STATE OF MISSOURI

HOSPITAL MANUAL

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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

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

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

1.1.A(2) MO HealthNet for Kids

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

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

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

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

ME CODE	DESCRIPTION
58	Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility.
59	Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did *not* qualify for regular MO HealthNet benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter. NOTE: Providers should encourage women with a TEMP card to apply for regular MO HealthNet.

1.1.A(4) Voluntary Placement Agreement for Children

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

1.1.A(5) State Funded MO HealthNet

ME CODE	DESCRIPTION

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

1.1.A(6) MO Rx

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

1.1.A(7) Women's Health Services

ME CODE	DESCRIPTION

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

1.1.A(8) ME Codes Not in Use

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

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

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

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

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

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

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

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

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

1.2.A FORMAT OF MO HEALTHNET ID CARD

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

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

1.2.B ACCESS TO ELIGIBILITY INFORMATION

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

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

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

58, 59

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

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

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

1.2.C(5) Presumptive Eligibility for Children

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

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

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

Women determined eligible by the Department of Health and Senior Services' Breast and Cervical Cancer Control Project (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:

ME CODE DESCRIPTION

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

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

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

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

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

- *Group 3 previously consisting of General Relief participants has been deleted from inclusion in the managed care program at this time.*

- Group 4 generally consists of those children in state care and custody. The following ME codes fall into this group: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70, and 88.

- Group 5 consists of uninsured children.

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

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

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

participant, parent or guardian.

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

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

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

1.5.D HOSPICE BENEFICIARIES

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

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

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

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

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

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

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

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

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

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

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

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

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

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

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

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

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

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

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

1.5.G TEMP PARTICIPANTS

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

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

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

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

1.5.G(1) TEMP ID Card

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

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

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

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

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

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

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

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

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

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

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

1.5.I(1) Eligibility Criteria

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

- Screened by a Missouri BCCCP Provider;

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

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

1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

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

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

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

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

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

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

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

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

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

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

- Routine Medical/Dental Care;

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

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

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

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

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

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

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

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

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

1.6.B SPENDDOWN

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

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

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

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

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

1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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

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

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

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

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

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

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

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

1.7.A NEW APPROVAL LETTER

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

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

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

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

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

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

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

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

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

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

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

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

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

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

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

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

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

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

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

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

1.8 TRANSPLANT PROGRAM

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

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

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

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

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

1.8.B PATIENT SELECTION CRITERIA

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

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

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

1.8.C CORNEAL TRANSPLANTS

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

1.8.D ELIGIBILITY REQUIREMENTS

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

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

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

1.8.E MANAGED CARE PARTICIPANTS

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

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

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

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

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

1.8.F MEDICARE COVERED TRANSPLANTS

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

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

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

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

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

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

A provider wishing to submit claims or attachments electronically or access the Internet web site, www.emomed.com, *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 on-line Application for MO HealthNet Internet Access Account. Please reference http://manuals.momed.com/Application.html and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com 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 website can be accessed to retrieve current and aged remittance advices.

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

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

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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/.

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.
    - "This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Are Code (XXX-XXX-XXXX on file)."

- If PCP lock-in exists, the IVR states the provider's name and phone number for services on the applicable dates.
    - "This participant is locked into Provider (Provider Name) for services on (from date) through (to date). The participant's primary care provider is (PCP Name). The lock-in provider's phone number is Area Code (XXX-XXX-XXXX on file)."

This information is also available on www.emomed.com.

Sub-Option 2. Eye Glass and Eye Exam Information

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

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

- If frames, lens, and/or exam information exist, then the IVR will read different types of responses based on the data. A couple of examples include:
    - If frames, lens, and exam information exists and all occur on the same date.
    - Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
    - If frames, lens exist for different dates and no exam date.
    - Eye glass frames were last issued on (Frames Date).
    - Eye glass lenses were last issued on (Lens Date).
    - This 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.
    - Third party insurance is provided by (TPL NAME).
    - If Court Ordered, the IVR will read that this coverage is court ordered.
    - If Policy Number = 'unknown, the IVR will read that the Policy number is unknown.
    - If Policy Number is known, the IVR will read the policy number is (Policy Number).
    - If Group Number = 'unknown, the IVR will read that the group number is unknown.
    - If the Group Number is known, the IVR will read that the group number is (Group Number).

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

Sub-Option 4 Medicare and QMB Information

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

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

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

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

Main Option 2. Provider IVR Check Inquiry

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

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

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

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

Main Option 3. Provider IVR Claim Information

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

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

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

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

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

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

Main Option 4. Provider Enrollment Status

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

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

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

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

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

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

Main Option 5. Participant Annual Review Date

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

The caller is prompted to enter the following information.

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

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

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

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

After valid or error response IVR then reads menu options.

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

Transfer Routine

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

Number of Inquiries

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

3.3.A(1) Using the Telephone Key Pad

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

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

3.3.B MO HEALTHNET SPECIALIST

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

• Review the provider manual and bulletins before calling the IVR.

• Have all material related to the problem (such as RA, claim forms, and participant information) available for discussion.

• Have the provider's NPI number available.

• Limit the call to three questions. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.

• Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

Please note that there are no limits on how many inquiries you can access through the MHD web-based www.emomed.com 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. Access to this information is restricted to users with authorization. In addition to the\RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

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

3.3.D WRITTEN INQUIRIES

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

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

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

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

3.4 PROVIDER EDUCATION UNIT

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

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

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

3.5 PARTICIPANT SERVICES

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

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

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

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

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

3.6 PENDING CLAIMS

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

3.7 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MHD website at www.dss.mo.gov/mhd/providers/index.htm. Choose the "MO HealthNet forms" link in the right column.

3.8 CLAIM FILING METHODS

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

Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in the Provider Manuals Section 15.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

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

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

3.10 Pharmacy & Clinical Services Unit

This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using

best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by emailingMHD.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 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.

END OF SECTION

TOP OF PAGE

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

RX Pharmacy

SC Nursing Home Skilled Care

SU Surgical

VI Vision

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

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

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

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

5.5 MEDICAL SUPPORT

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

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

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

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

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

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

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

5.6.A EXCEPTION TO TIMELY FILING LIMIT

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

5.6.B TPR CLAIM PAYMENT DENIAL

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

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

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

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

5.7 THIRD PARTY LIABILITY BYPASS

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

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

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

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

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

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

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

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

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

5.9 LIABILITY AND CASUALTY INSURANCE

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

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

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

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

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

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

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

5.9.A TPL RECOVERY ACTION

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

5.9.B LIENS

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

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

5.9.C TIMELY FILING LIMITS

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

5.9.D ACCIDENTS WITHOUT TPL

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

Examples are:

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

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

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

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

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

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

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

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

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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

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

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END OF SECTION

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SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

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

6.2.B(2)(ii) Copy Claim – Original

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

6.2.B(2)(iii) Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

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

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

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

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

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

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

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

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

END OF SECTION

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

Medical consultants and medical review staff review the Certificate of Medical Necessity form and the claim form to make a determination regarding payment of the claim. If the medical necessity of the service is supported by the documentation, the claim is approved for further processing. If medical necessity is *not* documented or supported, the claim is denied for payment.

7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Patient Name	Enter last name, first name and middle initial as shown on the ID card.
2. Participant MO HealthNet ID Number	Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant's ID card or letter of eligibility.
3. Procedure/Revenue Codes	Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).
4. Description of Item/Service	For each procedure/revenue code listed, describe in detail the service or item being provided.
5. Reason for Service	For each procedure/revenue code listed, state clearly the medical necessity for this service/item.

6. Months Item Needed (DME only)	For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).
7. Name and Signature of Prescriber	The prescriber's signature, when required, *must* be an original signature. A stamp or the signature of a prescriber's employee is *not* acceptable. A signature is *not* required here if the prescriber is the provider (Fields #12 thru #14).
8. Prescriber's MO HealthNet Provider Identifier	Enter the NPI number if the prescriber participates in the MO HealthNet Program.
9. Date Prescribed	Enter the date the service or item was prescribed or identified by the prescriber as medically necessary in month/date/year numeric format, if required by program. This date *must* be prior to or equal to the date of service.
10. Diagnosis	Enter the appropriate ICD code(s) that prompted the request for this service or item, if required by program.
11. Prognosis	Enter the participant's prognosis and the anticipated results of the requested service or item.
12. Provider Name and Address	Enter provider's name, address, and telephone number.
13. MO HealthNet Provider Identifier	Enter provider's NPI number.
14. Provider Signature	The provider *must* sign here with an original signature. This certifies that the information given on the form is true, accurate and complete.

END OF SECTION

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

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

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

- Medicare crossovers when Medicare makes the primary reimbursement and MO HealthNet pays only the coinsurance and deductible.
- Procedures requiring prior authorization that are performed incidental to a major procedure.
- Services performed as an emergency. An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The dates for the services requested *cannot* overlap dates that are already approved and *must* be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

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

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

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

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

1. The "from" date may *not* precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.
2. The "through" date *cannot* be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.

- Increase or decrease requested units or dollars.
  1. An increase in frequency and or duration in some programs require additional or revised information.
- Correct the National Provider Identifier (NPI). The NPI number can only be corrected if both of the following conditions are met:
  - The number on the original request is in error; and
  - The provider was *not* reimbursed for any units on the initial Prior Authorization Request.
- Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior

authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri.

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

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

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

The written request *must* include:

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

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

8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS

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

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

END OF SECTION

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

9.3 DIAGNOSIS CODE

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

9.4 INTERPERIODIC SCREENS

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

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

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

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

9.5 FULL HCY/EPSDT SCREEN

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

A full HCY/EPSDT screen includes the following:

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

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

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

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

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

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

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

9.6.A DEVELOPMENTAL ASSESSMENT

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

This screen includes the following:

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

9.6.A(1) Qualified Providers

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

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

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

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

PROCEDURE CODE	DESCRIPTION

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

The HCY unclothed physical and history includes the following:

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

9.6.B(1) Qualified Providers

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

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

9.6.C VISION SCREENING

PROCEDURE CODE	DESCRIPTION
9942952	Vision Screening
9942952UC	Vision Screening with Referral

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

9.6.C(1) Qualified Providers

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

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

- Optometrist.

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

9.6.D HEARING SCREEN

PROCEDURE CODE	DESCRIPTION
99429EP	HCY Hearing Screen
99429EPUC	HCY Hearing Screen with Referral

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

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

9.6.D(1) Qualified Providers

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

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

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

9.6.E DENTAL SCREEN

PROCEDURE CODE	DESCRIPTION
99429	HCY Dental Screen
99429UC	HCY Dental Screen with Referral

A dental screen is available to the HCY/EPSDT population on a periodicity schedule that is different from that of the full HCY/EPSDT screen.

Children may receive age-appropriate dental screens and treatment services until they become 21 years old. *A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems such as nursing caries, and educate parents in the prevention of dental disease in their child.* It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated.

When a child receives a full medical screen by a physician, nurse practitioner or nurse midwife*, it includes an oral examination, which is *not* a full dental screen. A referral to a dental provider *must* be made where medically indicated when the child is under the age of 1 year. When the child is 1 year or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician, nurse practitioner or nurse midwife may *not* bill the dental screening procedure 99429 or 99429UC separately.

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

9.6.E(1) Qualified Providers

A dental partial screen may only be provided by a MO HealthNet participating dentist.

9.6.F ALL PARTIAL SCREENERS

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) has identified all children between 6 months and 72 months to be at risk for lead poisoning and has mandated they *must* receive a lead risk assessment as part of the HCY full or partial screening.

A complete lead risk assessment consists of a verbal risk assessment and blood test(s) when indicated, and at the mandatory testing ages of 12 and 24 months. Lead risk assessment is included as a component of a full HCY medical screen, 99381EP through 99385EP and 99391EP through 99395EP, or a partial HCY screen, 9938152EP through 9938552EP and 9939152EP through 9939552EP, which also includes the following components: Interval History, Unclothed Physical, Anticipatory Guidance, Lab, and Immunization. See Section 9.7.B for additional information.

CMS has also determined that there are no guidelines or policies for states or local health departments to reference in determining that an area is a lead free zone. Until there is specific information or guidance from the Centers for Disease Control (CDC) on how lead free zones are

determined, CMS will *not* recognize them in the context of screening Medicaid eligible children for lead poisoning.

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

The signs and symptoms of lead exposure and toxicity may vary because of differences in individual susceptibility. A continuum of signs and symptoms exist, ranging from asymptomatic persons to those with overt toxicity.

Mild toxicity is usually associated with blood lead levels in the 35 to 50 µg/dL range for children and in the 40 to 60 µg/dL range for adults. Severe toxicity is frequently found in association with blood lead levels of 70 µg/dL or more in children and 100 µg/dL or more in adults.

The following signs and symptoms and exposure pathways are provided to assist providers in identifying children who may have lead poisoning or be at risk of being poisoned.

SIGNS AND SYMPTOMS

MILD TOXICITY
Myalgia or paresthesia
Mild fatigue
Irritability
Lethargy
Occasional abdominal discomfort

SEVERE TOXICITY
Paresis or paralysis
Encephalopathy—may abruptly lead to seizures, changes in level of consciousness, coma and death
Lead line (blue-black) on gingival tissue
Colic (intermittent, severe abdominal cramps)

MODERATE TOXICITY
Arthralgia
General fatigue
Decrease in play activity
Difficulty concentrating
Muscular exhaustibility
Tremor
Headache
Diffuse abdominal pain
Vomiting
Weight loss
Constipation

EXPOSURE PATHWAYS

OCCUPATIONAL
Plumbers, pipe fitters
Lead miners
Lead smelters and refiners
Auto repairers

HOBBIES AND RELATED ACTIVITIES
Glazed pottery making
Target shooting at firing ranges
Lead soldering (e.g., electronics)
Painting

Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers
Steel welders and cutters
Construction workers
Bridge reconstruction workers
Rubber products manufacturers
Gas station attendants
Battery manufacturers
Chemical and chemical preparation
Manufacturers
Industrial machinery and equipment operators
Firing Range Instructors
ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline
Preparing lead shot, fishing sinkers, bullets
Home remodeling
Stained-glass making
Car or boat repair

SUBSTANCE USE
Folk remedies
"Health foods"
Cosmetics
Moonshine whiskey
Gasoline "huffing"

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

9.7.B LEAD RISK ASSESSMENT

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

Risk is determined from the response to the questions on the HCY Lead Risk Assessment Guide. This verbal risk assessment determines the child to be low risk or high risk.

- If the answers to all questions is no, a child is *not* considered at risk for high doses of lead exposure.
- If the answer to any question is yes, a child is considered *at risk* for high doses of lead exposure and a capillary or venous blood lead level *must* be drawn. Follow-up guidelines on the reverse side of the HCY Lead Risk Assessment Guide *must* be followed as noted depending on the blood test results.

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

9.7.C(3) Screening Blood Tests

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

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

PROCEDURE CODE	DESCRIPTION
83655	Lead, quantitative blood

This code *must* be used by MO HealthNet enrolled laboratories. Laboratories *must* be CLIA certified to perform blood lead level tests. All blood lead level tests *must* be reported to the Missouri Department of Health and Senior Services as required in 19 CSR 20-20.

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

This level is *NOT* indicative of lead poisoning. No action required unless exposure sources change.

Recommended Interventions:

- The provider should refer to Section 9.8.C(3) and follow the guidelines for risk assessment blood tests.

9.7.E(2) Blood Lead Level 10-19 µg/dL

Children with results in this range are in the borderline category. The effects of lead at this level are subtle and are *not* likely to be measurable or recognizable in the individual child.

Recommended Interventions:

- Provide family education and follow-up testing.
- *Retest every 2-3 months.
- If 2 venous tests taken at least 3 months apart both result in elevations of 15 µg/dL or greater, proceed with retest intervals and follow-up guidelines as for blood lead levels of 20-44 µg/dL.

*Retesting *must* always be completed using venous blood.

9.7.E(3) Blood Lead Level 20-44 µg/dL

If the blood lead results are in the 20-44 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 2 weeks. Based upon the confirmation, a complete medical evaluation *must* be conducted.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

*Retesting *must* always be completed using venous blood.

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

If the blood lead results are in the 45-69 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 48 hours.

Children with symptomatic lead poisoning (with or without encephalopathy) *must* be referred to a setting that encompasses the management of acute medical emergencies.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.

- A child with a confirmed blood lead level greater than 44 µg/dL should be treated promptly with appropriate chelating agents and *not* returned to an environment where lead hazard exposure may continue until it is controlled.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

  * Retesting *must* always be completed using venous blood.

9.7.E(5) Blood Lead Level 70 µg/dL or Greater

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

If the blood lead results are in the 70 µg/dL range, a confirmatory venous blood lead level *must* be obtained immediately.

Recommended Interventions:

- Hospitalize child and begin medical treatment immediately.
- Begin coordination of care (case management), medical management, environmental investigation, and lead hazard control immediately.
- Blood lead levels greater than 69 µg/dL *must* have an urgent repeat venous test, but chelation therapy should begin immediately (*not* delayed until test results are available.)
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, the lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

  * Retesting *must* always be completed using venous blood.

9.7.F COORDINATION WITH OTHER AGENCIES

Coordination with local health departments, WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, local public health agencies' Childhood Lead Poisoning Prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. Local public health agencies may have the authority and ability to investigate a lead poisoned child's environment. We

encourage providers to note referrals and coordination with other agencies in the patient's medical record.

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

When two consecutive lab tests performed at least three months apart measure 15 µg/dL or above, an environmental investigation *must be obtained.* Furthermore, where there is a reading above 10 µg/dL, the child *must* be re-tested in accordance to the recommended interventions listed in Section 9.8.E.

9.7.G(1) Environmental Lead Investigation

Children who have a blood lead level 20 µg/dL or greater or children who have had 2 blood lead levels greater than 15 µg/dL at least 3 months apart should have an environmental investigation performed.

The purpose of the environmental lead investigation is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels. Environmental lead investigations are to be conducted by licensed lead risk assessors who have been approved by the Missouri Department of Health and Senior Services. Approved licensed lead risk assessors shall comply with the Missouri Department of Health and Senior Services Lead Manual and applicable State laws.

All licensed lead risk assessors *must* be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children *must* also be enrolled as a MO HealthNet provider. Lead risk assessors *must* use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

The following procedure codes have been established for billing environmental lead investigations:

T1029UATG	Initial Environmental Lead Investigation
T1029UA	First Environmental Lead Reinvestigation
T1029UATF	Second Environmental Lead Reinvestigation
T1029UATS	Subsequent Environmental Lead Reinvestigation Certificate of Medical Necessity *must* be attached to claim for this procedure

Federal Medicaid regulations prohibit Medicaid coverage of environmental lead investigations of locations other than the principle residence. The Missouri

Department of Health and Senior Services recommend that all sites where the child may be exposed be assessed, e.g., day care, grandparents' home, etc.

Federal Health Care Financing policy prohibits Medicaid paying for laboratory testing of paint, soil and water samples.

Contact the local health department to arrange for environmental lead investigation services.

9.7.H ABATEMENT

Medicaid *cannot* pay for abatement of lead hazards. Lead risk assessors may be able to provide information and advice on proper abatement and remediation techniques.

9.7.I LEAD CASE MANAGEMENT

Children with 1 blood lead level of 20 µg/dL or greater, or who have had 2 venous tests at least 3 months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services the lead case management agency *must* be an enrolled provider with MO HealthNet Division. For additional information on Lead Case Management, go to Section 13.66.D of the Physician's Program Provider Manual.

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning. The Department of Health and Senior Services, Section for Environmental Health, hotline number is (800) 392-0272.

9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING

Children's Mercy Hospital
2401 Gillham Rd.
Kansas City, MO 64108

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

LabCorp Holdings-Kansas City
1706 N. Corrington
Kansas City, MO 64120

Kansas City Health Department Lab
2400 Troost, LL#100
Kansas City, MO 64108

Physicians Reference Laboratory
7800 W. 110 St.
Overland, MO 66210

Missouri State Public Health Laboratory

Quest Diagnostics

101 Chestnut St,
Jefferson City, MO 65101

11636 Administration
St. Louis, MO 63146

Springfield-Greene County Public Health
227 E. Chestnut
Springfield, MO 65802

St. Francis Medical Center
211 St. Francis Drive
Cape Girardeau, MO 63703

St. Luke's Hospital Dept. of Pathology
4401 Wornall
Kansas City, MO

St. Louis County Environmental Health Lab
111 S. Meramec
Clayton, MO 63105

University of MO-Columbia Hospital & Clinics
One Hospital Drive
Columbia, MO 65212

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

Arup Laboratories

500 Chipeta Way

Salt Lake City, UT 84108

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Hygenic Lab

Wallace State Office Building

Des Moines, IA 50307

Iowa Methodist Medical Center
1200 Pleasant St.
Des Moines, IA 50309

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

Physician's Reference Laboratory
7800 W. 110th St.
Overland Park, KS 66210

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Tamarac Medical

7800 Broadway Ste. 2C

Centennial, Co 80122

Specialty Laboratories
2211 Michigan Ave.
Santa Monica, CA 90404

9.8 HCY CASE MANAGEMENT

PROCEDURE CODE	DESCRIPTION
T1016EP	HCY Case Management
T1016TSEP	HCY Case Management; Follow-up

For more information regarding HCY Case Management, refer to Section 13 of the Physician's Program Provider Manual.

9.9 IMMUNIZATIONS

Immunizations *must* be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is *not* provided, the patient's medical record *must* document why the appropriate immunization was *not* provided. Immunization against polio, measles, mumps, rubella, pertussis, chicken pox, diphtheria, tetanus, haemophilus influenzae type b, and hepatitis B *must* be provided according to the Recommended Childhood Immunization Schedule found on the Department of Health and Senior Services' website at: http://www.dhss.mo.gov/Immunizations/index.html.

9.9.A VACCINE FOR CHILDREN (VFC)

For information on the Vaccine for Children (VFC) program, reference Section 13 of the Physician's Program Provider Manual.

9.10 ASSIGNMENT OF SCREENING TIMES

Participants under 21 years of age become eligible for the initial screening, as well as for the periodic screenings, at the time MO HealthNet eligibility is determined regardless of how old they are. A periodic screen should occur thereafter according to the established periodicity schedule. A notification letter is sent in the month the participant again becomes eligible for an HCY screening. The letter is to notify the participant that a screening is due.

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

The periodicity schedule represents the minimum requirements for frequency of full medical screening services. Its purpose is *not* to limit the availability of needed treatment services between the established intervals of the periodicity schedule.

Note: MO HealthNet recognizes that a full HCY screen is required for children/youth within 30 days of entering Children's Division custody. Such HCY screens are considered medically necessary even though they may occur in addition to the regular periodicity schedule.

Children may be screened at any time the physician, nurse practitioner or nurse midwife* feels it is medically necessary to provide additional screening services. *If it is medically necessary for a full medical screen* (s*ee Section 9.6 for procedure list) to occur more frequently than the suggested periodicity schedule, then the screen should be provided. There must, however, be documentation in the patient's medical record that indicates the medical necessity of the additional full medical screening service.*

The HCY Program makes available to MO HealthNet participants under the age of 21 a full HCY screening examination during each of the age categories in the following periodicity schedule:

Newborn (2-3) days	3 Years
By 1 Month	4 Years
2-3 Months	5 Years
4-5 Months	6-7 Years
6-8 Months	8-9 Years
9-11 Months	10-11 Years
12-14 Months	12-13 Years
15-17 Months	14-15 Years
18-23 Months	16-17 Years
24 Months	18-19 Years
	20 Years

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

9.11.A DENTAL SCREENING SCHEDULE

- Twice a year from age 6 months to 21 years.

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

The full HCY screen is to serve as a complete screen and should *not* result in a referral for an additional partial screen for the component that identified a need for further assessment or treatment. A child referred as a result of a full screen should be referred for diagnostic or treatment services and *not* for additional screening except for dental (see Section 9.7.E).

Diagnostic and treatment services beyond the scope of the Medicaid state plan may require a plan of care and prior authorization (see Section 9.13.A). Additional information regarding specialized services can be found in Section 13, Benefits and Limitations.

9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES)

Medically necessary services beyond the scope of the traditional Medicaid Program may be provided when the need for these services is identified by a complete, interperiodic or partial HCY screening. When required, a Prior Authorization Request form *must* be submitted to the MO HealthNet Division. Refer to instructions found in Section 13 of the provider manual for information on services requiring prior authorization. Complete the Prior Authorization Request form in full, describing in full detail the service being requested and submit in accordance with requirements in Section 13 of the provider manual.

Section 8 of the provider manual indicates exceptions to the prior authorization requirement and gives further details regarding completion of the form. Section 14 may also include specific requirements regarding the prior authorization requirement.

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

Providers *must* refer to appropriate program manuals for specific information regarding cost sharing and copay requirements.

9.15 STATE-ONLY FUNDED PARTICIPANTS

Children eligible under a state-only funded category of assistance are eligible for all services including those available through the HCY Program to the same degree any other person under the age of 21 years is eligible for a service. Refer to Section 1 for further information regarding state-only funded participants.

9.16 MO HEALTHNET MANAGED CARE

MO HealthNet Managed Care health plans are responsible for insuring that Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.

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

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

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

a) A comprehensive unclothed physical examination
b) A comprehensive health and developmental history including assessment of both physical and mental health development
c) Health education (including anticipatory guidance)
d) Appropriate immunizations according to age
e) Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated)
f) Lead screen according to established guidelines
g) Hearing screen
h) Vision screen
i) Dental screen

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

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

Full Screen 99381EP through 99385EP and 99391EP through 99395EP

Unclothed Physical and History	99381 through 99385 and 99391 through 99395
Developmental/Mental Health	9942959 9942959UC
Hearing Screen	99429EP 99429EPUC
Vision Screen	9942952 9942952UC
Dental Screen	99429 99429UC

The history and exam of a normal newborn infant and initiation of diagnostic and treatment programs may be reported by the plans with procedure code 99460. Normal newborn care in other than a hospital or birthing room setting may be reported by the plans with procedure code 99461. Both of the above newborn procedure codes are equivalent to a full HCY screening.

Plans are responsible for required immunizations and recommended laboratory tests. Lab services are *not* part of the screen and are reported separately using the appropriate CPT code. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice.

If a problem is detected during a screening examination, the child *must* be evaluated as necessary for further diagnosis and treatment services. The MO HealthNet Managed Care health plan is responsible for the treatment services.

9.17 ORDERING HEALTHY CHILDREN AND YOUTH SCREENING AND HCY LEAD SCREENING GUIDE

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

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 CyberAcess 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 reinsertion 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:

- 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), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),

Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

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

plan is *not* listed for the participant.

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

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

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

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

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

Managed Care Health Plan members fall into four groups:

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

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

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

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care–OAA), and 01 (Old Age Assistance-OAA);

- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State

Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);

- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;
- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
- AIDS Waiver participants (individuals twenty-one (21) years of age and over);
- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level;
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
- Individuals with ME code 81 (Temporary Assignment Category);
- Individuals eligible under ME code 82 (MoRx);
- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and

- Individuals eligible under ME code 88 (Voluntary Placement).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

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

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

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

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

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

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME Codes 73-75, and 97
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.
- Durable medical equipment (including but *not* limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers, diabetic supplies and equipment) and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP)
- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. Personal care/advanced personal care

- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), one pair of eyeglasses every two years (during any 24 month period of time), and replacement lens(es) when there is a .50 or greater change.
- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care Health Plan or through the local public health agency and paid by the MO HealthNet Managed Care Health Plan)
    - Screening, diagnosis and treatment of sexually transmitted diseases
    - HIV screening and diagnostic services
    - Screening, diagnosis and treatment of tuberculosis
    - Childhood immunizations

- Childhood lead poisoning prevention services, including screening, diagnosis and treatment

- Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but *not* be limited to:

  - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
  - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs
    - Crisis intervention/access services
    - Alternative services that are reasonable, cost effective and related to the member's treatment plan
    - Referral for screening to receive case management services.
    - Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments.

    - Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.

- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are *not* limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing
  - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME

Codes listed for Group 4, Section 1.5.C

- Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
- Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs

- Transplant-related services. The MO HealthNet Managed Care health plan is financially responsible for any inpatient, outpatient, physician, and related support services including pre-surgery assessment/evaluation prior to the date of the actual transplant surgery. The Managed Care Health Plan is responsible for the pre-transplant and post-transplant follow-up care.

11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than 21 years of age. For some members the age limit may be less than 19 years of age. Some services need prior approval before they are provided. Women must be in a MO HealthNet category of assistance for pregnant women with ME codes 18, 43, 44, 45, 61 and targeted low-income pregnant women and unborn children who are eligible under Show-Me Healthy Babies with ME codes 95, 96, and 98

to receive these extra benefits.

- Comprehensive day rehabilitation, services to help with recovery from a serious head injury;
- Dental services – All preventive, diagnostic, and treatment services as outlined in the MO HealthNet State Plan;
- Diabetes self-management training for persons with gestational, Type I or Type II, diabetes;
- Hearing aids and related services;
- Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two years, replacement lens(es) when there is a .50 or greater change, and, for children under age 21, replacement framesand/or lenses when lost, broken or medically necessary, and HCY/EPSDT optical screen and services;
- Podiatry services;
- Services that are included in the comprehensive benefit package, medically necessary, and not identified in the IFSP or IEP.
- Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

The following services are available to MO HealthNet Managed Care members outside the MO

HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a Fee-For-Service basis by the MO HealthNet Division:

- Abortion services (subject to MO HealthNet Program benefits and limitations)
- Adult Day Care Waiver
    - Home and Community based waiver services for Adult Day Care Services include but are not limited to assistance with activities of daily living, planned group activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation.
    - The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for ADC waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the ADC waiver. Information regarding the ADC waiver services may be located on the DHSS website at: http://health.mo.gov/seniors/hcbs/adhcproposalpackets.php
- Physical, occupational and speech therapy services for children included in:
    - The Individual Education Plan (IEP); or
    - The Individual Family Service Plan (IFSP)
- Parents as Teachers
- Environmental lead assessments for children with elevated blood lead levels
- Community Psychiatric Rehabilitation program services
- Tobacco cessation pharmacologic and behavioral intervention services
- Applied Behavior Analysis services for children with Autism Spectrum Disorder
- Comprehensive substance treatment and rehabilitation (CSTAR) services
    - Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
    - Newborn Screening Collection Kits
    - Special Supplemental Nutrition for Women, Infants and Children (WIC) Program
    - SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
- Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions
- Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
    - Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
    - Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with

both procurement and the transplant procedure.

