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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>
Children in a Nursing Facility/ICF/MR.

Children placed in foster homes or residential care by DMH.

Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.

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.

Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility.

Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT).

Ticket to Work Health Assurance Program (TWHAP) participants--premium

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>
40, 62 Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.

07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70 Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.

36, 56 Children who receive a federal adoption subsidy payment.

71, 72 Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)

73 Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.

74 Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.

75 Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families must pay a monthly premium. There is a premium.
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>
<tr>
<td>59</td>
<td>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.</td>
</tr>
</tbody>
</table>

1.1.A(4) Voluntary Placement Agreement for Children

<table>
<thead>
<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

| ME CODE | DESCRIPTION |
02 Individuals who receive a Blind Pension check.

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

52 Children who are in the custody of the Division of Youth Services (DYS-GR) who do not meet MO HealthNet for Kids non-CHIP criteria. (NOTE: GR in this instance means general revenue as services are provided by all state funds. Services are not restricted.)

57 Children who receive a state only adoption subsidy payment.

64 Children who are in the custody of Juvenile Court who do not qualify for federally matched MO HealthNet under ME codes 30, 69 or 70.

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

1.1.A(6) MO Rx

ME CODE DESCRIPTION

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

1.1.A(7) Women’s Health Services

ME CODE DESCRIPTION
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 (573) 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>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
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<table>
<thead>
<tr>
<th></th>
<th>Program Description</th>
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<tbody>
<tr>
<td>01</td>
<td>MO HealthNet for the Aged</td>
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<tr>
<td>04</td>
<td>Permanently and Totally Disabled (APTD)</td>
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<tr>
<td>05</td>
<td>MO HealthNet for Families - Adult (ADC-AD)</td>
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<td>19</td>
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<td>85</td>
<td>Ticket to Work Health Assurance Program (TWHAP) --premium</td>
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<tr>
<td>86</td>
<td>Ticket to Work Health Assurance Program (TWHAP) -- non-premium</td>
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</tbody>
</table>

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

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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.
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.I(1) Eligibility Criteria

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

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

The BCCT MO HealthNet Application must be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be approved, if the woman was eligible. Coverage cannot begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.
1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

An individual and/or spouse must have earnings from employment or self-employment. There is no minimum level of employment or earnings required. The maximum 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:

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

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

- Infants living with the inmate in the public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release (except when reporting to a public institution for overnight stay); or
- Individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (for example, transfer to a community residence).
All specific eligibility groups, including children, pregnant women, and elderly, blind or disabled are considered to determine if the individual meets all eligibility factors of the program for which they are applying.

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

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

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

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

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

MO HealthNet participants with ME code 83 are eligible for coverage beginning on the day the BCCCP provider determines the woman is in need of treatment for breast or cervical cancer. Presumptive Eligibility coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is last.
MO HealthNet participants with ME code 84 are eligible for coverage beginning the 1st day of the month of application. Prior quarter coverage may also be approved, if the woman is eligible. Coverage cannot begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001.

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

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

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

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

Immediately following the current statement, “The participant is eligible for service on MONTH, DAY, YEAR through MONTH, DAY, YEAR with a medical eligibility code of
XX,” the IVR says, “This participant is subject to day specific eligibility.” The Internet gives this information in the same way as the IVR.

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

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

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

1.6.B SPENDDOWN

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

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

• submitting incurred medical expenses to their Family Support Division (FSD) Eligibility Specialist; or

• paying the monthly spenddown amount to the MO HealthNet Division (MHD).

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

Individuals have the option of changing the method in which their spenddown is met each month. A choice is made to either send the payment to MHD or to send bills to the FSD Eligibility Specialist. For those months that the individual does not pay-in or submit bills, no coverage is available.
1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

MO HealthNet coverage begins on the first day in which spenddown is met in each of the prior months. Each of the three prior quarter month's medical expenses are compared to that month's spenddown separately. Using this process, it may be that the individual is eligible for one, two or all three months, sometimes not
consecutively. As soon as the FSD Eligibility Specialist receives bills to meet spenddown for a prior quarter month, eligibility is met.

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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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

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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

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

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

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

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

END OF SECTION

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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/](http://mmac.mo.gov/).
3.2.A PROVIDER ENROLLMENT UNIT

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

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.

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

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

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

The IVR system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service that occurred during their period of enrollment as an active MO HealthNet provider. The 10-digit
National Provider Identification (NPI) number must be entered each time any of the IVR options are accessed.

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

Main Option 1. Participant Eligibility

The caller is prompted to enter the following information:

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

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

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

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

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

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

The Sub-Options menu options include:

- For Health plan and Lock-in Information, Press 1.
- For eye glass and eye exam information, Press 2.
• For Third Party Liability Information, Press 3.
• For Medicare and QMB Information, Press 4.
• For MO HealthNet ID, Name, spelling of name and eligibility information, Press 5.
• For Confirmation Number, Press 6.
• For Another MO HealthNet Participant, Press 7.
• To Return to the Main Menu, Press 8.
• To End this Call, Press 9.
• To speak with a MO HealthNet specialist, Press 0.

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

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

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

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

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

• If health plan lock-in exists, the IVR states the health plan name for services on the applicable dates.
  o “This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Are Code (XXX-XXX-XXXX on file).”

• If PCP lock-in exists, the IVR states the provider’s name and phone number for services on the applicable dates.
  o “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.

**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 (XXXXXXXXXXX) has not been issued any checks to date.

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

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

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

The provider can access claim status information, including processing status, denial, and approved status.
Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID.

Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.

Once 6 digit number is entered, the IVR prompts for the type of claim.
  - If Drug claim is selected, then IVR prompts for prescription number entry.

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

- If claim is in process:
  - The IVR reads that the claim accessed with this date of service is being processed.

- If claim is denied:
  - The IVR will read up to five Explanation of Benefits (EOB) applicable codes. The claim accessed with this date of service has been denied with EOB (EOB Code 1-5).
  - After EOB codes are read, the IVR prompts to hear EOB descriptions.
  - Press 1 for EOB Description. If the caller presses 1, the IVR will read the EOB descriptions for the EOB codes (up to five).

- IVR then reads RA information. If the claim is denied, the IVR reads that the claim accessed with this date of service is denied on the (RA Number) Remittance Advice dated (RA Date).

- If claim is approved for payment:
- The IVR reads that the claim accessed with this date of service has been approved for payment.
- If claim paid and the claim is being recouped or adjusted, the IVR reads for more information, speak with a MO HealthNet Specialist.
- If claim paid, the IVR will read that the claim accessed with this date of service was paid on the (RA Number) Remittance Advice dated (RA Date) in the amount of (RA Amount).

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

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

Main Option 4. Provider Enrollment Status
The provider’s enrollment status can be obtained through this option. The following will be repeated up to five times depending on the number of providers for the inquiry. The caller is prompted to enter the provider’s NPI number.

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

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

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

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

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

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

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

The caller is prompted to enter the following information.

- Please enter the 10 digit NPI number. Once a valid 10 digit number is entered, the IVR prompts for the participant MO HealthNet ID.
- Please enter the 8 digit MO HealthNet ID. Once a valid 8 digit number is entered, the IVR retrieves Data.
- If valid annual review date found, the IVR reads the following.
  - MO HealthNet ID (MO HealthNet ID) is registered to (First, Last Name). Annual Review Date (date on file). For information specific to the MO
HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.

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

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

After valid or error response IVR then reads menu options.

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

Transfer Routine

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

Number of Inquiries

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

3.3.A(1) Using the Telephone Key Pad

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

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

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

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

Please note that there are no limits on how many inquiries you can access through the MHD web-based www.emomed.com 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. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please access the application http://manuals.momed.com/Application.html and select the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The internet inquiry options, located at 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 as the first option, prior to accessing the IVR. The provider will be able to read and review the data and results, instead of having to call to hear the results. All the same functions and additional functions compared to the IVR are available and include: eligibility verification by Participant ID, case head ID and child's date of birth, or Social Security Number and date of birth, claim status, and check inquiry, provider enrollment status, and participant annual review date. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.
Providers also have the capability to receive and download their RAs from [www.emomed.com](http://www.emomed.com). Access to this information is restricted to users with authorization. In addition to the RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

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

### 3.3.D WRITTEN INQUIRIES

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

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

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

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

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

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

The Provider Education Unit can be contacted for training information and scheduling via telephone at (573) 751-6683 or email at mhd.provtrain@dss.mo.gov. 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. NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

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

These attachments may not be submitted via the Internet when additional documentation is required. The web site address for these submissions is www.emomed.com.

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/.

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

3.11 Pharmacy and Medical Pre-certification Help Desk

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

To become a CyberAccess user, contact the help desk at 888-581-9797 or 573-632-9797, or email cyberaccesshelpdesk@xerox.com. 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 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
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

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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](http://www.emomed.com) to provide real-time direct access for administrators, providers, and clearinghouse users. This describes the process and tools providers should use to adjust claims.

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the ICN of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and select the highlighted ‘submit claim’ button. The claim has now been submitted for payment.
6.2.B(2)(ii) Copy Claim – Original

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

6.2.B(2)(iii) Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

Provider Communications Unit may be contacted at (573) 751-2896, for questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verifications. Please contact Provider Education Unit at (573) 751-6683 or email mhd.provtrain@dss.mo.gov 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.

END OF SECTION

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

The Certificate of Medical Necessity form must be either submitted electronically with the electronic claim or submitted on paper attached to the original claim form. For information regarding submission of the Certificate of Medical Necessity for claims submitted by a Durable Medical Equipment provider see Section 7.1.A. If a claim is resubmitted, the provider must again attach a copy of the Certificate of Medical Necessity form.

Medical consultants and medical review staff review the Certificate of Medical Necessity form and the claim form to make a determination regarding payment of the claim. If the medical necessity of the service is supported by the documentation, the claim is approved for further processing. If medical necessity is not documented or supported, the claim is denied for payment.
7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS

The Certificate of Medical Necessity for durable medical equipment should not be submitted with a claim form. This attachment may be submitted via the Internet (see Section 3.8 and Section 23) or mailed to:

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

If the Certificate of Medical Necessity is approved, the approved time period is six (6) months from the prescription date. Any claim matching the criteria (including the type of service) on the Certificate of Medical Necessity for the approved time period can be processed for payment without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

<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

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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.
1. The “from” date may not precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.

2. The “through” date cannot be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.

- Increase or decrease requested units or dollars.

1. An increase in frequency and or duration in some programs require additional or revised information.

- Correct the National Provider Identifier (NPI). The NPI number can only be corrected if both of the following conditions are met:
  - The number on the original request is in error; and
  - The provider was not reimbursed for any units on the initial Prior Authorization Request.

- Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

All services authorized by the DHSS, Division of Senior and Disability Services (DSDS) or its 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, Diagnostic and Treatment (EPSDT). The Social Security Act authorizes Medicaid coverage of medical and dental services necessary to treat or improve defects and physical and mental/behavioral health conditions 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.

The HCY Program works to equip MO HealthNet providers with the necessary tools and knowledge to carry out preventive services appropriate to the American Academy of Pediatrics’ standard for pediatric preventive health care, Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. Information about Bright Futures screening services can be found on their website at: https://brightfutures.aap.org/clinical-practice/Pages/default.aspx.

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 MO HealthNet Division 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>
</tbody>
</table>

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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/behavioral health development;
- 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 provider document in the patient’s medical record that a preventive screening was provided. The provider can document the screenings in an electronic medical record, written medical record, or use the Bright Futures screening forms. Whether written or electronic, the record must contain all of the components of a full HCY screening.

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. Providers must document the screening in the medical record if billing a screening.

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/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.
**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/Behavioral Health partial screen</td>
</tr>
<tr>
<td>99429 59UC</td>
<td>Developmental/Mental/Behavioral Health partial screen with Referral</td>
</tr>
</tbody>
</table>

Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective. The MHD encourages providers to use age appropriate, validated screening tools rather than less rigorous methods to screen for developmental and mental/behavioral health conditions. The Screening Technical Assistance & Resource (STAR) Center of the AAP provides a list of validated screening tools for children 0 to 5 years that address the following areas:

- Development
- Autism
- Social-emotional development
- Maternal depression
- Social determinants of health

The STAR Center list may be accessed at [https://screeningtime.org/star-center/#/screening-tools#top](https://screeningtime.org/star-center/#/screening-tools#top).

Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child’s health. As a reminder, MHD covers procedure code 96161, which may be billed under the child’s DCN, for administering a maternal depression screening tool during a well-child visit.

**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

**PRODUCTION : 11/20/2021**
• 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>
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<tbody>
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<td>9938152EP-9938552EP</td>
<td>HCY Unclothed Physical and</td>
</tr>
<tr>
<td>9939152EP-9939552EP</td>
<td>History</td>
</tr>
<tr>
<td>9938152EPUC-9938552EP</td>
<td>HCY Unclothed Physical and</td>
</tr>
<tr>
<td>9939152EPUC-9939552EPUC</td>
<td>History with Referral</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429EP</td>
<td>HCY Hearing Screen</td>
</tr>
<tr>
<td>99429EPUC</td>
<td>HCY Hearing Screen with Referral</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429</td>
<td>HCY Dental Screen</td>
</tr>
<tr>
<td>99429UC</td>
<td>HCY Dental Screen with Referral</td>
</tr>
</tbody>
</table>

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
Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers
Steel welders and cutters
Construction workers
Bridge reconstruction workers
Rubber products manufacturers
Gas station attendants
Battery manufacturers
Chemical and chemical preparation
Manufacturers
Industrial machinery and equipment operators
Firing Range Instructors

ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
Painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline

HOBBIES AND RELATED ACTIVITIES
Glazed pottery making
Target shooting at firing ranges
Lead soldering (e.g., electronics)
Painting
Preparing lead shot, fishing sinkers, bullets
Home remodeling
Stained-glass making
Car or boat repair

SUBSTANCE USE
Folk remedies
“Health foods”
Cosmetics
Moonshine whiskey
Gasoline “huffing”

Regardless of risk, all families must be given detailed lead poisoning prevention counseling as part of the anticipatory guidance during the HCY screening visit for children up to 72 months of age.
9.7.B LEAD RISK ASSESSMENT

The HCY Lead Risk Assessment Guide should be used at each HCY screening to assess the exposure to lead, and to determine the risk for high dose exposure. The HCY Lead Risk Assessment Guide is designed to allow the same document to follow the child for all visits from 6 months to 6 years of age. The HCY Lead Risk Assessment Guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels.

A comprehensive lead risk assessment includes both the verbal lead risk assessment and blood lead level determinations. Blood Lead Testing is mandatory at 12 and 24 months of age and if the child is deemed high risk.

The HCY Lead Risk Assessment Guide is available for provider’s use. The tool contains a list of questions that require a response from the parent. A positive response to any of the questions requires blood lead level testing by capillary or venous method.

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

All children between the ages of 6 months and 72 months of age MUST receive a lead risk assessment as a part of the HCY full or partial screening. Providers are not required to wait until the next HCY screening interval and may complete the lead risk assessment at the next office visit if they choose.

The HCY Lead Risk Assessment Guide and results of the blood lead test must be in the patient’s medical record even if the blood lead test was performed by someone other than the billing provider. If this information is not located in the medical record a full or partial HCY screen may not be billed.

9.7.C(1) Risk Assessment

Beginning at six months of age and at each visit thereafter up to 72 months of age, the provider must discuss with the child’s parent or guardian childhood lead poisoning interventions and assess the child’s risk for exposure by using the HCY Lead Risk Assessment Guide.

9.7.C(2) Determining Risk

Risk is determined from the response to the questions on the HCY Lead Risk Assessment Guide. This verbal risk assessment determines the child to be low risk or high risk.
• If the answers to all questions is no, a child is not considered at risk for high doses of lead exposure.

• If the answer to any question is yes, a child is considered at risk for high doses of lead exposure and a capillary or venous blood lead level must be drawn. Follow-up guidelines on the reverse side of the HCY Lead Risk Assessment Guide must be followed as noted depending on the blood test results.

Subsequent verbal lead risk assessments can change a child’s risk category. As the result of a verbal lead risk assessment, a previously low risk child may be re-categorized as high risk.

9.7.C(3) Screening Blood Tests

The Centers for Medicare & Medicaid Services (CMS) requires mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age regardless of risk. If the answer to any question on the HCY Lead Risk Assessment Guide is positive, a venous or capillary blood test must be performed.

If a child is determined by the verbal risk assessment to be high risk, a blood lead level test is required, beginning at six months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter (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 CODE</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

<table>
<thead>
<tr>
<th>Laboratory Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mercy Hospital</td>
<td>2401 Gillham Rd., Kansas City, MO 64108</td>
</tr>
<tr>
<td>Kneibert Clinic, LLC PO Box</td>
<td>PO Box 220, Poplar Bluff, MO 63902</td>
</tr>
<tr>
<td>Hannibal Clinic Lab</td>
<td>LabCorp Holdings-Kansas City</td>
</tr>
<tr>
<td>711 Grand Avenue</td>
<td>1706 N. Corrington, Kansas City, MO 64120</td>
</tr>
<tr>
<td>Hannibal, MO 63401</td>
<td></td>
</tr>
<tr>
<td>Kansas City Health Department Lab</td>
<td>Physicians Reference Laboratory</td>
</tr>
<tr>
<td>2400 Troost, LL#100</td>
<td>7800 W. 110 St., Overland, MO 66210</td>
</tr>
<tr>
<td>Kansas City, MO 64108</td>
<td></td>
</tr>
<tr>
<td>Missouri State Public Health Laboratory</td>
<td>Quest Diagnostics</td>
</tr>
<tr>
<td>101 Chestnut St., Jefferson City, MO 65101</td>
<td>11636 Administration, St. Louis, MO 63146</td>
</tr>
<tr>
<td>Springfield-Greene County Public Health</td>
<td>St. Francis Medical Center</td>
</tr>
<tr>
<td>227 E. Chestnut, Springfield, MO 65802</td>
<td>211 St. Francis Drive, Cape Girardeau, MO 63703</td>
</tr>
<tr>
<td>St. Luke’s Hospital Dept. of Pathology</td>
<td>St. Louis County Environmental Health Lab</td>
</tr>
<tr>
<td>4401 Wornall, Kansas City, MO</td>
<td>111 S. Meramec, Clayton, MO 63105</td>
</tr>
<tr>
<td>University of MO-Columbia Hospital &amp; Clinics</td>
<td></td>
</tr>
<tr>
<td>One Hospital Drive</td>
<td></td>
</tr>
<tr>
<td>Columbia, MO 65212</td>
<td></td>
</tr>
</tbody>
</table>

9.7.L  OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

<table>
<thead>
<tr>
<th>Laboratory Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arup Laboratories</td>
<td>Esa</td>
</tr>
<tr>
<td>500 Chipeta Way</td>
<td>22 Alpha Rd., Chelmsford, MA 01824</td>
</tr>
<tr>
<td>Salt Lake City, UT 84108</td>
<td>Iowa Methodist Medical Center</td>
</tr>
<tr>
<td>Iowa Hygenic Lab</td>
<td>1200 Pleasant St.</td>
</tr>
<tr>
<td>Wallace State Office Building</td>
<td></td>
</tr>
</tbody>
</table>

PRODUCTION : 11/20/2021
9.8 HCY CASE MANAGEMENT

<table>
<thead>
<tr>
<th>PROCEDURE 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.

The MO HealthNet Division follows the Bright Futures Periodicity schedule as a standard for pediatric preventive services. Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA).

