<td>MO HealthNet Covered Services</td>
<td>Covered services under the MO HealthNet program.</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>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 not 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 must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.</td>
</tr>
<tr>
<td>Medical Service Provider</td>
<td>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.</td>
</tr>
</tbody>
</table>
### 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 not 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 not life threatening illness/injury. Examples include, but are not limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not 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**

<table>
<thead>
<tr>
<th>Provider/Service Type</th>
<th>Urban Access County</th>
<th>Basic Access County</th>
<th>Rural Access County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>PCPs</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Neurology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Dermatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Physical Medicine/Rehab</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Vision Care/Primary Eye Care</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Allergy</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Cardiology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nephrology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Specialty</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Urology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>General surgery</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Psychiatrist-Adult/General</td>
<td>15</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>Psychiatrist-Child/Adolescent</td>
<td>22</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>Psychologists/Other Therapists</td>
<td>10</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
</tbody>
</table>

**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

PRODUCTION: 09/06/2019
Residential mental health treatment providers 20 30 50

Ancillary Services

<table>
<thead>
<tr>
<th>Service</th>
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<td>Physical Therapy</td>
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<td>Occupational Therapy</td>
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<td>Speech Therapy</td>
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<td>Audiology</td>
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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

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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.

PRODUCTION : 09/06/2019
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.
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.

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.