- The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.

- Behavioral health services for MO HealthNet Managed Care children (Group 4) in state care and custody
  - Inpatient services—patients with a dual diagnosis admission (physical and behavioral) have their hospital days covered by the MO HealthNet Managed Care Health Plan.
  - Outpatient behavioral health visits are *not* the responsibility of the MO HealthNet Managed Care Health Plan for Group 4 members when provided by a:
    - Licensed psychiatrist;
    - Licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor or provisionally licensed professional counselor ;
    - Psychiatric Clinical Nurse Specialist, Psychiatric Mental Health Nurse Practitioner state certified behavioral health or substance abuse program; or
    - A qualified behavioral health professional in the following settings:
      - Federally qualified health center (FQHC); and
      - Rural health clinic (RHC).
- Pharmacy services.
- Home birth services.
- Targeted Case Management for Behavioral Health Services.

11.8 QUALITY OF CARE

The state has developed quality improvement measures for the MO HealthNet Managed Care Health Plan and will monitor their performance.

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are included in the MO HealthNet Managed Care Program are identified on eMOMED or the IVR system when verifying eligibility. The response received identifies the name and telephone number of the participant's selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member's primary care provider (PCP). For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan *must* have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

MO HealthNet Managed Care health plans may also issue their own individual Managed Care health plan ID cards. The individual *must* be eligible for the Managed Care Program and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

11.9.A NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access eMOMED or the Interactive Voice Response (IVR) only if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued an atypical provider identifier that permits access to eMOMED or the IVR; however, it is *not* valid for billing MO HealthNet on a Fee-For-Service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at mmac.providerenrollment@dss.mo.gov.

11.10 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

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

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

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

11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates

the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

11.11.A ELIGIBILITY FOR PACE

Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive service delivery system and finance model for the frail elderly. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the participant. All medical services that the participant requires, while enrolled in the program, are the financial responsibility of the PACE provider. Enrollment in a PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is the entry point for referrals to the PACE provider and assessments for PACE program eligibility. Referrals for the program may be made to DSDS by completing the PACE Referral/Assessment form and faxing to the DSDS Call Center at 314/877-2292 or by calling toll free at 866/835-3505. The PACE Referral/Assessment form can be located at http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. All services are provided solely through the PACE provider. Lock-in information is available to providers through eMOMED and the IVR at (573) 751-2896. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the Fee-For-Service system at any time.

11.11.D PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:

- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;
- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
- In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- Pharmaceutical services, prescribed drugs, and over the counter medications;
- Medical and surgical specialty and consultation services;
- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;

- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through Fee-For-Service.

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SECTION 12-REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

The MO HealthNet Division is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

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 INSTATE HOSPITALS

The reimbursement methodology for hospitals is found in State Regulation 13 CSR 70-15.010, Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. Copies of this regulation can be found at www.sos.mo.gov.

12.3 OUT-OF-STATE HOSPITALS

The reimbursement methodology for out-of-state hospitals is found in State Regulation 13 CSR 70-15.190, Out-of-State Hospital Services Reimbursement Plan. Copies of this regulation can be found at www.sos.mo.gov.

There is no provision for inpatient or outpatient cost settlements for out-of-state hospitals.

12.3.A INPATIENT SERVICES

Inpatient services provided in out-of-state hospitals are reimbursed at the lower of the following options, multiplied by the number of days approved by Conduent, Inc.

1) The statewide average per diem rate for instate hospitals or, at the hospital's election, the rate established by MHD based on the facility's Medicare base year cost report.
2) The amount of total charges billed by the hospital.
3) When applicable, Medicare Part A and Part C's deductible, coinsurance or copayment. See Section 12.4 – Medicare/MO HealthNet Reimbursement (Crossover Claims) for payment methodology.

12.3.B OUTPATIENT SERVICES

Outpatient services provided in out-of-state hospitals are reimbursed at the projected statewide average outpatient payment percentage of their billed usual and customary charge. However, the facility may request to have their prospective outpatient percentage rate set based on their cost report in accordance with State Regulation 13 CSR 70-15.190. Certain services, such as clinical laboratory and radiology tests are paid based on a fee schedule.

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, coinsurance and, when appropriate, copayment amounts otherwise charged to the participant by the provider. See Section 16 – Medicare/Medicaid Crossover Claims of the Hospital manual for a detailed explanation of these claims.

12.4.A LIMITATION ON REIMBURSEMENT OF MEDICARE PART A INPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A 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. The provider's Remittance Advice (RA) shows the amount paid for each repriced crossover with a Group

and Reason Code CO-45 "Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement".

To ensure the provider is reimbursed at the proper rate, the MO HealthNet Division (MHD) utilizes data from the provider's Medicare cost report to obtain pass-through costs. It is important that the provider promptly notify MHD if their Medicare cost reports are amended. Changes in the Notice of Program Reimbursement (NPR) should also be reported. Please send amendments and changes to:

MO HealthNet Division
Part A Crossover Repricing
P.O. Box 6500
Jefferson City, MO 65102

Failure to promptly send this data to MHD may result in erroneous MO HealthNet payments.

Amounts *not* reimbursed by MO HealthNet for allowable crossover claims may *not* be billed to the participant.

Following are two examples of repriced crossovers:

EXAMPLE 1:

Inpatient stay of 3 days:

Medicare payment plus pass-through costs	$2,000.00
MO HealthNet payment schedule for 3 days	$1,350.00
	$650.00

In this example, no amount is due as Medicare's payment exceeds MO HealthNet's payment schedule for the services by $650.00.

EXAMPLE 2:

Inpatient stay of 6 days:

Medicare payment plus pass-through costs	$1,158.00
MO HealthNet payment schedule for 6 days	$1,950.00
Amount MO HealthNet payment exceeds Medicare	($792.00)
Medicare coinsurance	$942.00
Amount of MO HealthNet payment for hospital stay	$792.00

In this example, the payment would be $792.00 since MO HealthNet reimburses the lower of the Medicare coinsurance or the amount that exceeds Medicare's payment.

12.4.B APPLICATION OF PART A MEDICARE DEDUCTIBLE

The Part A Medicare deductible for inpatient services is always applied to the day of admission or the first day in the hospital stay that the individual becomes Medicare eligible. If the patient is *not* MO HealthNet eligible on the day the deductible is applied, MO HealthNet does *not* pay the deductible and it becomes the responsibility of the patient to pay for the deductible.

12.4.C LIMITATION ON REIMBURSEMENT OF MEDICARE PART B/PART C OUTPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part B crossover claims and copayment amounts for Medicare Advantage/Part C crossover claims for participants with QMB coverage. The reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services will be calculated at seventy-five percent (75%) of the allowable coinsurance, deductible or Part C copayment amount. This methodology results in payment that is comparable to the fee-for-service (FFS) amount that would be paid by MO HealthNet for those same services.

This reimbursement methodology does not impact outpatient hospital crossover claims submitted by public hospitals operated by the Department of Mental Health (DMH).

12.4.C(1) Reporting Medicare's Bad Debt

MO HealthNet expects a portion of the cost to the hospitals for nonpayment of the coinsurance, deductible or Part C copayment amount for Medicare Part B to be recovered through Medicare's bad debt reimbursement policies as set forth in 42 CFR §413.89 and the Medicare Provider Reimbursement Manual. Bad debts associated with services paid under a reasonable charge-based methodology (such as ambulance services) or a fee schedule (such as therapies and laboratory services) are not reimbursable by Medicare. The bad debts associated with nonpayment of the coinsurance, deductible or Part C copayment amount for Medicare Part C claims related to QMB or QMB plus participants are not eligible for reimbursement from Medicare. Hospitals will be responsible for properly reporting the allowable bad debt relating to the coinsurance, deductible or Part C copayment amount for Medicare Part B not paid by MO HealthNet on their Medicare cost report to receive Medicare reimbursement. If the allowable bad debt is not properly reported on the Medicare cost report, the hospitals may not receive reimbursement from Medicare. To assist hospitals with identifying the amounts they can report as bad debt for Medicare reporting purposes, MHD will utilize Group and Reason Code of OA45 "Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and a Remark code of N59

"Please refer to your provider manual for additional program and provider information" which will be reflected on the hospital's remittance advice (RA).

12.5 PARTICIPANT COPAYMENT

Certain MO HealthNet services are subject to participant copayment. The copayment amount is paid by the participant at the time services are rendered. Services of the Hospital Program described in this manual are subject to a copayment amount. The provider *must* accept in full the amounts paid by the state agency plus any copayment amount required of the participant. Refer to Section 13 – Benefits and Limitations of the Hospital manual for program specific information.

12.6 A MO HEALTHNET 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 MO HealthNet Managed Care health plan; however, some services are *not* included and are covered by MO HealthNet on a fee-for-service basis.

Hospital services are included as a plan benefit in the MO HealthNet Managed Care program.

12.6.A MO HEALTHNET MANAGED HEALTH CARE

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

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

The MO HealthNet Program utilizes the managed care delivery system for certain included MO HealthNet eligibles. Refer to Section 1 – Participant Conditions of Participation and Section 11 – MO HealthNet Managed Health Care Delivery System for a detailed description.

12.7 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 MMAC 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 MMAC 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 website can be accessed to retrieve current and aged remittance advices

Please be aware that any updates or changes you make to your emomed file will not update your provider master file. Therefore updates or changes should be requested in writing. You can email your request to the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section

(www.ProviderEnrollment@dss.mo.gov). The MO HealthNet Remittance Advice is available to view and print on the MO HealthNet Web portal at www.emomed.com.

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SECTION 13 - BENEFITS AND LIMITATIONS

Section 13 contains information common to the policies, benefits, and limitations to both the Inpatient and Outpatient Hospital Programs. This section contains issues relating specifically to the Outpatient Program and specifically to the Inpatient Program.

13.1 PROVIDER PARTICIPATION

To participate in the MO HealthNet Hospital Program, the hospital provider *must* satisfy the following requirements:

- The provider is licensed by the Missouri Department of Health and Senior Services as an acute care, psychiatric or rehabilitation hospital unless the facility is exempt from licensure because it is a city or state operated facility. Out-of-state hospitals *must* be licensed by the appropriate agency of the state in which the hospital is located;
- The provider is certified by the Missouri Department of Health and Senior Services for participation in the Title XVIII Medicare Programs. Out-of-state hospitals *must* be certified by the appropriate agency of the state in which the hospital is located;
- The provider completes a Title XIX Participation Agreement/Questionnaire, a MO HealthNet Enrollment application and the Self-Evaluation for Compliance (MOA-10); and
- The Department of Social Services (DSS) accepts the provider's application for enrollment.

Additional information on provider conditions of participation can be found in Section 2 – Provider Conditions of Participation.

13.2 DOCUMENTATION OF PHYSICIAN ORDERS

13.2.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (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.

Medical Necessity is defined as services or supplies that: are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. Medical necessity shall be reasonable and necessary for the prevention of illness, not mainly for the convenience of the participant or the participants' doctor. The services or supplies shall be provided for the diagnosis, direct care, and treatment of your medical condition, and furnished in accordance with accepted medical standards.

13.2.B INPATIENT HOSPITAL SERVICES

Inpatient hospital services *must* have signed and dated physician or other medical professional (person who is authorized by State licensure law to order hospital services for diagnosis or treatment of a patient) orders within the patient's medical record for services billed to the MO HealthNet agency.

13.2.C OUTPATIENT HOSPITAL SERVICES

For patients registered on hospital records as outpatient, the patient's medical record *must* contain signed and dated physician or other medical professional orders for services billed to the MO HealthNet agency.

Where the hospital acts as an independent laboratory or independent radiology service for persons considered by the provider as "nonhospital" patients, the hospital *must* have a written request or requisition slip ordering the tests or procedures. The order does *not* have to be signed by a physician or other medical professional; however, the request for laboratory/pathology or radiologic procedures *must* be traceable to a physician, or other medical professional, order in the medical record (such as in a nursing home or physician's office). If the request or referral is by telephone, the request *must* be committed to a written format.

The minimum information required on a written request or referral is the following: name of patient, name of referring entity (such as nursing home, laboratory, physician or other medical professional), procedure and date ordered/received.

All records, whether signed orders or written requests for nonhospital patients, *must* be kept for five years.

Services billed to the MO HealthNet agency that are *not* fully documented in the patient's medical records or for which there is no record that services were performed may be considered to be false or fraudulent billing, and thus, subject to investigation.

13.3 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet on each date that a service is provided in order for a provider to receive MO HealthNet payment for those services.

Eligibility status can be obtained by viewing the letter of eligibility or through the following methods:

1. Calling (573) 751-2896. This number is answered by an interactive voice response (IVR) system;
2. Logging onto the Web portal at www.emomed.com

Additional information about participant eligibility can be found in Section 1 – Client Conditions of Participation.

13.3.A ADMINISTRATIVE LOCK-IN PARTICIPANTS

The MO HealthNet "lock-in" Program has been in effect for several years. Section 1 - Client Conditions of Participation of this manual has a more detailed discussion of this policy. "Lock-in" is the term used to describe restrictions that have been placed on participants who have been identified as misusing MO HealthNet services. Those participants are restricted to specific providers. The MO HealthNet eligibility file lists the provider(s) to whom the individual is restricted.

For participants with physician or hospital restrictions, only those providers named on the MO HealthNet eligibility file are authorized to provide services. For outpatient hospital services or physician services to be payable for a participant who is locked-in to a physician or hospital different from the billing provider, one of the following exceptions *must* apply:

1. Emergency services: If emergency services are provided, a completed Certificate of Medical Necessity form and medical records *must* be attached to the claim when it is submitted for payment explaining the emergency.

2. Referrals made by the authorized provider: In this situation, a PI-118 referral form *must* be completed by the managing physician before services are provided. The completed referral form *must* be attached to the paper claim or submitted on-line through the eMOMED Web portal.

It is the provider's responsibility to determine if a participant has restricted eligibility. Payment is *not* made if an unauthorized provider provides nonemergency, non-referred services to a "lock-in" participant.

13.3.B HOSPICE

The hospice benefit is designed to meet the needs of patients with terminal illnesses and to help their families cope with the problems and feelings related to this difficult time. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care.

When a participant elects hospice services, the hospice provides or arranges for all care, supplies, equipment, and medicines related to the terminal illness. The provider of the service(s) *must* send the charges to the hospice. MO HealthNet reimburses the hospice who in turn reimburses the provider of the service(s).

Services *not* related to the terminal illness are available from any MO HealthNet participating provider of the participant's choice. The provider of a service *not* related to the terminal illness should submit claims to the fiscal agent, Wipro Infocrossing. These claims suspend in the claims processing system for review by a medical consultant to determine that the service billed was *not* related to the terminal illness.

13.3.B(1) Identification of Hospice Enrollees

Services related to the terminal illness *must* be billed by, and reimbursed to, the hospice provider elected by the participant. Therefore, it is important that all providers be able to readily identify participants who have elected hospice services.

When providers verify participant eligibility, the hospice participant is identified by a lock-in to a hospice provider. Eligibility may be verified by calling (573) 751-2896, which is answered by an interactive voice response (IVR) system, or logging onto the Internet at www.emomed.com. Reference Section 1 – Client Conditions of Participation for more information.

13.3.B(2) Inpatient Services—Respite Care

Respite care, when necessary to relieve family members or other persons caring for the individual at home, is a covered service under the Hospice Program. Respite care is limited to five consecutive days per calendar month and may be provided in a nursing home or a hospital. The hospice reimburses the nursing home or hospital. Claims submitted directly to MO HealthNet are denied.

The hospital is *not* required to obtain admission certification from Conduent for hospice respite care.

13.3.B(3) Inpatient Services—Crisis Care

Inpatient hospital services are covered under the Hospice Program for palliative care during a period of an acute medical crisis. The hospice provider is limited to using no more than 20% of its total reimbursed days for inpatient hospital care. The hospice reimburses the hospital. Claims for crisis care by the hospital submitted directly to MO HealthNet are denied.

The hospital is *not* required to obtain admission certification from Conduent for crisis care.

13.3.C PRESUMPTIVE ELIGIBILITY PROGRAM (TEMP)

Reference Section 1 – Participant Conditions of Participation for more information.

13.3.C(1) TEMP Benefit and Limitations For Hospital

The TEMP card and letter may only be used to obtain *ambulatory prenatal services*. The diagnosis on the claim form must be a pregnancy/prenatal diagnosis.

If the TEMP participant is provided illness care, the illness diagnosis code *must* appear as the primary diagnosis code. However, a pregnancy/prenatal diagnosis code *must* also appear on the claim form.

Reference Section 1 – Participant Conditions of Participation for more information on what is and is *not* covered for TEMP participants.

Inpatient hospital services are *not* considered "ambulatory prenatal services;" therefore, inpatient hospital claims billed for participants with only TEMP eligibility are denied.

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 overlap a TEMP eligibility period. Approved individuals receive an approval letter that shows their eligibility dates and type of assistance coverage. 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.

13.3.C(2) Full MO HealthNet Eligibility After TEMP

Reference billing information for TEMP participants in Section 15 – Billing Instructions.

13.3.D AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

A child born to a woman who is eligible for *and receiving* federally funded MO HealthNet benefits on the date the child is born is automatically eligible for MO HealthNet. Coverage begins with the date of birth and extends through the month the child becomes one year of age. Refer to Section 1 – Client Conditions of Participation for further information.

13.3.E QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM

Section 301 of the Medicare Catastrophic Coverage Act of 1988 makes individuals who are Qualified Medicare Beneficiaries (QMB) a mandatory coverage group under MO HealthNet for the purpose of paying Medicare deductible, coinsurance and Part C copayment amounts on their behalf. This program provides payment for:

- Medicare premiums; and
- Deductible and coinsurance for Medicare covered services. This includes Medicare services from providers who by choice do *not* otherwise participate in MO HealthNet and from providers whose services are *not* covered by MO HealthNet such as chiropractors, independent therapists, and independent psychologists (except children under age 21). Refer to Section 1 – Client Conditions for Participation and Section 16 – Medicare/Medicaid Crossover Claims for more information.

13.3.E(1) How The QMB Program Affects Providers

It is critically important for providers to understand the difference between the services MO HealthNet reimburses for those individuals with QMB only and for those with QMB and MO HealthNet eligibility.

- For a QMB only participant (ME Code “55”), MO HealthNet only reimburses providers for Medicare deductible, copayment and coinsurance amounts. MO HealthNet *does not* reimburse for non-Medicare services, such as prescription drugs, eyeglasses, most dental services, adult day health care, personal care services, most eye exams performed by an optometrist, or nursing care services *not* covered by Medicare.
- A QMB and MO HealthNet eligible participant may receive all services (within limitations) covered by MO HealthNet provided by enrolled providers. MO HealthNet also covers all Medicare deductible and coinsurance amounts for services provided by providers who may or may not participate in MO HealthNet. Reference Section 1 – Client Conditions of Participation for further information.

13.3.E(2) Additional QMB Information

Under the QMB Program there is a group of providers who may be reimbursed only for Medicare deductible and coinsurance for QMB participants. The kinds of providers who may enroll only for the QMB Program are suppliers and providers of Medicare covered services who are *not* otherwise eligible to participate in MO HealthNet, such as chiropractors, independent therapists, independent psychologists, etc., and those physicians, ambulance providers, DME providers, etc., who choose *not* to participate in MO HealthNet. Providers enrolled only for the QMB Program may *not* be reimbursed for MO HealthNet services.

Providers are reminded of the importance of *verifying* participant eligibility *each time services are provided*. The eligibility status of the participant, any applicable service restrictions, and verification of the individual's identity as the legal user of the card are all critical to a provider's appropriate and successful claim submission.

13.4 PARTICIPANT NONLIABILITY

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

13.4.A PARTICIPANT LIABILITY

The participant is liable for inpatient hospital services in the following circumstances:

- When a preadmission request for certification is denied and the participant is notified in writing of the denial but chooses to be admitted, the participant is liable for all days.
- When a post admission request for certification of an urgent or emergency admission is denied, the participant is liable for those days after notification of the denial.
- When the participant's eligibility was *not* established on or by the date of admission and the post admission review request for certification is denied, the participant is liable for all days.
- When the participant has signed a written agreement with the provider indicating that MO HealthNet is *not* the intended payer for the specific inpatient service, the participant is liable for all days. The agreement *must* be signed prior to receiving the services. In this situation, the participant accepts the status and liabilities of a private pay patient in accordance with 13 CSR 70-4.030.
- When a service is related to non-covered procedures, the service is also non-covered. If any non-covered procedure is the chief reason for hospital services, none of the hospital charges are reimbursable.

The participant is *not* liable for inpatient hospital services in the following circumstances:

- 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.
- When a post admission request for certification is denied, the participant is *not* liable for any days prior to notification of the denial.
- When Conduent performs a validation review based on medical records and determines a stay was *not* medically necessary for inpatient services, the participant is *not* liable for any days.

NOTE: Although Conduent sends the participant a written notification of a denial, it is acceptable and may be to the hospital's benefit to advise the participant of the Conduent decision as soon as possible. If the hospital chooses to advise the participant of the decision, documentation of the participant's receipt of the notification *must* be maintained by the hospital.

13.5 OUT-OF-STATE, NONEMERGENCY SERVICES

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

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

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

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

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

The written request *must* include:

1. A brief past medical history.

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

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

13.5.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

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

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

13.5.B DEFINITION OF EMERGENCY SERVICES

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

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

13.6 HOSPITALS WITH SNF WINGS

Hospitals with Skilled Nursing Facility (SNF) units that are *not* enrolled as MO HealthNet Nursing Facility providers *must not* submit crossovers for their Medicare/MO HealthNet patients using their hospital National Provider Identifier (NPI/Taxonomy number). Billing SNF services with the hospital number is considered fraudulent billing. These SNF units may be enrolled in MO HealthNet as Nursing Facility providers and then both crossovers and MO HealthNet-only long-term care days may be billed. Contact Provider Enrollment by e-mail at providerenrollment@dss.mo.gov to inquire about Nursing Facility enrollment.

13.7 SCREENING POTENTIAL NURSING HOME PLACEMENTS

The following information is important when a patient faces a potential nursing home placement from an inpatient setting to inform them of community long-term care options, and to identify mentally ill, intellectually disabled (ID) or developmentally disabled (DD) individuals.

13.7.A MISSOURI CARE OPTION PHILOSOPHY

The main objective of the Missouri Care Option Philosophy is to make individuals aware of the broad choice of services and settings that are available in the long-term care system. It is an effort to assist individuals in identifying and accessing services that best meets their needs for long-term care.

This philosophy is *not* intended to prevent people from entering nursing homes. It is an opportunity to make sure that people are aware of all available care options.

The Missouri Care Option Philosophy is part of a long-range effort to design and develop an adequate continuum of long-term care services. A key to the success of this concept is that home- and community-based care options are available and that access to these alternative services is easily arranged.

13.7.A(1) Procedures

Prior to or at the time of admission to a long-care facility, each resident must be informed of the home- and community-based services available. The long-term care facility must provide the resident a copy of the most current Missouri's Guide to Home and Community Based Services. The guide may be found at http://www.dhss.mo.gov/SeniorServices/index.html. Copies may also be obtained by calling the Division of Senior and Disability Services' Information and Referral line at 1-800-235-5503.

13.7.B PREADMISSION SCREENING (PASRR)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires states to have in effect a preadmission screening program for mentally ill (MI), intellectually disabled (ID) and developmentally disabled (DD) individuals who are potential residents of Title XIX certified beds. The intent of OBRA is to assure that the mentally ill, intellectually disabled and developmentally disabled are placed in appropriate settings and receive services appropriate for their condition.

The law requires that a nursing facility *must not admit* any new resident who is MI, ID or DD unless the State Mental Health or Developmental Disability Authority (Department of Mental Health) has determined that the nursing home is appropriate for the individual. A determination for an individual in a special admission category, which is explained later in

this section, does *not* have to be done prior to admission. The law applies to every applicant to a Title XIX certified bed whether or not the applicant is or will be Title XIX eligible. MO HealthNet payments *are not* made for services provided to an individual for whom a determination is required but has *not* been performed.

The process for preadmission screening is divided into two parts: Level I and Level II. The purpose of Level I is to identify any applicant to a nursing facility who is known or suspected of being MI, ID or DD. The purpose of Level II is to evaluate if the individual with MI, ID or DD needs nursing facility level of care and, if so, whether or not the individual needs specialized services.

13.7.B(1) Preadmission Screening Procedure—Level I—DA-124C

Identification of suspected MI, ID or DD individuals is made on the DA-124C form. Prior to a nursing home admitting any new resident to a MO HealthNet certified bed this form *must* be completed.

Not Known or Not Suspected to be MI, ID or DD

If Section B of the DA-124C form, the screening criteria for serious mental illness, or Section C of the form, the screening criteria for intellectual disabilities/related condition, indicates no further mental health evaluation is required, the person is considered "not suspected" to be MI, ID or DD. The individual may be admitted to the nursing home.

The DA-124C form *must* be filed in the patient's medical record and be available for review by state or federal surveyors.

If the individual is applying for MO HealthNet nursing home services, a DA-124A/B *must* be completed to determine level of care. However, the DA-124A/B form must be completed prior to admission. When submitting the DA-124 for MO HealthNet eligibility purposes, the A/B and C sections *must* be submitted together.

Known or Suspected to be MI, ID or DD

If Section B or C of the DA-124C form indicates a serious mental illness or intellectual disabilities/related condition the person is considered a "suspected" MI, ID or DD, and a Level II evaluation *must* be performed prior to the person's admission to the home unless a special admission category applies.

The following are terms used on the DA-124C:

- Dementia

  An individual with a primary or secondary diagnosis of dementia (including Alzheimer's disease or a related disorder) is *not* considered seriously

mentally ill for the purpose of PASRR and does *not* require a Level II evaluation. This person may be admitted to a nursing home without further screening. However, if a person with a diagnosis of dementia also has a diagnosis of ID or DD, a Level II is required prior to admission.

- Special Admission Categories

  Special Admission Categories only apply for persons who are suspected of being MI, ID, or DD. There are five such categories.

  With two of the categories, Terminal Illness and Serious Physical Illness, the Level II evaluation is *not* performed prior to admission. The Level II evaluation is conducted immediately following admission.

Each of the other three categories has a strict time period and are described below.

- Respite Care: An individual may be admitted and remain in a facility for 30 consecutive days or less in order to provide respite for the caregiver. A Level II is *not* required. The Family Support Division controls the nursing home authorized payment dates by means of a form they send to the state office. *No payment can be made to the nursing facility beyond the thirty days.* If a situation arises in which the respite care is longer than 30 days, the nursing home *must* contact the Department of Health and Senior Services/Central Office Medical Review Unit (DHSS/COMRU). If continued stay is authorized, a Level II is performed. FSD is notified if vendor payments may continue and they change the nursing home dates to allow payment.
- Emergency Provisional Admission: This category is for the situation in which an individual needs placement to protect the individual from serious physical harm to self or others. The nursing home *must* contact DHSS/COMRU. This type stay *must* be prior authorized by DHSS/COMRU as an emergency. No more than seven days is allowed for an emergency admission. Again, the Family Support Division manages those dates based on information DHSS/COMRU. If the resident stays in the home longer than seven days, the home *must* immediately notify DHSS/COMRU to determine continued stay. A Level II evaluation may be performed after the initial seven-day period, depending on the circumstances.
- Direct Transfer From a Hospital: Under the final PASRR rule a transfer from a hospital for a stay of 30 days or less is exempt from the PASRR process. If a physician attests that the individual is likely to need 30 days nursing home care or less for the condition for which the individual has hospitalized, no Level II evaluation is necessary. Nursing home payment is made for no more than 30 days. If it becomes apparent that the individual

needs longer than 30 days, the home *must* immediately notify DHSS/COMRU. If continued stay is approved, a Level II evaluation is performed.

13.7.B(2) Preadmission Screening Procedure—Level II

To begin the process for a Level II review, the DA-124A/B form *must* also be completed. All forms, the DA-124A/B and DA-124C, should be mailed to:

Department of Health and Senior Services
Division of Regulation and Licensure
Section of Long Term Care Regulation/Central Office Medical Review Unit
(SLCR/COMRU)
3418 Knipp Drive, Suite F
P.O. Box 570
Jefferson City, MO 65102

DHSS/COMRU determines the level of care and sends the information to the Department of Mental Health who is responsible for completing the Level II review.

For individuals suspected of being intellectually disabled, developmentally disabled or of having a related condition, the Department of Mental Health (DMH)/Division of Developmental Disabilities (DDD) Regional Center conducts the required Level II screening activities.

For individuals suspected of having mental illness, the Department of Mental Health/Division of Comprehensive Psychiatric Services (DCPS) contracts with an independent agent who conducts Level II screening activities.

If an individual is suspected of having both mental illness and developmental disability the Level II reviews are completed by both the state developmental disability authority and the contract agent of the state mental health authority.

13.7.C POLICY ISSUES REGARDING PREADMISSION SCREENING

- Preadmission screening is required for any resident who is placed in a MO HealthNet certified bed without respect to payment source. This includes private pay, Medicare beneficiaries as well as MO HealthNet residents.
- Nursing homes or hospitals are responsible for the PASRR Level I (DA-124 A/B and C) screening process, which *must* be completed prior to a resident's admission to a certified bed.
- If an individual transfers from a noncertified bed to a certified one, whether or not the transfer is made within the same facility or to a different one, the nursing home *must*

complete the Level I screening process. If a Level II evaluation is needed, this *must* be performed prior to transfer.

- There is no need to complete a second DA-124C form when:
    1. a participant transfers from a certified bed in one facility to a certified bed in another facility;
    2. a participant is discharged from a certified bed to a hospital and returns to a certified bed, whether in the same or different nursing home;
    3. a participant is discharged from a certified bed to home but returns to a certified bed in the same or a different nursing home in less than 60 days. If length of stay is more than 60 days, another Level I (DA-124C) *must* be performed.

  NOTE: There *must* be a DA-124C in a resident's file. Be sure to obtain a copy when a person transfers. If a copy of the DA-124C is *not* obtained for one reason or another, complete a new DA-124C and submit it to DHSS/COMRU. Attach a note to the form saying why another "C" form is being submitted.