Note: MO HealthNet recognizes that a full HCY screen is required for children/youth within 30 days of entering Children’s Division custody. Also, the American Academy of Pediatrics recommends additional monitoring for children and adolescents in foster care (see https://pediatrics.aappublications.org/content/pediatrics/136/4/e1131.full.pdf and https://pediatrics.aappublications.org/content/136/4/e1142). Such HCY screens are considered medically necessary even though they may occur in addition to the standard 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>Newborn</th>
<th>3 Years</th>
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</thead>
</table>

PRODUCTION : 11/20/2021
<table>
<thead>
<tr>
<th>Age Range</th>
<th>Corresponding Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 Days</td>
<td>4 Years</td>
</tr>
<tr>
<td>By 1 Month</td>
<td>5 Years</td>
</tr>
<tr>
<td>2 Months</td>
<td>6 Years</td>
</tr>
<tr>
<td>4 Months</td>
<td>7 Years</td>
</tr>
<tr>
<td>6 Months</td>
<td>8 Years</td>
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<tr>
<td>9 Months</td>
<td>9 Years</td>
</tr>
<tr>
<td>12 Months</td>
<td>10 Years</td>
</tr>
<tr>
<td>15 Months</td>
<td>11 Years</td>
</tr>
<tr>
<td>18 Months</td>
<td>12 Years</td>
</tr>
<tr>
<td>24 Months</td>
<td>13 Years</td>
</tr>
<tr>
<td>30 Months</td>
<td>14 Years</td>
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<tr>
<td></td>
<td>15 Years</td>
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<td>16 Years</td>
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<td>19 Years</td>
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</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, prior authorization must be requested prior to delivering services. 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

The MO HealthNet Division (MHD) does not require participant cost sharing or copays for any services at this time. Providers will be notified when participant cost sharing and copay requirements are reinstated.

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 ensuring that Early and Periodic, Screening, Diagnostic 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 improve 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/behavioral 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:

<table>
<thead>
<tr>
<th>Screen Type</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclothed Physical and History</td>
<td>99381 through 99385 and 99391 through 99395</td>
</tr>
<tr>
<td>Developmental/Mental Health</td>
<td>9942959</td>
</tr>
<tr>
<td>Hearing Screen</td>
<td>99429EP</td>
</tr>
<tr>
<td>Vision Screen</td>
<td>9942952</td>
</tr>
<tr>
<td>Dental Screen</td>
<td>99429</td>
</tr>
</tbody>
</table>

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 HCY LEAD SCREENING GUIDE

The HCY Lead Screening Guide may be ordered from Wipro Infocrossing Healthcare Services, P.O. Box 5600, Jefferson City, Missouri 65102 by checking the appropriate item on the Forms Request. If a provider needs additional screening forms they can also make copies.

END OF SECTION

TOP OF SECTION
SECTION 10-FAMILY PLANNING

10.1 FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

It is important to correctly identify family planning services by both diagnosis and procedure code, since the federal financial participation rate of the payment for these procedures is 90% (rather than the normal rate of approximately 60%). The remaining percentage is funded by state general revenue.

Family planning services for which the higher federal financial participation rate is available are elective sterilizations and birth control products including drugs, non-biodegradable drug delivery implant system, IUDs, and diaphragms.

Providers must mark the family planning field whenever a procedure or service is performed that relates to family planning.

- Professional Claim Form: Mark Field #24H “FP” if the service relates to family planning. This goes in the white section of the field.
- UB-04: Code A4 should be entered in Fields #18-24 of the UB-04 if any part of the claim (inpatient or outpatient service) relates to family planning. The occurrence code (C1 or C3) must be in Field #18, followed by A4, if appropriate, in Fields #19-24.
- All family planning services must have a diagnosis code within the ranges of Z30.011 – Z30.9.

10.2 COVERED SERVICES

A physician may charge the appropriate Evaluation and Management (E/M) procedure code that includes one (1) or more of the following services: obtaining a medical history, pelvic examination, breast examination, and the preparation of smears, for example, a Pap smear, bacterial smear.

NOTE: MO HealthNet payment for screening and interpretation of a Pap smear can only be made to a clinic or certified independent laboratory employing an approved pathologist (cytologist) or to an individual pathologist (cytologist). All providers of laboratory services must have a Clinical Laboratory Improvements Act (CLIA) certificate.
10.2.A LONG-ACTING REVERSIBLE CONTRACEPTION (LARC) DEVICES

The MO HealthNet Division (MHD) will allow separate reimbursement for long-acting reversible contraception (LARC) devices inserted during an inpatient hospital stay for a delivery. LARC devices, including intrauterine devices (IUDs) and birth control implants, are defined as implantable devices that remain effective for several years to prevent pregnancies. Separate reimbursement applies to the LARC device only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital per diem rate.

To receive separate reimbursement for LARC devices inserted during inpatient hospital stays for delivery, providers can submit an outpatient or pharmacy claim with the most appropriate National Drug Code (NDC). Providers will receive their inpatient per diem rate in addition to being reimbursed separately for the LARC device.

MHD currently has a Fiscal Edit in place to prevent duplicate billing of non-oral contraceptive products. Providers are responsible for checking criteria to confirm their patient’s eligibility for a LARC device prior to billing MHD. The criteria for non-oral contraceptive products are available at: http://dss.mo.gov/mhd/cs/pharmacy/pdf/non-oral-contraceptives.pdf Login to CyberAccess to check the patient’s history or contact the MHD helpdesk at 800-392-8030 for confirmation. Claims for separate reimbursement of the LARC device are subject to post-payment review.

The outpatient reimbursement methodology for covered LARC implantations remains unchanged.

10.2.A(1) Intrauterine Device (IUD)

- The fee for procedure code 58300, insertion of an IUD, includes the physician’s fee.
- Procedure code 58301, removal of an IUD, includes the physician’s fee for removal of the IUD.

10.2.A(2) Non-biodegradable Drug Delivery Implant System

MO HealthNet covers the non-biodegradable drug delivery implant system.

The following procedure codes are for insertion only, removal only, or removal with reintertion only and do not include reimbursement for the device.

11981 Insert Non-Bio Drug Del Implant
11982 Remove Non-Bio Drug Del Implant

11983 Remove/Reinsert Non-Bio Drug Del Implant

The E/M procedure code may not be billed in addition to any of the non-biodegradable drug delivery implant system procedure codes, as it is included in the reimbursement for insertion and/or removal.

10.2.B ORAL CONTRACEPTION (BIRTH CONTROL PILL)

Prescribed oral contraceptives may be reimbursed by MO HealthNet through the Pharmacy Program. Additional information can be found in Section 10.2.B. of the Pharmacy Provider Manual.

10.2.C DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an E/M procedure code. The cost of the cervical cap may be billed using supply code A4261. The cost of the diaphragms may be billed using supply code A4266. An invoice indicating the type and cost of the diaphragm or cervical cap must be attached to the claim for manual pricing or a pharmacy claim form with the NDC can be submitted.

10.2.D STERILIZATIONS

For family planning purposes, sterilizations shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services.

10.2.D(1) Consent Form

The following procedures require that a (Sterilization) Consent Form be completed and submitted:

55250, 58565, 58600, 58605, 58611, 58615, 58670, 58671

The (Sterilization) Consent Form should be completed and submitted separately from a claim to Wipro Infocrossing either by mail or via the Internet. Reference Section 23 of this manual for additional information. Any claim for a sterilization procedure performed that does not have a signed, Missouri-approved (Sterilization) Consent Form is denied in accordance with mandated regulations set forth by the Centers for Medicare & Medicaid Services. All fields must be legible.

For any emergency voluntary sterilization service provided in non-bordering states for which a consent form is required, a consent form approved for use in another state...
may be accepted, providing it includes all the federally prescribed content and the same required information that the Missouri-approved form contains.

The (Sterilization) Consent Form, as described above, must be completed and signed by the participant at least 31 days, but not more than 180 days, prior to the date of the sterilization procedure. There must be 30 days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days.

The only exceptions to these time requirements are for situations involving premature delivery or emergency abdominal surgery.

- **Premature delivery**: The (Sterilization) Consent Form must be completed and signed by the participant at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. Expected date of delivery is required on the (Sterilization) Consent Form. (This also applies to consent forms used in lieu of the Missouri-approved (Sterilization) Consent Form for services provided in non-bordering states.)

- **Emergency abdominal surgery**: The (Sterilization) Consent Form must be completed and signed by the participant at least 72 hours prior to sterilization. The nature of the emergency abdominal surgery must be documented on the (Sterilization) Consent Form. (This also applies to consent forms used in lieu of the Missouri-approved (Sterilization) Consent Form for services provided in non-bordering states.)

**10.2.D(2) Informed Consent**

Informed consent has been given only if the person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure and if that person provided a copy of the (Sterilization) Consent Form to the individual to be sterilized.

The person obtaining consent has met the informed consent requirement if he/she orally provided all the following information or advice:

- The individual has been advised that he/she is free to withhold or withdraw consent to this procedure at any time before the sterilization. This decision does not affect the right to future care or treatment, and it does not cause the loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.

- The individual has been given a description of available alternative methods of family planning and birth control.
• The individual has been advised that the sterilization procedure is considered permanent and irreversible.

• The individual has been given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing.

• The individual has been advised of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthetic to be used.

• The individual has been given a full description of the benefits or advantages that may be expected as a result of the sterilization.

• The individual has been advised that the sterilization will not be performed for at least 30 days after the date the (Sterilization) Consent Form is signed, except under the circumstances specified on the form under Premature Delivery or Emergency Abdominal Surgery.

• For blind, deaf, or otherwise handicapped participants, suitable arrangements were made to ensure that all the information in this list was effectively communicated.

• An interpreter was provided if the individual to be sterilized did not understand either the language used on the (Sterilization) Consent Form or the language used by the person obtaining consent.

• The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.

_Informed consent for a sterilization procedure may not be obtained from a participant under the following conditions:_

• The participant is in labor or childbirth.
• The participant is seeking to obtain or is obtaining an abortion.

• The participant is under the influence of alcohol or other substances that affect the individual’s state of awareness.

_The (Sterilization) Consent Form must be signed and dated by:_

PRODUCTION : 11/20/2021
• The individual to be sterilized. (The (Sterilization) Consent Form must be signed and dated at the same time. The form will not be returned to the provider for addition of the participants missing signature or date.) If either of these requirements is not met, the procedure will be denied.
• The interpreter (if one was necessary).
• The person who obtained the consent (on or after the date of the participant signature).
• The physician who performed the sterilization.

All applicable items of the (Sterilization) Consent Form must be completely filled out.

The physician’s statement on the (Sterilization) Consent Form must be signed and dated by the physician who performed the sterilization on or after the date the sterilization procedure was performed. The date of the sterilization must match the date of service on the claim form.

The participant must:
• Be at least 21 years old at the time consent is obtained. There are no exceptions (42 CFR 441.253).
• Not be a mentally incompetent individual or an institutionalized individual (42 CFR 441.251).
• Have voluntarily given informed consent, in accordance with mandated regulations set forth by the Centers for Medicare & Medicaid Services and requirements by the Department of Social Services.

10.2.D(3) Definitions

Mentally Incompetent Individual:
• An individual who has been declared mentally incompetent for any purpose by a federal, state, or local court of competent jurisdiction unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Institutionalized Individual:
• An individual who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness.
• An individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
10.3 SERVICES NOT COVERED UNDER FAMILY PLANNING

- Condoms and devices or supplies available as non-prescribed, over-the-counter products are not covered services.
- Reversal of sterilization procedure is not covered.
- Abortions are not to be reported as family planning services.
- Hysterectomies for the purpose of family planning are not covered.

END OF SECTION
TOP OF SECTION
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), Pulaski (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),
Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Southwestern Missouri Managed Care Program began providing services to members on May 1, 2017. The southwestern Managed Care region includes the following counties: Barry (005), Barton (006), Christian (02), Dade (029), Dallas (030), Douglas (034), Greene (039), Hickory (043), Howell (046), Jasper (019), Lawrence (055), McDonald (060), Newton (073), Oregon (075), Ozark (077), Shannon (101), Stone (104), Taney (106), Texas (107), Webster (112), and Wright (114).

11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Western Missouri Managed Care Program (Kansas City area) began providing services to members on November 1, 1996. The western Managed Care region includes the following counties: Cass (019), Clay (024), Jackson (048), Johnson (051), Lafayette (054), Platte (083) and Ray (089). St. Clair (093) and Henry (042) counties were incorporated into the Western region effective 2/1/99. On January 1, 2008 four new counties were added to this region: Bates (007), Cedar (020), Polk (084) and Vernon (108).

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

The state has contracted with an independent enrollment agent to assist current and future MO HealthNet Managed Care participants to make an informed decision in the choice of a MO HealthNet Managed Care Health Plan that meets their needs.

The Managed Care enrollment agent sends mailers/letters, etc., provides MO HealthNet Managed Care Health Plan option information, and has a hot line number available to participants in order to make the selection process easy and informative.

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are not enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does not appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health
plan is not listed for the participant.

"OPT OUT" POPULATIONS: The Department of Social Services allows participants the option of choosing to receive services on a Fee-For-Service basis or through the MO HealthNet Managed Care Program. Participants are eligible to opt out if they are in the following classifications:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
- Described in Section 501(a)(1)(D) of the Act (children with special health care needs);
- Described in Section 1902(e)(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a));
- Receiving foster care or adoption assistance under part E of Title IV of the Act;
- In foster care or otherwise in out-of-home placement; or
- Meet the SSI disability definition by the Department of Social Services.

Fee-For-Service Members or their parent/guardian should call Participant Services at 1-800-392-2161. Participant Services will provide a form to request “Opt Out”. Once all information is received, a determination is made.

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

Refer to Section 1.5.C, MO HealthNet Managed Care Participants, and 1.1.A, Description of Eligibility Categories, for more information on Managed Care Health Plan members.

Managed Care Health Plan members fall into four groups:

- Individuals with the following ME Codes fall into Group 1: 05, 06, 10, 19, 21, 24, 26, 40, 60, and 62.
- Individuals with the following ME Codes fall into Group 2: 18, 43, 44, 45, 61, 95, 96, and 98.
- Individuals with the following ME Codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 64, 66, 68, 69 and 70.
- Individuals with the following ME Codes fall into Group 5: 71, 72, 73, 74, 75 and 97.

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

The following categories of assistance/individuals are not included in the MO HealthNet Managed Care Program.

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care–OAA), and 01 (Old Age Assistance-OAA);
- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State
Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);

- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);

- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;

- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);

- AIDS Waiver participants (individuals twenty-one (21) years of age and over);

- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;

- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);

- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);

- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;

- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women’s health services for one year plus 60 days, regardless of income level;

- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;

- Individuals with ME code 81 (Temporary Assignment Category);

- Individuals eligible under ME code 82 (MoRx);

- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);

- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and
• Individuals eligible under ME code 88 (Voluntary Placement).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

The MO HealthNet Managed Care Health Plans are required to provide health benefits to MO HealthNet Managed Care members for each date they are enrolled in the MO HealthNet Managed Care health plan. Managed Care members select a primary care provider (PCP) to provide routine care.

MO HealthNet enrolled providers (also called MO HealthNet Managed Care approved providers) who provide services to a Managed Care member do not receive direct reimbursement from the state for Managed Care health plan benefits furnished while the participant is enrolled in a MO HealthNet Managed Care health plan. MO HealthNet enrolled providers who wish to provide services for MO HealthNet Managed Care members must contact the Managed Care health plans for participation agreements/contracts or prior authorization.

The MO HealthNet Managed Care member must be told in advance of furnishing the service by the non-Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant must sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non- MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.

MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans must provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the Fee-For-Service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan’s administration of health care benefits.

Some services continue to be provided outside the MO HealthNet Managed Care health plan with direct provider reimbursement by the MO HealthNet Division. Refer to Section 11.7.

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

• Inpatient hospital services
• Outpatient hospital services
• Emergency medical, behavioral health, and post-stabilization care services
• Ambulatory surgical center, birthing center
• Asthma education and in-home environmental assessments
• Physician services (including advanced practice nurse and certified nurse midwife)
• 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

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• 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

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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](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
- Applied Behavior Analysis services for children with Autism Spectrum Disorder
- Comprehensive substance treatment and rehabilitation (CSTAR) services
  - Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
  - Newborn Screening Collection Kits
  - Special Supplemental Nutrition for Women, Infants and Children (WIC) Program
  - SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
- Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions
- Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
  - Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
  - Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure.

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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

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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](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 (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The MHD 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.

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 HOME HEALTH SERVICES

Reimbursement for home health services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Division (MHD) to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider’s actual billed charge (should be the provider’s usual and customary charge to the general public for the service), or the maximum allowable per unit of service. The billed amount for supplies must reflect only the provider’s cost.

12.2.A UNIT OF SERVICE

A unit of service, for both professional and home health aide service, is a visit. A visit is a personal contact for a period of time not to exceed three hours, in the participant’s place of residence. The visit is made for the purpose of providing one or more covered home health services.
12.2.B MAXIMUM PAYMENT

The statewide MO HealthNet reimbursement capitation for home health services is established by the MHD as the maximum rate allowable that assures cost containment and maximizes the availability of home health services.

The established maximum payment is effective for both in-state and out-of-state providers.

12.3 DETERMINING A FEE

Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established.

In determining what this fee should be, the MO HealthNet Division (MHD) uses the following guidelines:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee;
- Medicare’s allowable reasonable and customary charge payment or cost-related payment, if applicable;
- 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.

The MHD then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

12.3.A ON-LINE FEE SCHEDULE

MO HealthNet fee schedules through the MHD are available at http://dss.mo.gov/mhd. The on-line fee schedule identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The on-line fee schedule is updated quarterly and is intended as a reference not a guarantee for payment.

The on-line fee schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the fee schedule are set up by the service rendered and are not necessarily provider specific.

Refer to Section 13 of the Home Health 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. See Section 16 of the Home Health Provider Manual for a detailed explanation of these claims.

12.5 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay. The copay amount is paid by the participant at the time services are rendered. Services of the Home Health Program described in this manual are not subject to a copay amount. The provider must accept in full the amounts paid by the state agency plus any copay amount required of the participant. Refer to Section 13 of the Home Health 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.

Home health services are included as a plan benefit in MO HealthNet's managed care program.

12.6.A MANAGED HEALTH CARE

Under a managed care health plan, a basic set of services is provided either directly or through subcontractors. Managed care health plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage. Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month must provide for all needed health care to all participants in the group covered.

The health plan is at risk for staying within the overall budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month but many more cases cost less than the negotiated rate.

The MO HealthNet Program utilizes the managed care delivery system for certain included MO HealthNet eligibles. Refer to Section 1 and Section 11 of the Home Health Provider Manual for a detailed description.
SECTION 13-BENEFITS AND LIMITATIONS

13.1 HOME HEALTH SERVICES

The conditions of coverage of the MO HealthNet Home Health Program are set forth in 13 CSR 70-90.010 Home Health Care Services. The Rule incorporates, in large part, Medicare's standards and guidelines regarding coverage of home health services. Accordingly, the following sections of the Medicare Home Health Manual have been incorporated into the MO HealthNet policy:

• Skilled nursing care;

• Regarding the therapies, the conditions of coverage set forth in this section are applicable to MO HealthNet coverage, as long as the participant requires physical, occupational or speech therapy for conditions described later in this section;

• Services of a home health aide; and

• Medical supplies. This includes Medicare's exclusion of coverage for drugs and biologicals as supplies. MO HealthNet does not incorporate the Medicare policy regarding medical appliances and durable medical equipment because such items are available to participants through the Durable Medical Equipment Program.

Section 13 defines the benefits and limitations of the MO HealthNet Home Health Program and clarifies existing differences in Medicare and MO HealthNet policy regarding covered and non-covered services. Those Medicare standards and guidelines applicable to the coverage of MO HealthNet home health services are included.

13.2 SERVICE DEFINITIONS

Home health services provide primarily medically-oriented treatment or supervision to individuals with an acute illness, or an exacerbation of a chronic or long-term illness, which can be therapeutically managed at home. The care follows a written plan of treatment established and periodically reviewed by a physician. The following is a brief description of the types of home health services available under MO HealthNet.

13.2.A SKILLED NURSING

Nursing services are specifically skilled services used in the treatment of an illness or injury. These services include assessing, teaching, planning, interviewing, and evaluating patient or family needs and their responses to nursing care, as well as supervising and providing nursing care to persons in their own homes. The services are provided by, or under the supervision of, a registered nurse in accordance with the physician prescribed treatment plan.
Skilled nursing activities include making the initial evaluation visit, regularly reevaluating the patient’s nursing needs, initiating appropriate preventive and rehabilitative nursing procedures, preparing clinical assessment documentation and progress notes, coordinating services, informing the physician and other personnel of changes in the patient’s condition and needs, counseling the patient and family in meeting nursing and related needs, participating in in-service programs, and supervising and teaching other nursing personnel, including home health aides.

13.2.B HOME HEALTH AIDE SERVICES

These services are given under the direction and supervision of a registered nurse or appropriate professional staff member such as a physical or occupational therapist, when there is a prescribed specific need for simple skills and personal care services in helping the assigned patient with the activities of daily living. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Home health aide activities include performing simple procedures as an extension of therapy services, personal care, and household services essential to health care at home, assisting with medications that are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively, reporting changes in the patient’s condition and needs and completing appropriate records.

13.2.C PHYSICAL THERAPY

Physical therapy is a specifically prescribed program directed toward the development, improvement or restoration of neuro-muscular or sensory-motor function, relief of pain or control of postural deviations to attain maximum performance. Physical therapy services include the evaluation and treatment related to range of motion, muscle strength, functional abilities and the use of adaptive/therapeutic equipment. Activities include, but are not limited to, rehabilitation through exercise, massage, the use of equipment and therapeutic activities.

13.2.D OCCUPATIONAL THERAPY

Occupational therapy is the provision of services that address the developmental or functional needs of a person related to the performance of self-help skills, adaptive behavior and sensory, motor and postural development. Evaluation and treatment services are available to correct or ameliorate physical and/or emotional deficits. Typical activities related to occupational therapy are:

- Perceptual motor activities;
- Exercises to enhance functional performance;
- Kinetic movement activities;
- Guidance in the use of adaptive equipment; and
• Other techniques related to improving motor development.

13.2.E  SPEECH THERAPY

Speech/language therapy is the evaluation and provision of treatment for the redemption and development of age appropriate speech, expressive and receptive languages, oral motor and communication skills. Speech treatment includes activities that stimulate and facilitate the use of effective communication skills. Speech/language therapy includes treatment in one or more of the following areas:

• Articulation;
• Language development;
• Oral motor/feeding;
• Auditory rehabilitation;
• Voice disorders; and
• Augmentative communication modes.

13.2.F  Habilitative Services

Effective July 1, 2021, habilitative skilled therapy (physical, occupational and speech) services are covered for participants in a category of assistance for the adult expansion group (Medicaid eligibility code E2). Habilitative skilled therapy services are physical, occupational or speech therapy services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for an individual who is not walking or talking at the expected age.

13.3 PROVIDER PARTICIPATION

To participate in the MO HealthNet Home Health Program, the home health agency must be currently licensed with the Missouri Department of Health and Senior Services, must be Medicare certified, and must have a current MO HealthNet provider agreement.

To apply for MO HealthNet Home Health Program participation, the following documentation must be submitted to the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Unit, P.O. Box 6500, Jefferson City, Missouri 65102.

• MO HealthNet “Title XIX Participation Agreement for Home Health Services” and “MO HealthNet Provider Questionnaire.”
• A signed “MO HealthNet Enrollment Application.”
• A copy of the provider’s Medicare Home Health Certification, which includes the Medicare number.
• A copy of the most recent Medicare rates notification letter.

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

Any changes in provider records must be submitted in writing to the Department of Health and Senior Services, Home Health Licensing, prior to submitting the information in writing to the Provider Enrollment Unit. The notification to the Provider Enrollment Unit must be made in writing and must include the provider name(s) and National Provider Identifier(s) (NPI), the requested change(s), a contact person and their phone number, and the original signature of the owner. Examples of changes are: address or telephone number change; change of ownership; change of name; change from a Social Security number to a taxpayer or employer I.D. number; Medicare rate changes or change of medical directors.

Specific information about MO HealthNet participation requirements for the Home Health Program can be obtained from the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Unit, P.O. Box 6500, Jefferson City, MO 65102.

13.4 PARTICIPANT ELIGIBILITY

The participant must be eligible for MO HealthNet services on the day the service is delivered, or the provider will not be reimbursed through MO HealthNet. This is a requirement even when the service has been prior authorized. It is the responsibility of the provider to verify eligibility by contacting the interactive voice response (IVR) system at (573) 751-2896 or through emomed.com on the day the service is provided, to determine that the participant is eligible as of that date.

Home Health Program skilled therapy services are not covered for individuals covered under a limited benefit package as described in Section 1.5.A of the Home Health Provider Manual. For further information regarding participant MO HealthNet eligibility reference Section 1 of the Home Health Provider Manual.

Effective July 1, 2021, habilitative skilled therapy (physical, occupational and speech) services are covered for participants in a category of assistance for the adult expansion group (Medicaid eligibility code E2).

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

### 13.6 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 Home Health program described in this manual are *not* subject to a copay amount.

### 13.7 MO HEALTHNET MANAGED CARE

Health plans are required to provide home health services for all MO HealthNet Managed Care enrollees as needed. Plans may arrange for these services in the manner they choose.

### 13.8 REIMBURSEMENT

MO HealthNet payment for home health services is the lower of the provider's usual and customary charge to the general public or the MO HealthNet maximum allowable fee for service. See Section 12 of the Home Health Provider Manual for further information.

#### 13.8.A PLACE OF SERVICE

Home health services may be provided in an individual's residence and in any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities or any setting in which payment is or could be made under MO HealthNet for inpatient services.

Home health services *must* be reasonable and necessary and may *not* duplicate services already available in that facility.

### 13.9 CONDITIONS TO BE MET FOR COVERAGE OF HOME HEALTH SERVICES

A home health provider shall be entitled to payment from MO HealthNet for therapeutic or rehabilitative services when all of the following conditions are met:

- The home health provider is a Medicare-certified home health agency, licensed by the State of Missouri and enrolled with the MO HealthNet Program;
- The services are covered within the MO HealthNet Home Health Program;
• The participant is an eligible MO HealthNet participant on the date of service and meets the home health eligibility criteria;

• The services constitute active treatment for an illness or injury, and are reasonable and necessary in relation to the diagnosis for which care is required;

• The services are prescribed by a MO HealthNet enrolled physician and provided in accordance with a written Plan of Care, which clearly documents the need for services and is reviewed by the physician at least every 60 days; and

• The combined total of all skilled nurse and home health aide visits reimbursed on behalf of the participant do not exceed 100 visits per calendar year.

13.9.A DETERMINATION OF COVERAGE

The participant’s health status and medical need, as reflected in the home health Plan of Care (CMS-485, CMS-486 and CMS-487) provide the basis for determination as to whether services are reasonable and necessary. The determination of coverage is based upon the objective clinical evidence contained in this document regarding the participant’s individual need for care. Services must be consistent with the nature and severity of the individual's illness or injury and accepted standards of medical practice. Reimbursement is only made if a physician certifies the need for services and establishes a Plan of Care. Services directed solely to the prevention of illness or injury is not covered under the MO HealthNet Home Health Program.

13.9.B FACE-TO-FACE REQUIREMENTS

Home health program services are covered only if a face-to-face encounter occurs with the participant that meets the requirements of 42 CFR 440.70. The face-to-face encounter must:

• Be related to the primary reason that the participant requires home health services;

• Occur between the participant and the ordering physician or one of the following non-physician practitioners (NPP):
  o Nurse practitioner or clinical nurse specialist working in collaboration with the ordering physician and in accordance with state law
  o Certified nurse midwife
  o Physician Assistant under the supervision of the ordering physician
  o Attending acute or post-acute physician if the participant is admitted to home health services immediately after an acute or post-acute stay

• Occur within a period that is no more than 90 days before or 30 days after the start of home health services.

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If an allowed NPP performs the face-to-face encounter, the clinical findings of that face-to-face encounter must be communicated to the enrolled ordering physician.

The face-to-face encounter may occur through telehealth, as allowed by State law.

13.9.B.2 Face-to-Face Documentation Requirements

The home health agency must obtain documentation substantiating that the face-to-face requirements have been met. The documentation may be maintained in either hard copy or electronic form in the Home Health Agency (HHA) participant’s medical record. The documentation must include the following:

- The clinical findings of the face-to-face encounter, substantiating the need for home health services;
- The primary reason for which home health services are required;
- The date of the face-to-face encounter; and
- The name and credentials of the practitioner who conducted the encounter.

The home health agency must ensure that it has received this documentation for each participant for whom a face-to-face visit is required. The home health agency must maintain the documentation in hard copy or electronic form, as part of the participant’s medical record at the home health agency.

Documentation substantiating the need for home health services will be based on initial orders from the ordering physician’s medical record and/or the acute/post-acute care facility’s medical records. Home health agency documentation may be used to support the need for home health and must be signed off on by the ordering physician and incorporated into the medical record.

13.9.C PLAN OF CARE

The term "Plan of Care" refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse or medical home health professional. Providers must use the CMS-485, CMS-486 or CMS-487 or forms developed by the agency that contains all fields and information on the standardized forms for MO HealthNet participants. Plan of Care documents and interim order(s) must be maintained in the patient's record. Section 14 of the Home Health Manual, Special Documentation Requirements, contains sample forms and instructions for completion.

The Plan of Care must contain all pertinent diagnoses, including participant’s mental status, the types of services, supplies, the frequency of the visits to be made, prognosis, rehabilitation potential, medications and treatments, safety measures to protect against injury,
discharge plans, and any additional items the home health agency or physician choose to include.

The orders on the Plan of Care must indicate the type of services to be provided to the participant both with respect to the professional who will provide them and with respect to the nature of the individual services, as well as the frequency of the services.

EXAMPLE: SN 7/wk x 1/wk; 3/wk x 4/wk; 2/wk x 3/wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedures).

Orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of service is provided to home health participants. Under MO HealthNet, interim orders and plans of care may not exceed a one-visit variance in the frequency of the ordered care. For example, the order may read 1 to 2 times per week. The frequency of service delivery within the one visit range is at the discretion of the provider, as long as the medical necessity for each visit, and for increasing/decreasing visits, is clearly documented in the plan of care or interim order and maintained in the patient's record.


"PRN" may be used if the number of visits is specified and the order does not exceed a one-visit variance in the frequency of the ordered care (e.g., PRN 2-3 times per week).

The Plan of Care must be reviewed and re-established by the physician at least every 60 days. Any increase in the frequency of services or addition of new services during a certification period must be authorized by the physician by way of a verbal order or written order prior to the provision of the increased or additional services. If a verbal order is given by the attending physician, the nurse or therapist must immediately put the order in writing and date and sign it. It must then be countersigned by the physician as soon as possible and maintained in the patient's record.

Services that are provided from the beginning of the certification period and before the physician signs the Plan of Care are considered to be provided under a Plan of Care established and approved by the physician only when there is a verbal order for the care prior to delivery of the services. The verbal order must be documented and the services must be included in a signed Plan of Care. Services that are provided after the expiration of a Plan of Care, but before the acquisition of a verbal order or a signed Plan of Care, cannot be considered for payment by MO HealthNet.

Any changes to the Plan of Care must be documented on an interim order which must be maintained in the patient's record.
13.9.D PHYSICIAN CERTIFICATION

The home health agency must be acting upon a physician certification which is part of the Plan of Care (CMS-485). The physician must certify that:

- The participant requires intermittent skilled nursing services which are reasonable and necessary for the treatment of an injury or illness; or
- Physical, occupational or speech therapy are necessary for conditions noted later in Section 13 of the Home Health Provider Manual;
- A Plan of Care had been established while the individual was under the care of a physician; and
- The services were furnished while the individual was under the care of a physician.

The physician certification may cover a period less than but not greater than 60 days. The Plan of Care for any certification period must be signed and dated by the attending physician before a claim is submitted for payment. The form may be signed by another physician who is authorized by the attending physician to care for the participant in the physician’s absence. If the physician omits the date, the provider must enter the date the Plan of Care was received back from the physician.

13.10 COVERAGE LIMITATIONS

13.10.A INTERMITTENT SKILLED NURSING SERVICES

MO HealthNet adheres to the Medicare home health definition of "intermittent" as "a medically predictable recurring need for skilled nursing services." In most instances, this definition refers to a participant requiring a skilled nursing service at least once every 60 days and in rare instances, every 90 days.

The MO HealthNet Division evaluates claims involving skilled nursing services furnished less frequently than once every 60 days. Payment is made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

- The patient with an indwelling silicone catheter who generally needs a catheter change only at 90-day intervals or three months;
- The person who experiences a fecal impaction due to the normal aging process (e.g., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to pinpoint a specific time frame; or
• The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, are to observe and determine the need for changes in the level and type of care which have been prescribed, thus supplementing the physician's contacts with the patient.

When the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit is reimbursable. However, a one-time order (e.g., to give gamma globulin following exposure to hepatitis) is not considered a need for "intermittent" skilled nursing care since a recurrence of the problems that require this service is not medically predictable.

Although most participants require services no more frequently than several times a week, MO HealthNet pays for part-time medically reasonable and necessary skilled nursing care seven days a week for a short period of time (two-three weeks). See Section 13.14 of the Home Health Provider Manual for an explanation of MO HealthNet coverage of part-time and intermittent skilled nursing and home health aide services.

There may also be a few cases involving unusual circumstances when the patient's prognosis indicates the medical need for daily skilled services that extends beyond three weeks. When the patient's physician makes this judgment, which usually should be made before the end of the three-week period, the home health agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time; i.e., a patient who requires institutionalization, usually does not qualify for home health benefits.

13.10.B DAILY VISITS

When a patient has a medical condition requiring daily visits and these visits are judged to be reasonable and necessary, three weeks of service is paid beginning with the onset of daily visits. After this initial period, there must be medical documentation justifying need for continued daily visits including an estimate of the length of time additional visits are necessary. Daily visits may be covered for up to three weeks and, in unusual cases, for more than three weeks. Documentation for all daily visits must include a projected stop date. Beyond three weeks, the medical necessity and appropriateness of the service are very closely reviewed.

13.10.C MULTIPLE/VISITS PER DAY

MO HealthNet pays for daily skilled nursing visits twice per day when documentation clearly substantiates that the service is reasonable and necessary for the active treatment of an illness.
or injury and that the need for such service is short-term. Twice a day visits are not normally paid for more than seven consecutive days, but the final decision on payment is based on the treatment being provided and the complexity of the patient's condition.

13.10.D FIRST VISIT POST-HOSPITALIZATION

The first visit after a patient has been discharged from the hospital is not reviewed on the basis of the time that has elapsed since discharge. The review focuses on whether or not a reasonable and necessary skilled service for the treatment of the patient's illness or injury has been delivered. If the only service provided during the initial visit consists of evaluation, it must be an evaluation of the patient's unstable medical condition, supported by the diagnosis and treatment(s) ordered, and meeting the other requirements for the payment of skilled observation and evaluation. The service provided in this situation may be provided simultaneously with, but is distinct from, the initial assessment of environmental factors, attitude of family members, etc., required for determining whether or not the provider accepts the patient for care. Such initial assessment, by itself, does not qualify for payment.

13.10.E VISITS MADE WHEN PARTICIPANT IS NOT AT HOME

Home health services are not covered while the patient is in a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF). No payment is made for services that were not delivered due to the patient's absence from home, except for one visit when the patient's absence was due to death, hospitalization, or placement in a nursing home, if the provider was unaware of the absence. The provider must document the circumstances on the medical update or addendum.

13.10.F DUPLICATION OF HOME HEALTH CARE WITH PHYSICIAN/CLINIC VISITS

When the claims review process indicates that a participant has routinely and frequently visited a physician or clinic, the MO HealthNet Division will question why home health skilled nursing services cannot be provided in the physician's office or clinic.

Documentation supporting the need for the home health visit in addition to the routine visit to the physician must be entered on the Plan of Care.

13.10.G ADMINISTRATIVE EVALUATION VISITS

Home health agencies are required by regulation to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit.
since at this point the patient has not yet been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of treatment, the visit becomes the first billable visit.

NOTE: The Plan of Care must be established with evidence of physician's orders to justify reimbursement for the evaluation visit as a skilled visit.

13.10.G(1) Supervisory Visit

A supervisory visit made by a nurse or other appropriate personnel to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is considered an administrative function and is not chargeable to MO HealthNet or the patient as a skilled visit.

13.10.H IMPACT OF OTHER AVAILABLE CAREGIVERS

A MO HealthNet eligible participant who meets the criteria for coverage of home health services is entitled to have the costs of reasonable and necessary services reimbursed by MO HealthNet without regard to whether there is someone available in the home to furnish them. However, when a family member or other caring person is or will be providing services that adequately meet the patient's needs, it is not considered reasonable and necessary for home health agency personnel to furnish such services.

Home health services are reimbursable by MO HealthNet even if the participant qualifies for institutional care (e.g., hospital care or skilled nursing facility care), as long as the care is reasonable and necessary and can be safely delivered in the home.

13.10.I MEDICARE\MO HEALTHNET ELIGIBLE FOR HOME HEALTH SERVICES

When a participant of home health services is eligible for both Medicare and MO HealthNet, and the services are covered by both Medicare and MO HealthNet, the provider must bill Medicare first. If Medicare denies the claim, it may be submitted to MO HealthNet with the Medicare denial information attached, for consideration of payment.

The MO HealthNet fiscal agent automatically denies all home health claims for services to Medicare/MO HealthNet eligible participants, unless the claim is accompanied by evidence of a Medicare denial. Those claims that have such an attachment are reviewed to determine if they met MO HealthNet criteria, despite the Medicare denial.
In order to permit MO HealthNet reimbursement for services that are not payable by Medicare, there must be one of the following valid attachments on the submitted claim:

- A denial letter from Medicare referring to the service billed.
- A Medicare RA/EOMB that denies the service (e.g., exhaustion of benefits part of the service not covered, participant ineligible for Medicare on date of service).
- A CMS-1600 form (Request for claim number verification) which is dated no earlier than 365 days before the date of service.

For further information regarding billing instructions for participant’s over 65 years of age, please reference Section 15 of the Home Health Provider Manual.

13.11 SKILLED NURSING CARE SERVICES

Skilled nursing care is a covered home health service and is reimbursable under the MO HealthNet Program provided that all of the following conditions are met:

- The services are ordered by and included in the Plan of Care established by the physician for the patient.
- The services are required on an intermittent basis.
- The services are performed by or under the direct supervision of a licensed nurse (RN or LPN) to assure the safety of the patient and to achieve the medically desired result.
- The services are reasonable and necessary to the treatment of an illness or injury.

Services for skilled nursing care can be paid without regard to whether the patient has a terminal, chronic or acute illness or the condition is stable or unstable, as long as the skilled nursing care is reasonable and necessary to treat an illness or injury.

Services are considered reimbursable skilled nursing services on the basis of complexity, e.g., intravenous and intramuscular injections or insertion of catheters, or based on the condition of the participant. Following are examples in which the condition of the participant may cause a service that is ordinarily considered unskilled to be considered a skilled nursing service.

EXAMPLE 1: The presence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, the patient with a pre-existing peripheral vascular or circulatory condition might need skilled nursing to observe for complications and to monitor medication administration for pain control.

EXAMPLE 2: The condition of a participant who has irritable bowel syndrome, or who is recovering from rectal surgery, may be such that the participant can be given an enema safely and effectively only by a skilled nurse. If the enema is necessary to treat the illness or injury, then the visit is covered as a skilled nursing service.
A service is *not* considered skilled because it is performed by a nurse. The unavailability of a competent person to provide a non-skilled service does *not* make it a skilled service even if a skilled nurse provides it.

A service that requires the skills of a licensed nurse is considered a skilled service even if it is taught to the patient, the patient's family or other caregivers.

**EXAMPLE:** A participant was discharged from the hospital with an open draining wound that required irrigation, packing and dressing twice each day. The home health agency has taught the family to perform the dressing changes. The home health agency continues to see the patient for the wound care that is needed during the time that the family is *not* available and willing to provide it. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as it is required by the patient.

### 13.11.A SKILLED OBSERVATION AND EVALUATION

For skilled observation and evaluation to be considered a reasonable and necessary active treatment for an injury or illness, a probability *must* exist that significant change(s) will occur in the patient's condition. This probability derives from the onset of a new condition or exacerbation of a previously existing condition and is no longer considered a reasonable probability when there is a three-week period in which no significant change in the patient's condition actually occurs. Suitable documentation of a significant change in condition includes either a recent exacerbation of condition or a change in medication or treatment order.

Observation of fluctuating vital signs does *not* suffice, in most cases, as the sole documentation of the need for observation and evaluation. Indications such as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment when these indications are likely to result in changes to the treatment of the participant. Observation and evaluation by a skilled nurse is *not* reasonable and necessary to the treatment of the illness or injury when these indications are part of a long-standing pattern of the participant’s condition, and there is no attempt to change the treatment to resolve them.