- If there is enough of a change in the mental health status of an individual that the provider feels the resident requires a Level II evaluation, complete another DA-124C form writing on it in large letters, "CHANGE IN STATUS," and submit the form to DHSS/COMRU.
- The revised DA-124C has been designed so that upon its completion, the provider should know if the individual can be admitted to the home or if a Level II evaluation *must* be performed before admittance.
- An individual transferred from an out-of-state nursing facility to one in Missouri *must* be screened under the state's plan if Missouri is going to pay for services. Therefore, a Level I and Level II, where applicable, *must* be performed before payment is authorized.
- The physician signature, discipline, license number and date are required in Section F of the DA-124C form. The date is very significant for a resident applying for MO HealthNet nursing home benefits because *eligibility for nursing home benefits can be no earlier than the date shown in Section F.*
- For those individuals who are seriously mentally ill, intellectually disabled or developmentally disabled or have a related condition and require a Level II evaluation, *MO HealthNet nursing home benefits can be no earlier than the date a Level II determination is made*.
- If MO HealthNet benefits for nursing home services are requested by the resident, the DA-124A/B *must* be completed and submitted with the DA-124C to the:

Department of Health and Senior Services
Division of Regulation and Licensure
Section of Long Term Care Regulation/Central Office Medical Review Unit
SLCR/COMRU
3418 Knipp Drive, Suite F
P.O. Box 570
Jefferson City, MO 65102

- A Pre-Long-Term-Care Screening (PLTC) by the DHSS/DSDS alternative services staff *must* be provided to any MO HealthNet or potential MO HealthNet individual prior to admission to a certified bed, unless exemptions apply. Authorization for nursing home payments *cannot* be made until a PLTC number has been assigned. This admission requirement is separate from the PASRR process. Both the PASRR and the PLTC processes are required.

13.8 "SPOUSAL IMPOVERISHMENT" PROVISIONS UNDER THE MEDICARE CATASTROPHIC COVERAGE ACT (MCCA)

One part of the Medicare Catastrophic Coverage Act of 1988 is commonly known as the "Spousal Impoverishment" section. Its purpose is to prevent forcing a married couple to deplete their savings in order for the one spouse receiving nursing care to qualify for MO HealthNet. Often this left the spouse remaining at home impoverished. The law seeks to reduce that threat by protecting a portion of the income and resources of a couple for maintenance of the community spouse.

For determining MO HealthNet eligibility when one member of a married couple enters a MO HealthNet certified bed in a nursing home and the other remains in the community, all countable resources held by either or both spouses are considered available equally to both spouses. The couple's home and personal goods, however, are excluded from such countable resources. Under the spousal impoverishment provisions, the community spouse can keep the greater of $21,912 or one-half of the countable resources up to $109,560 effective January 1, 2009.

The amounts are adjusted upward every January. In determining the spousal share (what the community spouse can keep), it is always the resources held at the *beginning of a continuous period of nursing home institutionalization* that is used. The institutionalized spouse can qualify for MO HealthNet when the remaining portion of countable resources is at or below the eligibility limit of $999.99.

13.9 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

Under the Clinical Laboratory Improvement Amendments Act of 1988 (CLIA), all laboratory testing sites, as defined in 42 CFR 493.2, *must* have either a CLIA certificate of waiver or certificate of

registration to legally perform clinical laboratory testing anywhere in the United States. Claims from laboratories without CLIA numbers are subject to denial.

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

To obtain information on how to obtain a CLIA Certificate, providers should call (573) 751-6318 or write to:

Missouri Department of Health and Senior Services
CLIA Section
P.O. Box 570
Jefferson City, MO 65102-0570

Reference Section 13 – Benefits and Limitations in the Physician manual for detailed information.

13.10 PARTICIPANT COPAYMENT

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

13.10.A PROVIDER RESPONSIBILITY TO COLLECT COPAYMENT AMOUNTS

Providers of service *must* charge and make a reasonable effort to collect the copayment amount. Providers of service may *not* deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged. A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copayment amounts collected and of the copayment amount due but uncollected because the participant did *not* make payment when the service was rendered.

The copayment amount is *not* to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copayment amount is deducted from the MO HealthNet maximum allowable amount, as applicable, before reimbursement is made. Refer to Section 15 – Billing Instructions for specific billing information.

13.10.B PARTICIPANT RESPONSIBILITY TO PAY COPAYMENT AMOUNTS

Unless otherwise exempted (Refer to Section 13.10.C), it is the responsibility of the participant to pay the required copayment amount due. Whether or not the participant has the ability to pay the required copayment amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. A participant is not required to pay more than one copayment amount on a given date of service. For example, if a participant is seen in an outpatient hospital based clinic, both the physician's services and outpatient hospital charge have assigned copayment amounts. The participant is only required to pay one copayment amount. The copayment only applies to identified services and participants with certain ME codes. Only one copayment may be collected per date of service.

13.10.B(1) COPAYMENT AMOUNTS

The following copayment amounts are applied to services:

Inpatient Hospital	$10.00 per hospital stay (applicable on date of admission and charged to the participant prior to discharge)
Outpatient Clinic or Emergency Room	$3.00 for each date of service

13.10.C EXEMPTIONS TO THE COPAYMENT AMOUNT

The following participants or conditions are exemptions to the participant's responsibility to the copayment amount:

- Services provided to participants under nineteen (19) years of age; or participants receiving Medicaid under the following categories of assistance: ME Codes 06, 33, 34, 36, 38, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87, and 88;

- Services provided to participants residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital; or participants receiving Medicaid under the following categories of assistance: ME Codes 23 and 41;

- Services provided to participants who have both Medicare and Medicaid if Medicare covers the service and provides payment for it; or participants receiving Medicaid under the following category of assistance: ME Code 55;

- Emergency or transfer inpatient hospital admission;

- Emergency services provided in an outpatient clinic or emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part;

- Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

- Services provided to pregnant women who are receiving Medicaid under the following categories of assistance only: ME Codes 18, 43, 44, 45, 58, 59 and 61;

- Services provided to foster care participants who are receiving Medicaid under the following categories of assistance: ME Codes 07, 08, 28, 29, 30, 37, 38, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Services identified as medically necessary through an Early Periodic Screening, Diagnostic and Treatment (EPSDT) screen;

- Services provided to persons receiving Medicaid under a category of assistance for the blind: ME Codes 02, 03, 12 and 15;

- Services provided to MC+ MO HealthNet Managed Care enrollees;

- Mental Health services provided by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;

- Family planning services;

- Medicaid Waiver services;

- Hospice services; and

- Personal Care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which

enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility.

13.11 HEALTHY CHILDREN AND YOUTH (HCY) (ALSO KNOWN AS EPSDT)

The purpose of the Healthy Children and Youth Program (HCY), also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT), is to ensure a comprehensive, preventative health care program for MO HealthNet eligible children who are under the age of 21. HCY is designed to link the child and family to an ongoing health care delivery system. The HCY Program provides early and periodic medical/dental/vision/hearing screening, diagnosis, and treatment to correct or ameliorate defects and chronic conditions found during the screening.

Every eligible participant under age 21, or the child's parents or the child's legal guardian, is informed of the HCY service by the Family Support Division caseworker at the initial application for assistance. The participant is reminded of the service at each annual reinvestigation.

An HCY screening consists of a health and developmental history, unclothed physical examination, developmental assessment, immunization status including the administration of any needed immunizations, nutritional status, vision testing, hearing testing, lead toxicity screening, laboratory procedures, dental status and referrals for follow-up care or evaluation of any abnormality detected whether or not treated during the course of the screening.

Medical or dental services that the Social Security Act permits to be covered under MO HealthNet and that are necessary to treat or ameliorate defects, physical and mental illness or conditions identified by an HCY screen, are covered by MO HealthNet regardless of whether or not the services are covered under the MO HealthNet State Plan.

There is a full discussion of the HCY Program in Section 9 – Healthy Children and Youth Program of the manual and billing instructions in Section 15 – Billing Instructions.

13.11.A PLAN OF CARE

The need for evaluation or care *must* be established by a physician, nurse practitioner or other appropriate screening provider during the HCY screening. If diagnosis or evaluation indicates that therapy is needed, a plan of care *must* be developed. The MO HealthNet Division does *not* provide a standardized plan of care. The Individual Education Plan (IEP), Individualized Family Service Plan (IFSP), or other comprehensive treatment plan that is developed for a specific child may serve as the HCY plan of care.

The care plan *must* specify:

- diagnosis;

- desired outcome;
- nature of the treatment;
- frequency of treatment (times per day/week/month); and
- duration (weeks or months) of services.

13.11.A(1) Physical Therapy

Physical therapy (PT) is a MO HealthNet covered service for participants under age 21. Physical therapy for adults is explained in Section 13.13 Therapy Services. Use CPT procedure codes in the 97000 range. For physical therapy provided to a participant under 21 years of age as a result of a screening, enter code "A1" in Fields #18-#28 of the UB-04 claim form to indicate that it is an EPSDT/HCY service.

NOTE: Reimbursement made to hospitals for HCY therapy services is based on that hospital's interim outpatient reimbursement percentage; however, the final outpatient settlement does *not* include HCY costs or charges nor are occupational and speech therapy cost centers allowed in computing the final outpatient cost settlement.

13.11.A(2) Occupational Therapy

Occupational therapy (OT) in the outpatient hospital is covered for participants under age 21. Occupational therapy for adults is explained in Section 13.13 – Therapy Services.

Under the EPSDT/HCY Program, OT is covered for participants under 21 years of age when:

- the need is identified by an HCY screen; or
- there is a physician referral; or
- the service regimen is incorporated into a plan of care.

Codes in the HCY (modifier EP) OT Program are in fifteen minute units only. Refer to Section 19 – Procedure Codes of the Rehabilitation Center Manual for codes.

13.11.A(3) Speech/Language Therapy

Speech/language therapy in the outpatient hospital is covered for participants under age 21. Speech/language therapy for adults is explained in Section 13.13 – Therapy Services.

Under the EPSDT/HCY Program, speech/language is covered for participants under 21 years of age when:

- the need is identified by an HCY screen; or
- there is a physician referral; or
- the service regimen is incorporated into a plan of care.

Codes in the HCY (modifier EP) Speech/Language Program are in fifteen minute units only. Refer to Section 19 – Procedure Codes of the Rehabilitation Center Manual for codes.

13.11.A(4) Limitations of HCY Therapy

Evaluations are limited to four hours per discipline per provider in a 12 month period.

Therapy treatment services that exceed one hour and fifteen minutes (five units) in one day *must* have documentation attached to the claim that justified the need for intensive therapy treatment. Claims with six or more units for occupational or speech/language therapy suspend in the claims processing system for a consultant to review the documentation. If documentation is *not* attached or the consultant does *not* approve the additional units, the total number of units is reduced to those considered medically necessary; however, the total units are *not* reduced to less than five units per day. Documentation includes the evaluation, the treatment plan and the physician's orders or referral.

13.11.A(5) Physical Therapy, Occupational Therapy and Speech Therapy Identified in an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP)

Refer to Section 13 – Benefits and Limitations of the Therapy Manual.

13.11.B IMMUNIZATIONS

Through the Vaccine for Children (VFC) Program, federally provided vaccines are available at no cost to public and private providers for eligible children ages 0 through 18 years of age. Children that meet at least one of the following criteria are eligible for VFC vaccine:

- MO HEALTHNET ENROLLED—means a child enrolled in the MO HealthNet Program
- UNINSURED—means a child has no health insurance coverage
- NATIVE AMERICAN/ALASKAN NATIVE—means those children as defined in the Indian Health Services Act

- UNDERINSURED—means the child has some type of health insurance, but the benefit plan does *not* include vaccinations. The child **must** be vaccinated in a Federally Qualified Health Clinic (FQHC) or a Rural Health Clinic (RHC).

MO HealthNet enrolled providers **must** participate in the VFC Program administered by the Missouri Department of Health and Senior Services and **must** use the free vaccine when administering vaccine to qualified MO HealthNet eligible children. For more information regarding the specific guidelines of the VFC Program contact the following:

VFC Program
Missouri Department of Health and Senior Services
930 Wildwood, PO Box 570
Jefferson City, MO 65102
Telephone: (800) 219-3224 or (573) 526-5833
Fax: 573-526-5220
http;//www.dhss.mo.gov/Immunizations/VFC-Providers.html

For adult (over 18 years of age) immunizations, the appropriate CPT code should be used.

13.12 CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

13.12.A INPATIENT HOSPITAL

When anesthesiology charges are billed to Medicare on a CMS-1500 claim form, they are *not* included on their Medicare Cost Report, and therefore the hospital may *not* include the anesthesiology charges on their MO HealthNet Cost Reports. Hospitals that include anesthesiology charges on their Medicare Cost Report have those charges recognized on their MO HealthNet Cost Report. For those providers, hospital based or contractually compensated CRNA/AA's costs for MO HealthNet patients *cannot* be separately billed on a CMS-1500 claim form but *must* be shown as ancillary charges on the inpatient claim.

Providers who may have hospital salaried or contractually compensated CRNA/AAs whose services are billed to Medicare on a CMS-1500 should enroll them as MO HealthNet providers. The CRNA/AA's charges for MO HealthNet patients can be billed to MO HealthNet on a CMS-1500 claim form using the CRNA/AA MO HealthNet provider identifier. Hospitals employing CRNA/AA's and that have a professional "group" provider identifier and taxonomy code may bill with those numbers and enter the CRNA/AA MO HealthNet provider identifier in Field #24J as the rendering provider.

Inpatient services of CRNA/AAs *not* employed by the hospital may be billed on a CMS-1500 claim form by the CRNA/AA or the employer. Charges for those services *must not* appear on the hospital's inpatient claim.

13.12.B OUTPATIENT HOSPITAL

All CRNA services provided in the outpatient department of a hospital *must* be billed on a CMS-1500 claim form, regardless of the method of cost reporting. Hospital based or contractually compensated CRNAs should be enrolled as MO HealthNet providers to bill for their services. Any CRNA costs incurred by the outpatient hospital are non-allowable on the hospital's MO HealthNet outpatient cost reports for cost settlement purposes.

The billing provider may be the hospital if the CRNA is hospital salaried or contractually compensated. Hospitals employing CRNA/AA's and that have professional "group" provider identifier and taxonomy code may bill with those numbers and enter the CRNA MO HealthNet provider identifier in Field #24J as the rendering provider.

If the CRNA is employed by a physician, the physician may bill for those services. CRNAs who are self-employed and receive no financial compensation from the hospital, may bill for outpatient hospital services under their own provider number using the CMS-1500 claim form. Refer to Section 13.39 – Anesthesia Services of the Physician Manual, for more information.

13.13 THERAPY SERVICES

Physical therapy is covered in the Hospital Program for adult participants age 21 and over, in the assistance categories for pregnant women, blind participants or nursing facility residents. Physical therapy coverage for participants under age 21 is explained in Section 13.11 – Healthy Children & Youth (HCY).

Occupational and speech therapy are covered in the outpatient hospital setting for adult participants age 21 and over, in the assistance categories for pregnant women, blind participants or nursing facility residents when needed for adaptive training to use an orthotic or prosthetic device. Expanded therapy services are covered in a hospital for participants under age 21, if the need for services has been identified by an HCY screening. Occupational and speech therapy coverage for participants under age 21 is explained in Section 13.11 – Healthy Children & Youth (HCY).

13.14 HEARING AID SERVICES

Hospital-based audiologists *must* individually enroll as MO HealthNet providers to participate in the Hearing Aid Program. Under HCY, diagnostic audiological services are covered. The HCY services *must* be prior authorized. Reimbursement is fee-for-service based on the submission of a CMS-1500 claim form.

13.15 STERILIZATION

Sterilization is defined as any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

In all situations involving voluntary sterilization, it is mandatory that the (Sterilization) Consent Form used by MO HealthNet be attached to each paper claim or be submitted on-line through the eMOMED Web portal. Each provider involved in the sterilization-related procedure, including inpatient hospital and outpatient hospital, is required to obtain a copy of the (Sterilization) Consent Form from the performing physician. *Refer to the* MO HealthNet fee schedule *for a list of procedures that require attachments.*

The use of the (Sterilization) Consent Form is mandatory in all situations involving voluntary sterilization in accordance with the Code of Federal Regulation 42 CFR 441.250-441.259. If in these situations premature delivery or emergency abdominal surgery is necessary, the following special instructions with regard to time requirements apply:

- Premature delivery—The (Sterilization) Consent Form *must* be completed and signed by the participant at least 72 hours prior to the sterilization and at least 30 days prior to expected date of delivery.
- Emergency abdominal surgery—The (Sterilization) Consent Form *must* be completed and signed by the participant at least 72 hours prior to the sterilization.

All voluntary sterilization procedures *must* be identified as family planning procedures.

Refer to Section 10 - Family Planning, for detailed information regarding program coverage, required consent, and other guidelines. The (Sterilization) Consent Form is found under the MO HealthNet Forms link at www.dss.mo.gov/mhd/providers.

13.16 HYSTERECTOMY PROCEDURES

A hysterectomy is covered if:

- the person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing; and
- the individual or her representative has signed the Acknowledgement of Receipt of Hysterectomy Information form. The completed form *must* be attached to the MO HealthNet paper claim or submitted on-line through the eMOMED Web portal. *Refer to the* MO HealthNet fee schedule *for a list of procedures that require attachments.*

A hysterectomy is *not* covered if:

- the hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- there was more than one purpose to the procedure, but it would *not* have been performed except for the purpose of rendering an individual permanently incapable of reproducing.

The Acknowledgement of Receipt of Hysterectomy Information form is found under the MO HealthNet Forms link at www.dss.mo.gov/mhd/providers.

13.16.A EXCEPTIONS TO AN ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM

- The individual was already sterile before the hysterectomy. The physician who performs the hysterectomy *must* certify in writing that the individual was already sterile at the time of the hysterectomy and state the cause of the sterility. This *must* be documented by an operative report or admit and discharge summary attached to the claim for payment.
- The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is *not* possible. The physician *must* certify in writing to this effect and include a description of the nature of the emergency.
- The participant was *not* MO HealthNet eligible at the time the hysterectomy was performed but eligibility was made retroactively. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted along with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service but has become eligible retroactively to that date. The physician who performed the hysterectomy *must* certify in writing that the individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing.

It is the hospital's responsibility to obtain the necessary certification from the performing physician.

Hysterectomies *must not* be reported as family planning services.

13.17 ABORTIONS

In accordance with Public Law 105-78 (1997), relating to abortions, MO HealthNet payment is only available for abortions performed when the life of the mother would be endangered if the fetus were carried to term or that the pregnancy is the result of an act of rape or incest.

In these situations, the physician *must* complete the Certification of Medical Necessity for Abortion form certifying the medical necessity of the procedure. The definition of a medically necessary

abortion is when the performing physician has found and certified in writing on the Certification of Medical Necessity for Abortion form, that on the basis of the physician's professional judgment:

1. the pregnancy is the result of an act of rape or incest; or
2. the woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by the performing physician, place the woman in danger of death unless an abortion is performed.

The physician *must* certify that in the physician's professional judgment this service meets the above criteria based on full consideration of all factors described in the medical records and attached to the claim form, e.g., physician's office medical records, emergency room report, history and physical, ultrasound interpretation report, physician's progress notes, consultant reports, laboratory reports, operative report, pathology report.

The Certification of Medical Necessity for Abortion form *must* be personally signed and dated by the performing physician. A facsimile signature or signature of the physician's authorized representative is *not* acceptable. Each provider submitting a claim for abortion services (e.g., physician, inpatient hospital, outpatient hospital, clinic) *must* attach a completed certification form with an original signature. All relevant documentation *must* be attached with the Certification of Medical Necessity for Abortion form to the claim form when submitted for processing.

Claims for missed or spontaneous abortions (miscarriages) must be submitted on a paper claim form with the above mentioned medical records or the Certificate of Medical Necessity form attached. The Certificate of Medical Necessity form is found under the MO HealthNet Forms link at www.dss.mo.gov/mhd/providers.

NOTE: Abortions are *not* to be reported as family planning services.

13.18 CONCURRENT DATES OF SERVICE

Any outpatient service performed *after* a participant has been formally admitted as an inpatient *must* be shown as ancillary charges on the inpatient claim. Formally admitted refers to the time in which the medical professional ordered the participant into inpatient status. It is an improper billing procedure for a provider to submit an inpatient claim and the same or a different provider to submit an outpatient claim for concurrent dates of service for the same participant. Outpatient services provided on the day of admission, but prior to admission, or on the day of discharge, but following discharge, are *not* considered concurrent care for the purpose of this policy. Such outpatient services provided on the day of admission or the day of discharge are reimbursable as outpatient services.

As an example of concurrent dates of service that are *not* separately reimbursable, consider the following circumstance: A participant receives emergency room services on Monday and is then admitted that day. The participant is discharged on Friday and on Friday begins the first of a series

of outpatient therapy services. The outpatient services received on Monday and Friday are reimbursable. Any services performed in the outpatient department on Tuesday, Wednesday, or Thursday of that inpatient stay are considered concurrent dates of service that are *not* reimbursable as outpatient services.

When procedures or services, such as complex laboratory or radiology procedures are furnished by a provider outside the hospital, the services are to be billed as ancillaries on the inpatient claim. It is the responsibility of the inpatient hospital to make arrangements with the outside provider for payment of those services. Any claim submitted to the fiscal agent for outpatient services when there are concurrent inpatient services is denied. If an outpatient claim is paid before the inpatient claim is processed, the inpatient claim is paid and a recoupment of the outpatient claim is made.

13.19 FETAL MONITORING

13.19.A INTERNAL

Initiation and/or Supervision of *internal* fetal monitoring during labor by a consultant, is a MO HealthNet covered service. This procedure may only be performed on an inpatient hospital basis.

13.19.B EXTERNAL

Fetal contraction stress tests and fetal non-stress tests, may be billed on an outpatient claim if the service is physician ordered based on circumstances that indicate the fetus may be experiencing difficulties.

Routine fetal monitoring, including auscultation of fetal heart tones by use of Doppler (e.g., doptone), performed as outpatient services is *not* separately billable.

13.20 INTRAOPERATIVE NEUROPHYSIOLOGICAL MONITORING

Intraoperative neurophysiological monitoring may be used to identify and/or prevent complications during surgery on the nervous system, its blood supply, or adjacent tissue. Monitoring can identify new neurologic impairment, identify, or separate nervous system structures (e.g., around or in a tumor), and can demonstrate which tracts or nerves are still functional. Intraoperative neurophysiological testing may provide relative reassurance to the surgeon that no identifiable complication has been detected up to a certain point, allowing the surgeon to proceed further and provide a more thorough or careful surgical intervention than would have been provided in the absence of monitoring.

Some high-risk patients may be candidates for a surgical procedure only if monitoring is available. Intra-operative testing may be indicated with the following types of surgery:

- Surgery to the aortic arch, its branch vessels, or thoracic aorta, including internal carotid artery surgery, when there is risk of cerebral ischemia;
- Resection of epileptogenic brain tissue or tumor;
- Resection of brain tissue close to the primary motor cortex and requiring brain mapping;
- Protection of cranial nerves:
  - tumors that are on optic, trigeminal, facial, or auditory nerves;
  - cavernous sinus tumors;
  - oval or round window graft;
  - endolymphatic shunt for Ménière's disease;
  - vestibular section for vertigo;
  - microvascular decompression of cranial nerves.
- Correction of scoliosis or deformity of spinal cord involving traction on the cord;
- Protection of spinal cord where work is performed in close proximity to cord as in the removal of old hardware or where there have been numerous interventions;
- Spinal instrumentation requiring pedicle screws or distraction;
- Decompressive procedures on the spinal cord or cauda equina carried out for myelopathy or claudication where function of spinal cord or spinal nerves is at risk;
- Resection of:
  - Spinal cord tumors;
  - Neuromas of peripheral nerves or brachial plexus, when there is risk to major sensory or motor nerves;
- Surgery for:
  - intracranial AV malformations;
  - arteriovenous malformation of spinal cord;
  - surgery for intractable movement disorders;
  - cerebral vascular aneurysms;
  - surgery for intractable movement disorders;
- Arteriography, during which there is a test occlusion of the carotid artery;

- Circulatory arrest with hypothermia;
- Distal aortic procedures, where there is risk of ischemia to spinal cord;
- Leg lengthening procedures, where there is traction on sciatic nerve or other nerve trunks;
- Basil ganglia movement disorders;
- Surgery as a result of traumatic injury to spinal cord/brain;
- Deep brain stimulation

13.20.A LIMITATIONS

This test must be requested by the operating surgeon and the monitoring must be performed by a physician other than the operating physician, the technical/surgical assistant or the anesthesiologist rendering the anesthesia. The monitoring must be performed by a specifically trained technician, preferably registered with one of the credentialing organizations, and in continuous attendance in the operating room, recording and monitoring a single surgical case, with either the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology.

Intra-operative monitoring is not medically necessary in situations where historical data and current practices reveal no potential for damage to neural integrity during surgery. Monitoring under these circumstances will exceed the patient's medical need.

Undivided attention to a unique patient may be required during some surgeries, such as during response to acute events or identification of the cerebral cortex to be resected or spared from resection. When monitoring this type of case, the physician must have a plan in place to transfer care of all other cases to another physician. When paying undivided attention to a unique patient, the physician must code and bill for only that one case during those times. For other medically necessary intraoperative neurophysiologic monitoring, a physician may code and bill for up to three cases simultaneously.

MO HealthNet does not cover "incident to" care in the hospital setting. More than one patient may be monitored at once; however, claims for physician services must be submitted only for the time devoted to monitoring. This time, however, may be cumulative, and does not have to be continuous, i.e., one-half hour of continuous attendance followed by another one-half hour later in the procedure will constitute one hour of monitoring.

13.20.A(1) Technical Criteria

Technical criteria includes at least eight recording channels be available (16 if EEG is monitored) for all intraoperative neurophysiological monitoring. The

supervising physician may remotely monitor the tracings but the remote monitoring must include routine real-time auditory or written communication with the operating room and have the capability for telephone communications with the monitoring technologist, operating surgeon and anesthesiologist.

The equipment must also provide all the monitoring modalities that may be applied which include auditory-evoked response, electroencephalography/electrocorticography, electromyography and nerve conduction and somatosensory-evoked response.

13.21 PHARMACEUTICAL SERVICES

Hospitals that maintain outpatient pharmacies in the hospital are encouraged to enroll in the MO HealthNet Pharmacy Program. Federal matching funds for drug expenditures are only available for drugs produced by manufacturers that have entered into a rebate agreement with the Federal Department of Health and Human Services (HHS).

13.22 ITEMS AND SERVICES NOT COVERED IN THE HOSPITAL PROGRAM

The following is a list of items and services that are *not* covered through the Hospital Program. These items and services *may be* covered as benefits in another MO HealthNet Program; e.g., Physician, Dental, Durable Medical Equipment, Optical, Ambulance, etc. Charges for those items and services can be billed to MO HealthNet by an enrolled provider using the claim form and procedures appropriate to that program. They are *not* covered on the CMS-1450 (UB-04) form. It is not appropriate to include these charges in the hospital's facility charge on an outpatient claim.

- Ambulance services;
- Durable medical equipment and supplies furnished the patient to be used post-discharge;
- Eyeglasses and any related optical materials, including artificial eyes;
- Hearing aids and any related audiological materials;
- Prosthetic and orthotic devices which are furnished the patient to be used post-discharge;
- Physician services (See Section 13.22.A);
- Take home drugs, with the exception of one or two tablets due to pharmacy availability at night;
- Occupational outpatient therapy—except for participants under the age of 21 or in the assistance categories for pregnant women, blind participants or nursing facility residents when needed for adaptive training to use an orthotic or prosthetic device.

- Physical outpatient therapy—except for participants under the age of 21 or in assistance categories for pregnant women, blind participants or nursing facility residents.
- Speech outpatient therapy—except for participants under the age of 21 or in the assistance categories for pregnant women, blind participants or nursing facility residents when needed for adaptive training for an artificial larynx.

13.22.A PHYSICIAN SERVICES

The costs of patient-related physician services *must not* be included in any ancillary charge of the inpatient claim. Physician services that are patient related (as opposed to hospital related, such as a supervisory function) are *not* an allowable cost on the inpatient cost report. Those costs are *not* included in setting a reimbursement rate. The charges for physician services *must* be billed on a CMS-1500 claim form. The method by which a hospital may bill on a CMS-1500 for hospital-salaried or contractually compensated physician services is given in Section 13.43 – Physician, Anesthesiologist Assistant, and CRNA Services.

The services of the physician supervising infusion therapy in the inpatient or outpatient hospital setting are to be billed using the appropriate Evaluation and Management procedure codes. Infusion therapy by nurses in an inpatient or outpatient setting is included in the facility charge and is *not* separately billable (e.g., chemotherapy, antibiotic therapy, hydration therapy, immune globulin therapy, IV rate change, pitocin, etc.).

13.23 ITEMS AND SERVICES NOT COVERED BY MO HEALTHNET

Non-covered services may be billed to the patient. The following is a list of some of the services, procedures and items *not* covered by the MO HealthNet Program. It is not appropriate to include these charges in the hospital's facility charge on an outpatient claim.

- Acupuncture;
- Autopsy services;
- Biofeedback services;
- Circumcisions, unless prior authorized as medically necessary. For policy regarding circumcision procedures, reference Section 13 – Benefits and Limitations of the Physician Manual.
- Clinical studies, trials, testing and experimental medical procedures, drugs, equipment, etc.;
- Cosmetic surgery, unless prior authorized as medically necessary;
- Days of a custodial nature pending arrangements for placement;
- Leave of absence days;

- Non-care items, such as television, telephone, baby pictures, birth certificates, newspaper, guest cots or guest trays;
- Personal comfort items, including barber and beautician charges;
- Routine physical examinations requested by third parties, such as insurance companies unless required under the Health Insurance Premium Payment Program;
- Sex therapy;
- Treatment of infertility;
- Tuboplasty, sterilization reversal; and
- Weight control.

Services related to non-covered procedures are also non-covered. If any non-covered procedure is the chief reason for hospital services, none of the hospital charges are reimbursable.

13.24 SERVICES INCLUDED IN OTHER CHARGES

The following services are included in other charges shown on a claim and are *not* to be shown as a separate charge or cannot be included in the facility charge. They *cannot* be billed to the participant.

- After-hours services;
- Call-back services;
- Claim filing fees;
- Education/instruction, e.g. colostomy care, cardiac care, etc.;
- Handling charge for specimens referred to an independent laboratory;
- Late discharge fee;
- Preparation of special reports sent to insurance companies;
- Psychiatric reports for court evaluation or juvenile court;
- Standby equipment; and
- Stat charges.