The Plan of Care *must* document all significant changes in condition: vital signs and symptoms should be included, together with physician contacts and subsequent changes in treatment. *All observations and activities should be dated.*

The frequency of covered visits solely for observation and evaluation depends on the complexity of the participant’s condition and the necessity for the service. In general, however, reimbursement is made for one visit per week unless documentation justifies
greater frequency. Providers should note, however, that when the patient is visiting the physician once per week, the necessity for additional nurse visits is questioned.

13.11.B MANAGEMENT AND EVALUATION OF A PATIENT CARE PLAN

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary when underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the participant’s Plan of Care, the complexity of the necessary unskilled services which are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the participant’s overall condition. The management and evaluation of the care plan must be identifiable in the nursing documentation.

13.11.C TEACHING AND TRAINING

Teaching and training a participant, the participant’s family, or caregivers how to manage the treatment regimen are MO HealthNet covered home health services under the following conditions:

- The teaching and training is reasonable and necessary to the treatment of the illness or injury;
- The teaching and training activities require the skills or knowledge of a nurse; and
- The teaching and training must be documented in the record.

The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught.

When it becomes apparent after a reasonable period of time that the patient, family or caregiver will not or is not able to learn or be trained, then further teaching and training ceases to be reasonable and necessary. The reason that the patient, family or caregiver will not or is not able to learn or be trained should be documented in the record. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training is considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the participant’s illness, functional loss or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration is given to whether the teaching provided in the home constitutes a reinforcement of teaching provided in an institutional setting or constitutes the initial instruction received by the patient. If it constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training. However, this
does not preclude payment for more than the average number of visits when the facts indicate that the ability of the patient to comprehend and utilize the teaching given in the hospital in the home setting is such that additional teaching visits to the home were required. Visits made solely to remind or emphasize to the patient or the patient’s family the need to follow the instruction provided do not require the skills of a nurse.

Visits by a nurse as part of an initial training program to supervise and evaluate the practical application of the training provided requires the skills of a nurse and is considered reasonable and necessary when the complexity of the service being taught indicates such visits are warranted, for example, insulin injections or preparation of formula feedings for gastrostomy patients.

If a physical therapist or occupational therapist is visiting the home it is not considered necessary to have a licensed nurse visit the home to provide instruction in the use of supportive devices, self-care activities, body alignment and positioning, and transfer activities since such activities are generally carried out within the physical therapy or occupational therapy program established for the patient.

If visits to provide needed training exceed the usual number of visits required to teach the average non-medical person how to perform a particular procedure or service, the provider is required to furnish documentation as to why the additional visits were necessary upon submission of the claim.

Re-teaching and retraining for an appropriate period may be considered reasonable and necessary when there is a change in the procedure or the participant’s condition that requires re-teaching, or when the participant, family or caregiver is not properly carrying out the task. The Plan of Care should document the reason that the re-teaching or retraining is required.

13.11.C(1) Teaching and Training Activities

Teaching and training activities that require the skills of a licensed nurse include, but are not limited to the following:

- Teaching administration of medical gases;
- Teaching wound care when the complexity of the wound, the overall condition of the participant or the ability of the caregiver makes teaching necessary;
- Teaching care for a recent ostomy or when reinforcement of ostomy care is needed;
- Teaching self-catheterization;
- Teaching self-administration of gastrostomy or enteral feedings;

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• Teaching bowel or bladder training when bowel or bladder dysfunction exists;
• Teaching how to perform the activities of daily living when the participant or caregiver must use special techniques and adaptive devices due to a loss of function;
• Teaching transfer techniques, e.g., from bed to chair, which are needed for safe transfer;
• Teaching proper body alignment and positioning, and timing techniques of a bed-bound participant;
• Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to recent functional loss;
• Teaching prosthesis care and gait training;
• Teaching the use and care of braces, splints and orthotics and associated skin care;
• Teaching the proper care and application of any specialized dressings or skin treatments (for example, dressings or treatments needed by participants with severe or widespread fungal infections, active or severe psoriasis or eczema, or due to skin deterioration from radiation treatments);
• Teaching the preparation and maintenance of a therapeutic diet; and
• Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

13.11.D ADMINISTRATION OF MEDICATIONS

Drugs and biologicals are specifically excluded from MO HealthNet coverage under the Home Health Program. However, the services of a licensed nurse that is required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. When these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the participant’s illness or injury, and there must be a medical reason that the parenteral medication cannot be taken orally. Moreover, the frequency and duration of the
administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances which justify the need for the additional injections.

Vitamin B-12 injections are considered specific therapy only for the following conditions:

- Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;
- Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome; and
- Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

For an individual with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injections of vitamin B-12, at a dose of from 100 to 1000 micrograms no more frequently than once monthly, are the accepted reasonable and necessary dosage schedules for maintenance treatment and are covered by MO HealthNet. More frequent injections are appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose. Injections more frequent than once a month must be physician ordered and the need must be documented in the Plan of Care.

13.11.E INSULIN INJECTIONS

Insulin is customarily self-injected by patients or is injected by their families. However, when a participant is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the participant, the injections are considered reasonable and necessary skilled nursing services and reimbursable under MO HealthNet subject to the 100-visit limit.

EXAMPLE: A participant who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss which cause the participant not to be able to fill syringes or to self-inject the needed insulin. If there is no able and willing caregiver to inject the insulin, skilled nursing care is reasonable and necessary for the injection of the insulin.

The pre-filling of syringes with insulin (or other medication that is self-injected) is a covered service when the participant meets the home health eligibility criteria and requires additional skilled nursing care on an intermittent basis or physical, occupational or speech therapy. If the participant needs someone only to pre-fill syringes (and therefore needs no skilled nursing care on an intermittent basis, or physical, occupational or speech therapy), the
participant does not qualify for MO HealthNet home health coverage. Provision of this service is available through the Personal Care Program (Authorized Nurse Visit) for qualifying individuals. Referral must be made through the local office of the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS).

13.11.F ORAL MEDICATIONS

The administration of oral medications by a licensed nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the participant’s condition, the nature of the drugs prescribed and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The Plan of Care must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

13.11.G EYE DROPS AND TOPICAL OINTMENTS

The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer them, the visits cannot be covered as a skilled nursing service. This does not preclude coverage of skilled nursing visits for teaching self-care and for observation and evaluation of the participant’s condition, as in the case of post-cataract surgery.

13.11.H TUBE FEEDINGS

Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and the replacement, adjustment, stabilization and suctioning of the tubes are skilled nursing services. If the feedings are required to treat the participant’s illness or injury, the feedings, and the replacement or adjustment of the tubes are covered as skilled nursing services.

13.11.I NASOPHARYNGEAL AND TRACHEOSTOMY ASPIRATION

Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the participant’s illness or injury, are covered as skilled nursing services.

13.11.J CATHETERS

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. When the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use are considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally
require skilled care once every 60-90 days and this frequency of service is considered reasonable and necessary. However, when there are complications that require more frequent skilled care related to the catheter, such care is, with adequate documentation, covered.

EXAMPLE: A participant who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to 2 additional visits per month for skilled observation and evaluation and/or catheter changes if the participant or participant’s family reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the participant’s family contacts the home health agency because the participant has an elevated temperature, abdominal pain, and scant urine output. The skilled nurse visits the participant and determines that the catheter is plugged and that there are symptoms of a urinary tract infection. The skilled nurse changes the catheter, and contacts the physician regarding the findings, and to discuss treatment. The skilled nursing visit to change the catheter and to evaluate the participant is reasonable and necessary to treatment of the illness or injury.

13.11.K WOUND CARE

Wound care, (including, but not limited to ulcers, burns, pressure ulcers, open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency and quantity), condition and appearance of surrounding skin of wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. MO HealthNet coverage or denial of skilled nursing visits for wound care is not based solely on the stage classification of the wound, but upon all of the documented clinical findings contained in the Plan of Care. Moreover, the Plan of Care must contain the specific instructions for the treatment of the wound. When the physician has ordered appropriate active treatment (e.g., sterile or complex dressing changes, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or which have a foul odor present or for which the participant is receiving antibiotic therapy;
- Wounds with a drain T-tube which requires adjustment or repositioning of such drains;
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
• Recently debrided ulcers;
• Pressure sores (decubitus ulcers) which present the following characteristics:
  • There is partial tissue loss with signs of infection such as a foul odor or purulent drainage, or
  • There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as a muscle or bone;
• Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
• Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
• Post-operative wounds when there are complications such as infection or allergic reaction or when there is an underlying disease which has a reasonable potential to adversely affect healing (e.g., diabetes);
• Third degree burns, and second degree burns when the size of the burn or presence of complications causes skilled nursing care to be needed;
• Skin conditions requiring application of nitrogen mustard or other chemotherapeutic medication which present a significant risk to the beneficiary; or
• Other open or complex wounds that require treatment that can only be safely and effectively provided by a licensed nurse.

Following are examples of the types of wound care that are reimbursable under MO HealthNet:

EXAMPLE 1: A participant has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services.

EXAMPLE 2: A participant experiences a pressure ulcer with full thickness tissue loss that extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment and understanding of cellular adherence and/or exudate or tissue healing or necrosis.

NOTE: This section relates to the direct, hands on skilled nursing care provided to participants with wounds, including any necessary dressing changes on those wounds.
Wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication or skilled teaching of wound care to the participant or the participant’s family.

13.11.L OSTOMY CARE

Ostomy care during the post-operative period and in the presence of associated complications when the need for skilled nursing care is clearly documented in the Plan of Care is a reimbursable skilled nursing service under MO HealthNet. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

13.11.M HEAT TREATMENTS

Heat treatments that have been specifically ordered by a physician as part of active treatment of an illness or injury and which require observation by a licensed nurse to adequately evaluate the patient's progress are considered MO HealthNet covered skilled nursing services.

13.11.N MEDICAL GASSES

Initial phases of a regimen involving the administration of medical gasses which are necessary to the treatment of the participant’s illness or injury, is reimbursed under MO HealthNet as skilled nursing care for skilled observation and evaluation of the participant’s reaction to the gasses, and to teach the patient and family when and how to properly manage the administration of the gasses.

13.11.O REHABILITATION NURSING

Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) qualifies for coverage under MO HealthNet as a skilled nursing service.

13.12 STUDENT NURSE VISITS

Visits by a student nurse may be covered as skilled nursing care under MO HealthNet when a home health agency participates in training programs in which it utilizes student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care, and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurses on each visit.
13.13 PSYCHIATRIC NURSING SERVICES

MO HealthNet home health covers psychiatric nursing as skilled nursing services when, in addition to meeting the home health eligibility criteria, all of the following conditions are met:

- The patient has one of the following primary psychiatric diagnoses certified in writing by a physician;
  - Schizophrenic disorders
  - Paranoia;
  - Bipolar disorders;
  - Unspecified psychosis;
  - Major depression recurrent; or
  - Dementia and other conditions complicated with delusional disorder, mood disorder or anxiety disorder.*
- The patient required active treatment under the care of a physician on either an outpatient or inpatient basis as a result of a psychiatric disorder;
- The services are prescribed by a physician and provided in accordance with a Plan of Care which clearly documents the need for services and is reviewed by the physician at least every 60 days;
- The services are delivered by a nurse with specialized psychiatric training; and
- The objectives of the prescribed active treatment are measurable by physical criteria (i.e., increased appetite, increased energy level, appropriate affect) and the treatment and results are well documented.

When the patient meets the above-stated criteria, psychiatric nurse services may be reimbursed for a stabilization period of not more than three weeks with a frequency of not more than twice a week.

Additional three-week periods may be covered with documentation of continued instability and the determination by the unit reviewing the claim(s) that the services are reasonable and necessary to the stabilization of the illness.

Psychiatric nurse services include patient education and assessment, medication management and supportive counseling. These services are distinguished from the psychiatric services of a physician and do not include medical psychotherapy. MO HealthNet interprets "medical psychotherapy" to mean that the physician is personally involved on a one-to-one basis in an individual setting with the patient, during which there is discussion about the patient's problems as related to the diagnosis.

13.13.A PSYCHIATRIC NURSE QUALIFICATIONS
A nurse with specialized psychiatric training is a nurse who has special training and/or experience beyond the standard curriculum required for an R.N. Examples of such special training or experience includes a master’s degree in psychiatric, or mental health nursing or equivalent training, experience as a member of the nursing staff in an active treatment unit or a psychiatric hospital (this experience is beyond that gained as part of a registered nurse's training), or experience as a member of an outpatient mental health clinic or hospital. Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as home health agencies, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases.

Services of non-psychiatric nursing such as intramuscular injections of behavior modifying medications are a covered home health benefit as long as the psychiatric patient has a medically predictable recurring need for a skilled nursing visit at least every 90 days and continues to meet the home health eligibility criteria.

13.14 HOME HEALTH AIDE SERVICES

Home health aide services are MO HealthNet covered services when the participant meets the home health qualifying criteria.

The services of the aide must be reasonable and necessary to maintain the participant at home and there must be no other person available who could and would perform the services.

The services of the aide must be supervised by a registered nurse or other appropriate professional staff member, whose visits are not separately reimbursed unless a covered skilled nursing or therapy service, as prescribed on the Plan of Care, is performed concurrently.

The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician who indicates the participant’s need for personal care services. The reason for the visits by the home health aide must be to provide hands-on personal care of the participant, or services that are needed to maintain the participant’s health or to facilitate treatment of the participant’s illness or injury.

The physician's order should indicate the frequency of the home health aide services required by the participant. These services may include but are not limited to:

- Personal care. Personal care means:
  - bathing, dressing, grooming, caring for hair, nail and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the participant’s health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care.
  - feeding, assistance with elimination including enemas, unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine

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colostomy care, assistance with ambulation, changing position in bed, assistance with transfers.

- Simple dressing changes which do not require the skills of a licensed nurse (e.g., application of a topical ointment and gauze to unbroken skin).
- Assistance with medications which are ordinarily self-administered and which do not require the skills of a licensed nurse to be provided safely and effectively.
- Assistance with activities which are directly supportive of covered skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises, and repetitive speech routines to support speech therapy.
- Routine care of prosthetic and orthotic devices.


When a home health aide visits a patient to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping). However, the purpose of a home health aide visit may not be solely to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

Part-time or intermittent services of home health aides are usually services for a few hours a day several times a week. Occasionally, more services, i.e., up to eight hours per day, may be provided for a limited period when recommended by the physician in the Plan of Care and when, because of unusual circumstances, neither the alternative of part-time care nor institutionalization is feasible.

Home health aide visits usually last from one to two hours a day and generally are provided two or three times a week. When these norms are exceeded the agency must furnish documentation justifying the need for additional services.


For the very few ill patients who need extensive personal care services, MO HealthNet pays for part-time medically reasonable and necessary aide services seven days a week for a short period of time (two-three weeks). There may also be a few cases involving unusual circumstances when a patient's personal care needs extend beyond three weeks. For example, the patient's condition is terminal; or the patient has suffered a relapse which, while requiring more intensive care, either does not necessitate institutionalization, or institutionalization cannot immediately be arranged.

When the physician makes the judgment, which usually should be made before the end of the three-week period, the home health agency must forward medical documentation justifying the need for additional services.
the need for such additional services and include an estimate of how much longer daily services will be required.

MO HealthNet pays for daily home health aide visits twice per day when documentation clearly substantiates that the service is reasonable and necessary for the active treatment of an illness or injury, and that the need for such service is short-term. Daily visits may be covered for up to three weeks and, in unusual cases, as in those described above, for more than three weeks. Documentation for all daily visits must include a projected stop date. Beyond three weeks, the medical necessity and appropriateness of the service is very closely reviewed. Twice a day visits are not normally paid for more than seven consecutive days, but the final decision on payment is based on the treatment being provided and the complexity of the patient's condition.

The combined total of all skilled nurse, psychiatric nurse and nurse aide visits reimbursed on behalf of a MO HealthNet participant may not exceed 100 visits per calendar year.

Claims for home health aide visits to provide personal care to a participant who is already receiving services under the Personal Care Program are recouped as a duplicative and more costly service. This does not apply to home health aide visits to provide a service that a personal care worker cannot perform due to the skill level required by the service itself or by the complexity of the patient's condition. The Plan of Care must document why the higher level skills of the home health aide are required.
13.15 MATERNITY STAYS AND POST-DISCHARGE HOME VISIT

House Bills, numbers 1069, 794, 807, 936, 1128, 1153 and 102 were enacted by the 88th General Assembly to mandate that insurance coverage is provided for inpatient maternity benefits. Coverage shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly born child.

A shorter length of hospital stay for services related to maternity and newborn care may be approved if:

1. The shorter stay meets with the approval of the attending physician after consulting with the mother. The physician’s approval to discharge shall be made in accordance with the most current version of the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and

2. The insurance entity provides coverage for post-discharge care to the mother and her newborn.

Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.

“Attending physician” shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.

13.15.A MO HEALTHNET COVERAGE OF POST-DISCHARGE VISITS

MO HealthNet reimburses up to two post-discharge skilled nurse visits in the home within two weeks of an early inpatient discharge for a stay of less than 48 hours for a vaginal delivery and for a stay of less than 96 hours for a cesarean section delivery when

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provided by a home health agency. Visits must be physician ordered and included in a Plan of Care. The criterion for an early inpatient discharge and the post-discharge visits as outlined by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists must be met.

The first post-discharge visit shall be provided within 48 hours of an inpatient discharge unless otherwise ordered by a physician and the second post-discharge visit, if appropriate (e.g., breast feeding not well established) shall be provided within 2 weeks of an inpatient discharge. The post-discharge visit(s) shall be provided by a skilled nurse with experience in antepartum, intrapartum and postpartum care and experience in newborn assessment. The post-discharge visit(s) covers both the mother and newborn.

The home health agency shall make a report to the attending physician within 24 hours of the post-discharge visit.

Please refer to the current version of the International Classification of Diseases (ICD) code book for the appropriate diagnosis code indicating the services are a post-discharge visit for a routine postpartum follow-up.

The post-discharge visit(s) must be billed using the mother’s Departmental Client Number (DCN).

Under the “expanded” Healthy Children and Youth (HCY) Program for individuals age 20 and under, additional medically necessary services may be approved for the newborn. If medically necessary skilled nurse visits are required to treat or ameliorate a medical condition, they must be prior authorized by the Department of Health and Senior Services, Bureau of Special Health Care Needs (BSHCN) office located in the region of the child’s residence.

**13.15.B PATIENT CRITERIA FOR EARLY DISCHARGE**

In accordance with the most current version of the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, the following criteria are considered appropriate for early discharge and subsequent home health follow-up:

- The antepartum, intrapartum and postpartum courses for both mother and baby are uncomplicated;
- Term (38-42 weeks) with birth weight appropriate for gestational age;
- Vital signs for baby are normal and stable for at least 12 hours: heart rate 100-160/minute, respiratory rate <60/minute and axillary temperature 97F to 98F in an open crib with appropriate clothing;
• Two successful feedings with coordinated sucking, swallowing and breathing while feeding;
• No evidence of excessive bleeding at the circumcision site for at least 2 hours;
• Physician examination reveals no abnormalities that require continued hospitalization;
• There is no evidence of significant jaundice in the first 24 hours;
• The mother has received instruction regarding: bottle or breast feeding, adequacy of breast feeding assessed by latch-on and swallowing, urine and stool frequency, cord, skin and infant genital care, recognition of signs of illness, common problems, jaundice, infant safety (car seat and position for sleeping) and mother verbalized/demonstrated her knowledge, ability and confidence;
• Support person(s) available in the home to assist the mother;
• No unresolved family, environmental or social risk factors present such as: untreated parental substance abuse, history of child abuse or neglect, mental illness of parent in the home, no fixed home, or untreated domestic violence, especially during this pregnancy;
• Mother has stable vital signs and is able to ambulate without vertigo;
• Initial hepatitis B vaccine is administered or appointment made for administration within the first week of life;
• Initial newborn screenings performed prior to discharge, if performed before 24 hours of milk feeding, a repeat is ordered or scheduled during the follow-up visit;
• Follow-up care within 48 hours with result reported to physician on the same day.

13.15.C VISIT CRITERIA

The home health visit shall be made within 48 hours of hospital discharge unless otherwise requested by the physician. The visit includes:

• Physical and emotional assessment of the mother;
• Physical assessment of the newborn’s general health, hydration, degree of jaundice and evaluation for any new problems;
• Review of infant feeding pattern and technique;
• Evaluation of infant stool and urine output;
• Observation of breast-feeding for adequacy of position, latch-on and swallowing;
• Performance or repeating of screening tests in accordance with state regulations and other tests that are clinically indicated;
• Assessment of maternal-infant interaction and details of infant behavior;
• Maternal/family education for post-partum maternal/infant care reinforced; and
• Review with mother the health maintenance plan including: access to emergency health care services, preventive care and immunizations, regularly scheduled physician examinations.

13.15.D  MO HEALTHNET MANAGED CARE HOME HEALTH SERVICES

Health plans are required to provide all medically necessary home health services to MO HealthNet Managed Care enrollees including the post discharge visit(s) for early inpatient post-discharge for a stay of less than 48 hours for a vaginal delivery and for a stay of less than 96 hours for a cesarean-section delivery. Reference Section 11 of the Home Health Provider Manual for further information.

13.16 CHILDREN'S SERVICES

Participants under 21 years of age must meet all home health eligibility criteria in order to receive covered MO HealthNet home health services.

13.16.A  LOW BIRTHWEIGHT

Low birth weight is defined as less than five pounds at birth. The infant's weight at birth must be documented on a standardized weight-for-height chart, and the need for short-term skilled nursing services in the home must be documented on the plan for care. The plan of care and weight-for-height chart must be maintained in the patient's records.

Not all low birth weight infants require or benefit from home nursing services, and routine monitoring should be performed in the physician's office.

In cases when short term teaching, assessment, or other intervention is needed in the home, skilled nursing visits are reimbursed for up to eight weeks. The frequency of visits may be determined by the physician. However, the number of visits may not exceed 12 visits over the eight-week period.

Weight and height must be recorded at each visit, along with the date of observation.

13.16.B  FAILURE-TO-THRIVE

Failure-to-thrive (FTT) is an abnormal deceleration of the growth process, caused by eating disorders, organic disorder of the endocrine or central nervous systems, neglect, or a combination of these factors.

Failure to thrive may be chronic or acute; it is the acute condition due to malnutrition for which skilled nursing treatment in the home is reimbursed under MO HealthNet.
In acute cases, deficient weight relative to height is normally the earliest indicator of failure-to-thrive. A child diagnosed as failure-to-thrive is eligible for eight weeks of nursing service if there is documentation of deficient weight relative to the child's height. The number of visits may not exceed 12 visits over the eight-week period.

Weight-for-height must fall lower than 90% of expected weight-for-height, or a weight-for-height deficit of more than 10%. A 10% deficit is equivalent to the 5th percentile on a direct weight-for-height graph and indicates a mild grade of acute malnutrition.

Because eligibility for the failure-to-thrive benefit depends on the child's weight-for-height deficit, a growth chart must be maintained in the patient's file. The child's weight and height with dates of observation must be clearly recorded on the growth chart.

Weight-for-height should be distinguished from weight and height measurements. A child's weight and height may both be below the 5th percentile for age. However, when weight-for-height is graphed accordingly, the child's overall body proportion may be at the 50th percentile. Although the child is smaller than average, the weight-for-height is considered to be in proportion and does not meet the FTT eligibility criteria for a weight-for-height deficit.

It is recommended that providers use the chart developed by the National Center for Health Statistics, but any standardized chart that measures both height and weight against age, or which measures weight-for-height directly, is sufficient. Section 14 of the Home Health Provider Manual contains a copy of a standardized chart. Both the weight and height with dates of observation must be clearly recorded on the growth chart and maintained in the patient's record.

The weight-for-height deficit as a percentage can be calculated graphically using a standard growth chart. The state medical consultant uses the following formula, taken from Suskind and Varma, "Assessment of Nutritional Status of Children," *Pediatrics in Review*, Vol. 5, No. 7, January, 1984, pp. 195-202. The patient's actual weight divided by the expected weight-for-height (50th percentile) times 100 equals weight-for-height as a percentage.

1. Graph actual height for age.
2. Graph expected age for height (50th percentile) at patient's height by extending line left or right from patient's actual height to the 50th percentile.
3. Graph corresponding expected weight by dropping line from 50th percentile for height to the 50th percentile for weight. The intersection determines the expected weight-for-height.
4. Divide the actual weight by the expected weight-for-height, then multiply the ratio of 100 to calculate the percentage of expected weight-for-height attained by the child. The result must be less than 90% for the child to be eligible for this specific benefit.
This benefit for children with failure-to-thrive is intended to be limited to eight weeks, or one certification period. When a failure-to-thrive condition remains unimproved after eight weeks of nursing intervention, it is likely that either the condition itself is organic in nature and requires more intensive treatment than can be given by the home health nurse, or the situation in the home is neglectful, requiring intervention by appropriate authorities. If child neglect is suspected, the home health nurse is legally required to report the family to the Family Support Division.

Payment is *not* normally made for nursing visits beyond eight weeks. However, if a child with failure-to-thrive is still less than 90% of expected weight-for-height at the end of the first eight weeks, an additional four weeks of visits are considered for reimbursement. The Plan of Care for these extended services *must* show the *medical necessity* for the services and specify goals to be achieved and progress made during the four weeks.

MO HealthNet home health does *not* cover medical social services and therefore does *not* reimburse services directed solely at resolving social or emotional problems that have been identified as an impediment to the effective treatment of the participant’s medical condition or the maintenance of the participant’s health. In cases in which these problems have been identified, other intervening agencies and professionals *must* be identified.

### 13.17 MEDICAL SUPPLIES

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling Home Health Agency (HHA) personnel to conduct home visits or to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Medical supplies are classified as:

- **Routine** – medical supplies used in small quantities for patients during the usual course of most home visits; or

- **Non-routine** – medical supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

Parenteral and enteral nutrition, prosthetics, orthotics and supplies required for operation of medical equipment are not considered medical supplies for the purpose of this policy; therefore, are not required to be supplied by the HHA. However, specifically excluded from the term "orthotics and prosthetics" are medical supplies that include catheters, catheter supplies, ostomy bags and supplies related to ostomy care. These medical supplies should be furnished by an HHA if such non-routine medical supplies are included in the plan of care and used by the nurse during the course of a visit.
13.17.A MEDICAL SUPPLIES PURCHASED BY THE PATIENT PRIOR TO THE START OF CARE

A patient may use his or her own medical supplies as long as the supplies are part of the HHA’s plan of care and clinically appropriate. The HHA is not required to duplicate the medical supplies if the patient elects to use his or her own supplies. However, if the patient prefers to have the HHA provide medical supplies that are included in the patient’s home health plan of care, then the HHA must provide the medical supplies. The HHA may not bill MO HealthNet for non-routine medical supplies not provided to the patient by the HHA.

Given the possibility of subsequent misunderstandings arising between the HHA and the patient on this issue, the HHA should clearly document the patient’s decision to decline HHA furnished medical supplies and use their own resources.

13.17.B ROUTINE MEDICAL SUPPLIES (NOT BILLABLE)

Routine medical supplies are customarily used in small quantities during the course of most home care visits. They are usually included in the staff’s supplies and not designated for a specific patient. These medical supplies are included in the cost per visit of home health care services and are not separately reimbursed. Routine medical supplies would not include those that are specifically ordered by the physician or are essential to HHA personnel in order to effectuate the plan of care.

The HHA is responsible for the routine medical supplies ordered by the physician and included in the plan of care and used while the patient is under a home health plan of care. Routine medical supplies must not be billed to MHD.

Examples of medical supplies which are usually considered routine and therefore not billable include, but are not limited to:

**Dressings and Skin Care**
- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Non-sterile applicators; and
- Non-sterile 4 x 4's.

**Infection Control Protection**
- Non-sterile gloves;
- Aprons;
- Masks; and
• Gowns.

**Incontinence Supplies**

• Incontinence briefs and Chux covered in the normal course of a visit.

For example, if a home health aide in the course of a bathing visit determines the patient requires an incontinence brief change, the incontinence brief in this example would be covered as a routine medical supply.

**Other**

• Thermometers;

• Tongue depressors; and

• Specimen containers.

Note: There are occasions when the above medical supplies would be considered non-routine and thus would be considered billable. For example, if they are required in large quantities, for recurring need, and are included in the physician-approved plan of care. Examples include, but are not limited to: tape and 4x4s for dressings.

Comfort items that are not necessary for the therapeutic or diagnostic treatment of the participant’s condition are not covered, nor are supplies used for preventive care.

**13.17.C NON-ROUTINE MEDICAL SUPPLIES (BILLABLE)**

MO HealthNet home health covers the provision of non-routine supplies identified as specific and necessary to the delivery of a participant’s nursing care when specific criteria are met.

All HHAs are expected to separately identify in their accounting records the cost of medical supplies that are not routinely furnished in conjunction with patient care visits. The use of medical supplies should be identifiable to each individual patient.

Billable non-routine medical supplies are identified by the following terms:

1. The HHA follows a consistent charging practice for MHD, Medicare and other patients receiving the item;

2. The item is directly identifiable to an individual patient;

3. The cost of the item can be identified and accumulated in a separate cost center; and

4. The item is furnished at the direction of the patient's physician and is specifically identified in the plan of care.
All non-routine medical supplies must be specifically ordered by the physician, or the physician’s order for services must require the use of the specific non-routine medical supplies in order to effectively furnish the services.

Examples of medical supplies that can be considered non-routine include, but are not limited to:

**Dressings/Wound Care**
- Sterile dressings;
- Sterile gauze and toppers;
- Kling and Kerlix rolls;
- Telfa pads;
- Eye pads;
- Sterile solutions, ointments;
- Sterile applicators; and
- Sterile gloves.

**Intravenous Supplies**
- Dressing change kit;
- Extension set;
- Administration set;
- Statlock;
- Saline flush;
- Clave micro connector;
- Huber needles;
- Central line dressing;
- Dial-a-flow/stat master or other flow monitor manager; and
- IV tubing.

**Ostomy Supplies**

**Catheters and Catheter Supplies**
- Foley catheters; and
- Drainage bags, irrigation trays.

**Enemas and Douches**

**Syringes and Needles**
Home Testing

- Blood glucose monitoring strips;
- Urine monitoring strips; and
- PT/INR test strips.

Other items that are often used by persons who are not ill or injured will be considered billable medical supplies only where:

- The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation; and
- The item is required as a part of the actual physician-prescribed plan of care for a patient's existing illness or injury.

For example, items that generally serve a routine hygienic purpose, e.g., soaps, shampoo, and items that generally serve as skin conditioners, such as lotions, baby oil, skin softeners, and powders are not considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician's prescribed plan of care for the patient's existing skin (scalp) disease or injury.

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or other caregivers. These items must be part of the plan of care in which the home health staff is actively involved. For example, the patient’s family has been taught how to change the wound dressings daily, but the nurse visits only twice a week to observe and measure the wound for healing or signs and symptoms of infections. The wound dressings/irrigation solution may be left in the home between visits.

Medical supplies such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits. If the medical supplies do not require administration by a nurse, the items can be left in the home between visits.

13.17.D REIMBURSEMENT OF MEDICAL SUPPLIES

Each item/supply must be billed under the correct Health Care Procedure Coding System (HCPCS) code and the applicable quantity on separate detail lines of the claim. The service date for medical supplies must correspond with the date of delivery of the medical supply. Reference the HCPCS manual to verify the definition for what a unit consists of for each type of medical supply.

MHD’s maximum reimbursement for medical supplies is the lower of the provider’s billed charges or the medical supply cost. The medical supply cost is defined as the invoiced acquisition cost of the supply, multiplied by 2 which cover the cost of the overhead.
(including taxes and shipping). The invoiced acquisition cost is defined as the amount shown on the invoice received for purchase of the medical supply. This amount must include any reduction in cost the provider receives (i.e., discounts, allowances) and does not include shipping or sales tax. The overhead percentage may be reviewed annually by MHD to determine if adjustments are needed.

The state may obtain cost data from the most current Medicare home health cost reports (both freestanding and hospital-based) from an industry accepted source. The data will be used to assess any changes in the relationship and/or amount of indirect/overhead costs to the direct costs for home health. Indirect/overhead costs include both administrative and capital costs. If the indirect/overhead cost factor increases or decreases in relation to direct costs, the state may adjust the indirect/overhead cost factor to reflect the HHA’s change in indirect/overhead cost.

13.17.E DOCUMENTATION OF MEDICAL SUPPLIES

All medical supplies provided to a participant and reimbursed by MHD must be adequately documented in the HHA’s participant medical record as indicated in Section 2.3.A of the Home Health Provider Manual.

The HHA must maintain adequate documentation of all non-routine medical supply costs. Adequate documentation means the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Costs (i.e. an invoice) for medical supplies are not required to be documented in the individual participant medical record. The HHA may maintain a separate file of appropriate invoices for audit purposes. The documentation in the HHA’s participant medical record must then clearly identify the product or supply that matches to an invoice. The following is an example of how an HHA may maintain adequate documentation of non-routine medical supply charges:

1. The HHA maintains a file of the most current invoices for each non-routine medical supply effective the first day of the HHA’s fiscal year.

2. The HHA produces a list of all non-routine medical supplies used by their agency and the most current invoice of cost effective the first day of the HHA’s fiscal year.

3. The HHA updates the file of invoices and the list indicated in numbers 1 and 2 above annually for the new fiscal year.

Should the HHA be required to add a new non-routine medical supply during the course of a fiscal year, the invoice for the new non-routine medical supply should be added to the file, and the non-routine supply list updated including an effective date.
13.18 SERVICES OF INTERNS AND RESIDENTS

MO HealthNet home health services include the medical services of interns and residents-in-training under an approved hospital teaching program when:

- The provider home health agency has an affiliation with or is under common control of a hospital providing such medical services; and
- All medical services provided by the interns or residents-in-training are co-signed by the supervising physician.

NOTE: Medicare does not require the co-signature of the physician supervisor assigned to the intern or resident-in-training. However, the above conditions must be met in order to qualify the medical services of interns and residents-in-training for reimbursement as covered services under the MO HealthNet Home Health Program.

13.19 PART-TIME OR INTERMITTENT HOME HEALTH AIDE AND SKILLED NURSING SERVICES

When the participant qualifies for coverage of home health services, MO HealthNet also covers either part-time or intermittent home health aide services and skilled nursing services.

"Part-time" means any number of days per week:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined for less than eight hours per day; or
- Up to 35 hours per week of skilled nursing and home health aide services combined for less than eight hours per day subject to review by the fiscal intermediary on a case by case basis, based upon documentation justifying the need for and reasonableness of such additional care.

"Intermittent" means:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined provided on a less than daily basis;
- Up to 35 hours per week of skilled nursing and home health aide services combined which are provided on a less than daily basis, subject to review by MO HealthNet on a case by case basis, based upon documentation justifying the need for and reasonableness of such additional care; or
- Up to and including full-time (i.e., eight hours per day) skilled nursing and home health aide services combined which are provided and needed seven days per week for temporary, but not indefinite, periods of time of up to 21 days with allowances for extensions in exceptional circumstances when the need for care in excess of 21 days is definite and predictable.
A participant must meet the standard home health qualifying criteria for MO HealthNet coverage of home health services, before the part-time or intermittent coverage policy becomes applicable to skilled nursing services and/or home health aide services. The definition of "intermittent" with respect to the need for skilled nursing care when the participant qualifies for coverage based on the need for "skilled nursing care on an intermittent basis" remains unchanged.

The combined coverage of part-time and intermittent home health aide and skilled and psychiatric nursing services are subject to the 100-visit limit per calendar year set forth in the MO HealthNet home health state regulation.

13.20 SKILLED THERAPY SERVICES

Physical, speech, and occupational therapy furnished by a home health agency or by other professionals under an arrangement with and under the supervision of a home health agency are only covered under MO HealthNet when all of the following circumstances are met. Home Health Program skilled therapy services are not covered for individuals covered under a limited benefit package as described in Section 1.5.A of the Home Health Provider Manual with the exception of habilitative skilled therapy services as described below in Section 13.21.

1. The participant requires physical, occupational or speech therapy for one of the following medical conditions and services fall within the SERVICE PARAMETERS described later in this section.
   - AIDS related disabilities
   - Amputations
   - Burns
   - Cerebral vascular accidents
   - Communication disorders
   - COPD
   - Dysarthria
   - Dysphagia
   - Fractures
   - Impaired Cognition
   - Language disorders
   - Laryngectomy
   - Multiple trauma
   - Neurological disorders, e.g.; ALS, MS, Parkinson's, neuropathy
   - Neuromuscular disorders3-42
   - Orthopedic and musculoskeletal conditions
   - Spinal cord injuries
   - Total joint replacements and repair
   - Traumatic brain injuries
2. The therapy services relate directly and specifically to an active written Plan of Care by the physician after any needed consultation with the qualified therapist.

3. The skilled therapy services must be reasonable and necessary to the treatment of the participant’s illness or injury. To be considered reasonable and necessary for treatment:
   - The service must be consistent with the nature and severity of the illness or injury and the participant’s particular medical needs.
   - The service must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient’s condition.
   - The services must be provided with the expectation of good potential for rehabilitation based on assessment made by the participant’s physician. Good rehabilitation potential means the participant’s condition will improve measurably within a predictable period of time.
   - The services are necessary for the establishment of a safe and effective maintenance program, or for teaching and training a caregiver.
   - The service requires performance by an appropriate licensed or qualified professional to achieve the medically desired result. Services that can ordinarily be carried out by non-skilled personnel are not covered services. Determination that a professional is required to perform a service takes into account the nature and complexity of the service itself and the condition of the patient as documented in the Plan of Care.

Therapy services are not counted toward the 100-visit limit.

13.20.A SERVICE PARAMETERS FOR THERAPY SERVICES

13.20.A(1) Therapy Services That Do Not Require Prior Authorization

Services that meet the specified diagnosis criteria and are delivered within 60 days from the date of diagnosis of the condition, or within 60 days from the date of hospital discharge (that was directly related to the condition being treated through therapy), do not require prior authorization for one certification period (60 days).

1. Therapy services that do not require prior authorization may be provided for one certification period (60 days).

2. A frequency of three visits per week for each type of therapy is considered the maximum, except when the following conditions exist:
   - Total knee replacement: Daily visits of physical therapy for the first two weeks.
   - Burns: Daily visits of physical therapy may be covered for a certification period.
• Dysphagia: Daily visits may be covered for the first 21 consecutive days.

13.20.A(2) Therapy Services Requiring Prior Authorization

Prior authorization should be requested for any of the following:

• When therapy does not begin within 60 days of initial onset or discharge from hospital;

Other needs for therapy services may not meet these 60-day time frames. For example, acute reoccurrences and exacerbations of a chronic condition may not occur within 60 days of initial diagnosis or after a recent hospitalization. In cases of amputation, therapy may begin following the fitting of the prosthesis, which may not occur within 60 days of discharge. In cases when therapy cannot begin within 60 days of initial diagnosis, or within 60 days of hospital discharge, the provider must submit a Prior Authorization Request if the claim is to be billed to MO HealthNet.

• When therapy is to continue beyond one certification period;

A provider may request prior authorization for additional certification periods, if there is sufficient documentation of the need to continue the service. The approval of the Prior Authorization Request is based on a demonstration of continued functional improvement within a reasonably predicted time frame, and relative to achievable and reasonable goals.

• When therapy visits during the initial certification period are in excess of the frequency described parameters in the preceding section;

• When client’s condition does not clearly fall within the specified conditions.

13.20.A(3) Service Exclusions for Therapy Services

MO HealthNet does not cover the following:

• Passive range of motion for maintenance. These services are reimbursable under the MO HealthNet Personal Care Program as an advanced personal care service;

• Crutch training, unless prior authorized; and

• Therapy services documented as medically necessary in an Individualized Family Service Plan (IFSP).