13.24.A SERVICES NOT SEPARATELY BILLABLE

Services that are deemed *not* separately billable may be added to the facility charge. These services include but are *not* limited to IV Infusion services, such as:

- Chemotherapy
- Antibiotic therapy

- Hydration therapy
- Immune globulin therapy
- IV rate change
- Pitocin

Services performed by hospital staff that are incidental to physician services may not be separately billed or added to the facility charge.

13.24.B HOSPITAL COST CENTERS

The charges for hospital staff services included in routine cost centers should be reflected in the inpatient room accommodation rate or outpatient facility charge. Services such as venipuncture, specimen collection, taking vitals, monitoring services, prepping, positioning, etc. are included in the cost center. If hospital staff services are part of the performance of specific diagnostic or therapeutic procedures, those costs can be shown in the charge for that specific procedure.

13.24.B(1) Supply Charges

Supplies that can be shown on the claim form should be those that are consumed or disposed of after using for one patient.

Basic floor supplies kept as "bulk" supplies (*not* individually wrapped or packaged) *must not* be shown in a supply charge. Basic floor supplies are in the routine cost center for cost reporting purposes and reflected in the facility or specific procedure charge.

Items that are durable and reusable such as furniture, instruments, equipment, crutches, IV stands/pumps, IVAC regulators and reusable central service supplies *must not* be included in a supply charge. Their costs should be reflected in ancillary charges, room rate or facility charges.

13.25 PROVIDER PREVENTABLE CONDITIONS

Provider Preventable Conditions (PPC) is an umbrella term established by the Centers for Medicare and Medicaid Services (CMS) for hospital and non-hospital acquired conditions identified by the State for nonpayment to ensure the high quality of Medicaid services. PPCs include two distinct parts, Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). The CMS has mandated that state Medicaid agencies implement policies and procedures for reporting, review and, if appropriate, nonpayment or payment recoupments for services designated as a provider preventable condition.

13.25.A HEALTH CARE-ACQUIRED CONDITIONS

Health Care-Acquired Conditions (HCAC) are conditions that could reasonably have been prevented by the health care establishment, as well as through implementation of appropriate policies, procedures and protocols by a hospital. HCACs for state Medicaid agencies apply only to the inpatient hospital setting and are defined as the full list of Medicare's Hospital-Acquired Conditions, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients. A complete list of diagnosis and diagnosis/procedure combinations currently designated as HCACs can be found on the CMS Web site at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html**..

To meet the CMS mandated requirements, MO HealthNet providers are required to report all HCAC diagnosis codes to the MO HealthNet Division (MHD). Providers will report this information by entering the appropriate Present On Admission (POA) indicator for all diagnosis codes submitted on their claims. Present On Admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter prior to an admission to inpatient, including emergency department, observation or outpatient surgery, are considered Present On Admission.

The POA indicator will be required for all diagnosis codes submitted on claims when the last date of service billed is on or after July 1, 2012, excluding those diagnosis codes designated under the current version of the International Classification of Diseases (ICD) Official Guidelines for Coding and Reporting as exempt from the POA requirement. Claims containing an invalid or missing POA indicator will be denied unless the diagnosis is exempt from the POA requirement. Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting for proper assignment of the POA indicator. Valid POA indicator values are:

Y = Yes – present at the time of inpatient admission.

N = No – not present at the time of inpatient admission.

U = Unknown – documentation is insufficient to determine if condition is present on admission.

W = Clinically undetermined – provider is unable to clinically determine whether condition was present on admission or not.

As stated above, CMS and state regulation require MO HealthNet to capture and review claims data, as well as medical records when appropriate, for services billed with a HCAC diagnosis that was not present at the time of admission. The state regulation authorizes MO HealthNet to reduce or recoup claim payment if the condition is considered preventable,

resulted in additional hospital services not otherwise needed, and/or lengthened the hospital stay.

13.25.A(1) Post-payment Adjustment Process

The payment adjustment process is triggered when the condition is on the list of HCACs and the condition is acquired during the hospital stay (POA indicator of "N" or "U"). If the claim has indicated a HCAC and the POA indicator is an "N" or "U" a Diagnosis Related Grouping (DRG) will be assigned to the claim. DRG assignment is used for the purpose of identifying the effect of a HCAC on the resources needed to care for a patient. If removing the HCAC results in a DRG with a lower relative weight, payment on the claim will be affected. Payment will be adjusted by a percentage based on the difference in the DRG weights.

13.25.B OTHER PROVIDER PREVENTABLE CONDITIONS

The MO HealthNet Division (MHD) follows Centers for Medicare and Medicaid Services' (CMS) guidelines regarding Other Provider Preventable Conditions (OPPC). MO HealthNet will not cover a surgical procedure or other invasive procedure to treat a medical condition when the practitioner erroneously performs: 1) the wrong procedure, 2) the correct procedure but on the wrong body part, or 3) the correct procedure, but on the wrong patient.

In addition, MO HealthNet will not cover hospitalizations and other services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the OPPC occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. However, related services do not include performance of the correct procedure.

Effective for dates of service and inpatient discharges on or after March 1, 2011, services falling in an OPPC category will be denied MO HealthNet reimbursement by the claims processing system. Services must be billed appropriately when the following OPPCs occur: wrong procedure; the correct procedure but on the wrong body part; or the correct procedure but on the wrong patient.

• OPPC *medical* claims (CMS 1500 claim form or its electronic equivalent) must be billed with the surgical procedure code and modifier which indicates the type of OPPC: modifier PA (wrong body part), PB (wrong patient) or PC (wrong surgery) AND/OR the diagnosis code for wrong surgery, wrong patient or wrong body part must be present as one of the diagnoses codes on the claim.

• OPPC *outpatient* claims (CMS 1450 UB-04 claim form or its electronic equivalent) must be billed with diagnosis code for wrong surgery, wrong patient or wrong body part within the first five (5) diagnosis codes listed on the claim.

• OPPC *inpatient* claims must be billed with a type of bill 110.

o If there are covered services or procedures provided during the same stay as the OPPC, then the facility must submit two claims; one claim with covered services unrelated to the OPPC event and the other claim for any and all services related to the OPPC event.

o Type of Bill 110 claim should also contain one of the diagnosis codes to indicate the type of OPPC: wrong surgery, wrong patient or wrong body part within the first five (5) diagnosis codes listed on the claim.

A MO HealthNet participant shall not be liable for payment for an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the MO HealthNet Division.

13.25.C MEDICAL RECORD DOCUMENTATION

As stated in the Introduction to the ICD Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment and reporting of diagnoses. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. The context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

13.26 INPATIENT HOSPITAL DEFINITION

An "inpatient" service, which requires the submission of an inpatient claim, is one in which the hospital expects to provide service to the patient in the hospital for a 24 hour period or longer. The stay is considered inpatient upon the issuance of written physician or other medical professional's orders to that effect. A medical professional is a physician or other person authorized by State licensure law to order hospital services for diagnosis or treatment of a patient.

If a patient dies or is discharged prior to being assigned and/or occupy a room, the hospital may enter an appropriate room and board charge on the claim. The service is still considered inpatient if the intent is to stay 24 hours or longer even though the patient dies, is discharged or is transferred to another institution and does *not* actually stay in the hospital 24 hours. Services in an observation status, without a written admission order, regardless of the length of time, are *not* considered inpatient services. See Section 13.38 - Observation Services for more information.

13.26.A ADMISSION ORDERS

The physician or other medical professional may clarify the admission order at any time prior to the patient's death or discharge as long as this modification only serves to make the physician's or other medical professional's actions more consistent with the initial intent. The initial intent itself *cannot* be changed. However, if the written order is vague or inconsistent with the hospital's actions, the physician or other medical professional may clarify that order (intention) at any time prior to the hospital's initial claim submission. If the written admission order is completed after the patient has died or been discharged from the hospital, the inpatient stay is *not* payable and the participant *cannot* be held responsible for the charges incurred.

13.27 MAXIMUM NUMBER OF COVERED INPATIENT HOSPITAL DAYS

With certain exceptions noted below, the number of inpatient hospital days which are reimbursable by MO HealthNet is limited by the following:

- The number of days certified as medically necessary by the MO HealthNet review authority, Conduent.

13.28 COUNTING INPATIENT DAYS

For the purpose of administering the number of inpatient hospital days reimbursed by MO HealthNet, the counting of days begins with the latest of: the day of admission; the first day certified by Conduent; or the first day MO HealthNet eligibility begins. The counting of days by the hospital's Utilization Review Committee begins with the day of admission. For participants eligible under both Medicare Part A and MO HealthNet, the counting of days begins with the day following the last day of Medicare coverage. A midnight bed count is a common measure to determine a payable day. If a patient is in the hospital at midnight, that day is payable. A new day begins at 12:01 a.m.

13.28.A INTERIM BILLING

It is usually inappropriate to submit more than one claim for one continuous hospitalization, however there are some instances where is it required which are discussed in Section 13.28.I – Participant Ineligible During Stay. The reimbursement of interim billed claims is based on the Milliman Care Guidelines for stays authorized by Conduent, or the PAS length of stay for certain pregnancy and newborn related stays, as part of one continuous stay. Interim billed claims representing one continuous stay that exceed the number of PAS allowed days, the reimbursement is cut back to the number of approved days vs the number of days billed. The group and reason code on the Remittance Advice for this situation is CO 198,

"Precertification/authorization exceeded." Refer to Section 15 – Billing Instructions of the Hospital manual for more information regarding interim billing.

13.28.B DAY OF DISCHARGE, DEATH OR TRANSFER

MO HealthNet reimburses a facility for the day of admission. MO HealthNet does *not* cover the day of discharge, death or transfer unless it is also the day of admission and then is reimbursable. The day of discharge, death or transfer *cannot* be billed to the participant.

13.28.C PRIVATE ROOMS

Charges for "Private" room accommodations are covered by MO HealthNet only if medically necessary. Inpatient hospital claims with Revenue Codes in the ranges of 0110—0119 and 0140—0149 *must* substantiate a medical need. The documentation of need *must* be in the patient's medical records. If a private room is *not* considered medically necessary, the claim is only processed if the difference between the private room accommodation charge and the semi-private room charge times the number of covered days is shown in the non-covered charge column of the claim form. Hospitals with private rooms only are exempt from this policy and *must* contact the Clinical Program Development Unit with that information at (573)751-6963.

13.28.D TRANSFERS BETWEEN HOSPITALS

A transfer from one hospital to another is acceptable only when the transferring hospital *cannot* provide the services that the patient needs. There may be some exceptions to this policy; for example, if the attending physician feels that the patient needs the support of family members who do *not* live within visiting distance, transfer is acceptable. This information *must* be included in the patient's medical chart. Transfers for other reasons are subject to recoupment of payments made to the second hospital.

The hospital to which the patient has been transferred is subject to admission certification requirements.

13.28.E TRANSFERS WITHIN A HOSPITAL

It is improper to submit two claims when a participant is transferred from one part of a hospital to another. The counting of days that are allowable under the Conduent approved days is from the date of initial admission for a continuous period of hospitalization. Only one claim should be submitted covering the full continuous length of stay. This policy includes the following situations:

- Movement from one level of room accommodation to another level.
- Movement from the acute area of the hospital to another area, such as a psychiatric or rehabilitation unit.

- Written discharge from one unit and admission to another unit of the hospital.

13.28.F LATE CHARGES

Adjustments to paid claims for late charges are *not* accepted. Late charges may be considered on the Medicare/MO HealthNet cost report if identifying information is submitted.

To allow late charges on the cost report, the charges *must* be separately listed and filed with the cost report. This listing *must* identify each late charge by patient name, dates of admission and discharge, date claim paid, item of service, amount of late charge, and the total amount of charges for the stay including the late charge. This identification is necessary for the reconciliation of MO HealthNet data with late charges.

13.28.G INPATIENT PER DIEM RATE

Reimbursement for inpatient services is made at the applicable per diem rate in effect on the date of admission for Conduent certified days for which the participant is eligible. If a MO HealthNet per diem rate change occurs during a participant's stay, reimbursement is based on the per diem rate in effect on the day of admission.

13.28.H LEAVE OF ABSENCE DAYS

MO HealthNet does *not* reimburse for any day the patient is *not* in the facility.

The "from" and "through" dates in Field #6, Statement Covers Period, *must* be for continuous stay days and *must* represent only days that the patient was in the hospital. The midnight bed count is a guideline for this.

If a patient takes a temporary leave of absence and is gone overnight or on a weekend pass, the provider *must* submit two interim claims. The first claim *must* indicate a patient status of "30," Still a Patient, in Field #17, Patient Discharge Status. The through date entered in Field #6, Statement Covers Period, should be the last date that the patient was in the facility at midnight. The second claim *must* show the same admission date and certification numbers as the first claim, but the "from" date in Field #6, Statement Covers Period, is the date the patient returned to the hospital.

13.28.I PARTICIPANT INELIGIBILITY DURING A STAY

Sometimes a participant becomes ineligible for MO HealthNet during an inpatient stay. This occurs for spend-down participants at the beginning of each month. The provider needs to submit interim claims because Field #6, Statement Covers Period, "from" and "through" dates, *cannot* include ineligible days, nor can it house dates spanning two or more calendar months. Each interim claim must reflect the dates for one calendar month. The same certification data and admission date should be used on both claims. For example, a spend-

down eligible participant has an inpatient stay from March 28 to April 3. One interim claim will have the dates of March 28 – 31 with a status of "30" reflecting the participant was still a patient on March 31st. The other interim claim will have the dates of April 1 – 3 with the appropriate discharge status and admit date of March 28 on the claim.

13.29 INPATIENT HOSPITAL CERTIFICATION REVIEWS

Inpatient hospital admissions *must* be certified as medically necessary and appropriate before MO HealthNet reimburses for inpatient services. All MO HealthNet enrolled hospitals in Missouri and bordering states are subject to this admission certification requirement. The state has given authority for Conduent to receive all the appropriate information necessary to review admissions subject to admission certification.

13.29.A SERVICES EXEMPT FROM ADMISSION CERTIFICATION

Some inpatient stays are exempt from Conduent review. When the stay is exempt, the maximum number of days allowed for each exempt diagnosis can be referenced on the table accessed at the MO HealthNet web page at: **http://dss.mo.gov/mhd/providers/pdf/exempt-diagnosis-table.pdf** If the inpatient stay does not exceed the number of days allowed for the exempt diagnosis, the provider is not required to obtain a precertification. However, if the stay exceeds the allowed number of days, the provider must obtain a precertification for the entire inpatient stay; otherwise, payment will be made only for the allowed number of days listed for the exempt diagnosis on the MO HealthNet web page above.

13.29.A(1) Certain Pregnancy-Related Diagnosis Codes

The exempt pregnancy-related diagnosis codes can be referenced on the MO HealthNet web page at: **http://dss.mo.gov/mhd/providers/pdf/exempt-diagnosis-table.pdf**

NOTE: Diagnoses for missed abortion, pregnancy with abortive outcome, and postpartum care continue to require certification.

13.29.A(2) Admissions for Deliveries

The exempt delivery diagnosis codes can be referenced on the MO HealthNet web page at: **http://dss.mo.gov/mhd/providers/pdf/exempt-diagnosis-table.pdf**

13.29.A(3) Admissions for Newborns

The newborn diagnosis codes can be referenced on the MO HealthNet web page at: **http://dss.mo.gov/mhd/providers/pdf/exempt-diagnosis-table.pdf.**

13.29.A(4) Admissions of Participants Enrolled in Managed Care Health Plans

The health plan is responsible for certifying the hospital admission for Managed Care enrollees. The health plan is responsible for pre-transplant and post-transplant follow-up.

13.29.A(5) Admissions Covered By Medicare Part A

Claims for deductible and coinsurance for MO HealthNet participants with Medicare Part A benefits are exempt from admission certification. However, if Medicare Part A benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements *must* be met. MO HealthNet participants with both Medicare Part C and QMB coverage are exempt from admission certification. MO HealthNet participants with Medicare Part B only require admission certification.

Claims with an exempt principal diagnosis code do *not* require a certification number in Field #63 of the UB-04. Conduent does *not* need to be contacted under these circumstances.

13.29.B CONDUENT REVIEW PERSONNEL

The Conduent review staff consist of Utilization Review Assistants (URAs), Licensed Practical Nurses and Registered Nurses. The URAs and nurses perform all initial screening reviews for admission certification, continued stay review and validation review. Psychiatric Nurse reviewers screen medical records for youth under twenty-one (21) years of age under the Certification of Need audit program.

Physician reviewers for Conduent *must* be doctors of medicine or osteopathy, licensed and actively practicing medicine in Missouri.

13.29.B(1) Quality Management Program

The Conduent Quality Management Program (QMP) includes quality assessment and improvement (QA&I) which seeks to ensure that qualified Certification/Review Personnel implement and utilize review policies and procedures in accordance with standards of practice, and that such personnel deliver timely, valid, and appropriate determinations.

13.29.C CRITERIA USED IN REVIEW

Conduent utilizes the *Milliman Care Guidelines*® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations including those for adult and child psychiatric care, alcohol and drug abuse detoxification and physical rehabilitation. It is important to remember that screening criteria are *not* standards of care. Failure to meet any particular

screen does *not* mean that the patient does *not* require acute hospital level of care but rather that the case requires review by a physician.

13.29.D CONDUENT RESPONSIBILITIES

13.29.D(1) Conduent Review Responsibilities

Certification review is performed via CyberAccess within Conduent's Inpatient Certification Management System (ICMS) which uses the review criteria *Milliman Care Guidelines®*. The review is based on pertinent medical information received from the attending physician or hospital regarding the patient's condition and planned services. For certifications meeting criteria, CONDUENT expects to certify the admission at the time of the initial request when made via CyberAccess or telephone. Certifications meeting criteria when submitted by written or fax request will be made by the end of the next working day. Cases meeting criteria are assigned a unique seven-digit admission certification number to be entered in Field #63 of the UB-04 claim form submitted to MO HealthNet for payment. Refer to billing instructions in Section 15 – Billing Instructions of this manual for further detail.

The initial length of stay assignment and unique authorization number, for cases meeting criteria, are communicated via CyberAccess and/or during the initial telephone conversation. Cases *not* meeting criteria are referred to a physician reviewer for a medical necessity determination. A decision is made within two (2) working days after receipt of all required information. Decisions to deny certification are only made by a physician reviewer. The physician reviewer is *not* bound by any criteria and makes the determination based on medical facts in the case using medical judgment. Prior to a potential denial determination, the physician reviewer contacts the attending physician who is allowed the opportunity to provide additional information. When Conduent informs a hospital that its admission request is referred to a physician reviewer, it is helpful if the hospital notifies the patient's attending physician. Alerting the attending physician that there may be a call from the Conduent physician reviewer helps facilitate discussion between the attending and reviewing physicians regarding the medical necessity of admission. Any additional information is considered by the physician reviewer prior to a decision to approve or deny admission.

The attending physician, other medical professional and hospital can obtain the status of all certification requests, including the authorization number, on CyberAccess. If inpatient admission is approved and surgery is planned, the nurse reviewer recommends that preadmission testing be accomplished on an outpatient basis to avoid unnecessary preoperative days. The date of surgery is the first date

approved for coverage unless the nurse or physician reviewer approves a preoperative day for evaluating concurrent medical conditions or other risk factors.

13.29.D(2) Daily Discharge/Expired Certification Report

Conduent will provide a daily report by facility on CyberAccess reflecting all approved certifications scheduled to expire or have already expired that do not contain a discharge date. This is called the Daily Discharge/Expired Certification Report. Each facility will access the report under the Case Management link. The facility must then add the discharge date to the report and save it. This lets Conduent know the certification is complete and can be closed.

13.29.D(3) Conduent Notifications

All admission certification decisions are available through the CyberAccess web portal. Written notification of approved certifications will not be sent. It is the provider's responsibility to obtain this information from CyberAccess. Written non-certification (denial) notices are sent to the participant, attending physician, and hospital. Certification of admission is *not* a guarantee of payment by MO HealthNet. The participant *must* be eligible on each date of service, and the provider *must* be in compliance with other program policies. Reconsideration rights are available to all parties of a denial determination and are explained in Section 13.29.F(6) – Request for Reconsideration.

Conduent review decisions related to certification or non-certification of MO HealthNet admissions are advisory in nature. The Missouri Department of Social Services is the final payment authority.

If Conduent denies a provider's request for admission certification after the patient has formally been admitted, charges for those inpatient services *cannot* be billed on an outpatient claim. Claims are monitored post-payment to ensure compliance with this policy.

13.29.D(4) Insufficient Information

Certification requests submitted via CyberAccess, fax or mail must have all information necessary for Conduent to review and complete the certification of the inpatient stay. If Conduent does not receive all necessary information, the certification request will be closed and the physician and hospital will receive a letter requesting all medically necessary information to complete the certification. This is **not** a denial of the certification. The certification request will be considered "closed" so the reconsideration and appeal rights awarded to each certification remain intact. The provider must then resubmit all information

pertaining to the inpatient stay. Conduent will review the information again to determine a benchmark length of stay and issue a certification number if the stay is approved. If the original request was submitted prior to discharge but did not contain sufficient information and a new complete request is not received by CONDUENT prior to discharge, the request will be considered retrospective and restricted to the retrospective certification guidelines explained in Section 13.29.F(4) – Retrospective (Post-Discharge).

13.29.E PROCEDURES FOR REQUESTING CONDUENT CERTIFICATION

Conduent *must* be contacted by the physician or the hospital to provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in 13 CSR 70-15.020. Providers may submit inpatient certification requests at www.cyberaccessonline.net/CyberAccess/Login.aspx. Submission via CyberAccess is the preferred method. CyberAccess is available twenty-four (24) hours a day, seven (7) days a week for admission certification prior to admission, on the day of admission, prior to discharge or within fourteen (14) days calendar days after discharge for continued stay reviews.

Other methods of submission include the following:

- Phone: (800) 766-0686
- Fax: (866) 629-0737
- Mail: CONDUENT

  P.O. Box 105110

  3425 West Truman Blvd

  Jefferson City, MO 65110

Requests for retrospective review require all medical records related to the inpatient stay. This type of request may be faxed or mailed to Conduent. The medical records must be shipped to the physical address when using Fed Ex, UPS, or any other mode of delivery outside the US Postal Service.

The Conduent office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except for established DSS approved holidays. Effective November 1, 2019 the Conduent office will be open from 7:30 a.m. to 4:30 p.m. CST, Monday through Friday, except for established DSS approved holidays. Telephone calls made before or after working hours receive a recorded message about the working hours.

The certification request can be made by hospital staff, physician, or other medical professional who is authorized by State law to order hospital services for diagnosis or

treatment of a patient. The hospital staff, physician or other medical professional making the request for inpatient certification must provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in 13 CSR 70-15.020. The physician or other medical professional is *not* required to be a MO HealthNet provider to request a certification. When a certification request is faxed or mailed, providers *must* use the Inpatient Certification Request form. This form can be found at www.dss.mo.gov/mhd/providers under the MO HealthNet Forms link.

13.29.F SUMMARY OF CERTIFICATION REQUESTS

There are six types of certification requests, each with a specific purpose and are detailed below:

13.29.F(1) Prospective (Pre-Admission)

This is a physician ordered inpatient stay that should be requested at least two (2) days prior to the participant's scheduled admission date. Requests are usually for elective surgery cases when hospitalization admission is planned. This request can be submitted online using CyberAccess, by telephone or fax. Use the Inpatient Certification Request form when submitting by fax.

13.29.F(2) Admission (Initial)

This is the initial request for an inpatient stay after the patient has already been admitted. This type of request should be submitted by the end of the first full working day after the date of admission or prior to discharge whichever comes first. This type of request is for urgent or emergency admissions while the patient is still in the hospital. The request should be submitted online using CyberAccess, by telephone or fax. Use the Inpatient Certification Request form when submitting by fax. Refer to Section 13.5.B - Definition of Emergency Services for more information.

Other potentially serious medical conditions, less severe than those meeting the definition of an emergency medical condition, may be classified as urgent. Prompt admission to the hospital is required to prevent deterioration of a medical condition from an urgent to an emergency situation.

13.29.F(3) Continued Stay Review (CSR)

This is a request for additional days required beyond what was initially certified due to unforeseen complications in the participant's condition. The hospital or attending physician must contact Conduent prior to the last approved day or within fourteen (14) calendar days after discharge, at which time a continued stay review (CSR) is conducted. Extensions are granted based upon the medical necessity of

the inpatient setting for care delivery. The approval process for CSRs is the same as mentioned in Section 13.29.D – Conduent Responsibilities. This request should be submitted online using CyberAccess, by telephone or fax. Use the Inpatient Certification Request form and any additional supporting documentation when faxing the request. Payment for the hospital stay is made according to the lesser of the actual discharge date or the cease payment date assigned by Conduent. CSRs submitted after fourteen (14) days post discharge are considered retrospective reviews.

13.29.F(4) Retrospective (Post Discharge)

This is a request for certification after the participant has been discharged from the hospital. A certification *would not* have been completed. Retrospective certification requests are only accepted when the participant has retroactive eligibility or the hospital provider has a retroactive enrollment date. All other retrospective certifications will only be accepted on a case by case basis. The Inpatient Certification Form *must* be mailed along with a copy of the patient's medical record for days of the inpatient stay requiring review.

Providers are encouraged to make their certification requests timely to reduce their liability for those cases that are denied. If a certification request is made after the date of discharge, or after fourteen (14) days post discharge for CSRs, Conduent's time for responding is different from their response time for timely requests. For retrospective reviews, Conduent *must* make the determination within 20 working days of receiving all necessary information.

13.29.F(5) Validation Review

This is a quarterly validation review which confirms the information provided at the time of the certification request is consistent with the documentation and clinical findings in the medical record. Conduent will choose a statistically valid sampling of certifications from each hospital which includes certified admissions and CSRs. Denied and exempt cases are excluded from the Conduent sample. Conduent will perform a utilization and quality of care review on those admissions chosen in the sampling. All admissions may be subject to focused validation if a potential quality of care issue was identified by the nurse reviewer. Cases are flagged in the Conduent's ICMS system for identification. Selection occurs quarterly even if the corresponding claim has not been paid.

For admissions subject to review, Conduent requests medical records. Providers have 30 calendar days from the date of request to submit documentation. Records *not* received within the 30 calendar days result in the admission being denied. Conduent reimburses for copies of the medical record for validation review cases

at a rate determined by Conduent. The mailing costs are also paid. Conduent includes an invoice with the request for records, which is to be submitted at the same time that the records are mailed to Conduent.

Admission certification is *not* a guarantee of payment. If the information provided during the certification process *cannot* be validated in the medical record by the nurse reviewer, or was false, misleading, or incomplete, the case is referred to a physician reviewer for a medical necessity determination. As in the admission certification process, the attending physician and hospital are allowed an opportunity to respond to a proposed denial prior to issuance of a final denial notice. If the physician reviewer determines the admission was *not* medically necessary, a denial notice is issued to the attending physician and the hospital. Reconsideration and appeal procedures also apply to this element of the review procedure.

A validation review determination that an inpatient stay was *not* medically necessary results in recovery of MO HealthNet payments in accordance with state regulation 13 CSR 70-3.030. Overpayment determinations may be appealed to the Administrative Hearing Commission.

13.29.F(6) Request For Reconsideration

An attending physician, hospital, or participant dissatisfied with a Conduent initial denial determination is entitled to reconsideration by Conduent. The reconsideration may be requested before or after discharge. However, the request must be made within three working days of receipt of denial letter if the participant is still inpatient, or within sixty (60) calendar days of receipt of the denial letter if the participant has already been discharged. Requests must be mailed using the Inpatient Certification Request form and all pertinent medical documentation.

The reconsideration is conducted by a Conduent physician reviewer who has had no previous involvement in the case. The physician is board certified or board eligible in the specialty that matches the care under review except in cases where meeting this requirement compromises the efficiency and effectiveness of the review. The reconsideration process consists of a review of all medical records including information that was used to make the initial determination. Conduent also considers any additional information submitted by a party to the reconsideration. Conduent reconsideration is the final level of review. Providers may *not* appeal this decision through Conduent but can appeal to the Administrative Hearing Commission.

Prior to Admission/Prior to Discharge

To request an expedited reconsideration for a patient *prior to admission* or for a patient *still in the hospital*, the provider should telephone a request to Conduent. To expedite the process, the provider *must* indicate that this is a request for reconsideration. Conduent will complete the reconsideration review and issue a determination within one working day of Conduent receipt of the request and all pertinent information. Pertinent information is defined as any information that the attending physician, hospital, or participant feels may justify or qualify the hospitalization.

Post Discharge

If the patient has been *discharged* from the hospital, the provider *must* submit a request for reconsideration in writing or by fax. This request may be initiated by telephone, but *must* be followed by a written request. The request *must* be made within sixty (60) calendar days of receipt of the written denial notice. Conduent will complete the reconsideration review within thirty (30) days after receipt of the request for reconsideration, medical records and all pertinent information submitted by parties to the denial notice. A written notice will be issued to the participant, attending physician, and hospital within three days after the reconsideration is completed.

13.29.F(7) Participant Liability

In some instances, the participant may be held financially responsible for all or part of an inpatient stay when an inpatient certification request is denied. The participant can be held responsible in the following circumstances:

- When the prospective request for certification is denied and the participant is notified of the denial but chooses to be admitted anyway;
- When an admission request for certification is denied, the participant is liable for those days of inpatient hospital service provided after the date of the denial notification to him/her if s/he chooses to remain in the hospital;
- When the participant's eligibility was not established on or by the date of admission and the request for certification is denied, the participant is liable for all days;
- When the participant has signed a written agreement with the provider indicating that MO HealthNet is not the intended payer for the specific item or service, s/he is liable for all days. The agreement must be signed prior to receiving the services. In this situation, the participant accepts the status and liabilities of a private pay patient in accordance with 13 CSR 70-4.030;

The participant can*not* be held financially responsible in the following conditions:

- When the provider fails to comply with prospective certification requirements, the participant is not liable for any days;
- When an admission request for certification of an admission is denied, the participant is not liable for those inpatient hospital services provided prior to and including the date of the notification to him/her of the denial;
- When the medical review agent performs a validation review and determines an admission was not medically necessary for inpatient services, the participant is not liable for any days.

13.29.F(8) Participant Right to a Hearing

If the participant disagrees with the reconsideration decision of Conduent, the participant has the right to a fair hearing. The participant has ninety (90) days from the date of the denial to request a hearing. The participant *must* make this request by calling the MO HealthNet Division at (800) 392-2161, (573) 751-6527; or by submitting a request in writing to the Participant Services Unit at P.O. Box 6500, Jefferson City, MO 65102.

13.30 CONTINUED LENGTH OF STAY FOR CHILDREN IN STATE CUSTODY

Neither MO HealthNet Managed Care health plans nor MO HealthNet (fee-for-service) pays for days beyond those that are medically necessary. The following information is to clarify the policy for reimbursement of continued stay days beyond those determined to be medically necessary.

Hospital stays beyond those determined to be medically necessary can occur when the hospital personnel have a concern about discharge plans for a child and continued days are no longer medically necessary. As mandated reporters, when hospital personnel have concerns about the parent/caretaker's ability to care for the child, they *must* notify the Child Abuse and Neglect Hotline at (800) 392-3738. It is the hospital's responsibility to do appropriate discharge planning prior to the occurrence of non-medically necessary days. Early notification allows the appropriate services to be in place prior to the child's discharge. Notification should be done immediately, as the child needs to be discharged as planned when services are no longer medically necessary.

Services for children who are *not* in state custody are *not* paid by the Children's Division (CD), MO HealthNet or MO HealthNet Managed Care health plans when the hospital keeps the child longer than the medically necessary length of stay days.

In those instances involving children who are in state custody, hospital discharge planners *must* coordinate the discharge in advance with CD regardless of the payment source for the medically

necessary days. It is the hospital's responsibility to notify CD staff of the medically necessary length of stay days. Information regarding the child's discharge date needs to be relayed to CD staff as soon as the medically necessary length of stay is determined. In accordance to FSD policy, it is the CD worker's responsibility to secure a placement for the child upon discharge from the hospital. Also in accordance to CD policy, CD is mandated to find the least restrictive environment to meet a child's needs. Therefore, hospitals are *not* an appropriate placement when the child's medical condition no longer warrants such.

Hospitals should only allow children in CD custody to remain in the hospital beyond the medically necessary length of stay days if they have written authorization from CD staff. This is the only way in which CD becomes financially responsible for the days beyond the medically necessary length of stay. The written authorization *must* clearly state that CD is responsible for payment beyond the medically necessary length of stay days.

In the event that CD does authorize hospital days that are *not* medically necessary, they instruct the hospital how to bill the Children's Division for authorized days beyond the medically necessary length of stay.

In the event the child is in the custody of the Department of Mental Health or Division of Youth Services, the hospital should communicate with the appropriate case manager the discharge plans for the child.

13.31 INSTITUTIONS FOR MENTAL DISEASES

Institutions for Mental Diseases (IMD) are those facilities maintained primarily for the care and treatment of patients with mental illness. According to CMS, a facility is considered an IMD if fifty percent (50%) or more of all patients in the facility have a mental disease diagnosis for which treatment is being provided. The facility must have seventeen (17) or more beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. CMS also states that alcohol or substance abuse is classified as a mental disorder under ICD Clinical Modification coding.

There are two federal programs that permit MO HealthNet reimbursement to an IMD. One program authorizes services to individuals age sixty-five (65) years or older. The other provides for services to individuals under age twenty-one (21), or if the individuals were receiving services immediately before they reached age twenty-one (21), services may continue until they reach age twenty-one (22). *Inpatient services provided in an IMD are not reimbursed for any MO HealthNet participant between the ages of twenty-one (21) and sixty-five (65).* This age limitation also applies to Medicare Part A and Part C deductible/coinsurance/copayment claims, unless the participant is a Qualified Medicare Beneficiary.

13.32 INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21 IN PSYCHIATRIC HOSPITALS

Federal regulations at Title 42 CFR 441 Subpart D and 456 Subparts D and G are very specific about the requirements for psychiatric services for participants under age twenty-one (21) in *psychiatric* facilities. Audits are performed by state and federal personnel to monitor hospital compliance with this program. MO HealthNet payments are recouped for cases that do *not* have documentation that indicates compliance.

13.32.A REQUIREMENTS FOR PSYCHIATRIC SERVICES FOR CHILDREN AND YOUTHS IN PSYCHIATRIC FACILITIES

The following requirements are specific to this program and *must* be documented. Each requirement is separately discussed.

- Medical, psychiatric and social evaluation;
- Certification of need for services;
- Plan of care;
- Active treatment.

13.32.B MEDICAL, PSYCHIATRIC AND SOCIAL EVALUATION

Before admission to a psychiatric hospital, the physician member of the team responsible for the certification of need for services *must* make a medical evaluation of a participant's need for care in the hospital. The team responsible for certification of need for services *must* make a psychiatric and social evaluation.

The medical evaluation *must* include:

1. diagnoses;
2. summary of present medical findings;
3. medical history;
4. mental and physical functional capacity;
5. prognoses; and
6. a recommendation by a physician concerning:
    a. admission to the mental hospital; or
    b. continued care in the mental hospital for individuals who apply for MO HealthNet while in the mental hospital.

13.32.B(1) Admission Status

The status of the child or youth at time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for the certification of need for inpatient care.

It is important for psychiatric hospitals serving children and youths under age twenty-one (21) to determine whether or not an admission is an emergency. The type of admission determines if the certification for need for inpatient services and the medical/psychiatric/social evaluation *must* be made by an independent team or the hospital's interdisciplinary team. Following is a definition of psychiatric emergency.

A psychiatric emergency is a condition requiring immediate psychiatric intervention as evidenced by:

1. impairment of mental capacity whereby the person is unable to act in his/her own best interest; or
2. behavior that is by intent an action dangerous to others; or
3. behavior and action that is dangerous to self.

13.32.B(2) Independent Review Team

If the admission is *not* an emergency and the individual is an eligible MO HealthNet participant at the time of admission, an independent team *must* make the certification of need on admission.

It is the hospital's responsibility to establish an independent team. The team *must* include at a minimum a physician knowledgeable in mental illnesses and one other mental health professional. Team members *must not* be affiliated with the admitting hospital. Referrals made by the child's or youth's attending physician, if *not* affiliated with the hospital, can serve as the independent team for that admission. A physician and other mental health professionals employed part time by the hospital can be members of the independent team if they maintain a private practice or work at another hospital *not* under the same ownership at least fifty percent (50%) of the time.

13.32.B(3) Interdisciplinary Review Team

If the admission is an emergency or if the individual applies or is approved for MO HealthNet while in the facility, the facility's interdisciplinary team is responsible for the certification of need for inpatient care. The interdisciplinary team is responsible for the plan of care. For emergency admissions, certification of need *must* be made within fourteen (14) days of admission. Certification of need for

individuals who become MO HealthNet eligible while in the hospital *must* be made before submitting a claim for payment and *must* cover any period for which MO HealthNet claims are made.

The required composition of the treatment facility's interdisciplinary team is given in state regulation at CSR 70-15.070. The team *must* have either:

1. a psychiatrist; or
2. a doctoral psychologist and a physician; or
3. a physician with training and experience treating mentally ill patients, and a psychologist with a master's degree.

In addition the team *must* include at least one other individual or professional who is either a psychiatric social worker, a registered nurse, an occupational therapist, or a master's level psychologist. The registered nurse and occupational therapist *must* have specialized training or experience in treating mentally ill individuals.

13.32.C CERTIFICATION OF NEED FOR SERVICES

For inpatient psychiatric services provided in a psychiatric facility, an appropriate team *must* certify that:

- ambulatory care resources in the community do *not* meet the needs of the youth;
- proper treatment of the individual's condition requires inpatient services under the direction of a physician; and
- the services can reasonably be expected to improve the patient's condition or prevent further regression, so that services are no longer needed.

A Certification of Need for Psychiatric Services (IM-71) form is used to document and certify the need for inpatient psychiatric service. The form *must* be signed and dated by two of the team members, including the physician member. Blank IM-71 forms are kept in the Family Support Division office. A copy of a completed IM-71 form should be sent to the Family Support Division office in the participant's county of residence.

13.32.D PLAN OF CARE

An individual plan of care *must* be developed and implemented within fourteen (14) days of admission and reviewed every thirty (30) days by the facility's interdisciplinary team.

The plan of care *must*:

1. be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the participant's situation and reflects the need for inpatient psychiatric care;

2. be developed by a team of professionals in consultation with the participant, the parents, legal guardians, or others to whose care the participant will be released after discharge;
3. state treatment objectives;
4. prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
5. include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the participant's family, school, and community upon discharge.

13.32.E ACTIVE TREATMENT

Inpatient psychiatric services *must* involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care. Reference 42 CFR 441.154.

NOTE:

- Certification of inpatient admission by Conduent is required for claims payment purposes for this program as with all hospital admissions except deliveries, newborns and certain pregnancy-related cases.
- The requirements of inpatient psychiatric services are in lieu of many of the utilization control requirements. However, the Department of Health and Senior Services continues to perform annual on-site inspection of care review. It is important that all MO HealthNet patients in-house at the time of the inspection are identified for review.

13.33 UTILIZATION REVIEW PLANS

Federal regulation Title 42, CFR 456, Subparts C and D, prescribes the requirements for control of utilization of inpatient hospital services for acute care hospitals and mental hospitals. These requirements include certification of need for care, plan of care, and utilization review plans.

All instate MO HealthNet inpatient providers are required to have a current utilization review (UR) plan on file with and approved by the MO HealthNet Division. The UR plans *must* be signed and dated by a representative of the hospital. A list of current hospital UR committee members and their professional status is to be included with the UR plan. Any revisions or updates made in the UR plan or UR committee members *must* be submitted to the division for inclusion in the state's files.

All utilization review plans, updates, or changes in committee members *must* be sent to:

Missouri Medicaid Audit and Compliance
ATTN: Program Integrity Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Out-of-state hospital providers *must* perform utilization review but are *not* required to submit their plans to the division.

Please refer to the UR Plan Checklist.

13.34 LIMITATION FOR INPATIENT DETOXIFICATION AND ALCOHOL AND DRUG REHABILITATION

MO HealthNet does *not* cover alcohol or drug rehabilitation as either inpatient or outpatient services under the Hospital Program. Detoxification services are covered benefits as stated in Section 13.34.B – Detoxification Services.

13.34.A REHABILITATION SERVICES

Alcohol and drug rehabilitation is *not* covered as an inpatient service. A program under the rehabilitative services option, administered jointly by the Department of Mental Health and the MO HealthNet Division, offers alcohol and drug rehabilitation services under MO HealthNet through the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program. For additional information, refer to the CSTAR Program Manual.

13.34.B DETOXIFICATION SERVICES

Detoxification services, the acute phase of alcohol or drug abuse, are covered by MO HealthNet under the Hospital Program. When Conduent is contacted to perform required admission certification for these cases, an initial length of stay is assigned. The nurse reviewer assigns a unique certification number with the length of stay based upon the number of days the attending physician or hospital requests, up to a maximum of three days. To extend the length of stay beyond the initially assigned days, either the attending physician or hospital *must* call Conduent. The nurse will review the medical information to see if criteria is met (Milliman Care Guidelines®). If criteria is met, the nurse reviewer may extend the hospital stay to a maximum of five days. If the screening criteria is *not* met or the provider requests more than five days, the case is referred to a physician reviewer for a medical necessity determination. The physician reviewer is *not* bound by the screening criteria and makes a determination based on medical facts in the case using the physician reviewer's medical judgment.

Procedures for decision notification, reconsideration process, validation review, and participant liability remain the same as for admission certification. Refer to Section 13.29 – Inpatient Hospital Certification Reviews in this manual.

13.35 COMMUNITY PSYCHIATRIC REHABILITATION PROGRAM

Participants with serious and persistent mental illnesses may be eligible to receive Community Psychiatric Rehabilitation (CPR) program services following discharge from inpatient hospital care. For additional information, refer to the CPR Program Manual.

13.36 EVALUATION OF INPATIENT HOSPITAL ADMISSIONS AND CONTINUED DAYS OF STAY

State Regulation 13 CSR 70-15.090 establishes the basis on which hospitals providing inpatient care to MO HealthNet participants are audited to determine that admissions/lengths of stay were medically necessary, that duration and setting were appropriate, and that MO HealthNet rules and policies were followed. This audit rule is for review of the continued days of stay of certified admissions and of admissions/continued days of stay for cases exempt from the admission certification procedure. MO HealthNet participating hospitals in Missouri and bordering states are subject to desk or on-site audit procedures performed by the Missouri Medicaid Audit and Compliance Division.

A notice letter of an audit is sent to the hospital administrator with the following time requirements:

- The hospital receives fifteen calendar days' notice prior to the date upon which an on-site audit is to begin; or
- The hospital has thirty calendar days from the date of notice to furnish medical records for the desk audits.

Payment for requested copies is reimbursed by the division in accordance with state statute 191.227 RSMo. Copies *must* be legible.

The Milliman Care Guidelines® are used as screening criteria for medical, adult and pediatric generic and body systems, adult and adolescent/child psychiatric care, rehabilitation care and alcohol/drug abuse treatment. If the medical record documentation regarding the patient's condition and planned services meet the applicable criteria, the services are approved as medically necessary. If the criteria are *not* met, the nurse reviewer refers the case to a physician reviewer for determination of medical necessity and appropriateness of setting. The physician reviewer uses his/her medical judgment to make a determination based on the documented medical facts in the record. Medically necessary inpatient services mean medical treatment for health reasons requiring continuous direction by a physician in an acute care setting.

If the physician reviewer denies the admission or continued days of stay, a preliminary denial notice is mailed to the attending physician and hospital. The attending physician and hospital have fifteen (15) working days from the date of notice to send in additional documentation. The physician reviewer examines the medical record and additional documentation prior to a determination to approve or deny the admission or continued days of stay. The determination made by the physician reviewer completes the final level of review. A written report of the physician reviewer's determination, as approved by the division, is issued.

A policy compliance audit can be performed to determine conformity with written and published policies and procedures of the MO HealthNet Inpatient Hospital Program.

A utilization review audit can be performed to determine compliance of the hospital's utilization review plan as it applies to the MO HealthNet Program and is defined in federal regulation Title 42 CFR 456, Subparts C and D, and Title 42 CFR 482.30.

All pertinent and adequate hospital inpatient medical record documentation and utilization review records *must* be available to the division at the time of the review and copies provided by the hospital, if requested. Adequate hospital inpatient medical records are records that are of the type and in a form required of good medical practice and contain:

1. patient identification data;
2. medical history of the patient;
3. report of a relevant physical examination;
4. diagnostic and therapeutic orders;
5. evidence of appropriate informed consent. When consent is *not* available, the reason shall be entered in the record;
6. clinical observations, including results of therapy;
7. reports of procedures, tests, and their results; and
8. conclusions at termination of hospitalization or evaluation/treatment.

Medical history means chief complaint; details of present illness, including assessment of the patient's emotional behavioral and social status; relevant past, social and family histories; and inventory by body systems where necessary for diagnosis and treatment.

The audit and decision are based upon the medical record documentation provided at the time of review for the specific date of admission. Hospitals are notified by the Missouri Medicaid Audit and Compliance Division if an adjustment of MO HealthNet payment is required as a result of audit findings. The following MO HealthNet policies apply for calculation of MO HealthNet payment:

- MO HealthNet shall reimburse at a nursing facility care rate when that level of service is provided in the inpatient hospital setting in accordance with 13 CSR 70-15.010(12);

- No MO HealthNet payment is made on behalf of any participant who has received inpatient hospital care and was *not* in need of either inpatient or nursing facility care. No payment is made for outpatient services rendered on an inpatient basis; or
- MO HealthNet does *not* pay for admissions or continued days of stay for social situations, placement problems, court commitments, or abuse/neglect without medical risk.

In accordance with the provisions of Sections 208.156 and 621.055, RSMo 1986, overpayment determinations may be appealed to the Administrative Hearing Commission.

13.37 OUTPATIENT

An outpatient hospital that is licensed by its state's licensing authority and certified under Medicare Conditions of Participation may participate in the Outpatient Hospital Program. For MO HealthNet billing purposes, an off-site entity is considered to be an outpatient hospital if it is designated by Medicare as part of the hospital and given a Medicare number assigned to the hospital.

Outpatient hospitals may be organized as clinics and/or emergency room departments. Outpatient clinics are established to provide services on a scheduled basis. Outpatient emergency rooms are established to provide services on an unscheduled basis as response treatment of an imminently life-threatening condition, traumatizing injury, or illness, or when delay in treatment may permanently impair the health of the individual. When nonemergency services are provided in the emergency room, they should be considered clinic services for billing purposes. MO HealthNet's definition of emergency services can be found in Section 13.5.B – Definition of Emergency Services.

13.37.A OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are those services provided to a person who has *not* been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services from the hospital.

Subject to the limitations given in this manual, the following types of treatment and services are covered when provided in the outpatient hospital clinic or emergency room and under the direct supervision of a medical professional. A medical professional is a physician or other person authorized by State licensure law to order hospital services for diagnosis or treatment of the patient:

- Preventive;
- Diagnostic;
- Therapeutic;
- Palliative;
- Therapies including:

—Chemotherapy

—Radiation therapy

—Physical therapy

—Routine dialysis treatment;

- Medical and surgical supplies;
- Medications that are administered on-site;
- Injections and immunizations;
- Observation.

Direct supervision of a nurse practitioner in the hospital setting means the supervising physician must be on the grounds and immediately available to provide assistance and direction though out the time the nurse practitioner is performing the service. Direct supervision of a physician assistant means the supervising physician must be in the same facility sixty-six percent (66%) of the time for practice supervision and collaboration. Physician assistants must practice within thirty (30) miles of the supervising physician. The supervising physician must be readily available in person or via telecommunication during the time the physician assistant is providing patient care.

13.37.B OUTPATIENT RADIOLOGY SERVICES

Effective for dates of service on or after October 1, 2011, all radiology procedures performed in the outpatient hospital and emergency department setting are no longer reimbursed at the hospital's prospective outpatient payment percentage rate. Reimbursement for the technical component of radiology procedures are based on the Medicare Physician Fee Schedule rate using Missouri Locality 01**.** A complete fee schedule of affected procedure codes with the new MO HealthNet allowed amount can be found at https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm? under the "Outpatient Hospital Radiology Fee Schedule" link. Policy and billing procedures regarding outpatient hospital and emergency department radiology services remain the same and were not affected by this change in reimbursement. Physician reimbursement of the professional component has not been changed.

The outpatient reimbursement regulation, 13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology, has been amended to reflect this change. A proposed amendment was published in the MO Register on August 1, 2011, and an emergency amendment was filed on September 20, 2011, which became effective October 1, 2011. For reporting purposes in the outpatient MO HealthNet data, services reimbursed on a fee schedule basis shall not be included as allowable MO HealthNet costs in cost settlement.

13.37.B(1) Precertification for High-Tech, Cardiac Imaging Services

The following high-tech and cardiac imaging procedure codes require precertification for services delivered in the outpatient setting. These services are exempt from the precertification requirement when performed in emergency situations or while the participant is in outpatient observation. Medicare covered services provided on participants with active Medicare Part B are also exempt from the precertification requirement. **Participants with Medicare Part C coverage and do not have QMB benefits are required to obtain a precertification.**

A list of procedure codes requiring precertification can be found at https://portal.healthhelp.com/mohealthnet

13.37.B(2) Initiating Precertification Requests

All requests *must* be initiated by an enrolled MO HealthNet provider and approved by MHD. Requests for precertification may be made by using the Web tool - CyberAccess or by calling the MO HealthNet Call Center at (800) 392-8030, option 5. In order to be approved, requests *must* meet the clinical edit criteria established by the MO HealthNet Division contractor, HealthHelp. Clinical guidelines for the above listed codes are available at https://portal.healthhelp.com/mohealthnet

Ordering providers are responsible for providing a copy of the precertification number to the rendering provider for billing purposes. Precertifications are reviewed and approved on an individual patient basis. Each precertification must specify the performing provider. Performing providers must be certified through the DiagnosticSite program in order to receive a referral from an ordering provider. When choosing a performing provider in the precertification web tool, make sure the NPI and address match the facility location where the procedure is to be performed.

An approved precertification request does *not* guarantee payment. The provider *must* verify participant eligibility on the date of service using the Interactive Voice Response (IVR) system at (573) 751-2896 or by logging on to the MO HealthNet Web portal at www.emomed.com.

13.37.B(3) DiagnosticSite Certification

DiagnosticSite is a standardized medical imaging safety and quality program designed to assess and credential the medical imaging equipment, personnel, and policies of facilities that perform diagnostic imaging services.

All enrolled MO HealthNet providers that perform any of the procedures listed on the HealthHelp Web portal at https://portal.healthhelp.com/mohealthnet must complete a DiagnosticSite Certification questionnaire. This questionnaire must be completed by each provider location that will be performing and billing for any of the above mentioned high-tech and cardiac imaging procedures for MO HealthNet eligible participants. The goal of the certification is to ensure the participant is treated at a high quality facility with current and well maintained equipment and the procedures are performed by licensed, qualified technicians. Providers will be approved for one or more procedures and locations in accordance with the results of their questionnaire, within their submitted scope of practice. If you have questions concerning the questionnaire and approval process, please contact HealthHelp by phone: 800-546-7065, fax: 800-546-7081 or email: SiteSupport@HealthHelp.com

Starting February 1, 2016, providers can complete their DiagnosticSite certification online at: https://portal.healthhelp.com/radsitenet/registration.aspx.

All enrolled MO HealthNet rendering facilities will be temporarily "certified" for 90 days, allowing ordering providers to choose the rendering facility to perform the imaging services. Facilities that do not receive their certification by April 30, 2016, will no longer be able to perform imaging services until they have completed the DiagnosticSite certification.

- For sites that have never been certified or were certified more than 12 months ago by another vendor, enrollment will begin at the go-live date of February 1, 2016.
- For sites that were certified less than 12 months ago through another RBM vendor, re-certification must begin by August 1, 2016.
- For sites that have already been certified through HealthHelp's DiagnosticSite process for another payer, the current certification will fulfill the MO HealthNet requirement. (Certification renewal will be the same as the existing scheduled certification renewal process for that site.)
- Providers will be responsible for reassessing their facility/equipment every two years. You will receive a 45 day notice prior to the expiration date. If your facility acquires new equipment after you are certified, you must log in and report your new equipment.
- As with the current RBM program, hospitals providing imaging services are exempt from the DiagnosticSite certification process.

13.37.B(4) Certification Approval Time Frame

All radiological precertifications are issued for a thirty (30) day period. Approved procedures *must* be performed within thirty (30) days from the date for which approval is issued. This approval time frame applies to all radiological procedures which require precertification.

13.37.B(5) Participant Appeal Rights

When a precertification request is denied, the participant receives a letter outlining the reason for the denial and the procedure for appeal. A State Fair Hearing may be requested by the participant, in writing, to:

MO HealthNet Division
Participant Services Unit (PSU)
P.O. Box 6500
Jefferson City, MO 65102-3535.

The participant may also call the Participant Services Agent at (800) 392-2161 toll free, or (573) 751-6527. The participant *must* contact PSU within ninety (90) days of the date of the denial letter to request a hearing. After ninety (90) days, requests to appeal are denied.

13.37.C CORNEAL TRANSPLANTS

Corneal transplants are covered for eligible MO HealthNet participants and do *not* require prior authorization.

13.37.C(1) Restricted to Outpatient and Ambulatory Surgical Centers (ASC)

Corneal transplants are among those procedures that may be denied for admission certification as inpatient services by the review authority Conduent. The services are restricted to an outpatient or ambulatory surgical center (ASC) place of service unless the provider is able to justify inpatient admission for performance of the procedure. Refer to Section 19 – Procedure Codes of the Hospital Manual for coding.

13.38 FACILITY CHARGE

A facility charge should be shown on the outpatient claim if the patient sees a physician or other medical professional authorized by State licensure law to order hospital services for diagnosis or treatment of the patient, for evaluation or treatment of the condition that caused the need for hospital services.

The charge for a facility procedure should include the following hospital operational cost elements:

- Administrative costs;
- Basic floor stock supplies;
- Durable, reusable items or medical equipment;
- Fixed building costs;

- Furnishings;
- Insurance;
- Laundry;
- Maintenance;
- Nursing salaries;
- Paramedical salaries;
- Records maintenance;
- Utilities.

Services performed by hospital staff that are incidental to physician services *must not* be separately billed or added to the facility charge. Included in a facility charge are such services as venipuncture, specimen collection, taking and monitoring vitals, prepping, positioning, injecting, call back, stat charges, and routine fetal monitoring. It is *not* appropriate in include non-covered and non-allowed charges in the facility charge.

Services provided by a physician assistant (PA) are payable when provided under the physician supervision guidelines as mentioned in Section 13.37.A -- Outpatient Hospital Services A facility charge may be billed when a PA provides services in the hospital setting, including those provided in an outpatient hospital-owned clinic.

The costs of diagnostic testing and treatment type equipment should be included in the charge for the specific service provided to the patient. The costs of hospital staff necessary to the performance of the specific service should be included in the charge for that service. Examples are radiology procedures, renal dialysis, and physical therapy.

Refer to Section 19 – Procedure Codes for facility, supply and medication codes and their descriptions.

13.39 OBSERVATION ROOM SERVICES

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another medical professional authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

General standing orders for observation services following outpatient surgery are **not** recognized. Hospitals should not report as observation care, services that are part of another covered outpatient

service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours). Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services. The participant must have been seen and/or received a service/procedure and had a complication arise or the participant is not recovering as quickly as expected, etc… and requires additional hospital care for observation until stabilized or formally admitted as an inpatient. Documentation in the participant's medical record must record this complication or the need for the observation services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services.

13.39.A OBSERVATION TIME

Observation time begins at the clock time documented in the participant's medical record, which coincides with the time that observation care is initiated in accordance with a physician's or other medical professional's order. Charges for observation time must be submitted using revenue code 0762 with procedure code G0378 and the actual number of hours the participant was in observation as units billed. Hospitals should round to the nearest hour.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit as appropriate). Alternatively, the end time of observation services may coincide with the time the participant is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the participant is discharged. However, reported observation time would not include the time participants remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

13.39.B OUTPATIENT HOSPITAL SERVICES EXCEEDING 24 HOURS

MO HealthNet covers up to twenty-four (24) hours of observation time. Only one observation code per stay may be billed. If the hospital has a patient in an observation room more than twenty-four (24) hours, the charges beyond that time *must* be absorbed as an expense to the hospital. Those charges *cannot* be billed to MO HealthNet or to the participant. If the stay spans past midnight, only one date of service is billed, which is the date the patient was placed in observation status. Diagnostic and procedural services, performed after the initial twenty-four (24) hour period has expired, may be billed to MO HealthNet. The date of service is the date the services were provided. Outpatient hospital

services beyond twenty-four (24) hours *must not* be billed as inpatient services. If a patient was never formally admitted into inpatient status, the services *must* be billed as outpatient services.

13.39.C FACILITY CHARGES

There are circumstances in which a facility charge may be shown on a claim in addition to the observation room charge. An example is emergency room services or operating room services provided prior to observation status. Hospital providers cannot bill a facility charge when there was a direct referral of the patient to outpatient observation.

13.40 BEHAVIORAL HEALTH SERVICES

Please refer to the Behavioral Health Services Provider Manual for guidelines and restrictions for Behavioral Health services.

13.41 CARDIAC REHABILITATION

Cardiac rehabilitation is a covered service through the outpatient department of the hospital. Revenue code 0943 covers the equipment and personnel needed to provide outpatient hospital cardiac rehabilitation services (do *not* use a CPT or HCPCS procedure code on the same pricing line as this revenue code). A facility charge code may *not* be billed by the hospital on the same date of service unless a medical professional provided services on that day. A medical professional is a physician or other person authorized by State licensure law to order hospital services for diagnosis or treatment of the patient.

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician and have one of more of the following:

(a) have a documented diagnosis of acute myocardial infarction within the preceding twelve (12) months; and/or

(b) have had coronary bypass surgery; heart valve repair/replacement, heart or heart-lung transplant and/or

(c) have stable angina pectoris

13.42 OUTPATIENT CLAIM FOR AN INPATIENT ADMISSION

If Conduent denies a provider's request for inpatient admission certification and the patient is or has been formally admitted, charges for those inpatient services *cannot* be billed on an outpatient claim. Outpatient claims are monitored post payment to ensure compliance with this policy.

13.43 PHYSICIAN, ANESTHESIOLOGIST ASSISTANT, AND CRNA SERVICES

Services provided by hospital salaried physicians, Anesthesiologist Assistants (AA), and Certified Registered Nurse Anesthetists (CRNAs), or other medical professionals able to individually enroll as MO HealthNet providers, in the inpatient or outpatient hospital setting including those provided in a clinic or emergency room *must* be billed on a CMS-1500 claim form or an electronic equivalent. This policy includes the professional components of radiology and pathology services. Physician benefits and CMS-1500 billing instructions can be found in the MO HealthNet Physician Manual.

The following information is provided for hospitals billing for hospital-salaried or contractually compensated physicians or other medical professionals. Reimbursement for professional services is based on the lesser of billed charge or an established fee schedule. Costs of these services *must not* be included on the MO HealthNet cost reporting data for hospital cost settlement purposes.

Individual departments within a hospital *must* enroll in the MO HealthNet Physician Program. Each physician or other medical professional with a valid NPI and performing services in that department *must* also enroll as a rendering/performing provider. A rendering provider's NPI *must* be shown in the Rendering (or Performing) Provider field when billing for hospital department professional charges. The hospital, using the department specific NPI and taxonomy, bills each department's services on a separate CMS-1500 claim form or electronic equivalent and shows the appropriate medical professional's NPI number as the rendering provider. When billing, if physicians from two or more different departments provide professional services for one participant, then a CMS-1500 claim forms or electronic equivalent need to be submitted for each professional service.

> **NOTE:** When a provider bills Medicare for participants who are eligible under both Medicare and MO HealthNet, the provider identifier used to bill Medicare *must* be on the fiscal agent's MO HealthNet file in order for a claim to "crossover." For example, if the Medicare claim is billed under a physician identifier but that physician is *not* enrolled with MO HealthNet, MO HealthNet does *not* have the Medicare number on file and that claim *cannot* cross over electronically from the Medicare carrier/intermediary. In that situation, the provider has to file the claim with MO HealthNet through the Web portal at www.emomed.com or through the 837 claims transmission under its department identifier to receive reimbursement for the deductible/coinsurance.

13.44 REPORTING CHILD ABUSE CASES

State statute at 210.115 RSMo (Cum Supp. 1992) requires hospitals and other specified personnel to report possible child abuse cases to the Family Support Division Child Abuse Hot Line, (800) 392-3738. It is *not* necessary to report this information on the UB-04. For questions, contact Provider Relations at (573) 751-2896.