13.20.B REQUESTING PRIOR AUTHORIZATION FOR THERAPY SERVICES
13.20.B(1) Initial Prior Authorization

If services are expected to be necessary beyond one certification period, do not fall within the 60 days of diagnoses or hospital discharge limitation, exceed frequency limitations or the client’s condition does not clearly fall within the specified conditions, the provider must complete a Prior Authorization Request form. The Prior Authorization Request form and Plan of Care for the next certification period, the CMS-485 and hospital discharge summary and/or medical history, and progress notes of previous services must then be submitted to the fiscal agent. It is the provider’s responsibility to provide enough supporting documentation to justify the service requested.

A Prior Authorization Request form should be submitted at least three weeks prior to the end of the certification period to allow time for review of the request and a response. The provider may initiate the Prior Authorization Request form on the basis of documented verbal orders, which must be followed up by written orders maintained in the medical record.

Providers are notified of the approval of the Prior Authorization Request on the MO HealthNet Authorization Determination, which is specific as to the dates and amounts of services that may be reimbursed. Prior authorization approves only the medical necessity of the required service and does not guarantee payment. The participant must be MO HealthNet eligible on the date the service is rendered. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896. Reference Sections 1 and 3 of the Home Health Provider Manual for more information.

If a Prior Authorization Request is denied, providers are notified of the reason for denial on the MO HealthNet Authorization Determination. Providers do not have a right to appeal the denial of a Prior Authorization Request. Participants do have appeal rights and receive written notification of Prior Authorization Request denials.

Providers may submit a new Prior Authorization Request for reconsideration of a denied Prior Authorization Request or denied detail lines. If additional information is adequate to approve the service and the provider verifies when the original Prior Authorization Request was submitted, the original dates of service may be approved.

Reference Section 8 of the Home Health Provider Manual for more information regarding the Prior Authorization Request form.

13.20.B(2) How to Request a Change to an Approved Prior Authorization
Changes to approved Prior Authorization Requests may be made for any of the following reasons:

- To correct the provider number.
- To increase or decrease the number of units for service, as a result of a revised Plan of Care. Additional units should be approved prior to service delivery.
- To change a procedure code.
- To change "from" or "through" dates. Changing "from" or "through" dates does not apply to requesting prior authorization to provide services in a new certification period. A new Prior Authorization Request must be submitted for additional certification periods.

Reference Section 8.8 of the Home Health Provider Manual for more information regarding requesting a change to an approved Prior Authorization Request.

13.21 HABILITATIVE SKILLED THERAPY SERVICES

Effective July 1, 2021, habilitative skilled therapy (physical, occupational and speech) services are covered for participants in a category of assistance for the adult expansion group (Medicaid eligibility code E2). The combination of habilitative skilled therapy services for participants age 21 and over in the adult expansion group is limited to a total of 20 visits per rolling year, inclusive of services from all MO HealthNet providers. Participants under the age of 21 in the adult expansion group may receive all medically necessary habilitative skilled therapy services. Prior authorization is not required.

13.22 NON-COVERED SERVICES

13. 22.A MEDICAL SOCIAL SERVICES

The MO HealthNet Home Health Program does not provide coverage of Medical Social Services as defined in Section 206.2 of the Medicare Home Health Agency Manual.

13. 22.B OUTPATIENT SERVICES

The MO HealthNet Home Health Program does not reimburse any outpatient services as defined in the Medicare Home Health Agency Manual. Home health services must be delivered in the home to meet the criteria for reimbursement under MO HealthNet home health.

13. 22.C DRUGS AND BIOLOGICALS
Drugs and biologicals are excluded from coverage as items or services administered by MO HealthNet home health agencies. Drug coverage is available through the MO HealthNet Pharmacy Program.

13. 22.D DURABLE MEDICAL EQUIPMENT

Necessary items of durable medical equipment prescribed by the physician are available to participants of home health services through the MO HealthNet Durable Medical Equipment (DME) Program, subject to the limitations of amount, duration and scope applicable to the MO HealthNet DME Program.

13. 22.E PREVENTIVE CARE

MO HealthNet home health does not allow coverage for preventive care. Preventive care includes these services:

- Ongoing observation of a client's condition without the provision of treatment or the adjustment of the plan/orders.
- Repetitive nutrition and medication instruction.
- Encouragement to increase physical activity.
- Monitoring to ensure compliance with a treatment regimen.

The above mentioned services are considered preventive because they are meant to help a patient avoid complications or setbacks. Regardless, they do not constitute the provision of therapeutic services and are not MO HealthNet covered services.

13.23 PERSONAL CARE

All home health providers should be aware of the MO HealthNet Personal Care Program. This program provides personal care services for individuals who meet the eligibility criteria as assessed by the Department of Health and Senior Services, Division of Senior and Disability Services (DHSS/DSDS). Home health agencies should refer those individuals who do not qualify for home health aide services but do need personal care services to avoid institutionalization, to the DHSS/DSDS for assessment.

Under the MO HealthNet Personal Care Program the services of the personal care worker are supervised by a Registered Nurse (RN). Supervision includes a brief health assessment of the participant and the amount and duration of supervision is based on the participant's need. The RN may also be authorized to pre-fill insulin syringes, monitor for medication compliance and set out daily dosages of prescribed medication. The services are prior authorized by the DHSS/DSDS and participants may apply for services by contacting the county DHSS/DSDS office.
13.24 HOME HEALTH FOR CHILDREN THROUGH HEALTHY CHILDREN AND YOUTH (HCY)


The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated expanded MO HealthNet services for children. This mandate has allowed MO HealthNet, based solely on a child’s documented medical need, to cover a broader range of services and to lift some of the limitations that are present under the standard MO HealthNet Program. MO HealthNet eligible participants who are age 0 through 20 are eligible for expanded HCY services. Eligibility for expanded services is terminated on the child’s 21st birthday. This is important to remember when serving a child nearing the age limit as the benefits available to them, at that time, are converted to those available under the standard MO HealthNet Program.

13.24.A(1) Exempt from 100-Visit Limit

The 100-visit limit does not apply to HCY home health services.

13.24.A(2) MO HealthNet Managed Care Enrollees Under Age 21

HCY services, including the HCY screening and treatment services, are included as a health plan benefit.


The following modifiers must be used in addition to the five-digit procedure codes when billing for HCY evaluation and treatment services.

The EP modifier is used when billing MO HealthNet PT, OT and ST evaluation and treatment services that are not identified in an official IEP for participants. Reference Section 13.23.E of the Home Health Provider Manual for IEP services.

PT, OT and ST services provided and identified with the EP modifier may not be billed for a MO HealthNet Managed Care enrollee. PT, OT and ST services billed using the EP modifier are only covered for participants under 21 who are not in a MO HealthNet Managed Care health plan.

13.24.B  HCY HOME HEALTH NURSING SERVICES

The Healthy Children and Youth, or EPSDT Program (Early Periodic, Screening, Diagnosis and Treatment) provides a means for MO HealthNet eligible children under age 21 to receive comprehensive and preventive health care beyond the current program limitations, if the plan of treatment is the result of a Healthy Children and Youth screening.
The home health agency may, on occasion, receive referrals to provide intermittent skilled nurse and nurse aide visits. The following must take place for prior authorization of these services to be considered:

1. The child must be referred for a Healthy Children and Youth (EPSDT) Screening. Screening procedures are described in more detail in Section 9 of the Home Health Provider Manual.

2. The Bureau of Special Health Care Needs (BSHCN) office, located in the region of the child’s residence, must be contacted to request prior authorization of services. The Bureau may be contacted by phone, or a Prior Authorization Request form may be completed by the agency and sent to the appropriate BSHCN office (see the BSHCN Area Office County Listing and Bureau of Special Health Care Needs Area Offices map). If the request is not accompanied by a Plan of Care which has been approved by a physician, the request should state the name of the physician ordering the home health service. When requesting home health services the provider must clearly document the medical needs of the child and provide enough information to support the amount, frequency, and duration of services called for in the care plan. If there is additional information about the child which cannot be thoroughly addressed on the Plan of Care, the provider may send any additional information available such as the written evaluation, assessments or reports from other sources. The Bureau must have enough information about the child to make a decision to either approve or deny the service requested, or in some cases they may approve a reduced level, frequency, or duration.

3. The BSHCN approves or denies the request for prior authorization of services. The Prior Authorization Request form is forwarded by the BSHCN to the fiscal agent for keying. The fiscal agent returns a MO HealthNet Authorization Determination to the provider. The MO HealthNet Authorization Determination serves as notification to providers of approvals or denials.

4. The provider may request prior authorization for up to six months; however the requested period of time should always end with the last day of a month. For example, an initial authorization requesting services to begin on May 1, 2010 would have a requested through date of October 31, 2010. If services were still needed after the initial authorization period, the reauthorization would be requested for November 1, 2010 through April 30, 2011.

5. The provider must maintain the Plan of Care in the child’s record, and provide a current Plan of Care which has been approved by a physician, with each request for reauthorization.

6. The home health agency may request reauthorization of services near the end of each authorization period. Verification that the physician has reviewed and approved the
current Plan of Care must be provided to the BSHCN with each request for reauthorization. Each request must include a summary of services, a progress report, and a current Plan of Care approved by a physician. Verbal orders from the physician are acceptable.

7. If the home health agency determines that it is necessary to request a change to an approved Prior Authorization Request, agency staff must submit this request through the BSHCN.

The BSHCN authorizes the most economical services available that meet the needs of the child.

13.24.B(1) Procedure Codes for HCY Nursing Services

In cases when a Plan of Care has not been initiated or approved by a physician the provider may bill MO HealthNet separately for an initial face-to-face evaluation to assess and develop a Plan of Care. The evaluation procedure code, which does not require prior authorization, may be billed twice per year, per agency, per child. See Section 19 of the Home Health Provider Manual for the procedure code to be utilized for HCY home health nurse evaluation for children under the age of 21.

13.24.C HCY HOME HEALTH THERAPY SERVICES FOR CHILDREN

One visit per day, up to five days a week, of physical therapy, occupational therapy and speech therapy may be delivered and billed to MO HealthNet.

Appropriate medical records, such as a written Plan of Care, physician’s orders and progress notes including a description of the service must be kept on file by the provider, as with any other home health service.

13.24.D HCY HOME HEALTH SUPPLIES

Medical supplies for children are defined as items that are medically necessary due to their therapeutic or diagnostic capabilities and are ordered in the physician’s prescribed treatment plan. Medically necessary supplies may be left in the home between visits for use by the patient or by the patient’s family members when warranted due to medical necessity. Supplies must be billed at cost.

13.24.E IEP

Physical therapy, occupational therapy, and speech/language therapy services are considered IEP therapy when they are included in an Individual Education Plan (IEP) as defined by the Individuals with Disabilities Education Act Part B (34 CFR 300 and 301). School districts may contract with home health agencies to provide therapy services documented in an IEP. All IEP therapy services are reimbursed to the home health agency at the federal financial
participation (FFP) rate. The FFP is calculated using the MO HealthNet allowed amount times the appropriate FFP percentage. The remaining Certified Public Expenditures (CPE) are the responsibility of the school district. The CPE must not be billed to the patient, but must be recovered from the school district originating the IEP therapy services. IEP services provided to students who are eligible for MO HealthNet under an eligibility category funded by state funds are not reimbursed by MO HealthNet. The state-only funded eligibility codes are: 02, 08, 52, 57, 64, and 65. The school district is responsible for service provided to students who have state-only funded eligibility.

13.24.F PRIVATE DUTY NURSING

Home health providers should be aware of the Private Duty Nursing Program that is available to MO HealthNet eligible children, when the need for that service has been identified through a Healthy Children and Youth screening. Home health providers wishing to enroll as MO HealthNet providers of Private Duty Nursing should contact the Provider Enrollment Unit at the address below:

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Requests to provide personal care services to children, or nursing services more extensive than on an intermittent basis through home health are denied by the BSHCN as these services are available through the MO HealthNet Personal Care Program and the MO HealthNet Private Duty Nursing Program for children.

13.24.G MEDICALLY FRAGILE ADULT WAIVER

The Medically Fragile Adult Waiver was designed to provide home and community-based services to individuals who have reached the age of 21 and are no longer eligible for services through the HCY Program. Private duty nursing, specialized medical supplies and waiver attendant care services may be authorized through this waiver. Services for the Medically Fragile Adult Waiver require prior authorization by the DHSS, Bureau of Special Health Care Needs.
**SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS**

The purpose of this section is to aid the provider in being able to identify and correctly complete the documentation required for coverage of MO HealthNet home health services. Copies of the required documentation *must* be maintained in the patient's record.

### 14.1 PLAN OF CARE

Each submitted home health claim *must* be documented in the medical record with a physician signed and dated plan of care. The CMS-485 Home Health Certification and Plan of Treatment is designed to meet the regulatory requirements for both the physician's home health plan of care and home health certification and recertification requirements.

Providers may use either the old or new (04/87) versions of the CMS-485, CMS-486 and CMS-487 forms or forms developed by the agency that contain all the fields and information on the standardized forms for MO HealthNet participants.

### 14.2 CMS-485—HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT (FOR DOCUMENTATION PURPOSES)

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
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<tbody>
<tr>
<td>1 Patient's HI Claim No.</td>
<td>Enter the patient's eight-digit MO HealthNet Identification Number as shown on the patient's ID card or temporary eligibility notice.</td>
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<tr>
<td>(Patient’s eight-digit MO HealthNet ID Number)</td>
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<tr>
<td>2 SOC Date</td>
<td>Enter the day on which covered home health services began in six-digit month, day, year format (MMDDYY), (e.g., 061504).</td>
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<tr>
<td>3 Certification Period</td>
<td>Enter the six-digit month, day, year (MMDDYY), (e.g., 061504-081504), which identifies the period covered by the physician's plan of care. The &quot;From&quot; date for the initial certification <em>must</em> match the start of care date. The &quot;To&quot; date can be <em>up to</em>, but never exceed, two calendar months and mathematically never exceed 62 days. Always repeat the &quot;To&quot; date on a subsequent recertification as the next sequential &quot;From&quot;</td>
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date. Services delivered on the "To" date are covered in the next certification period.

EXAMPLE: Initial certification "From" date 061504. Initial certification "To" date 081504.

Recertification "From" date 081504.
Recertification "To" date 101504.

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<tr>
<td>4</td>
<td>Medical Record No.</td>
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<td>Provider No.</td>
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<td>Patient's Name and Address</td>
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<td>Provider's Name and Address</td>
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<td>Date of Birth</td>
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<td>Sex</td>
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<td>10</td>
<td>Medications: Dose/Frequency/Route</td>
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<tr>
<td>11</td>
<td>Principal Diagnosis, Applicable Version of ICD</td>
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diagnosis most related to the current plan of treatment. It may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

Enter the applicable ICD code for the diagnosis in the space provided. The code must be the full ICD diagnosis code including all digits.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan of care.

List the actual medical diagnostic term next to the applicable ICD code. Do not describe in narrative format any symptoms or explanations. Do not use surgical procedure codes.

The date is always represented by six digits (MMDDYY); if the exact day is not known, use 00 in the middle section. The date of onset is specific to the medical reason for home health care services. If a condition is chronic or long term in nature, use the date of exacerbation. Use one or the other, not both. Always use the latest date. Enter all dates as close as possible to the actual date.

Enter the surgical procedure relevant to the care rendered. If a surgical procedure was not performed or is not relevant to the plan of care, do not leave the box blank. Enter N/A. Use the addendum (CMS-487) for additional relevant surgical procedures. At a
minimum, the month and year *must* be present for the date of surgery. Use 00 if the day is unknown.

13 Other Pertinent Diagnoses

**Applicable Version of ICD Code, Date**

Enter all pertinent diagnoses, both narrative and applicable ICD codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or subsequently developed. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care. These diagnoses can be changed to reflect changes in the patient's condition. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. If there are more than four pertinent diagnoses, use the addendum (CMS-487) to list them. Enter N/A if there are no pertinent secondary diagnoses.

The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. Note the date of onset or exacerbation for each as close to the actual date as possible. If the date is unknown, note the year and place 00 in the month or day *not* known.

**NOTE:** When billing for postnatal assessment and follow-up care on a paper claim, the date and time of delivery should be included in this field.

14 DME and Supplies

Enter all non-routine supplies which are being billed to MO HealthNet. For example, dressing changes may require use of 4x4's, telfa pads, kling and non-allergic tape. Catheter changes may require catheter kit and irrigation kit as well as irrigating solutions. Exact amount of usage need *not* be listed. Enter N/A if no supplies are billed.
MO HealthNet home health does not provide coverage of DME items. Do not enter item(s) of DME ordered by the physician that are billed to the MO HealthNet DME Program.

15 Safety Measures Enter the physician's instructions for safety measures.

16 Nutritional Req Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Record fluid needs or restrictions. Total Parenteral Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications. If more space is necessary, use the CMS-487.

17 Allergies Enter medications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, iodine). "No known allergies" may be an appropriate response.

18A Functional Limitations Check all items which describe the patient's current limitations as assessed by the physician and agency.

18B Activities Permitted Check the activity(ies) which the physician allows and/or for which physician orders are present. If "Other" is checked under either the "Functional Limitations" or "Activities Permitted" category, provide a narrative explanation in Item 17 of the CMS-486.

19 Mental Status Check the block(s) most appropriate to describe the patient's mental status. If "Other" is checked, specify the conditions.

20 Prognosis Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, or good.

21 Orders for Discipline Specify the frequency and expected duration
and Treatments (Specify Amount/Frequency/ Duration) of the visits for each discipline ordered. State the duties/treatments to be performed by each. A discipline may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social services (MSS), home health (AIDE), or others (e.g., nutritionist, male orderly, respiratory therapist). Orders must include all disciplines and treatments, even if they are not billable to MO HealthNet.

22 Goals/Rehabilitation Potential/Discharge Plans

Enter information which reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone, are not acceptable. Add descriptors.

EXAMPLE: Rehabilitation potential good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, be specific as to the goals and when the need for daily care is expected to end.

EXAMPLE: Granulation of wound with daily wound care is expected to be achieved in four weeks. Skilled nursing visits are decreased to 3x/week at that time.

Discharge plans to include a statement of where, or how, the patient will be cared for once home health services are not provided.

23 Verbal Start of Care

Nurse's Signature and Date

This verifies that a nurse spoke to the attending physician and has received verbal
authorization to visit the patient. This date may precede the SOC date in Item 2, and may precede the "From" date in Item 3.

The item is signed by the nurse receiving the verbal orders, by the nurse responsible for the completion of the form or by the nonclerical agency representative responsible for review. The date is necessary. If the nurse who received the orders does not prepare the CMS-485, then the orders must be transcribed to a form, signed and dated by the nurse and retained in the agency files. Document the initial and ongoing communications with the physician.

This item is applicable only to certification. Enter N/A if recertification, or if not applicable to the certification period.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>24</td>
<td><strong>Physician's Name and Address</strong></td>
</tr>
<tr>
<td></td>
<td>Print the physician's name and address. The attending physician is the physician who establishes the plan of care and who certifies and recertifies the medical necessity of the visits and/or services. Mention supplemental physicians involved in a patient's care only on the CMS-486.</td>
</tr>
<tr>
<td>25</td>
<td><strong>Date HHA Received Signed POC</strong></td>
</tr>
<tr>
<td></td>
<td>Enter the date the provider received the signed POC from the attending/referring physician. Enter N/A if Item 27 DATE is completed.</td>
</tr>
<tr>
<td>26</td>
<td><strong>Physician Certification</strong></td>
</tr>
<tr>
<td></td>
<td>Check whether this is an initial certification or a recertification.</td>
</tr>
<tr>
<td>27</td>
<td><strong>Attending Physician's Signature and Date Signed</strong></td>
</tr>
<tr>
<td></td>
<td>The attending physician signs and dates the plan of care/certification prior to submitting the claim. Rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for the patient in the attending physician’s absence.</td>
</tr>
</tbody>
</table>
Do not predate the orders for the physician, nor write the date in this field. If the physician left it blank, enter the date the provider received the signed POC under Item 25. Do not enter N/A. Retain a copy of the CMS-485 for record keeping purposes.