13.45 SEXUAL ASSAULT FINDINGS EXAMINATION (SAFE) AND CHILD ABUSE RESOURCES EXAMINATION (CARE) NETWORK

State statute at 210.115 RSMo (Cum Supp, 1992) requires hospitals and other specified personnel to report possible child abuse cases to the Family Support Division Child Abuse Hot Line, (800) 392-3738.

There is a SAFE/CARE Network, a group of physicians throughout the state, which is committed to a comprehensive and competent examination of child victims of sexual abuse. The SAFE/CARE Network was developed in response to a number of concerns about sexually abused children. Physicians in the SAFE/CARE Network have participated in a Department of Health and Senior Services training session where topics such as sexual abuse examinations, court testimony and child interview techniques were discussed. Physicians interested in joining the SAFE/CARE Network should contact:

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

MO HealthNet managed care enrolled children receive SAFE/CARE services as a benefit outside of the MO HealthNet Managed Care health plan on a fee-for-service basis. Reference Section 19 – Procedure Codes for a list of acceptable procedure codes to bill SAFE/CARE examinations in the outpatient hospital or emergency room setting.

13.46 POISON CONTROL HOTLINE

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning.

13.47 LEVONORGESTREL IMPLANT (NORPLANT)

The Levonorgestrel Implant (Norplant) for birth control is a covered service. When billing for Norplant, use the correct National Drug Code (NDC). The charges may be submitted on an electronic Pharmacy or Outpatient claim, available on the MO HealthNet Web portal www.emomed.com or via an 837I claim transaction.

When completing the outpatient claim or 837I claim transaction, Family Planning *must* be shown by coding “A4” in one of the Condition Code Fields. All services on that claim form *must* be family planning services. If non-family planning services are also provided, they *must* be billed on a separate claim.

13.48 THERAPEUTIC APHERESIS (PLASMA AND/OR CELL EXCHANGE)

Apheresis is a medical procedure utilizing specialized equipment to remove selected blood components (plasma or cells) from whole blood and return the remaining components to the person from whom the blood was taken.

Plasma exchange for eligible MO HealthNet participants is allowed without prior authorization.

Therapeutic apheresis is covered for the following indications:

- Leukapheresis in the treatment of leukemia;
- Plasma exchange for acquired myasthenia gravis;
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom);
- Plasmapheresis or plasma exchange as a last resort treatment of thromobotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease;
- Plasma exchange in the treatment of Goodpasture's Syndrome;
- Plasma exchange in the treatment of blomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for patients with severe or life threatening symptoms who have failed to respond to conventional therapy;
- Treatment of life threatening scleroderma and polymyositis when the patient is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome;
- Treatment of last resort for life threatening systemic lupus erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration; and
- Treatment of hyperblobulinemias, including (but *not* limited to) multiple myelomas, cryoglobulinemia and hyperviscocity syndromes.

13.49 FACTOR VIII

Claims for Factor VIII must be billed using the correct National Drug Code (NDC). The charges may be submitted on a electronic Pharmacy or Outpatient claim, available on the MO HealthNet Web portal www.emomed.com or via an 837I claim transaction.

13.50 FACTOR IX

Claims for Factor IX, must be billed using the correct National Drug Code (NDC). The charges may be submitted on an electronic Pharmacy or Outpatient claim, available on the MO HealthNet Web portal www.emomed.com or via an 837I claim transaction.

13.51 IMPLANTABLE INTRAVENOUS INFUSION PUMP OR VENOUS ACCESS PORT

An implantable intravenous infusion pump or a venous access port is a covered service. This service is manually priced; therefore, providers *must* attach an invoice to their claim.

13.52 CONTRAST MATERIALS AND RADIOPHARMACEUTICALS

Radiopharmaceuticals administered during the performance of radiologic procedures may be billed using the appropriate HCPCS procedure code and/or the National Drug Code (NDC) representing the agent used in the procedure. If the manufacturer has entered into a rebate agreement, the radiopharmaceutical should be billed with an NDC. For more information and a list of manufacturers that have entered into an agreement with the Federal Government, see Section 13.1.B of the Pharmacy manual.

If the material or agent used does not have an NDC, the appropriate HCPCS procedure code along with the manufacturer Invoice of Cost is acceptable. All HCPCS procedure codes for contrast materials are manually priced and must be billed with the manufacturer's invoice of cost attached to the claim.

13.53 MULTI-TEST LABORATORY PANELS

CPT has established specific tests that *must* be provided when billing certain Multi-test Laboratory Panels. Tests included in these specific panels should be billed using the appropriate panel code instead of billing individually for each code. It is possible that tests in addition to those in the panel may also be necessary and those tests may be billed in addition to the panel test.

13.54 CLINICAL DIAGNOSTIC LABORATORY SERVICES

Clinical diagnostic laboratory services are paid on the basis of a fee schedule rather than a percentage of billed charge in order to comply with the Deficit Reduction Act of 1984 (DEFRA). That act established the requirement that specified laboratory services *must* be based on a fee schedule. DEFRA further stated that the MO HealthNet payment for these services *cannot* exceed Medicare's. The MO HealthNet fee schedule was developed using as a guide the Medicare carrier serving the majority of Missouri providers. In 1985, the Consolidated Budget Reconciliation Act

(COBRA) required that national limitation amounts be applied to payments for clinical diagnostic laboratory services. The MO HealthNet payment schedule was adjusted to comply with that act.

For reporting purposes in the outpatient MO HealthNet data, services reimbursed on a fee schedule basis shall *not* be included as allowable MO HealthNet costs in cost settlement.

The MO HealthNet list of clinical diagnostic laboratory codes is *not* included in this manual since it is federally mandated that it *must* be identical to Medicare's list. All procedures on the Medicare list may *not* be covered by MO HealthNet.

13.55 OUTSIDE LABORATORY REIMBURSEMENT

MO HealthNet enrolled hospitals may bill for outpatient laboratory services if the services are performed:

- in their hospital's laboratory
- by an independent laboratory enrolled as a MO HealthNet provider under an arrangement which documents that the hospital is responsible for billing the services provided by the independent laboratory.
- by an independent laboratory not enrolled as a MO HealthNet provider under an arrangement which documents that the hospital is responsible for billing the services provided by the independent laboratory.

Providers need to keep a copy of this documentation as well as the appropriate CLIA certification on file and be able to provide upon request.

Additionally, MO HealthNet enrolled independent laboratories also have the choice to bill for outpatient laboratory services. However, laboratory services that are billed by the hospital cannot be billed by the independent laboratory and vice versa. This is considered duplicate billing and claims are subject to recoupment.

Please note that facility charges cannot be billed if laboratory services are the only services provided during a visit.

13.56 SLEEP STUDIES

Polysomnographic studies **must** be performed in a facility-based sleep study laboratory, and **not** in the home**.** Unattended studies, **s**leep studies performed by a DME provider, and portable multi-channel home sleep testing devices are not covered services or products.

13.57 TAKE-HOME DRUGS AND SUPPLIES

Only drugs and items used at the hospital are covered services. Take home medications and supplies are *not* covered by MO HealthNet through the Hospital Program with the exception of one or two tablets due to pharmacy availability at night. Take home medications and supplies may be billed to the participant. The participant should be made aware that take home medications and supplies may be reimbursable by MO HealthNet if they are obtained from an enrolled pharmacy provider or durable medical equipment provider.

13.58 ULTRASOUND EXAMS (SONOGRAMS) IN PREGNANCY

Routine ultrasounds are *not* indicated in normal pregnancies. However, reimbursement is available for up to three ultrasound procedures during any one rolling calendar year when reasonable and necessary based on medical indications. Ultrasounds provided in excess of three during any one rolling year *must* submit a completed Certificate of Medical Necessity with the claim demonstrating the appropriateness of use in proper diagnosing, management and treatment of pregnancy, complicating, or potentially complicating conditions. Denied services may *not* be submitted for exception consideration; however, a medical review of a denied service may be requested. Referring physicians are encouraged to provide information regarding the patient's diagnosis for use by the billing provider.

Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedure codes.

Failure of medical records to adequately document and support the utilization of ultrasonography procedures shall subject all payments made for these inadequately documented and unsupported services to recovery at the provider's liability.

This policy of limitation applies only to program reimbursement that may be made for the service. It does *not* apply to the exercise of medical judgment by the attending physician as to need.

13.58.A ULTRASOUND INDICATION CHECKLIST

- First day of last menstrual period (LMP) *not* known within one week
- Prior still birth
- Use of fertility drugs for this pregnancy
- Menstrual cycle length varies more than two weeks
- Size-date discrepancy three weeks
- Prior small for gestational age (SGA) baby
- Diabetes Mellitus
- Chronic hypertension

- Chronic renal disease
- Suspected pelvic disease
- Suspected pelvic mass
- Suspected fetal demise
- Suspected ectopic pregnancy
- Suspected molar pregnancy
- Suspected twin pregnancy
- Suspected Intrauterine Growth Retardation (IUGR)
- Amniocentesis
- Cervical cerclage
- Vaginal bleeding undetermined etiology
- Abnormal Maternal Serum Alpha-fetoprotein (MSAFP) screen
- Fetal malpresentation
- Suspected abruptio placentae
- Suspected olio/polyhydramnios
- Suspected macrosomia
- Preeclampsia
- Preterm labor
- Premature Rupture of Membrane (PROM)
- Suspected placenta previa
- Post-date pregnancy
- Suspected fetal anomaly
- Other (requires definition)

13.59 DIABETES SELF-MANAGEMENT TRAINING

Diabetes self-management training services are used in the management and treatment of type 1, type 2 and gestational diabetes. These services are covered for participants under twenty-one (21) or adults in the categories of assistance for pregnant women, the blind or nursing facility residents when prescribed by a physician or a health care professional with prescribing authority and may be provided by a Certified Diabetes Educator (CDE), Registered Dietician (RD) or Registered Pharmacist (RPh).

Diabetes education services provided on an inpatient basis by hospital staff are included in the hospital per diem rate.

When diabetes education services are provided in an outpatient setting by hospital staff, the CDE, RD or RPh enrolls as a diabetes self-management training provider with payment designated to the hospital on the provider enrollment forms. Please refer to Section 13 – Benefits and Limitations of the Physician's manual for enrollment criteria, limitations and billing procedures.

13.60 CIRCUMCISIONS

For policy regarding circumcision procedures, reference Section 13 – Benefits and Limitations of the Physician Manual.

13.61 HOSPITAL BASED DIALYSIS CLINICS

Below are the MO HealthNet accepted revenue codes for dialysis services provided in hospital-based dialysis clinics.

REVENUE CODE DESCRIPTION

0821.....Hemodialysis

0831.....Peritoneal Dialysis

0841.....Continuous Ambulatory Peritoneal Dialysis (CAPD)

0851.....Continuous Cycling Peritoneal Dialysis (CCPD)

END OF SECTION

TOP OF SECTION

SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require prior authorization or medical necessity. Reference Section 14.5 – Certificate of Medical Necessity for specific requirements on medical necessity. Reference Section 7 - Medical Necessity, and Section 8 - Prior Authorization of the Hospital manual for sample forms and general instructions on completing the forms.

Please be aware that when a specific 5-digit procedure code requires an attachment, and that same procedure code exists with a modifier, such as 50 - bilateral, any attachment requirements applicable to the 5-digit code remain a positive requirement for the code with the modifier. Refer to the MO HealthNet fee schedule for the required attachment(s) for surgical procedures.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Sections 15 - Billing Instructions, and 16 - Medicare/Medicaid Crossover Claims, for further information. Refer to the General Sections 1-11, 17, and 20-23 for general program documentation requirements.

14.1 REQUIRED ATTACHMENTS

When submitting claims requiring attachments, be sure to:

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

Some claim attachments required for payment of certain services are separately processed from the claim form. Refer to Section 23 - Claims Attachment Submissions, for specific information.

14.1.A RESUBMISSIONS

When a paper claim requiring an attachment is resubmitted, *the provider must include a legible copy of the attachment with the resubmitted paper claim*. The fiscal agent *cannot* match the new submission to the attachment sent with the previous claim.

14.1.B HOW TO OBTAIN ATTACHMENT FORMS

All MO HealthNet forms necessary for claims processing, including attachment and claim forms, are available at www.dss.mo.gov/mhd/providers/. Choose the "MO HealthNet Forms" link on the right hand side of the page.

14.2 CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

The Certification of Medical Necessity for Abortion form is required for every abortion performed when the life of the mother would be endangered if the fetus were carried to term, as specified in Public Law 105-78 (1997), or if the pregnancy is the result of rape or incest. Refer to Section 13 – Benefits and Limitation of the Hospital manual for additional information and specific guidelines on the abortion policy.

Refer to the MO HealthNet fee schedule for a list of procedures that require attachments.

14.2.A INSTRUCTIONS FOR COMPLETING THE CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

The fields on the form are self-explanatory. The Certification of Medical Necessity for Abortion form *must* be completed in full and the signature of the performing physician *must* be original. A signature by the performing physician's authorized representative is *not* acceptable. Medical documentation to support the information on the medical necessity form *must* be attached to the form. Claims for abortion services may *not* be billed electronically.

14.3 ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

The Acknowledgement of Receipt of Hysterectomy Information form is required when a hysterectomy procedure is performed. This form is required regardless of the age of the woman. Information regarding hysterectomies is provided in Section 13 – Benefits and Limitations in the Hospital manual. Refer to the MO HealthNet fee schedule for the procedures that require attachments. It is the hospital's responsibility to obtain the necessary certification from the performing physician. The hospital is also required to send a copy of the completed form whenever one of the identified procedures is performed unless an exemption applies. The Acknowledgement of Receipt of Hysterectomy Information form is separately processed from the claim form. This attachment should be mailed separately to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 695102

Refer to Section 23 - Claim Attachment Submissions, for specific instructions.

Hysterectomies are *not* to be reported as family planning services.

The (Sterilization) Consent Form *may not* be used instead of the Acknowledgement of Receipt of Hysterectomy Information form.

The paragraph at the bottom of the form indicates that the form *must* be signed by the individual or her representative prior to the surgery, but there are no time limits. The Centers for Medicare & Medicaid Services (CMS) has given guidelines on this policy that in exceptional cases, the individual or her representative may sign the form after surgery if the patient or representative was informed of the hysterectomy procedure prior to the surgery.

Instructions for completing the Acknowledgement of Receipt of Hysterectomy Information form can be found on the back of the form.

14.3.A EXCEPTIONS

There are exception situations in which this form is *not* required; however, other physician certification is required in these situations.

Exceptions to the requirement for an Acknowledgement of Receipt of Hysterectomy Information form may be made in the following situations:

- **The individual was already sterile before the hysterectomy**. The physician who performs the hysterectomy *must* certify in writing that the individual was already sterile at the time of the hysterectomy and *must* state the cause of the sterility. This *must* be documented by an operative report or admit and discharge summary attached to the claim for payment.
- **The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is *not* possible.** The physician *must* certify in writing to this effect and include a description of the nature of the emergency.
- **The individual was retroactively found eligible for the period when surgery was performed.** If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. The physician who performed the hysterectomy *must* certify in writing that one of the following situations occurred:
    - The individual was informed before the operation that the hysterectomy will make her permanently incapable of reproducing and the procedure is *not* excluded from MO HealthNet coverage under "A";
    - The individual was already sterile before the hysterectomy; or

- The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was *not* possible. A description of the nature of the emergency *must* be included.

14.4 INVOICE FOR MANUALLY PRICED PROCEDURES

An invoice should be attached to the claim for payment of certain procedures, supplies and tests that *must* be manually priced by the State Medical Consultant. As some procedures involve up-front costs to the provider for some material/supply, it is helpful if an invoice is attached outlining pertinent information regarding the material/supply.

Refer to the MO HealthNet fee schedule for a list of procedures that require attachments.

14.5 CERTIFICATE OF MEDICAL NECESSITY

Effective July 1, 2005, the medical necessity requirement was dropped for certain procedure codes, services and situations listed below. Although the Certificate of Medical Necessity form is no longer required to be submitted with the claim, the MO HealthNet policy remains the same, unless otherwise noted. Proof of medical necessity *must* be retained in the patient's file and be available upon request by the MO HealthNet Division.

- All co-surgeon services;
- All assistant surgeon services;
- 11980 (Subcutaneous hormone pellet implant);
- 15850 (Removal of sutures under anesthesia, other than local, same surgeon);
- 15851 (Removal of sutures under anesthesia, other than local, other surgeon);
- 36475 (Endovenous RF, 1st Vein);
- 36478 (Endovenous laser, 1st Vein);
- 54150 (Circumcision, using clamp or other device, newborn);
- 54160 (Circumcision, surgical excision other than clamp, device or dorsal slit, newborn);
- 92311 EP (Prescription and fitting of contact lens, corneal lens for aphakia one eye);
- 92312 EP (Prescription and fitting of contact lens, corneal lens for aphakia, both eyes);
- 92396 EP (Supply of permanent prosthesis for aphakia, contact lenses);
- Case management services limited to one per calendar month;
- Delivery codes restricted to within six months of each other;
- Delivery/Post-Partum codes within ten months of each other;

- Diabetes Self-Management Training initial visit limited to once per lifetime;
- Diabetes Self-Management Training subsequent visits limited to no more than two per rolling year;
- Initial hospital visit limitation;
- More than one 77432 (Stereotactic radiation treatment management of cerebral lesions) per rolling year;
- More than one nursing home visit by the same provider per calendar month;
- More than three obstetric ultrasounds per rolling year;
- Services for TEMP participants;
- Two prenatal consults within ten months of a global prenatal service.

14.5.A WHEN A CERTIFICATE OF MEDICAL NECESSITY IS REQUIRED

Each circumstance that requires a Certificate of Medical Necessity form is discussed separately. Refer to the MO HealthNet fee schedule for procedures that require attachments.

Section 7 – Medical Necessity of the Hospital manual provides a full explanation of the purpose of this form, including instructions for completion and a sample form.

14.5.A(1) Private Room

A private room is covered if there is a medical justification (e.g., infection control). Proof of medical necessity explaining why a private room was necessary *must* be retained in the patient's file and be available upon request by the MO HealthNet Division.

A private room is also covered if all patient rooms in a facility are private. The provider *must* contact the Clinical Services Program Development Unit at (573) 751-6963 if all its rooms are private rooms. Proof of medical necessity is *not* required to be retained in the patient's file in this instance.

A private room is *not* covered if requested by the patient solely for the patient's convenience. When billing for a non-covered private room, the difference between the private room and semiprivate room charge *must* be shown on the claim form in the non-covered column. It is the participant's responsibility to pay the difference between the semiprivate and the private room rate.

14.5.A(2) Sonograms

Claims for obstetrical sonograms exceeding three per participant, per rolling year *must* have the medical necessity of the additional procedures attached to the claim.

14.5.B WHEN A CERTIFICATE OF MEDICAL NECESSITY FORM MAY BE USED INSTEAD OF THE REQUIRED ATTACHMENT

There are situations that normally require specific policy documentation, but because of an unusual or emergency situation, a form could *not* be completed or is inappropriate for the situation. In these instances, a Certificate of Medical Necessity form *must* be completed fully describing the circumstances. The different types of circumstances are discussed below. Only the MO HealthNet Certificate of Medical Necessity form is acceptable.

14.5.B(1) Definition of Emergency Services

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

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

14.5.B(2) Lock-In Participants

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

14.5.B(3) Procedures That Require Prior Authorization

When procedures that require prior authorization are performed on an emergency basis, a Certificate of Medical Necessity form fully explaining the emergency situation *must* be attached to the claim.

14.5.C WHEN A CERTIFICATE OF MEDICAL NECESSITY CANNOT BE USED

A Certificate of Medical Necessity form *cannot* be used for procedures that require the (Sterilization) Consent Form or Acknowledgement of Receipt of Hysterectomy Information form when performed as an emergency procedure. Other documentation is required in this situation. Refer to Sections 10 – Family Planning and 13 – Benefits and Limitations of the Hospital manual for specific information.

14.6 (STERILIZATION) CONSENT FORM

A (Sterilization) Consent Form *must* be submitted in conjunction with the hospital claim whenever a voluntary sterilization procedure is performed. The (Sterilization) Consent Form is separately processed from the claim form. This attachment can be submitted on-line through the eMOMED Web portal or mailed to

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

Refer to Section 23 - Claim Attachment Submissions, for specific information regarding this form. Refer to Section 13 – Benefits and Limitations for further information on sterilizations. Refer to Section 10 - Family Planning, for complete information concerning sterilization procedures. That section includes instructions for completing the form, exceptions to the required attachment and a completed (Sterilization) Consent Form.

14.7 ADMISSION CERTIFICATION FORMS

All inpatient hospital admissions except for admissions of participants enrolled in an MO HealthNet Managed Care health plan, enrolled in Medicare Part A, pregnancy-related cases, deliveries and newborns require admission certification. For detailed information, please refer to Section 13.29.A: Services Exempt from Admission Certification.

Online, written or telephone contact *must* be made by the hospital, the admitting or attending physician to Conduent Care and Quality Solutions, Inc. This procedure is explained in detail in Section 13 – Benefits and Limitations in the Hospital manual. If the contact is in writing, the request must be submitted using the Inpatient UR Certification Request form. This form is available at www.dss.mo.gov/mhd/providers/. Choose the "MO HealthNet Forms" link on the right hand side of the page.

14.8 CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)

Certification of need for inpatient psychiatric services is one of the requirements for the Inpatient Psychiatric Services for Individuals Under Age 21 Program. The IM-71 form was developed to assist providers in complying with this requirement. This form or a similar one developed by the hospital *must* be in the participant's medical record and a copy sent to the Family Support Division office in the participant's county of residence. This certification is required for *psychiatric hospitals* providing services to participants under twenty-one (21) years of age. This certification *is not required* for acute care hospitals providing psychiatric care to participants under twenty-one (21) years of age, even though the hospital may have a psychiatric unit exempt for Medicare Prospective Payment Systems (PPS).

The status of the child or youth at the time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for certifying need for inpatient care.

Refer to Section 13 – Benefits and Limitations of the Hospital manual for a detailed explanation of this and other requirements for psychiatric services to children and youth under age twenty-one (21) in a psychiatric hospital.

14.8.A INSTRUCTIONS FOR COMPLETION OF CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)

FIELD NUMBER	INSTRUCTIONS FOR COMPLETION
1. Name of Patient	Enter name of individual.
2. Case Number	Enter participant's MO HealthNet identification number (DCN).
3. Date of Admittance	Enter the date the individual was admitted.
4. Name of JCAH Certified Facility	Enter the name of the hospital.
5. Physician Team 6. Member 7. Date 8. Team Member/Title Date	The physician and a member of the independent or interdisciplinary team *must* each sign and date the certification. The signatures *must* be original. Include the title of the non-physician team member.
9. Claimant's name or "myself"	Enter participant's name if form is signed by a parent or guardian; enter "myself" if participant signs authorization for the release of information.
10. Authorize	Enter the name of the facility.
11. Month/Day/Year	Enter the date of expiration of this authorization, normally *not* to exceed thirty days from date of signing.
12. Claimant, Parent or 13. Guardian 14. Date Relationship	The participant, parent or guardian *must* sign and date the form. If parent or guardian signs here, state the relationship

15–20.	Witness, Date, Address	If participant is unable to sign his/her name, the signature may be made by mark. The signature, date, and address of two witnesses *must* then be entered.

The Certification of Need for Psychiatric Services (IM-71) form can be found at www.dss.mo.gov/mhd/providers/. Choose the "MO HealthNet Forms" link on the right hand side of the page.

14.9 NURSING HOME FORMS

The information on nursing home forms is important to hospitals that *must* consider nursing home placement in the discharge plans of patients.

14.9.A PRE-LONG-TERM-CARE SCREENING (PLTC)—DA-13

The Pre-Long-Term-Care screening is a program aimed at making individuals aware of the broad range of choices for services and settings that are available in the long term care system. All participants considering a nursing home placement *must* be screened by a Division of Regulation and Licensure alternative services staff person unless an exemption applies. This is discussed in Section 13 – Benefits and Limitations of the Hospital manual. If the individual still wants to enter a nursing home after community options have been explained, the Division of Regulation and Licensure worker will complete a LTACS Client Report (DA-13) form. This form should accompany the participant to the nursing home.

14.9.B NURSING FACILITY PRE-ADMISSION SCREENING/RESIDENT REVIEW FOR MENTAL ILLNESS/MENTAL DISABILITY OR RELATED CONDITION (DA-124C)

Section 13 – Benefits and Limitations of the Hospital manual discusses in detail the purpose and process of preadmission screening. Briefly, nursing homes are required to screen all applicants for Title XIX certified beds to determine if the individual is known or suspected to be mentally ill (MI), intellectually disabled (ID), or developmentally disabled (DD). If the applicant is known or suspected to be MI, ID or DD and no exemption category applies or the applicant does *not* have a diagnosis of dementia, the applicant *cannot* be admitted to the certified bed until a determination regarding appropriate placement has been completed by the Department of Mental Health.

A Level I screening *must* be performed on all applicants to a certified bed in order to identify an individual suspected of being MI, ID or DD. The DA-124C form should be used to complete the Level I screening. The form may be completed by a nursing home, hospital, or physician.

- If the applicant is *not* known or suspected of being MI, ID or DD, the applicant may be admitted to the facility. The DA-124C *must* be filed in the resident's medical records.
- If the applicant is suspected of being MI, ID or DD, forms DA-124A/B, and DA-124C *must* be completed. The DA-124A/B and DA-124C *must* be sent to:

Department of Health and Senior Services
Division of Regulation and Licensure
Section of Long Term Care Regulation/Central Office Medical Review Team
(SLCR/COMRU)
P.O. Box 570
Jefferson City, MO 65102

If an exemption has been marked on the DA-124C, the person may be admitted to the nursing home before a Level II screening is performed. If no exemption applies, the person *cannot* be admitted until a Level II screening is done.

14.9.B(1) Completion of DA-124C

This form may be completed by a nursing home, hospital social worker or physician, but it *must* be signed and updated by a physician.

The form may be typed or legibly written in ink.

Instructions appear on the back of the DA-124C.

14.9.C DA-124A/B FORM

Eligibility for MO HealthNet nursing home benefits is based on MO HealthNet categorical eligibility, determined by the Family Support Division, and medical eligibility, determined by the Division of Regulation and Licensure. These determinations of eligibility *must* be made before a MO HealthNet nursing home payment can be made on behalf of a participant. A medical consultant in the Division of Regulation and Licensure makes the determination if the applicant for nursing home services needs nursing home level of care. The consultant's determination is based on the established guidelines found in state regulation 13 CSR 15-9.030 and the information given on the DA-124 forms.

The primary responsibility for providing the information on the forms belongs to the physician who signs it. These forms should be completed as fully as possible to allow the state consultant to make a valid determination. The forms may be typed or written legibly in ink. Be certain the information is clearly imprinted on all four copies.

Most of the information requested on these forms is self-explanatory and so only a few instructions are given. If a provider has any questions concerning how to complete the forms,

the provider may contact the Medical Review Unit at the Division of Regulation and Licensure, (573) 751-3082. Forms that are *not* completed fully may be returned to the entity that submitted them. To avoid having the forms returned, providers should note the following instructions:

Section A, Field #11—Give the name of the facility where the resident will be residing.

Section A, Field #13—There *must* be a PLTC number (the "R" number).

Section B, Fields #1-4—The physical information should be indicated.

Section B, Field #6—Check this field if any of the incidents listed are applicable to the resident. Be sure to include dates and types, where appropriate.

Section B, Field #8—List the drugs ordered by the physician for the patient. The medications should be appropriate to the diagnoses shown in Field #9. Give the dosage and frequency.

Section B, Field #10 and 15—Specialized nursing services should be listed that support the assessed needs indicated in Field #16.

Section B, Field #16—Completing the assessed needs field accurately is important in the determination of level of care. Be specific. For example, under "Mobility" to state, "Unable to ambulate," is *not* specific. A statement such as, "Resident requires the assistance of two to transfer" or "Resident ambulates with assistance of one and walker," is specific. Specificity under "Dietary" is, "Resident is on an 1800 calorie ADA diet and requires assistance to be fed" or "Resident needs set-up assistance but feeds self." All nine areas of assessed needs should be answered in relation to the needs of one particular resident and the assistance required for that participant. Also indicate areas in which the resident is capable of being self-sufficient, if any.

Section B, Field #19—The person filling out this form *must* sign and date it.

Section B, Field #12 and Section F of the DA-124C—This section *must* be completed, signed and dated by a physician. A rubber stamp or signature by the Director of Nursing is *not* accepted.

Forms that are completed with insufficient information or are *not* specific enough are returned to the sender. This just delays processing the forms.

14.10 RISK APPRAISAL FOR PREGNANT WOMEN

See Section 13 – Benefits and Limitations of the Physician's Manual for information on the Risk Appraisal for Pregnant Women.

END OF SECTION

TOP OF SECTION

SECTION 15-BILLING INSTRUCTIONS

This section has detailed instructions for completing the billing claim form for inpatient and outpatient services. In an effort to make this section as instructive for billing purposes as possible, we have presented information on a number of specific services. Some of these subjects have been discussed as policy issues in other sections of this manual and are cross-referenced.

Similar to the format used in Section 13 – Benefits and Limitations, Section 15 has been arranged by subjects common to both inpatient and outpatient services and then into the subjects specific to inpatient and outpatient billing information.

INPATIENT AND OUTPATIENT BILLING INFORMATION

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12N Version 5010 and NCPDP Telecommunication Standard Version D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site, www.emomed.com. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12N Version 5010 or NCPDP Telecommunication Standard Version D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://www.dss.mo.gov/mhd/providers/index.htm for further information. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The features of the Internet application include claim submissions, claim credits, claim attachment submissions, remittance advice retrieval, claim confirmation records, claim status inquiry and

eligibility verification. 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 UB-04 (CMS-1450) CLAIM FORM

The UB-04 (CMS-1450) claim form is always used to bill MO HealthNet for inpatient and outpatient hospital services unless a provider bills those services electronically. Instructions on how to complete the UB-04 claim form are on the following pages.

15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 – Provider and Participant Services of the Hospital manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit electronically or on an UB-04 claim form. A claim that has denied appropriately for failing timely filing should *not* be resubmitted.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, a claim indicates two (2) units instead of three (3). If everything else on the claim was correct, the provider is paid the maximum amount allowed for two (2) units. That claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit a "replacement" claim via the Internet billing portal, www.emomed.com. A replacement claim will recoup the incorrect payment received and replace that claim with a corrected one through real time adjudication so proper payment can be received. Providers also have the option to submit a paper Individual Adjustment Request form to manually correct the claim when the correction cannot be made through the eMOMED Web portal. Section 6 - Adjustments of the Hospital 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 payer. If the patient has Medicare but the service is *not* covered or the

limits of coverage have been reached previously, the denial information from the Medicare Remittance Advice must be submitted with the claim. The claim can be submitted via the eMomed Web portal or a paper claim with the Medicare Remittance Advice attached indicating the denial. Reference Section 16 - Medicare/Medicaid Crossover Claims of the Hospital manual for instructions for submission of claims to MO HealthNet when services are *not* covered by Medicare.

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 sixty (60) days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), you must submit the crossover claim to MO HealthNet via the Internet billing portal at www.emomed.com. A "Help" option is available for instructions on completing the crossover claim.

15.7 MAILING ADDRESSES

Wipro Infocrossing
P.O. Box (see below)
Jefferson City, MO 65102

Inpatient and Outpatient Claims .....Box 5600

Prior Authorization Requests.....Box 5700

CMS-1500 Claims .....Box 5600

Claim Attachment Submissions *not* Submitted with Claims.....Box 5900
(Refer to Section 23.1)

The following address *must* be used if a provider is sending claims by an express delivery service:

Wipro Infocrossing
905 Weathered Rock Road
Jefferson City, MO 65101

15.8 BILLING PROCEDURES FOR SERVICES EXEMPT FROM THE COPAYMENT REQUIREMENT

15.8.A INPATIENT

For emergency inpatient admissions, the claim should show admit code "1" in Field #14, Priority (Type) of Admission or Visit.

15.8.B OUTPATIENT

To properly identify services on the outpatient claim that are exempt from copayment, the following condition codes *must* be used:

Emergency Services .....Condition Code AJ (Admission Type 1)

Exempted Therapies (physical therapy,
chemotherapy, ...Condition Code AJ
radiation therapy, and chronic renal dialysis)

Family Planning Services.....Condition Code A4

When emergency or family planning services are provided in an outpatient setting, only one date of service may be shown on the claim. Claims are denied if multiple dates are shown with a condition code AJ and admission type 1 for emergency services or condition code A4 for family planning services.

When billing MO HealthNet, indicate the usual and customary charge for the service as the billed amount in the charge column. Do *not* deduct the participant's copayment amount from the billed charge and do *not* show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the copayment amount, thus determining the correct payable amount.

15.9 BILLING FOR TEMPORARY MO HEALTHNET DURING PREGNANCY (TEMP) ELIGIBLE PARTICIPANTS

It is important to view a TEMP card or a TEMP letter each time services are rendered to pregnant women receiving services through TEMP program. Reference Section 1 -- Client Conditions of Participation of the Hospital manual for information on TEMP participants.

A pregnancy/prenatal diagnosis code is required on the claim form in one of the diagnosis fields.

15.9.A INPATIENT HOSPITAL SERVICES

Inpatient hospital services are *not* considered "ambulatory prenatal services;" therefore, inpatient hospital claims billed for participants with only TEMP eligibility are denied.

An individual who has been TEMP eligible may be determined eligible for full MO HealthNet benefits; however, the eligibility period may *not* always go back to the beginning date of TEMP eligibility. In this situation a participant may be TEMP eligible for a portion of an inpatient hospitalization stay and also eligible for regular MO HealthNet for a portion of the hospital stay. The hospital *must* only bill as covered days those dates for which the participant was eligible for regular MO HealthNet. If the hospital bills the entire stay as covered days, the claim denies. Hospital providers of inpatient hospital services should show all TEMP only days as non-covered days. Field #6, Statement Covers Period, on the UB-04 claim form, should show the first date of regular MO HealthNet eligibility during the hospital stay. This is the first "covered" day of the hospital stay. If a provider is uncertain as to the dates of the participant's regular MO HealthNet coverage, they may call Provider Communications at

(573) 751-2896 to verify this information. The admission date in Field #12, Admission/Start of Care Date, on the UB-04 claim form *must* reflect the actual date the admission occurred.

15.10 THIRD PARTY LIABILITY (TPL)

Providers *must* bill any health insurance resource a participant has before billing MO HealthNet. All third party resource benefits received by the provider for MO HealthNet covered services *must* be shown on the MO HealthNet claim in Field #54, Prior Payments. Include the insurance resource name and address in Fields #50, Payer Name, and #61, Group Name, on the UB-04 claim form.

15.10.A TPL EDIT

In the processing of claims, the TPL edit compares a claim to the participant's eligibility file for third party resources. If the eligibility file indicates there is applicable insurance coverage but there is no TPL amount shown on the claim or no attachment showing denial of payment by the insurance company, the claim denies. If an insurance carrier denies payment, the information from that denial letter *must* be submitted with the claim. If submitting a paper claim, enter in Field #80, Remarks, that insurance denied the claim and that a copy of the denial letter is attached.

If the provider believes the insurance coverage shown on the MO HealthNet Division's participant file is incorrect, the MO HealthNet Insurance Resource Report (TPL-4) should be completed to report this. An explanation of this form is given in Section 5 - Third Party Liability of the Hospital manual. The TPL-4 *must not* be submitted with claims. Send the form to the address shown on the form.

15.11 BILLING FOR INPATIENT SERVICES THAT FOLLOW OUTPATIENT SERVICES

15.11.A OUTPATIENT SURGERY

When admission is necessary following outpatient surgery, the surgery and related services *must* be billed on the outpatient claim. The surgical procedure cannot be shown on the inpatient claim. Information given to Conduent . for admission certification *must* be clear that surgery was performed prior to admission. If a second surgery is performed following admission, that surgery code is entered on the inpatient claim.

15.11.B OBSERVATION ROOM

When admission is necessary following observation, the date of admission on the inpatient claim *must* be the date the hospital formally admits the patient. Services provided in the observation room must be billed on an outpatient claim.

15.12 BILLING FOR PHYSICIAN AND CRNA SERVICES

Services of hospital-salaried or contractually compensated physicians and CRNAs may be billed by hospital providers on the CMS-1500 claim form. Refer to Section 13 - Benefits and Limitations of the Hospital manual for more information.

INPATIENT BILLING INFORMATION

15.13 ADMISSION CERTIFICATION INFORMATION

A detailed explanation of the policy on admission certification is given in Section 13 - Benefits and Limitations of the Hospital manual. The following information is provided to assist in the proper completion of the claim form. The admission certification contains critical information a provider *must* enter on the claim in order to satisfy the claims processing edits for admission certification.

Conduent will post the status of all certification requests on CyberAccess. The certification information reflected in CyberAccess confirms the information previously given by either telephone, fax or during the online submission of the certification request. It is important that the information provided be verified for accuracy. It is suggested that the billing department staff be given access to the CyberAccess Web tool so a comparison can be done with the information on the claim that is submitted to MO HealthNet. If any information reflected in CyberAccess is different from the hospital's records, Conduent *must* be contacted to correct the certification. The data entered on the UB-04 discussed below *must* match the Conduent file or payment is *not* made.

NOTE: If Conduent denies a provider's request for admission certification after the patient has formally been admitted, charges for those inpatient services *cannot* be billed on an outpatient claim. Claims are monitored post payment to ensure compliance with this policy.

15.13.A TREATMENT AUTHORIZATION CODE—FIELD #63

This field is a *required field* for all claims except those for Medicare Part A, Medicare Part C with QMB coverage, certain pregnancy-related conditions, newborns and deliveries. Refer to Section 13 - Benefits and Limitations of the Hospital manual for complete information regarding services exempt from certification. For approved admissions, Conduent gives providers a unique seven-digit certification number. Enter this number in Field #63, Treatment Authorization Codes.

15.13.B ADMISSION DATE—FIELD #12

This field is a *required field.* The admission date on the UB-04 *must* match the admission date on the Conduent file or the claim denies. If the Conduent reviewer approves an inpatient service but denies a preoperative or weekend day, the provider may still admit for preoperative or weekend but that day(s) is *not* paid by MO HealthNet. In this situation the

provider can receive payment for covered days by entering the first day Conduent approves for coverage as the "from date" in Field #6, Statement Covers Period.

Example: The provider plans to admit a patient on Tuesday for surgery on Friday. Conduent approves the surgery but says admission should be Thursday for Friday surgery. If the provider admits the patient on Tuesday, enter that date in Field #12, Admission/Start of Care Date, and enter Thursday's date in Field #6, Statement Covers Period, as the "from" day. This will "match" the Conduent file and the claim can be reimbursed. In this situation the inpatient preoperative days are *not* payable by MO HealthNet as the days were denied by Conduent.

15.13.C PRINCIPAL PROCEDURE—FIELD #74

This is *not* a required field for MO HealthNet but may be important for payment if surgery is applicable to the hospitalization. This only applies if the CPT procedure code, equivalent to the ICD Surgical Procedure being used on the claim, is in the range 10000-69999. If the information given by the provider in the request for admission certification includes a date of surgery, this information is entered in the Conduent file. Therefore, the claim is edited to have that identical date. We realize changes in scheduling do occur, especially with surgery, or when the preadmission request is two weeks ahead of the planned date. If an admission is certified with surgery anticipated but *not* performed or the date of surgery changes, then Conduent *must* be contacted with updated information.

If an admission is certified with no surgery indicated at the time of request, it is *not* required to contact Conduent if a surgery is performed during the inpatient stay.

15.14 DIAGNOSES ON THE INPATIENT CLAIM

Providers should code the first diagnosis, Field #67, Principal Diagnosis Code and Present On Admission Indicator, of the UB-04, on the basis of the primary diagnosis. This is the diagnosis that, after study, explains why the patient was admitted to the hospital. The primary diagnosis is the condition chiefly responsible for the admission even though another diagnosis may be more severe.

If a diagnosis code that is considered invalid in the current ICD code book is used in the primary diagnosis field, a claim denies. However, if an invalid diagnosis code is shown in the secondary diagnosis field, the code is changed to "zeros" in processing the claim. This can result in reducing the number of PAS days a secondary diagnosis allows for inpatient days exempt from Conduent certification.

15.14.A PRESENT ON ADMISSION (POA)

In accordance with Section 5001(c) of the Deficit Reduction Act of 2005 and state regulation 13 CSR 70-3.230, MO HealthNet requires the Present on Admission (POA) indicator for all diagnosis codes submitted on inpatient hospital claims. Some diagnosis codes are exempt

from the POA requirement and can be found in the ICD Official Guidelines for Coding and Reporting. Claims containing an invalid or missing POA indicator will be denied unless the diagnosis is exempt from the POA requirement. When appropriate, the POA indicator must be present for all diagnosis codes reflected in the "Principal" and "Other" diagnosis code fields, including "External Causes" reported on claim forms UB-04 and 837 Institutional.

Present on admission is defined as a condition present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter prior to an admission to inpatient, including emergency department, observation or outpatient surgery, are considered as present on admission. Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting for proper assignment of the POA indicator. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned.

15.14.A(1) POA Values

As taken from the General Reporting Requirements in the ICD Official Guidelines for Coding and Reporting, the following values are to be used when assigning the POA indicator:

Y = Yes – present at the time of inpatient admission.

N = No – not present at the time of inpatient admission.

U = Unknown – documentation is insufficient to determine if condition is present on admission.

W = Clinically undetermined – provider is unable to clinically determine whether condition was present on admission or not.

Blank = Unreported/Not Used – exempt from POA reporting. (See the ICD Official Guidelines for Coding and Reporting for list of exempt diagnosis codes)

15.14.A(2) Medical Documentation

As stated in the Introduction to the ICD Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. The context of the official coding guidelines, the term "provider" means a physician or any

qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

15.15 ACCOMMODATION REVENUE CODE

An accommodation revenue code is required on an inpatient claim. Refer to Section 19 - Procedure Codes of the Hospital Manual for the Inpatient Hospital Revenue Codes listing. Accommodation codes are those numbered from 0110 to 0219. Ancillary codes are those from 0250 to 0949.

An ancillary code, for example 0720, Delivery/Labor Room, can *never* be considered an accommodation code even if the provider shows a rate and number of units (days). A claim denies if no valid, covered accommodation code is shown.

The number of covered and non-covered days is shown in Field # 39-41, Value Codes and Amounts. Code 80 is entered to reflect the number of covered days and code 81 is entered to reflect any applicable non-covered days. The total number of covered and non-covered days *must* equal the number of units shown in Field #46, Service Units. The number of covered days *must* equal the number of days in Field #6, Statement Covers Period.

It is important that the revenue code used corresponds with the diagnosis code on the claim. For example, a diagnosis code of 308, Acute reaction to stress, should be billed with a revenue code of 0114, Psychiatric. A diagnosis code of 541, Appendicitis, should be billed with a revenue code of 0121, Medical/Surgical/Gyn. More than one revenue code may be used to reflect multiple accommodations.

See Section 19 - Procedure Codes of the Hospital manual for a complete list of covered revenue codes for inpatient claims. Transplant facilities *must* refer to Transplant Manual for billing transplant revenue codes.

15.16 INTERIM BILLING

It is usually *not* appropriate to submit more than one claim for one continuous hospitalization. A patient should be discharged from the hospital before a claim is submitted to the fiscal agent. A "Patient Discharge Status" code 30, which means "Still a patient," in Field #17 of the claim form, should only be used in a very limited number of circumstances, such as the following:

1. The patient becomes ineligible for MO HealthNet benefits during the stay.
2. The hospital's utilization review committee does *not* certify as medically necessary all days of the stay.
3. The allowable number of days is unusually long and in order to ease the cash flow, the provider interim bills.
4. The claim is for days prior to the date of an authorized transplant.

5. The participant has spenddown eligibility which requires the hospital to bill each calendar month of the inpatient stay individually else the claim will deny.

If a provider does bill a second (or third) claim for the same hospitalization period, the certification information in Field #63, Treatment Authorization Codes, should be the same as the first claim. The claims processing system suspends interim billed claims to determine the correct number of allowed days under PAS for certification exempt inpatient stays and Medicare/MO HealthNet Part A crossover claims. Interim billed claims representing one continuous stay that exceed the PAS allowed number of days or Conduent approved days are cut back to the allowed days. Reference Section 13 - Benefits and Limitations of the Hospital manual for more information.

15.17 PRORATING TPL (THIRD PARTY LIABILITY) ON AN INPATIENT CLAIM

Insurance benefits to which a participant is entitled *must* be utilized as the first source of payment for hospital and medical expenses. Third party liability is discussed in Section 5 - Third Party Liability of the Hospital manual. When it has been established that the number of inpatient hospital days reimbursed by a third party insurer exceeds the number of MO HealthNet allowed days, the TPL amount needs to be prorated. It is the provider's responsibility to determine when this method of billing is necessary.

Field #54, Prior Payments, should be completed as follows:

> Field #54—If the private insurance company payment includes days that are in excess of PAS or Conduent approved days (non-reimbursable days or other non-covered services), prorate the reimbursement to coincide with the number of days MO HealthNet pays per PAS or Conduent limitations.
>
> ***Example***: The total number of days of confinement on a claim is fifteen (15) days and PAS/Conduent limitation allows ten (10) days (5 days non-reimbursable by MO HealthNet). The private insurance payment amount is $10,000.00 for 15 days of confinement. The prorated insurance amount is $666.67 ($10,000.00 / 15) per day x 10 days (PAS/Conduent) = $6,666.70. The amount of $6,666.70 *must* be entered in Field #54, Prior Payments.
>
> The provider may wish to show in Field #80, Remarks, the calculation of the prorated TPL in order to substantiate the dollar amount entered in Field #54, Prior Payments.

15.18 SURGICAL PROCEDURE—FIELD #74

This is to clarify situations in which Fields #74, Principal Procedure Code and Date, and #74 A-E, Other Procedure Codes and Dates, are to be completed on the inpatient claim form.

If it is necessary to use the operating room to perform a procedure, then the principal procedure Field #74, Principal Procedure Code and Date, on the claim should be completed. If more than one procedure was performed, identify and date any others in Field #74 A-E, Other Procedure Codes and Dates, using ICD Surgical Procedure Codes.

If a procedure is performed in the patient's room, in a treatment room, or in another area of the hospital that is *not* an operating room, do *not* complete the surgical procedure code fields of the claim form.

If a procedure is entered in this field, there *must* be a revenue code shown for operating or labor/delivery room. A claims processing edit monitors for compliance.

ICD procedure code for other genitourinary instillation is restricted by MO HealthNet and requires a Certificate of Medical Necessity for Abortion. The Procedural Cross Coder: Essential Links from ICD Volume 3 Procedural Codes to CPT Codes and HCPCS Level II Codes crosswalks the ICD procedure code for other genitourinary instillation to CPT procedure codes for abortion as well as some that are *not* abortion related. If the ICD procedure code for other genitourinary instillation is most appropriate for the procedure performed and is unrelated to an elective abortion, submit medical documentation which reflects the non-abortion related procedure that was performed or fetal demise prior to the procedure being performed.

15.19 MO HEALTHNET UB-04 (CMS-1450) INPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
*1. Provider Name, Address, Telephone Number	Enter the provider name and address.
2. Unlabeled Field	Leave blank.
3a. Patient Control Number	For the provider's own information, a maximum of twenty (20) alpha/numeric characters may be entered here.
3b. Med Rec #	Not required.

*4.	Type of Bill	The required three (3) digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The allowed values for each of the digits found in the type of bill are listed below: Type of Facility: 1st digit: (1) Hospital Bill Classification: 2nd digit: (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit (1) Admit thru Discharge Claim (2) Interim Bill—First Claim (3) Interim Bill—Continuing Claim (4) Interim Bill—Last Claim
5.	Federal Tax Number	Enter the provider's federal tax number.
	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format. It *should* include the discharge date as the through date when billing for the entire stay. Unless noted below, it *should* reflect all days of the hospitalization, including any non-covered days. It *should not* include date(s) of patient ineligibility. It *should not* include inpatient days that were *not* certified by Conduent, such as preoperative days or days beyond the cease payment date.

7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the patient's eight (8) digit MO HealthNet DCN or MO HealthNet Managed Care Plan identification number. **NOTE:** The MO HealthNet DCN or MO HealthNet Managed Care Plan identification number is *required* in Field #60, Insured's Unique Identifier.
*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/Start of Care Date	Enter in MMDDYY format the date that the patient was admitted for inpatient care. This should be the actual date of admission regardless of the patient's eligibility status on that date or Conduent certification/denial of the admission date.
13.	Admission Hour	Not required.
*14.	Priority (Type) of Admission	Enter the appropriate type of admission; the

	or Visit	allowed values are: 1—Emergency 2—Urgent 3—Elective 4—Newborn 5---Trauma 9—Information not available
**15.	Point of Origin of Admission or Visit	If this is a transfer admission, complete this field. The allowed values are: 1— Non-Health Care Facility Point of Origin 2— Clinic or Physician's Office 4—Transfer from a hospital 5—Transfer from a skilled nursing facility 6—Transfer from another health care facility 8— Court/Law Enforcement 9— Information Not Available B—Transfer from Another Home Health Agency D—Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer E---Transfer from Ambulatory Surgery Center F---Transfer from a Hospice Facility NEWBORN CODES 5---Born Inside This Hospital 6---Born Outside This Hospital
16.	Discharge Hour	Not required.
*17.	Patient Discharge Status	Enter the two (2) digit patient status code that best describes the patient's discharge status Common values are: 01—Discharged to home or self-care (routine discharge) 02—Discharged/transferred to a short-term

general hospital for inpatient care

03—Discharged/transferred to skilled nursing facility with Medicare certification in anticipation of skilled care

04—Discharged/transferred to a facility that provides custodial or supportive care

05—Discharged/transferred to a designated cancer center or children's hospital

06—Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care

07—Left against medical advice, or discontinued care

20—Expired

21---Discharge/transferred to Court/Law Enforcement

30—Still a patient

43---Discharged/transferred to a federal health care facility

61---Discharged/transferred to a hospital-based Medicare approved swing bed

62---Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63—Discharged/transferred to a Medicare certified long-term care hospital (LTCH)

64—Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.

65—Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

66---Discharged/transferred to a critical access hospital

70---Discharged/transferred to another type of health care institution not defined elsewhere in this code list

*18-24.	Condition Codes	Enter the appropriate two-character condition code(s). A complete list of values can be found in the Official UB-04 Data Specifications Manual. The values applicable to MO HealthNet are: C1—Approved as billed Indicates the facility's Utilization Review authority has certified all days billed. C3—Partial Approval The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. *If C3 is entered, Field #35 must be completed.* **NOTE:** CODE C1 OR C3 IS REQUIRED. A1—EPSDT/CHAP If this hospital stay is a result of an EPSDT referral or is an EPSDT related stay, this condition code *must* be entered on the claim. A4—Family Planning If family planning services occurred during the inpatient stay, this condition code *must* be entered.
25-28.	Condition Codes	Not required.
29.	Accident State	Not required
30.	Unlabeled Field	Leave blank.
**31-34.	Occurrence Code and Date	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. A complete list of values can be found in the Official UB-04 Data

		Specifications Manual. The values applicable to MO HealthNet are: 01—Accident/Medical Coverage 02—No Fault Insurance Involved – Including Auto Accident/other 03—Accident/Tort Liability 04—Accident/Employment Related 05—Accident/No Medical or Liability Coverage 06—Crime Victim 42—Date of Discharge -- To be entered when "through" date in Field #6, Statement Covers Period is *not* equal to the discharge date and the frequency code in Field #4, Type of Bill, indicates that this is the final bill.
**35.	Occurrence Span Codes and Dates (from and through)	Required if C3 is entered in Fields #18-24, Condition Codes. Enter code "M0" and the first and last days that were approved by Utilization Review.
36.	Occurrence Span Codes and Dates	Not required.
37.	Unlabeled Field	Leave blank.
38.	Responsible Party Name and Address	Not required.
*39-41.	Value Codes and Amounts	Enter the appropriate code(s) and unit amount(s) to identify the information necessary for the processing of the claim. 80—Covered Days Enter the number of covered days shown in Field #6, Statement Covers Period, minus the

date of discharge. The discharge date is *not* a covered day and should *not* be included in the calculation of this field.

The through date of service in Field #6, Statement Covers Period **is** included in the covered days, if the patient status code in Field #17, Patient Discharge Status, is equal to "30—still a patient."

NOTE: The units entered in this field *must* be equal to the number of days in "Statement Covers Period", less day of discharge. If patient status is "still a patient," units entered include through day.

81—Non-covered Days

If applicable, enter the number of non-covered days.

NOTE: The total units entered in this field for covered and non-covered days *must* be equal to the total accommodation units listed in Field #46, Service Units.

A complete list of values can be found in the Official UB-04 Data Specifications Manual.

*42. Revenue Code

List appropriate accommodation codes first in chronological order.

Ancillary codes should be shown in numerical order.

Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to ICU to general.

A private room *must* be medically necessary and the medical need *must* be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in Field #47, Total Charges. Enter the difference between the private room total charge and the semiprivate room total charge in Field #48, Non-covered Charges, non-covered charges.

Revenue codes for non-covered day(s) must have the corresponding room rate and ancillary charges reported in Field #48, Non-covered Charges.

After all revenue codes are shown, skip a line and list revenue code 0001, which represents total charges.

43.	Revenue Description	Not required.
*44.	HCPCS/Rates/HIPPS Code	Enter the daily room and board rate to coincide with accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use a separate line to report each rate.
45.	Service Date	Not required
*46.	Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days. **NOTE:** The number of units in Fields #39-#41, Value Codes and Amounts, *must* equal the number of units in this field.
*47.	Total Charges	Enter the total charge for each revenue code

		listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 0001. **NOTE:** The room rate multiplied by the number of units *must* equal the charge entered for room accommodation(s).
**48.	Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in Fields #39-#41, Value Codes and Amounts. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was *not* medically necessary should be shown as non-covered in this field.
49.	Unlabeled Field	Leave blank.
*50.	Payer Name	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.
51.	Health Plan ID	Not required.
52.	Release of Information Certification Indicator	Not required
53.	Assignment of Benefits Certification of Indicator	Not required.
**54.	Prior Payments	Enter the amount the hospital received toward payment of this bill from all other health

		insurance companies. Payments *must* correspond with the appropriate payer entered in Field #50, Payer Name. (See Note)[1] Do *not* enter a previous MO HealthNet payment, Medicare payment or copayment amount received from the patient in this field
55.	Estimated Amount Due	Not required.
*56.	National Provider Identifier (NPI)	Enter the hospital's ten (10) digit NPI number. If applicable: Enter the corresponding 10-digit Provider Taxonomy code in Field 81CCa, Code-Code Field.
57.	Other Provider ID	Not required.
**58.	Insured's Name	Complete if the insured's name is different from the patient's name. (See Note) [1]
59.	Patient's Relationship to Insured	Not required.
*60.	Insured's Unique ID	Enter the patient's eight (8) digit MO HealthNet or MO HealthNet Managed Care Plan identification number. If insurance was indicated in Field #50, Payer Name, enter the insurance number to correspond to the order shown in Field #50, Payer Name.
**61.	Insurance Group Name	If insurance is shown in Field #50, Payer Name, 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, Payer Name, 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	For claims requiring certification, enter the unique seven (7) digit certification number supplied by Conduent.
**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 thirteen (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	Not required.
*67.	Principal Diagnosis Code	Enter the complete ICD diagnosis code for the condition established after study to be chiefly responsible for the admission. Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book. Present On Admission (POA) Indicator is reported in eighth digit (shaded area) of this field. Values are: Y = Yes – present at the time of inpatient admission.

		N = No – not present at the time of inpatient admission. U = Unknown – documentation is insufficient to determine if condition is present on admission. W = Clinically undetermined – provider is unable to clinically determine whether condition was present on admission or not. Blank = Unreported/Not Used – exempt from POA reporting. (See the ICD Official Guidelines for Coding and Reporting for list of exempt diagnosis codes)
**67. A-D	Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received or the length of stay. Present On Admission (POA) Indicator is reported in eighth digit (shaded area) of this field. Values are listed above.
67. E-Q	Other Diagnosis Codes	Not required
68.	Unlabeled Field	Leave blank
69.	Admitting Diagnosis	Not required.
70.	Patient's Reason for Visit	Not required.
71.	Prospective Payment system (PPS) Code	Not required.
72.	External Cause of Injury Code (E Code)	Not required.

73.	Unlabeled Field	Leave blank.
**74.	Principal Procedure Code and Date	Enter the full ICD procedure code of the principal surgical procedure. The date on which the procedure was performed *must* be shown. Only month and day are required.
**74. A-E	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed.
75.	Unlabeled Field	Leave blank.
*76.	Attending Provider Name and Identifiers	Enter the attending provider's ten (10) digit NPI number. Enter the attending provider's name, last name first. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCb, Code-Code Field.
**77.	Operating Provider Name and Identifiers	Enter the operating provider's ten (10) digit NPI number. Enter the operating provider's name, last name first. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCc, Code-Code Field.
**78-79.	Other Provider Name and Identifiers	Enter the other provider's ten (10) digit NPI number. Enter the other provider's name, last name first. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCd, Code-Code Field.
**80.	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare

		Part B only, etc.
**81CCa.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 56, National Provider Identifier – Billing Provider: 1st Box: B3 Qualifier 2nd Box: Provider Taxonomy code
**81CCb.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 76, Attending Provider Name and Identifiers: 1st Box: B3 Qualifier 2nd Box: Provider Taxonomy code
**81CCc.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 77, Operating Physician Name and Identifiers: 1st Box: B3 Qualifier 2nd Box: Provider Taxonomy code
**81CCd.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Fields 78-79, Other Provider (Individual) Names and Identifiers: 1st Box: B3 Qualifier 2nd Box: 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 for further TPL information.

OUTPATIENT BILLING INFORMATION

15.20 OUTPATIENT FACILITY CHARGE

A facility charge may be shown on the outpatient claim when the hospital provides services to a person who is registered on the hospital records as an outpatient. Services *must* have been provided by a medical professional. A medical professional is considered a physician, or other person who is authorized by State licensure law to order hospital services for diagnosis or treatment of the patient.

If the following services are the *only* services provided during a visit, without any medical professional services, a facility charge *must not be shown*:

- Physical, occupational or speech therapy
- Renal dialysis
- Injections/immunizations
- Laboratory/pathology
- Radiology
- HCY/EPSDT services

These services can be billed by the hospital using the appropriate HCPCS Level I (CPT), Level II or Level III procedure code.

The facility charge should include the following hospital operational cost elements:

- Administrative costs
- Basic floor stock supplies
- Durable, reusable items or medical equipment other than diagnostic, testing or treatment equipment
- Fixed building costs
- Furnishings
- Insurance
- Laundry
- Maintenance
- Nursing salaries
- Paramedical salaries

- Records maintenance
- Utilities

Services performed by hospital staff that are incidental to physician services *must not* be separately itemized and added to the facility charge. Included in a facility charge are such services as venipuncture, specimen collection, taking and monitoring vital signs, prepping, positioning, injecting, and routine monitoring (e.g., fetal, cardiac, etc.).

The costs of diagnostic testing and treatment type equipment as well as the costs of hospital staff that are necessary to the performance of a specific diagnostic or therapeutic procedure should be included in the charge for that service. Examples of this are radiology procedures, renal dialysis, and physical therapy.

When two encounters occur on the same patient, a completed Certificate of Medical Necessity detailing the need for each visit must be submitted with the claim. The Certificate of Medical Necessity can be found at www.dss.mo.gov/mhd/providers under the "MO HealthNet Forms" link.

A charge for an observation service is *not* considered a facility charge. Therefore, as an example, a provider can show a surgery facility code and an observation code for the same date of service.

15.21 OUTPATIENT FACILITY AND SUPPLY CODES

15.21.A FACILITY CODES

MO HealthNet covered facility codes are:

0450	Emergency; nonsurgical
0459	Emergency; surgical
0490	Outpatient clinical; surgical
0510	Outpatient clinical; nonsurgical

15.21.B OUTPATIENT MEDICATION AND SUPPLY CODES

Each code may be billed once per visit. Multiple charges for the same supply revenue code must be combined into one charge.

0250	"General Classification: Pharmacy" for all medications
0260	I.V. supplies
0270(1)	Medical/Surgical supplies
0274	Prosthetic/Orthopedic supplies
0390	Blood

(1)Revenue code 270 should be reported only on an outpatient claim. It is to be reported for medical or surgical supplies or both combined.

15.22 OUTPATIENT SUPPLY CHARGES

Supply charges *must not* include services performed by hospital staff. This policy includes such services as venipuncture, specimen collection, taking vitals, monitoring services, prepping, positioning, etc.