14.3 CMS-486—MEDICAL UPDATE AND PATIENT INFORMATION (FOR DOCUMENTATION PURPOSES)

The fields required on the CMS-486 (04/87) version for MO HealthNet are as follows:

- Fields #1, 3, 5 (MO HealthNet Provider Number);
- Fields #6, 7, 8, 9, 10, 12, 14, 15, 16;
  
  NOTE: If the physician orders a change in frequency of services or a new discipline, enter a notation in Field #16 and attach a copy of the physician's signed order. Any other order change should be listed in the update of the CMS-486 form.
- Fields #17, 19 and 22.

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient's HI Claim No. (Patient's eight-digit MO HealthNet ID Number)</td>
<td>See CMS-485 instructions, Field #1.</td>
</tr>
<tr>
<td>2 SOC Date</td>
<td>Leave Blank</td>
</tr>
<tr>
<td>3 Certification Period</td>
<td>See CMS-485 instructions, Field #3.</td>
</tr>
<tr>
<td>4 Medical Record No.</td>
<td>Leave Blank</td>
</tr>
<tr>
<td>5 Provider NPI No.</td>
<td>See CMS-485 instructions, Field #5.</td>
</tr>
<tr>
<td>6 Patient's Name</td>
<td>See CMS-485 instructions, Field #6.</td>
</tr>
<tr>
<td>7 Provider's Name</td>
<td>See CMS-485 instructions, Field #7.</td>
</tr>
<tr>
<td>8 Medicare Covered</td>
<td>State the agency's opinion as to whether the patient's care is Medicare covered or noncovered. Check the appropriate box.</td>
</tr>
<tr>
<td>9 Date Physician Last Saw Patient</td>
<td>Enter the date the physician last saw the patient if this information can be obtained during the home visit. If unable to determine this date, enter &quot;Unknown&quot;.</td>
</tr>
<tr>
<td>10 Date Last Contacted Physician</td>
<td>Note the date MMDDYY (e.g., 071504) of</td>
</tr>
</tbody>
</table>

PRODUCTION : 11/20/2021
the most recent physician contact (verbal or written) regarding the status or problems encountered.

11 Is Patient Receiving Care in an 1861 (J)(1) SNF or Equivalent? Leave Blank

12 Certification/Recertification/Modification Check one of the blocks to identify this plan of care as a certification, recertification or modification. Modification refers to the CMS-486 form submitted with an interim claim to report changes in the disciplines or number of visits ordered.

13 Specific Services and Treatments Leave Blank

14 Dates of Last Inpatient Stay Enter the admission and dates (month, day and year: e.g., 060204-061004) of the last inpatient stay relevant to the care provided. Enter N/A if not applicable.

NOTE: When billing for postnatal assessment and follow-up care on a paper claim, the date and time of discharge should be included in this field.

15 Type of Facility Identify the type of facility (e.g., acute, NF, rehabilitation). Enter N/A if not applicable.

16 Updated Information Record any new orders, treatments or changes and associated date(s) from the time the CMS-485 is completed to the time the CMS-486 is completed.

On certifications, enter the clinical findings of the initial assessment visit for all disciplines involved in the care plan.

Describe the clinical facts about the patient that require skilled home health services. Include specific dates.

On recertifications, record significant clinical findings for each discipline incorporating all symptoms and changes in
the patient's condition during the last 60 days of service. Include specific dates. Document progress or nonprogress for each discipline. Include any pertinent information on a patient's inpatient stay and the purpose of any agency contact with the physician, if applicable.

17 Functional Limitations

Provide a narrative description of the patient's prior functional status and current limitations and activities permitted. Elaborate on the information in the checklist (CMS-485 Field #18A and #18B) and provide any other information needed to describe the patient. Clearly reflect the restrictions imposed by the physician. Include a description of ADL limitations and include any other information needed to describe the patient. Clearly reflect the restrictions imposed by the physician. Include a description of ADL limitations and indicate the type of scope of assistance needed. Include a brief statement of why the patient is homebound if the patient is homebound. Include a description of the home environment, if it is relevant to the homebound determination, e.g., patient lives in a third floor walk-up apartment and is recovering from congestive heart failure.

19 Unusual Home/Social Environment

Use this block to include information which would enhance the reviewer's concept of the home situation and help justify the need for services in the home, e.g., patient lives with retarded son who is unable to provide any assistance or to comprehend instructions.

22 Nurse or Therapist Completing or Reviewing Form/Date (MO,DAY,YR)

The nurse or therapist responsible for the completion of the form or a nonclerical agency representative or supervisor responsible for the review signs and dates the form.

14.4 CMS-487—ADDENDUM TO THE PLAN OF TREATMENT/MEDICAL UPDATE (FOR DOCUMENTATION PURPOSES OR TO BE ATTACHED TO A PAPER CLAIM)

PRODUCTION : 11/20/2021
The CMS-487 is used only as an addendum to the CMS-485/CMS-486 when additional space is needed to complete the fields on these forms. The data for each field must be initiated on the CMS-485 or CMS-486. Use a separate addendum for the plan of treatment and the medical update. If the addendum is used to continue items on the plan of treatment, forward the CMS-487 to the physician with the CMS-485 for the physician’s signature.

To provide additional documentation of items on the plan of treatment or medical information, check the appropriate block. Identify the item being addressed under Item 8. For example, if the plan of treatment block is checked and Item 11 (medications) requires additional space, specify Item 11 on the left margin of column 8. Upon completion of Item 11, note the next item number, e.g., Item 14 (Supplies) then complete that item.

Instruction for completion of the required fields follows. Please reference the sample CMS-487 included in this Section.

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient's HI Claim No. (Patient's eight-digit MO HealthNet ID Number)</td>
<td>See CMS-485 instructions, Field #1.</td>
</tr>
<tr>
<td>2 Start of Care Date</td>
<td>See CMS-485 instructions, Field #2.</td>
</tr>
<tr>
<td>3 Certification Period</td>
<td>See CMS-485 instructions, Field #3.</td>
</tr>
<tr>
<td>4 Medical Record Number</td>
<td>See CMS-485 instructions, Field #4.</td>
</tr>
<tr>
<td>5 Provider Number</td>
<td>See CMS-485 instructions, Field #5.</td>
</tr>
<tr>
<td>6 Patient's Name</td>
<td>See CMS-485 instructions, Field #6.</td>
</tr>
<tr>
<td>7 Provider Name</td>
<td>See CMS-485 instructions, Field #7.</td>
</tr>
<tr>
<td>8 Item Number</td>
<td>Indicate the item number for which additional information is being provided.</td>
</tr>
<tr>
<td>9 Signature of Physician</td>
<td>If the certification/plan of treatment block is checked, the physician's signature or an annotation is required on the CMS-485 which indicates that the physician is aware that he/she is signing for information contained on additional pages (e.g., page 1 of 2). Retain a copy for filing purposes. The physician enters the date the addendum was signed in this space.</td>
</tr>
<tr>
<td>10 Date</td>
<td>If the medical update/patient information block is checked, the Nurse/Therapist filling</td>
</tr>
</tbody>
</table>
14.5 INTERIM ORDER

Any changes to the plan of treatment must be documented on an interim order. If filing an electronic claim, the appropriate information must be provided in the home health segments of the institutional 837 transaction.

An interim order is required when:

- There has been an increase or decrease in frequency and/or duration of visits and/or addition of a new discipline since the certification/recertification; or
- There is an extension of daily visits beyond the initial 2-3 week period certified by the physician.

In the case of medication changes only, e.g. increase Amoxicillin from 250 mg to 300 mg, 3 x per day, it is not necessary to send the interim order when billing. Medication changes should be listed on the CMS-486 update.

MO HealthNet does not require a standard interim order form. However, in addition to the ordered changes, the interim order must contain the following items:

- The patient's name;
- The date the change was ordered; and
- The physician's signature and date.

14.6 WEIGHT-FOR-HEIGHT GRAPH

Because eligibility for low birth weight or failure-to-thrive (FTT) benefits depend upon the child's weight for height deficit, a growth chart must be maintained in the patient's record. A copy of the growth chart must be submitted with paper claims; if billing electronically, the necessary information should be provided in the home health segments of the institutional 837 transactions.

It is recommended that providers use the chart developed by the National Center for Health Statistics. Reference the Weight-for-Height Graph, Boys from Birth to 36 Months or Weight-for-Height Graph, Girls from Birth to 36 Months charts located at
Additional copies may be obtained from the Missouri Department of Health and Senior Services or providers may make copies of the sample form. Both the weight and height, with dates of observation, must be clearly recorded on the growth chart.
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 X12 Version v5010 and NCPDP Telecommunication D.O & 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
- X12 Version v5010 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 website address is www.emomed.com Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference www.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, 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 BILLING HOME HEALTH SERVICES
The UB-04 (CMS-1450) claim form, the internet claim located at www.emomed.com, or the institutional 837 transaction is used to bill MO HealthNet for home health services. Instructions on how to complete the UB-04 (CMS-1450) 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 Home Health Provider Manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any claim or line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. An example of a correctable error is the use of an invalid procedure code. The provider may resubmit the claim on UB-04 (CMS-1450) or may retrieve and resubmit electronically at the billing website at www.emomed.com.

If a line item on a claim paid but the payment was incorrect do not resubmit that line item. For instance, if a provider bills the incorrect amount for a service, the claim cannot be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider must submit an Individual Adjustment Request via the Internet at www.emomed.com. Section 6 of the Home Health Provider Manual explains the adjustment request process.

15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare and MO HealthNet coverage, a claim must be filed with Medicare first as primary payor. If the participant has Medicare but the service is not covered or the limits of coverage have been reached previously, a paper or an electronic claim must be submitted to MO HealthNet with the Medicare denial information. Reference Section 16.5 of Home Health Provider Manual for instructions for submission of claims to MO HealthNet.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is not received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), a crossover claim must be submitted to MO HealthNet. Reference Section 16 of the Home Health Provider Manual for billing instructions.
15.7 UB-04 CLAIM FILING INSTRUCTIONS

The UB-04 (CMS-1450) 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 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. Provider Name, Address, Telephone Number</td>
<td>Enter the provider name and address.</td>
</tr>
<tr>
<td>2. Unlabeled Field</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>3a. Patient Control Number</td>
<td>For the provider’s own information, a maximum of 20 alpha/numeric characters may be entered here.</td>
</tr>
<tr>
<td>3b. Med Rec #</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>*4. Type of Bill</td>
<td>The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The type of facility must be a &quot;3&quot;. Examples: 331, 341.</td>
</tr>
<tr>
<td>5. Federal Tax Number</td>
<td>Enter the provider's federal tax number or leave blank.</td>
</tr>
<tr>
<td>6. Statement Covers Period (from and through dates)</td>
<td>Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format. (Optional) If the “from” and “through” date is the same, the date of service need not be repeated in Field #45. If multiple dates are listed, each date must be listed individually in Field #45.</td>
</tr>
</tbody>
</table>
7. Unlabeled Field Leave blank.

8a. Patient's Name - ID Enter the patient's eight-digit MO HealthNet DCN or MO HealthNet Managed Care identification number. (Optional)

NOTE: The MO HealthNet DCN or MO HealthNet Managed Care identification number is **required** in Field #60.

*8b. Patient Name Enter the patient's name in the following format: last name, first name, middle initial.

9. Patient Address Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, state and zip code.

10. Patient Birth Date Enter the patient's date of birth in MMDDYY format.

11. Patient Sex Enter the patient's sex, "M" (male) or "F" (female).

12. Admission Date Leave blank.

13. Admission Hour Leave blank.

14. Admission Type Leave blank.

15. Source of Admission (SRC) Leave blank.

16. Discharge Hour Leave blank.

17. Patient Status Leave blank.

**18-24. Condition Codes Enter "A1" if the service is an EPSDT/HCY screening or the result of a screening. This is the only valid value.


29. Accident State Leave blank.

30. Unlabeled Field Leave blank.

**31-34. Occurrence Code and Date When billing physical, occupational or speech therapy for the *initial* certification period this field is required. In the first part of this field, enter the appropriate code from the following list:
35—Physical Therapy
44—Occupational Therapy
45—Speech Therapy

Enter the beginning date of the initial Plan of Care in the second half of the field for each code identified.

This field is required only in the above situations.

When billing for skilled nurse visits, home health aide or any service which has been prior authorized, regardless of the approval of the prior authorization, leave blank.

35-36. Occurrence Span Codes and Dates
Leave blank.

37. Unlabeled Field
Leave blank.

38. Responsible Party Name and Address
Leave blank.

39-41. Value Codes and Amounts
Leave blank.

42. Revenue Code
Leave blank.

*43. Revenue Description
Enter the description of the service, such as skilled nurse visit, supplies, etc.

*44. HCPCS/Rates/HIPPS Code
Enter the appropriate HCPCS procedure code, from Section 19 of the Home Health Provider Manual. Bill one visit per detail line.

*45. Service Date
Enter the date of service on each line billed in MMDDYY format. The service date for medical supplies must correspond with the date of delivery of the medical supply.

*46. Service Units
Enter the number of units for each procedure, revenue code or supply items billed. (If no entry is made, the system autoprops a unit of “1”). Reference the HCPCS manual to verify the definition of a unit for each type of medical supply.

*47. Total Charges
Enter the total charge for each line. After all
charges are shown, skip a line and enter the total of all charges for this claim.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.</td>
<td>Unlabeled Field</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>*50.</td>
<td>Payer Name</td>
<td>The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer and “MO HealthNet” is listed last.</td>
</tr>
<tr>
<td>51.</td>
<td>Health Plan ID</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>52.</td>
<td>Release of Information Certification Indicator</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>53.</td>
<td>Assignment of Benefits Certification of Indicator</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>**54.</td>
<td>Prior Payments</td>
<td>Enter the amount the provider received toward payment of this bill from all other health insurance companies. Payments <em>must</em> correspond with the appropriate payer entered in Field #50. (See Note)(1) Do <em>not</em> enter a previous MO HealthNet payment, Medicare payment or copay amount received from the patient in this field</td>
</tr>
<tr>
<td>55.</td>
<td>Estimated Amount Due</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>56.</td>
<td>National Provider Identifier (NPI)</td>
<td>Enter the provider’s 10-digit NPI number.</td>
</tr>
<tr>
<td>57.</td>
<td>Other Provider ID</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>**58.</td>
<td>Insured's Name</td>
<td>Complete if the insured’s name is different from the patient's name. (See Note)(1)</td>
</tr>
<tr>
<td>59.</td>
<td>Patient’s Relationship to Insured</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>*60.</td>
<td>Insured's Unique ID</td>
<td>Enter the patient's 8-digit MO HealthNet or MO HealthNet Managed Care identification number. If insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.</td>
</tr>
</tbody>
</table>
### **61. Insurance Group Name**
If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured. (See Note)(1)

### **62. Insurance Group Number**
If insurance is shown in Field #50, state the number assigned by the insurance company to identify the group under which the individual is covered. (See Note)(1)

### 63. Treatment Authorization Codes
Leave blank.

### **64. Document Control Number**
If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.

### 65. Employer Name
If the patient is employed, the employer's name may be entered here.

### 66. Diagnosis & Procedure Code Qualifier
Leave blank.

### *67. Principal Diagnosis Code*
Enter the applicable ICD diagnosis code for the condition for which the services were provided.

Remember to code to the highest level of specificity shown in the applicable version of the ICD diagnosis code book.

### **67. A-D Other Diagnosis Codes**
Enter any additional diagnosis codes that have an effect on the treatment received.

### 67. E-Q Other Diagnosis Codes
Leave blank.

### 68. Unlabeled Field
Leave blank.

### 69. Admitting Diagnosis
Leave blank.

### 70. Patient's Reason for Visit
Leave blank.

### 71. Prospective Payment system (PPS) Code
Leave blank.

73. Unlabeled Field  Leave blank.

74. Principal Procedure Code and Date  Leave blank.

74. A-E Other Procedure Codes and Dates  Leave blank.

75. Unlabeled Field  Leave blank.

76. Attending Provider Name and Identifiers  Physician's NPI is optional. Enter the attending physician's name, last name first.

77. Operating Provider Name and Identifiers  Use, if applicable. Physician's NPI is optional. Enter the operating physician's name, last name first.

78-79. Other Provider Name and Identifiers  Leave blank.

**80. Remarks  Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.

81CC. Code-Code Field  Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field # 56.

The appropriate qualifier is:
B3—Healthcare Provider Taxonomy code.

* These fields are mandatory on all Inpatient UB-04 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, employer’s name or other information appears in this field, the claim will deny. See Section 5 of the Home Health Provider Manual for further TPL information.

15.7 BILLING POST DISCHARGE HOME VISITS
The date and time of delivery are required on the CMS-485 in the field titled “Other Pertinent Diagnoses.” The date and time of discharge are required on the CMS-486 in the field titled “Dates of Last Inpatient Stay: Admission: Discharge:”

The post-discharge visit(s) are to be billed using the mother’s Departmental Client Number (DCN).

15.8 INSURANCE COVERAGE CODES

While providers are verifying the participant’s eligibility, they can obtain the TPL information contained on the MO HealthNet Division’s participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, 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 Home Health 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.

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 (CROSSEOVERS)

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>
<tr>
<td>MO HEALTHNET ID</td>
<td>The participant’s current 8-digit MO HealthNet identification number.</td>
</tr>
<tr>
<td>ICN</td>
<td>The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:</td>
</tr>
<tr>
<td></td>
<td>11— Paper Drug</td>
</tr>
<tr>
<td></td>
<td>13— Inpatient</td>
</tr>
<tr>
<td></td>
<td>14— Dental</td>
</tr>
<tr>
<td></td>
<td>15— Paper Medical</td>
</tr>
<tr>
<td></td>
<td>16— Outpatient</td>
</tr>
<tr>
<td></td>
<td>17— Part A Crossover</td>
</tr>
<tr>
<td></td>
<td>18— Paper Medicare/MO HealthNet Part B Crossover Claim</td>
</tr>
<tr>
<td></td>
<td>21— Nursing Home</td>
</tr>
<tr>
<td></td>
<td>40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.</td>
</tr>
<tr>
<td></td>
<td>41— Direct Electronic MO HealthNet Information (DEMI)</td>
</tr>
<tr>
<td></td>
<td>43— MTB/DEMI</td>
</tr>
<tr>
<td></td>
<td>44— Direct Electronic File Transfer (DEFT)</td>
</tr>
<tr>
<td></td>
<td>45— Accelerated Submission and Processing (ASAP)</td>
</tr>
<tr>
<td></td>
<td>46— Adjudicated Point of Service (POS)</td>
</tr>
<tr>
<td></td>
<td>47— Captured Point of Service (POS)</td>
</tr>
</tbody>
</table>

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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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE DATES FROM</td>
<td>The initial date of service in MMDDYY format for the claim.</td>
</tr>
<tr>
<td>SERVICE DATES TO</td>
<td>The final date of service in MMDDYY format for the claim.</td>
</tr>
<tr>
<td>PAT ACCT</td>
<td>The provider’s own patient account name or number. On drug claims this field is populated with the prescription number.</td>
</tr>
<tr>
<td>CLAIM: ST</td>
<td>This field reflects the status of the claim. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>1 — Processed as Primary</td>
</tr>
<tr>
<td></td>
<td>3 — Processed as Tertiary</td>
</tr>
<tr>
<td></td>
<td>4 — Denied</td>
</tr>
<tr>
<td></td>
<td>22 — Reversal of Previous Payment</td>
</tr>
<tr>
<td>TOT BILLED</td>
<td>The total claim amount submitted.</td>
</tr>
<tr>
<td>TOT PAID</td>
<td>The total amount MO HealthNet paid on the claim.</td>
</tr>
<tr>
<td>TOT OTHER</td>
<td>The combined totals for patient liability (surplus), participant copay and spenddown total withheld.</td>
</tr>
<tr>
<td>LN</td>
<td>The line number of the billed service.</td>
</tr>
<tr>
<td>SERVICE DATES</td>
<td>The date of service(s) for the specific detail line in MMDDYY.</td>
</tr>
<tr>
<td>REV/PROC/NDC</td>
<td>The submitted procedure code, NDC, or revenue code for the specific detail line.</td>
</tr>
<tr>
<td></td>
<td>NOTE: The revenue code only appears in this field if a procedure code is not present.</td>
</tr>
<tr>
<td>MOD</td>
<td>The submitted modifier(s) for the specific detail line.</td>
</tr>
<tr>
<td>REV CODE</td>
<td>The submitted revenue code for the specific detail line.</td>
</tr>
<tr>
<td></td>
<td>NOTE: The revenue code only appears in this field if a procedure code has also been submitted.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<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: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions 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: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes</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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<table>
<thead>
<tr>
<th>Medicare Part A Repricing</th>
<th>OA</th>
<th>Other Adjustment</th>
<th>45</th>
<th>Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment cut back to federal percentage (IEP therapy services)</td>
<td>OA</td>
<td>Other Adjustment</td>
<td>A2</td>
<td>Contractual adjustment</td>
</tr>
<tr>
<td>Payment reduced by co-payment amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>3</td>
<td>Co-Payment amount</td>
</tr>
<tr>
<td>Payment reduced by patient spenddown amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>178</td>
<td>Payment adjusted because patient has not met the required spenddown</td>
</tr>
<tr>
<td>Payment reduced by patient liability amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>142</td>
<td>Claim adjusted by monthly MO HealthNet patient liability amount</td>
</tr>
</tbody>
</table>

### 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 1) 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.

END OF SECTION

TOP OF SECTION
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 two 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 Health Care Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) 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>
</tr>
</thead>
<tbody>
<tr>
<td>G0299</td>
<td>Direct Skilled Nursing Services by a Registered Nurse in the Home Health or Hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0300</td>
<td>Direct Skilled Nursing Services by a Licensed Practical Nurse in the Home Health or Hospice Setting, each 15 minutes</td>
</tr>
<tr>
<td>G0156</td>
<td>Home Health Aide Services</td>
</tr>
<tr>
<td>G0162</td>
<td>Skilled Nursing Visit by a Registered Nurse for Management and Evaluation of the Plan of Care</td>
</tr>
<tr>
<td>G0164</td>
<td>Home Health Licensed Nurse (LPN or RN) for training of family member, each 15 minutes</td>
</tr>
<tr>
<td>99501</td>
<td>Maternity Post Discharge Home Visit</td>
</tr>
</tbody>
</table>

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A provider may only bill the following procedure codes for one certification period (60 days) if the certification period begins within 60 days of the onset of condition or 60 days of discharge.

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Physical Therapy Visit by a Qualified Physical Therapist</td>
</tr>
<tr>
<td>G0152</td>
<td>Occupational Therapy Visit by a Qualified Occupational Therapist</td>
</tr>
<tr>
<td>G0153</td>
<td>Speech Therapy Visit by a Qualified Speech and Language Pathologist</td>
</tr>
<tr>
<td>G0157</td>
<td>Physical Therapy Visit by a Qualified Physical Therapist Assistant</td>
</tr>
<tr>
<td>G0158</td>
<td>Occupational Therapy Visit by a Qualified Occupational Therapist Assistant</td>
</tr>
<tr>
<td>G0159</td>
<td>Physical Therapy Maintenance Visit by a Qualified Physical Therapist</td>
</tr>
<tr>
<td>G0160</td>
<td>Occupational Therapy Maintenance Visit by a Qualified Occupational Therapist</td>
</tr>
<tr>
<td>G0161</td>
<td>Speech Therapy Maintenance Visit by a Qualified Speech Language Pathologist</td>
</tr>
</tbody>
</table>

The following codes must be prior authorized. They must be billed through the UB-04 (CMS-1450) claim form, the internet at www.emomed.com or the 837 institutional transaction and do not require any attachments or home health loops populated when billing.

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151SC</td>
<td>Physical Therapy Visit by a Qualified Physical Therapist</td>
</tr>
<tr>
<td>G0152SC</td>
<td>Occupational Therapy Visit by a Qualified Occupational Therapist</td>
</tr>
<tr>
<td>G0153SC</td>
<td>Speech Therapy Visit by a Qualified Speech and Language Pathologist</td>
</tr>
<tr>
<td>G0157SC</td>
<td>Physical Therapy Visit by a Qualified Physical Therapist Assistant</td>
</tr>
<tr>
<td>G0158SC</td>
<td>Occupational Therapy Visit by a Qualified Occupational Therapist Assistant</td>
</tr>
<tr>
<td>G0159SC</td>
<td>Physical Therapy Maintenance Visit by a Qualified Physical Therapist</td>
</tr>
<tr>
<td>G0160SC</td>
<td>Occupational Therapy Maintenance Visit by a Qualified Occupational Therapist</td>
</tr>
<tr>
<td>G0161SC</td>
<td>Speech Therapy Maintenance Visit by a Qualified Speech Language Pathologist</td>
</tr>
</tbody>
</table>

19.2 HOME HEALTH SERVICES FOR CHILDREN THROUGH HEALTHY CHILDREN AND YOUTH (HCY)
The following codes do *not* require prior authorization. Evaluation visits are limited to two per year. Therapy service may be billed to MO HealthNet without prior authorization.

<table>
<thead>
<tr>
<th>PROC CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1001EP</td>
<td>Skilled Nurse Evaluation Visit through HCY</td>
</tr>
<tr>
<td>97161EP</td>
<td>Physical Therapy Evaluation through HCY Low Complexity – 20 minutes</td>
</tr>
<tr>
<td>97162EP</td>
<td>Physical Therapy Evaluation through HCY Moderate Complexity – 30 minutes</td>
</tr>
<tr>
<td>97163EP</td>
<td>Physical Therapy Evaluation through HCY High Complexity – 45 minutes</td>
</tr>
<tr>
<td>97164EP</td>
<td>Physical Therapy Re-Evaluation Establish Plan of Care</td>
</tr>
<tr>
<td>97165EP</td>
<td>Occupational Therapy Evaluation, Low Complexity – 30 minutes</td>
</tr>
<tr>
<td>97166EP</td>
<td>Occupational Therapy Evaluation, Moderate Complexity – 45 minutes</td>
</tr>
<tr>
<td>97167EP</td>
<td>Occupational Therapy Evaluation, High Complexity – 60 minutes</td>
</tr>
<tr>
<td>92521EP</td>
<td>Evaluation of speech fluency (eg, stuttering, cluttering)</td>
</tr>
<tr>
<td>92522EP</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);</td>
</tr>
<tr>
<td>92523EP</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)</td>
</tr>
<tr>
<td>92524EP</td>
<td>Behavioral and qualitative analysis of voice and resonance</td>
</tr>
<tr>
<td>G0151EP</td>
<td>Physical Therapy Visit by a qualified Physical Therapist through HCY</td>
</tr>
<tr>
<td>G0152EP</td>
<td>Occupational Therapy Visit by a qualified Occupational Therapist through HCY</td>
</tr>
<tr>
<td>G0153EP</td>
<td>Speech Therapy Visit by a qualified Speech and Language Pathologist through HCY</td>
</tr>
<tr>
<td>G0157EP</td>
<td>Physical Therapy Visit by a Qualified Physical Therapist Assistant</td>
</tr>
<tr>
<td>G0158EP</td>
<td>Occupational Therapy Visit by a Qualified Occupational Therapist Assistant</td>
</tr>
<tr>
<td>G0159EP</td>
<td>Physical Therapy Maintenance Visit by a Qualified Physical Therapist</td>
</tr>
<tr>
<td>G0160EP</td>
<td>Occupational Therapy Maintenance Visit by a Qualified Occupational Therapist</td>
</tr>
<tr>
<td>G0161EP</td>
<td>Speech Therapy Maintenance Visit by a Qualified Speech-Language Pathologist, Maintenance</td>
</tr>
</tbody>
</table>

The following codes *must* be prior authorized before they are delivered and *must not* be billed on the same claim as the services that are *not* prior authorized, which are listed in Section 19.1 of the Home Health Provider Manual. The following codes are valid only for MO HealthNet participants that are age 0-20.
<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0156EP</td>
<td>Home Health Aide through HCY</td>
</tr>
<tr>
<td>G0162EP</td>
<td>Skilled Nursing Visit by a Registered Nurse for Management and Evaluation of the Plan of Care through HCY</td>
</tr>
<tr>
<td>G0164EP</td>
<td>Home Health Licensed Nurse (LPN or RN) for training of family member, each 15 minutes</td>
</tr>
<tr>
<td>G0299EP</td>
<td>Home Health Hospice Skilled Nursing (RN), each 15 minutes</td>
</tr>
<tr>
<td>G0300EP</td>
<td>Home Health Hospice Licensed Practical Nurse (LPN), each 15 minutes</td>
</tr>
</tbody>
</table>

**19.3 HOME HEALTH SUPPLIES**

Home health agencies *must* bill HCPCS procedure codes for non-routine medical supplies utilized during home health visits.

Supply codes may be found in the HCPCS procedure range of A4206-A7527 and A9999. Each item/supply *must* be billed with the appropriate HCPCS procedure code and the applicable quantity (based on the HCPCS definition) on a separate detail line of a claim. HCPCS procedure code A9999 (miscellaneous DME supply or accessory) *must* only be used if the supply does not fit any other category.
SECTION 20-EXCEPTION PROCESS

20.1 EXCEPTION PRINCIPLE

Under certain conditions of medical need, the MO HealthNet Division may authorize payment for a MO HealthNet eligible participant to receive an essential medical service or item of equipment that otherwise exceeds the benefits and limitations of any one of the various medical service programs administered by the Division. Under specific criteria and on a case-by-case basis, an administrative exception may be made to limitations and restrictions set by agency policy. No exception can be made where requested items or services are restricted or specifically prohibited by state or federal law or regulation, or excluded under the restrictions section of this rule. The director of the MO HealthNet Division has the final authority to approve payment on a request made to the exception process. These decisions are made with appropriate medical or pharmaceutical advice and consultation.

With the exception of group 2 and group 3 pressure reducing support surfaces, mattress rentals, all services for individuals under age 21 determined to be medically necessary, may be considered for coverage under the EPSDT/HCY Program. Reference Section 9 for more information. Group 2 and group 3 pressure reducing support surface, mattress rentals, must be approved through the Exception Process prior to being dispensed, regardless of the participant's age.

Exception requests are only accepted from authorized health care prescribers licensed as a physician or advanced practice nurse.

20.2 REQUIREMENTS

Requirements for consideration and provision of a service as an exception to the normal limitations of MO HealthNet coverage are as follows:

- A prescriber must certify that MO HealthNet covered treatment or items of services appropriate to the illness or condition have been determined to be medically inappropriate or have been used and found to be ineffective in treatment of the participant for whom the exception is being requested;
- While requests may be approved, documentation verifying that all third party resource benefits have been exhausted must accompany claims for payment before the MO HealthNet Program pays for any item or service; for example,
  —Medicare
  —Private Insurance
  —The American Diabetes Society
  —The Veterans Administration
  —The American Cancer Society
  —A United Way Agency;
Except in the case of retroactive MO HealthNet eligibility determination, requests must be submitted prior to delivery of the service. Do not wait until after receipt of documentation of noncoverage from an alternative payor to submit the completed Exception Request form.

- Any requested medical, surgical or diagnostic service which is to be provided under the authority of the treating prescriber, must be listed in the most recent publication of *A Comprehensive Guide to Current Procedural Terminology, (CPT)* or the CMS-approved list of HCPCS codes. The CPT and HCPCS books may be purchased at any medical bookstore;

- Any individual for whom an exception request is made must be eligible for MO HealthNet on the date the item or service is provided. If requested, approval may be granted in the case of retroactive MO HealthNet eligibility determinations.

- The provider of the service must be an enrolled provider in the MO HealthNet Program on the date the item or service is provided;

- The item or service for which an exception is requested must be of a type and nature that falls within the broad scope of a medical discipline included in the MO HealthNet Program and does not represent a departure from the accepted standards and precepts of good medical practice. No consideration can be given to requests for experimental therapies or services;

- All requests for exception consideration must be initiated by the treating prescriber of an eligible participant and must be submitted as prescribed by policy of the MO HealthNet Division, 13 CSR 70-2.100;

- Requests for exception consideration must support and demonstrate that one (1) or more of the following conditions is met:
  1. The item or service is required to sustain the participant's life;
  2. The item or service would substantially improve the quality of life for a terminally ill patient;
  3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or
  4. The item or service is necessary to prevent a higher level of care.

- All requests must be made and approval granted before the requested item or service is provided. An exception to that requirement may be granted in cases in which the participant's eligibility for MO HealthNet is retroactively established or when emergency circumstances preclude the use of the established procedures for submitting a request, and a request is received not more than one (1) state working day following the provision of the service.
An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

• All exception requests must represent cost-effective utilization of MO HealthNet funds. When an exception item or service is presented as an alternative, lesser level-of-care than the level otherwise necessary, the exception must be less program costly; and
• Reimbursement of services and items approved under this exception procedure shall be made in accordance with the MO HealthNet established fee schedules or rates for the same or comparable services. For those services for which no MO HealthNet-established fee schedule or rate is applicable, reimbursement is determined by the state agency considering costs and charges.

20.3 RESTRICTIONS

The following are examples of types of requests that are not considered for approval as an exception. This is not an all-inclusive list:

• Requests for restricted program areas. Refer to Section 1 for a list of restricted program areas.
• Requests for expanded HCY/EPSDT services (individuals under age 21). These should be directed to the HCY/EPSDT coordinator. (Reference manual Section 9).
• Requests for orthodontic services;
• Requests for inpatient hospital services;
• Requests for alternative services (Personal Care, Adult Day Health Care, AIDS Waiver, Aged and Disabled Waiver, Hospice, and Respite Care) regardless of authorization by the Missouri Department of Health and Senior Services;
• Requests for chiropractic services;
• Requests for services that are provided by individuals whose specialty is not covered by the MO HealthNet Program;
• Requests for psychological testing or counseling not otherwise covered by the MO HealthNet Program;
• Requests for waiver of program requirements for documentation, applicable to services requiring a second surgical opinion, hysterectomy, voluntary sterilizations, and legal abortions;
• Requests for drug products excluded from coverage by the MO HealthNet Program;
• Requests relating to the failure to obtain prior authorization or pre-certification as required for a service otherwise covered by MO HealthNet;
• Requests for payment of dentures and/or partials placed after the participant is ineligible when fabrication occurred prior to that time;
• Requests for delivery or placement of any custom-made items following the participant's death or loss of eligibility for the service;
• Requests for removal from the Lock-In or Prepaid Health Programs;
• Requests for additional reimbursement for items or services otherwise covered by the MO HealthNet Program;
• Requests for air ambulance transportation;
• Requests for Qualified Medicare Beneficiary (QMB) services;
• Requests for MO HealthNet Waiver services such as AIDS Waiver;
• Requests for services exceeding the limits of the Transplant Program;
• Requests for services exceeding the limits of the regular MO HealthNet Program.

20.4 REQUESTING AN EXCEPTION

All Exception Request forms must be signed by the treating prescriber of an eligible participant. The requests are to be submitted to the Exceptions Unit. This unit processes the request, obtains a decision from the appropriate medical or pharmaceutical consultant and/or administrative official, and informs the treating prescriber, provider of service, and participant of all approved decisions. In the event of a denial, only the prescriber and participant are notified.

There are two categories of exception request—emergency and nonemergency, each of which are processed differently.
20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS

Requests for life-threatening emergencies may be submitted by the treating prescriber by calling the toll-free number (800) 392-8030. The office hours for the Exceptions Unit are from 8:00 A.M. to 5:00 P.M. Monday through Friday, except on observed holidays. All other provider inquiries regarding covered program benefits must be directed to the Provider Communications Unit at (573) 751-2896.

The treating prescriber must provide Exceptions Unit personnel with information consistent with that required on the Exception Request form. The request is processed within one (1) state working day with notification of approval communicated by fax to the provider of service. If the request is denied, the prescriber is notified within one (1) state working day.

20.4.B NON-EMERGENCY EXCEPTION REQUESTS

In order to ensure access to the Exceptions Unit for life-threatening emergency requests, all non-emergency requests must be submitted on an Exception Request form. Requests may be faxed to (573) 522-3061.

Non-emergency requests may also be submitted by mailing to:

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

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.
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
- ID/DD Waiver
- Nurse Midwife
- Optical
- Pharmacy
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy

END OF SECTION

TOP OF SECTION
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/Urbann/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
Emergency

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

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.
Free Transportation

Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.

Grievance (Participant)

A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are 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.

Grievance (Transportation Provider)

A written request for further review of a transportation provider’s complaint that remains unresolved after completion of the complaint process.

Inquiry

A request from a transportation provider regarding information that would clarify broker’s policies and procedures, or any aspect of broker function that may be in question.

Most Appropriate

The mode of transportation that accommodates the participant’s physical, mental, or medical condition.

MO HealthNet Covered Services

Covered services under the MO HealthNet program.

Medically Necessary

Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could 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.

Medical Service Provider

An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.
NEMT Services  Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does 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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCPs</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>15</td>
<td>30</td>
<td>60</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/Adelescent</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**

<table>
<thead>
<tr>
<th>Type</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Hospital</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Secondary Hospital</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

**Tertiary Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I or Level II trauma unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Neonatal intensive care unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Perinatology services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cancer services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cardiac services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric subspecialty care</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Mental Health Facilities**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
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</thead>
<tbody>
<tr>
<td>Inpatient mental health treatment facility</td>
<td>25</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Ambulatory mental health treatment providers</td>
<td>15</td>
<td>25</td>
<td>45</td>
</tr>
</tbody>
</table>
Residential mental health treatment providers | 20 | 30 | 50

**Ancillary Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>30</th>
<th>30</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 MO HealthNet Division (MHD) does not require copayments for any services at this time. Providers will be notified when copayments are reinstated.

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 or rideshare service;
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 ModivCare (formerly 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 ModivCare (formerly 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 except when a participant has an appointment to receive a vaccination.

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. **KCATA/RideKC Connection** KCATA 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 Agency DBA Metro Transit** Metro Transit 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, Transit** 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. **City of Jefferson/Jefftran** Jefftran is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Jefftran is provided to all eligible individuals with disability without priority given for trip purpose. Jefftran 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 City Hospital** Nevada City Hospital transports individuals who live within a 20 mile radius of Nevada.

8. **Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

### 22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker must consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker must adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker’s network, for as long as the broker is unable to
provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers must coordinate with the broker with respect to payment. The broker must ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does not apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers’ non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall not utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a “hit” on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under ‘Definition’, must be filed with the NEMT broker. The broker must resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite210
Maryland Heights, MO  63043
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants must be given the rights listed below:
1. **General rule.** The broker must comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker’s personnel and transportation providers take those rights into account when furnishing services to participants.

2. **Dignity and privacy.** Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

3. **Copy of transportation records.** Each participant is guaranteed the right to request and receive a copy of his or her transportation records.

4. **Free exercise of rights.** Each participant is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the broker and the broker’s transportation providers or the state agency treat the participant.

### 22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice must indicate that the broker has denied the services, the reasons for the denial, the participant’s right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant’s estate.

### 22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite 210
Maryland Heights, MO 63043
22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a ModivCare (formerly 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 ModivCare (formerly 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, ModivCare (formerly 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 ModivCare (formerly 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 ModivCare (formerly 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 ModivCare (formerly 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 ModivCare (formerly LogistiCare) Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.

2. A ModivCare (formerly 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, ModivCare (formerly LogistiCare) will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by ModivCare (formerly LogistiCare).

3. ModivCare (formerly 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 ModivCare (formerly LogistiCare) along with a copy of the ModivCare (formerly LogistiCare) Authorized Ancillary Services Form.
for the meals to ModivCare (formerly 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 ModivCare (formerly LogistiCare) Facility Department, 13690 Riverport Drive, Suite 210, Maryland Heights, MO 63043. 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 ModivCare (formerly 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. ModivCare’s (formerly LogistiCare) 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 ModivCare (formerly 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 ModivCare (formerly LogistiCare) at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All ModivCare (formerly 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, ModivCare’s (formerly 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 ModivCare (formerly 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 ModivCare (formerly 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 ModivCare (formerly LogistiCare) window decal is applied to the vehicle. This provides for a quick visual identification of a ModivCare (formerly LogistiCare) approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to ModivCare (formerly LogistiCare) through the WMR line referenced above. For reoccurring issues, the ModivCare (formerly 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. ModivCare (formerly LogistiCare) will attempt to schedule transport with the preferred provider; however ModivCare (formerly 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. ModivCare (formerly 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.