Supplies that can be billed on the claim form should be those that are consumed or disposed of after using for one patient. Basic floor stock supplies are included in the facility charge and should *not* be shown in the supply charge.

Items that are durable and reusable such as furniture, instruments, equipment, IV stands/pumps, IVAC regulators and reusable control service supplies *must not* be included in a supply charge. Their costs should be reflected in an ancillary or facility charge.

15.23 OUTPATIENT OBSERVATION SERVICES

Observation service charges may be shown separately on an outpatient claim. Listed below is the revenue code that represents the number of hours in an observation room. If the provider has a patient in an observation room more than twenty-four (24) hours, the charges beyond that time *must* be absorbed as an expense to the provider. Those charges *cannot* be billed to MO HealthNet or to the participant. If the patient stays past midnight, the date of service is the date the patient came in. Only one observation code per stay may be billed. See Section 13 - Benefits and Limitations in the Hospital manual for more detailed information regarding observation services.

Charges for diagnostic and procedural services that occur after the initial twenty-four (24) hours has expired may be billed to MO HealthNet.

15.23.A OUTPATIENT OBSERVATION CODES

Charges for observation time must be submitted using revenue code 0762 with procedure code G0378 and the actual number of hours the participant was in observation as units billed. Hospitals should round to the nearest hour.

Revenue Code	Procedure Code	Description
0762.....	G0378.....	Hospital Observation Per Hour; Maximum Units is 24.

There are circumstances in which a facility charge may be shown on a claim in addition to the observation room charge. An example of that is when emergency room services or operating room services are provided in addition to observation.

15.24 OUTPATIENT MEDICATIONS

Effective for dates of service on or after April 1, 2016, MO HealthNet Division (MHD) will require the National Drug Code (NDC) for all medications administered in the clinic or outpatient hospital setting to comply with federal law. The Deficit Reduction Act of 2005 (DRA) requires states to collect rebates for certain physician-administered drugs. As a result, state agencies must now collect the 11-digit NDC on all outpatient drug claims submitted to MHD from all providers for rebate purpose. Providers will be required to submit their claims with the exact NDC that appears on the product dispensed or administered. The NDC is found on the medication's packaging and must be submitted in the 5 digits-4 digits-2 digits format. If the NDC does not appear in the 5-4-2 digit format on the packaging, a zero(s) (0) may be entered in front of the section that does not have the required number of digits.

MHD pricing policies have not changed with regard to medications provided in the office or in the outpatient hospital setting. Please refer to Section 12, "Reimbursement Methodology" of the provider manuals available online at: http://manuals.momed.com/manuals/ for policy guidelines for each program. If a valid procedure code and/or NDC does not exist for the medication administered, revenue code 0250 "General Classification: Pharmacy" and/or the following J-Codes may be used:

J3490 - unclassified medication
J7599 - Immunosupppressive, not otherwise classified
J8499 - prescription drug, oral, non-chemotherapeutic, NOS
J8999 - oral prescription, chemotherapeutic, NOS

When billing with the 0250 revenue code, it must be listed with a quantity of one (1) and reflect the total charge of the medication(s) provided. It is not appropriate to include the charge of non-covered medication(s) under the revenue code 0250 and is considered fraudulent billing and is subject to post payment recoupment and possible sanctions against the provider.

15.24.A CLAIMS SUBMISSION

Drug charges submitted by providers on an electronic Professional or Institutional ASC X12 837 Health Care claim transaction or manually entered on a medical or outpatient claim into MHD's billing Web site eMOMED (www.emomed.com), are to be billed with a valid J-Code and a valid NDC for each medication, including injections, provided to the participant. Medical or outpatient claim lines submitted with a J-Code, without the corresponding NDC will be denied. For medical or outpatient claims correctly submitted with the appropriate J-Code and the corresponding NDC, the system will automatically generate a separate drug claim for the NDC to process as a Pharmacy claim and will appear as a separate claim on your Remittance Advice. The corresponding line with J-Code and NDC will be dropped from the medical or outpatient claim. If an NDC is not provided, the J-Code will remain on the claim to report the denied line. If the drug being provided does not have a J-Code associated with it, the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code

should be submitted with an NDC. For drugs without a valid HCPCS procedure code, revenue code 0250 "General Classification: Pharmacy" must be used with the appropriate NDC.

Only drugs and items used during the outpatient care in the hospital are covered. Take-home medications and supplies are not covered by MHD under the Hospital Program.

Note: Paper Pharmacy claims are not accepted by MHD. Any paper Pharmacy claims received will not be processed.

15.24.B PROCEDURE CODE/NDC VALIDATION

A critical component to submitting claims with an NDC is to ensure that the appropriate HCPCS procedure code is billed with each NDC. To ensure accurate billing of drug charges, MHD will use the Noridian Crosswalk (www.dmepdac.com) to determine whether the appropriate HCPCS procedure code is billed for the submitted NDC.

15.24.C 340B HEALTHCARE SETTINGS

All 340B health care facilities will be exempt from the NDC reporting requirement. Claims from 340B health care facilities for Outpatient Hospital covered drugs must be submitted with a valid J-Code and/or an NDC for MHD to be able to identify the drug being dispensed.

15.24.D CLINICAL AND PREFERRED DRUG LIST EDITS

All drug claims are routed through an automated computer system to apply edits specifically designed to ensure effective drug utilization. The Preferred Drug List (PDL) and clinical edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. The edits are based on evidence-based clinical criteria and nationally recognized peer-reviewed information. This clinical information is paired with fiscal evaluation, and then developed into a therapeutic class PDL recommendation. The PDL process incorporates clinical edits, including step therapies, into the MHD pharmacy program. Claims for drugs will automatically and transparently be approved for those patients who meet any of the system approval criteria. For those patients who do not meet the system approval criteria, the drugs will require a call to the MHD Drug Prior Authorization hotline at (800) 392-8030 to initiate a review and potentially authorize payment of claims.

Providers may also use the CyberAccess tool to determine if a drug is a preferred agent or requires edit override; electronically initiate an edit override review; and to review a participant's MHD paid claim history. To become a CyberAccess user, contact the CyberAccess help desk at (888) 581-9797 or (573) 632-9797, or send an e-mail to CyberaccessHelpdesk@Conduent.com. More information regarding the clinical edits, the

PDL and other pharmacy related programs can be found at: http://dss.mo.gov/mhd/cs/pharmacy/.

15.24.E QUANTITY DISPENSED

The quantity to be billed for injectables and other types of medications dispensed to MHD participants must be calculated as follows:

- Containers of medication in solution (for example, ampoules, bags, bottles,
- Vials, syringes) must be billed by exact cubic centimeters or milliliters (cc or ml) dispensed, even if the quantity includes a decimal (e.g., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill is 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Ointments must be billed per number of grams even if the quantity includes a decimal.
- Eye drops must be billed per number of cubic centimeters or milliliters (cc or ml) in each bottle even if the quantity includes a decimal.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit. Quantity will be the number of kits used.
- The product Herceptin, by Genentech, must be billed by milligram rather than by vial due to the stability of the drug.
- Non-VFC Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

15.24.F TAKE-HOME DRUGS AND SUPPLIES

Only drugs and items used at the hospital are covered services. Take-home medications and supplies are *not* covered by MO HealthNet in the Hospital Program. These items may be billed to the participant. The participant should be made aware by the provider that take-home medications may be reimbursable by MO HealthNet when a prescription is filled by an enrolled pharmacy provider.

In situations where a patient is seen during the night and a pharmacy will *not* be open until morning to dispense a prescription, it is permissible to send one or two day supply of an oral medication with the patient. The billing of this is subject to close scrutiny by Missouri Medicaid Auditing and Compliance (MMAC).

15.24.G CONTRAST MATERIALS & RADIOPHARMACEUTICALS

Effective January 1, 2012, all contrast materials and radiopharmaceuticals used in radiologic procedures may be billed separately using the appropriate HCPCS procedure code **and/or** the National Drug Code (NDC) representing the materials or agent used in the procedure. If available, MO HealthNet would prefer the NDC for reporting purposes. If the material or agent used does not have an NDC, the appropriate HCPCS procedure code alone is acceptable. All HCPCS procedure codes for contrast materials and radiopharmaceuticals are manually priced and must be billed with the manufacturer's invoice of cost attached to the claim.

15.25 MO HEALTHNET UB-04 (CMS-1450) OUTPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
*1. Billing Provider Name, Address and Telephone Number	Enter the provider name and address exactly as it appears on the provider label. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do *not* cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
2. Unlabeled Field	Leave blank.
3a. Patient Control Number	For the provider's own information, a maximum of twenty (20) alpha/numeric characters may be entered here.
3b. Med Rec #	Not required.
*4. Type of Bill	The required three (3) digits in this code

		identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The valid type of bill is "131."
5.	Federal Tax Number	Enter the provider's federal tax number or leave blank.
**6.	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format or leave blank.
7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the patient's eight (8) digit MO HealthNet DCN or MO HealthNet Managed Care Plan identification number. **NOTE:** The MO HealthNet DCN or MO HealthNet Managed Care Plan identification number is *required* in Field #60, Insured's Unique Identifier.
*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	Not required.
13.	Admission Hour	Not required.
**14.	Admission Type	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type '1.' Condition code AJ also *must* be listed in Field #18, Condition Codes, to exempt the patient from the $3.00 copayment amount for the service.
15.	Source of Admission (SRC)	Not required.
16.	Discharge Hour	Not required.
17.	Patient Discharge Status	Not required.
**18-24.	Condition Codes	Enter the applicable two-character condition code. A complete list of values can be found in the Official UB-04 Data Specifications Manual. The values are: A1—HCY/EPSDT If this service is the result of an HCY referral or is an HCY related visit, enter this condition code. A4—Family Planning. If the family planning service occurred during the visit, enter this condition code. Do *not* bill family planning services on the same claim as non-family planning services.

		AJ—Payer Not Responsible for Co-Payment If visit is the result of an emergency or therapy services are provided, then condition code *must* be entered to exempt the patient from the $3.00 copayment amount.
25-28.	Condition Codes	Not required.
29.	Accident State	Not required.
30.	Unlabeled Field	Leave blank.
**31-34.	Occurrence Code and Dates	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. A complete list of values can be found in the Official UB-04 Data Specifications Manual. The values applicable to MO HealthNet are: 01—Accident/Medical Coverage 02—No Fault Insurance Involved – Including Auto Accident/Other 03—Accident/Tort Liability 04—Accident/Employment Related 05—Accident/No Medical or Liability Coverage 06—Crime Victim
35-36.	Occurrence Span Codes and Dates	Not required
37.	Unlabeled Field	Leave blank.

38.	Responsible Party Name and Address	Not required
39-41.	Value Code and Amounts	Not required
*42.	Revenue Code	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s).
43.	Revenue Description	Not required
*44.	HCPCS/Rates/HIPPS Code	Enter the CPT or HCPCS procedure code(s) and any applicable modifier. Only enter the procedure code if for services *other* than outpatient facility charges listed in Field #42, Revenue Code.
*45.	Service Date	Enter the date of service on each line billed in MMDDYY format.
*46.	Service Units	Enter the number of units for each procedure or revenue code. **NOTE**: If no entry is made, the system auto plugs a unit of "1". Facility codes 0450, 0459, 0490, 0510 and 0943; supply codes 0260, 0270 and 0274 should always be billed with a unit of "1." The outpatient observation code 0762 should be billed with the appropriate number of hours the participant was in observation status.

*47.	Total Charges	Enter the total charge for each line item. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001. **NOTE:** When two encounters occur on the same patient, a completed Certificate of Medical Necessity detailing the need for each visit must be submitted with the claim.
48.	Non-covered Charges	Not required.
49.	Unlabeled Field	Leave blank.
*50.	Payer Name	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.
51.	Health Plan ID	Not required.
52.	Release of Information Certification Indicator	Not required.
53.	Assignment of Benefits Certification of Indicator	Not required.
**54.	Prior Payments	Indicate the amount the provider received toward payment of this bill from all other health insurance companies. Payments *must* correspond with the appropriate payer entered in Field #50, Payer Name. (See Note)(1) Do *not* enter a previous MO HealthNet payment, Medicare payment or copayment amount received from the patient in this

		field.
55.	Estimated Amount Due	Not required.
*56.	National Provider Identifier (NPI)	Enter the hospital's ten (10) digit NPI number. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCa, Code-Code Field.
57.	Other Provider ID	Leave blank.
**58.	Insured's Name	Complete if the insured's name is different from the patient's name. (See Note)(1)
59.	Patient's Relationship to Insured	Not required.
*60.	Insured's Unique ID	Enter the patient's eight (8) digit MO HealthNet or MO HealthNet Managed Care Plan identification number. If insurance was indicated in Field #50, Payer Name, enter the insurance number to correspond to the order shown in Field #50, Payer Name.
**61.	Insurance Group Name	If insurance is shown in Field #50, Payer Name, 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	Not required.
**64.	Document Control Number	If the current claim exceeds the timely filing limit of one (1) year from the "through" date, but was originally submitted timely and denied, the provider may enter the thirteen (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	Not required.
*67.	Principal Diagnosis Code	Enter the complete ICD diagnosis code for the condition the service was provided. Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book.
**67. A-D	Other Diagnosis Codes	Enter any additional diagnoses that have an effect on the treatment received.
67. E-Q	Other Diagnoses Codes	Not required
68.	Unlabeled Field	Leave blank
69.	Admitting Diagnosis	Not required

70.	Patient's Reason for Visit	Not required
71.	Prospective Payment system (PPS) Code	Not required
72.	External Cause of Injury Code (E-Code)	Not required
73.	Unlabeled Field	Leave blank.
**74.	Principal Procedure Code and Date	Enter the full ICD surgical procedure code. The date on which the procedure was performed *must* be stated. Only month and day are required.
**74. A-E	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed.
75.	Unlabeled Field	Leave blank.
**76.	Attending Provider Name and Identifiers	Enter the attending provider's ten (10) digit NPI number. Enter the attending provider's name, last name first. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCb, Code-Code Field.
77.	Operating Provider Name and Identifiers	Enter the operating provider's ten (10) digit NPI number. Enter the operating provider's name, last name first. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCc, Code-Code Field.

**78. - 79.	Other Provider Name and Identifiers	Enter the other provider's ten (10) digit NPI number. Enter the other provider's name, last name first. Administrative Lock-in: If the participant's services are restricted due to administrative lock-in, enter the lock-in provider's number in this field and attach the Medical Referral Form of Restricted Participant (PI-118). Emergency services are only considered for payment if the claim is supported by an attached Certificate of Medical Necessity and medical records documenting the emergency circumstances. If applicable: Enter the corresponding ten (10) digit Provider Taxonomy code in Field 81CCd, Code-Code Field.
80.	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
**81CCa.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 56, National Provider Identifier – Billing Provider. 1st Box: B3 qualifier 2nd Box: Provider Taxonomy code.
**81CCb.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 76, Attending Provider

		Name and Identifiers. 1st Box: B3 qualifier 2nd Box: Provider Taxonomy code.
**81CCc.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Field # 77, Operating Provider Name and Identifiers. 1st Box: B3 qualifier 2nd Box: Provider Taxonomy code.
**81CCd.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding ten (10) digit Provider Taxonomy code for the NPI number reported in Fields 78-79, Other Provider Name and Identifiers. 1st Box: B3 qualifier 2nd Box: Provider Taxonomy code.

* These fields are mandatory on *all* Outpatient 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 for further TPL information.

END OF SECTION

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SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS

16.1 GENERAL INFORMATION

This section includes general information about the Medicare and MO HealthNet Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and MO HealthNet are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

  Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.
- MO HealthNet is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. MO HealthNet is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Mo HealthNet benefits by completing an application form at a Family Support Division (FSD) office.

  In Missouri, MO HealthNet claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the MO HealthNet Division within the Department of Social Services, which is the single state agency for the administration of the MO HealthNet Program.
- For participants having both Medicare and MO HealthNet eligibility, the MO HealthNet Program pays the cost-sharing amounts indicated by Medicare due on the Medicare allowed amount. These payments are referred to as “Crossovers."
- “Cost-sharing” amounts include the participant’s co-insurance, deductible, and any co-pays that are due for any Medicare-covered service.

16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS)

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first. After making payment, the Medicare contractor forwards the claim information to MO HealthNet for payment of cost-sharing amounts. (Reference Section 16.3 for instructions to bill MO HealthNet when Medicare denies a service.)

The MO HealthNet payment of the cost-sharing appears on the provider's MO HealthNet Remittance Advice (RA).

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The Medicare contractor does *not* send crossovers to MO HealthNet
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for MO HealthNet.
- The MO HealthNet participant information on the crossover claim does *not* match the fiscal agent's participant file.
- The provider's National Provider Identifier (NPI) number is *not* on file in the MO HealthNet Division's provider files.

MO HealthNet no longer accepts paper crossover claims. Medicare/MO HealthNet (crossover) claims that do not cross automatically from Medicare to MO HealthNet must be filed through the MO HealthNet billing web portal at www.emomed.com 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.

8) The codes to enter in the "Reason Code" field on the "Other Payer" header and detail screens are found on the Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" that can be accessed at http://www.wpc-edi.com/codes/Codes.asp. For example, enter "Reason Code" of "1" for deductible amounts, "2" for coinsurance amounts and "3" for co-payment amounts.

16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS

For non-QMB MO HealthNet participants enrolled with a Medicare Advantage/Part C Plan, MO HealthNet will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet provider manual at http://manuals/momed.com. In accordance with this policy, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e., CMS-1500, UB-04). ***Do not use a crossover claim***.

16.5 TIMELY FILING

Claims that have been initially filed with Medicare within the Medicare timely filing requirements, and which are submitted as a crossover through an 837 electronic claim transaction or through the MO HealthNet Web portal at www.emomed.com meet the timely filing requirement by being submitted by the provider and received by the MO HealthNet Division within six months of the date of the allowed Medicare RA/EOMB or one (1) year from the date of service. Refer to Section 4 for further instructions on timely filing.

16.6 REIMBURSEMENT

The MO HealthNet Division reimburses the cost-sharing amount as determined by the Medicare contractor and reflected on the Medicare RA/EOMB. MHD prorates the reimbursement amount allowing a prorated amount for each date the individual was MO HealthNet eligible. Days on which the participant was not MO HealthNet eligible are not reimbursed.

16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A and deductible, coinsurance and copayment amounts for Medicare Advantage/Part C crossover claims only when the MO HealthNet applicable payment schedule exceeds the amount paid by Medicare plus calculated pass-through costs. In those situations where MO HealthNet has an obligation to pay a crossover claim, the amount of MO HealthNet's

payment is limited to the lower of the actual crossover amount or the amount the MO HealthNet fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participant to be considered a Medicare/Medicaid crossover claim. For further information, please see 12.4 of the Hospital Program Manual.

16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS

MO HealthNet reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services is seventy-five percent (75%) of the allowable cost sharing amount. The cost sharing amount includes the coinsurance, deductible and/or copayment amounts reflected on the Medicare RA/EOMB from the Medicare carrier or fiscal intermediary. The crossover claims for Medicare Advantage/Part C outpatient hospital services must have been provided to QMB or QMB Plus participant to be reimbursed at seventy-five percent (75%) of the allowable cost sharing amount. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

END OF SECTION

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SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com 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.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider's address.
PARTICIPANT NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are *not* on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant's current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11— Paper Drug 13— Inpatient 14— Dental 15— Paper Medical 16— Outpatient 17— Part A Crossover 18— Paper Medicare/MO HealthNet Part B Crossover Claim 21— Nursing Home 40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries. 41— Direct Electronic MO HealthNet Information (DEMI) 43— MTB/DEMI 44— Direct Electronic File Transfer (DEFT) 45— Accelerated Submission and Processing (ASAP) 46— Adjudicated Point of Service (POS) 47— Captured Point of Service (POS)

	49— Internet 50— Individual Adjustment Request 55— Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from “001” (January 1) to “365” (December 31) (“366” in a leap year). The last digits of an ICN are for internal processing. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider’s own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is *not* present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions PR—Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is *not* printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.
CHECK AMOUNT	The total check amount for the provider.

EARNINGS REPORT	
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
EARNINGS DATA	
NO. OF CLAIMS PROCESSED	The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED	The total dollar amount processed for the provider.
CHECK AMOUNT	The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

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

Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has *not* met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.

17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. 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.

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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 and may affect claims payment.

The diagnosis code *must* be entered on the claim form exactly as it appears in the most current version of the ICD Clinical Modifications code book. Note that the appropriate code(s) *must* be coded to the highest level of specificity and used as applicable to the patient's diagnosis(es). Claims may be denied if the diagnosis(es) is not coded to the highest level of specificity. The ICD Tabular List should be used as a guide in the selection of specificity of the appropriate diagnosis code. Diagnosis codes are *not* included in this section.

Additional information regarding the ICD coding may be found at www.cdc.gov/nchs/icd.htm.

END OF SECTION

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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.

19.1 CPT CODES

Except for those circumstances wherein specific reference is made to certain CPT procedure codes throughout the manual, lists of CPT procedure codes are *not* being reproduced in this section.

The professional services of physicians, anesthesiologists, CRNAs, etc., are *not* to be billed on the UB-04 (CMS 1450) claim form, but instead are to be billed by the physician or other medical professional on the CMS-1500 claim form.

Reference materials regarding the HealthCare 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 74008935
Chicago, IL 60674-8935
Telephone Number: (800) 621-8335
AMA Members (800) 262-3211
Fax Orders: (312) 464-5600
https://commerce.ama-assn.org/store/

19.2 OUTPATIENT REVENUE AND PROCEDURE CODES

Following is a list of revenue and procedure codes used in the Outpatient Hospital Program. Revenue code 0270 *must* appear only once on outpatient hospital claims submitted, combining surgical AND medical supplies on the same pricing line.

19.2.A FACILITY AND SUPPLY REVENUE CODES

FACILITY REVENUE CODE DESCRIPTION

0510.....Outpatient clinical; nonsurgical

0490.....Outpatient clinical; surgical

0450.....Emergency; nonsurgical

0459.....Emergency; surgical

SUPPLY REVENUE CODE DESCRIPTION

0270.....Medical/Surgical supplies

0260.....IV supplies

0274.....Orthopedic supplies

0250....."General Classification: Pharmacy"

0390……...Blood, excluding storage

19.2.B SURGICAL PROCEDURES ON A FEE SCHEDULE

Effective for dates of service on or after January 1, 2019, providers must follow the instructions below when billing for the surgical procedure codes listed on the Outpatient Hospital Surgical Procedure Fee Schedule at the following link: https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf. Reimbursement for facility and supplies are included in the global payment for surgeries listed on this fee schedule.

- Bill the charge amount on the same line as the surgical procedure when billing one of the surgical procedure codes listed on the Outpatient Hospital Surgical Procedure Fee Schedule.
- Bill one of the surgical revenue codes listed below when billing one of the surgical procedure codes listed on the Outpatient Hospital Surgical Procedure Fee Schedule.

  360, 361, 362, 367, 369, 370, 371, 372, 374, 379, 490, 499, 720, 721, 722, 723, 724, 729, 750, 759

- Include National Correct Coding Initiative (NCCI) modifiers when billing one of the surgical procedure codes listed on the Outpatient Hospital Surgical Procedure Fee Schedule.

Outpatient hospital providers should continue to bill zero ($0.00) on the surgical procedure line of their outpatient claims for any surgical procedures that do **not** appear on the Outpatient Hospital Surgical Procedure Fee Schedule. The facility and supply charges for surgical procedures that are **not** on the Outpatient Hospital Surgical Procedure Fee Schedule should continue to be billed on the appropriate revenue code line.

If there are multiple surgeries, and if any of those surgical procedures appear on the Outpatient Hospital Surgical Procedure Fee Schedule, reimbursement will be at the global rate listed on the fee schedule for the surgical procedure code.

Providers should submit only one outpatient claim per date of service. All items and services including the facility fee, supplies, lab, radiology and surgical procedure code should be billed on one claim. Radiology, laboratory and drug/pharmacy items are reimbursed separately based upon their respective fee schedules posted on our website at https://dss.mo.gov/mhd/providers/pages/cptagree.htm

19.2.C SEXUAL ASSAULT FINDINGS EXAMINATION AND CHILD ABUSE RESOURCE EDUCATION EXAMINATIONS

The laboratory studies for sexual or physical abuse, when requested or ordered by a MO HealthNet enrolled SAFE trained provider, for all MO HealthNet children (MO HealthNet Managed Care enrolled and fee-for-service MO HealthNet) *must* be billed using the following procedure code(s).

PROCEDURE CODE	DESCRIPTION
57452U7	Colposcopy
81025U7	Urine pregnancy test
86317U7	Chlamydia
86631U7	Chlamydia
86632U7	Chlamydia, IgM
87110U7	Chlamydia, culture
86592U7	RPR
87076U7	Culture, bacterial, any source definitive identification, each anaerobic organism
87077U7	Culture, bacterial; aerobic isolate, additional methods required for definitive identification
87210U7	Wet mount
86687U7	HIV
86688U7	HIV

86689U7..... HIV, Western Blot

87390U7..... HIV-1

87391U7..... HIV-2

87534U7..... HIV-1, direct probe technique

87535U7..... HIV-1, amplified probe technique

87536U7..... HIV-1, quantification

87537U7..... HIV-2, direct probe technique

87538U7..... HIV-2, amplified probe technique

87539U7..... HIV-2, quantification

19.2.D OBSERVATION CODES

REVENUE CODE	PROCEDURE CODE	QUANTITY	DESCRIPTION
0762……..	G0378……...	1-24 ....……..	Observation room

19.2.E HCY/EPSDT PROCEDURE CODES

19.2.D(1) Occupational and Speech Therapy Evaluation and Treatment Codes

See Section 19 – Procedure Codes of the Rehabilitation Center manual for procedure codes.

19.2.D(2) Screening Procedure Codes

See Section 9 – Healthy Children and Youth Program of the Hospital manual for procedure codes.

19.2.F IFSP/IEP THERAPY PROCEDURE CODES

Refer to Section 13 – Benefits and Limitations of the Rehabilitation Center Manual for details.

19.2.G LEVONORGESTREL IMPLANT (NORPLANT)

Use the correct NDC for Norplant.

19.2.H FACTOR VIII

Use the correct NDC for Factor VIII.

19.2.I FACTOR IX

Use the correct NDC for Factor IX.

19.2.J IMPLANTABLE INTRAVENOUS INFUSION PUMP OR VENOUS ACCESS PORT

PROCEDURE
CODE DESCRIPTION

A4300.....Implantable Intravenous Infusion Pump or Venous Access Port

19.2.K COCHLEAR IMPLANT DEVICE

PROCEDURE
CODE DESCRIPTION

L8614 .....Cochlear Implant Device (attach manufacturer's invoice for manual pricing)

19.2.L VITRASERT INTRAOCULAR IMPLANT

Use the correct NDC for Vitrasert Intraocular Implant.

19.2.M CORNEAL TRANSPLANT

When billing a corneal transplant, via outpatient claim, the following codes *must* be used together to be reimbursed tissue procurement.

REVENUE CODE DESCRIPTION

0812.....Cadaver Donor

AND

PROCEDURE
CODE DESCRIPTION

V2785.....Processing, preserving and transporting corneal tissue

19.3 INPATIENT HOSPITAL REVENUE CODES

19.3.A ACCOMMODATIONS

The following categories of accommodation revenue codes are covered by MO HealthNet. If a category of revenue code is not listed, it is not covered under the Hospital program. Some revenue codes within the below categories may not be covered. Refer to Section 19.3.C –

Non-Covered Revenue Codes for a list of individual non-covered revenue codes. Refer to the current version of the Official UB-04 Data Specifications Manual for a complete list of revenue codes and descriptions.

0001 Total Charge

011x Room & Board – Private (One Bed)

012x Room & Board – Semi-Private (Two Beds)

013x Room & Board – Three and Four Beds

014x Room & Board – Deluxe Private

015x Room & Board – Ward

016x Room & Board – Other

017x Nursery

020x Intensive Care Unit

021x Coronary Care Unit

19.3.B ANCILLARIES

The following categories of ancillary revenue codes are covered by MO HealthNet. If a category of revenue code is not listed, it is not covered under the Hospital program. Some revenue codes within the below categories may not be covered. Refer to Section 19.3. C – Non-Covered Revenue Codes for a list of individual non-covered revenue codes. Refer to the current version of the Official UB-04 Data Specifications Manual for a complete list of revenue codes and descriptions.

025x Pharmacy (also see 063x, an extension of 025x)

026x IV Therapy

027x Medical/Surgical Supplies and Devices (also see 062x, an extension of 027x)

028x Oncology

030x Laboratory

031x Laboratory Pathology

032x Radiology – Diagnostic

033x Radiology – Therapeutic and/or Chemotherapy Administration

034x Nuclear Medicine

035x	CT Scan
036x	Operating Room Services
037x	Anesthesia
038x	Blood and Blood Components
039x	Administration, Processing, and Storage for Blood and Blood Components
040x	Other Imaging Services
041x	Respiratory Services
042x	Physical Therapy
043x	Occupational Therapy
044x	Speech Therapy – Language Pathology
046x	Pulmonary Function
048x	Cardiology
061x	Magnetic Resonance Technology (MRT)
062x	Medical Surgical Supplies – Extension of 027x
063x	Pharmacy – Extension of 025x
071x	Recovery Room
072x	Labor Room/Delivery
073x	EKG/ECG (Electrocardiogram)
074x	EEG (Electroencephelogram)
075x	Gastro-Intestinal (GI) Series
079x	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)
080x	Inpatient Renal Dialysis
081x	Acquisition of Body Components (see Transplant manual for instructions to prevent claim denials)
086x	Magnetocencephalography (MEG)
088x	Miscellaneous Dialysis
090x	Behavioral Health Treatment/Services (also see 091x, an extension of 090x)

091x Behavioral Health Treatment/Services – Extension of 090x

092x Other Diagnostic Services

094x Other Therapeutic Services

19.3.C NON-COVERED REVENUE CODES

Within the categories shown in Sections 19.3.A – Accommodations and 19.3.B – Ancillaries, the following revenue codes are not covered. If a category of revenue codes is not listed above, it is not covered under the Inpatient Hospital program.

0115	0125	0135	0145	0155	0160	0167	0169
0253	0256	0273	0274	0277	0303	0362	0367
0374	0421	0431	0441	0624	0723	0732	0882
0900	0902	0903	0904	0905	0906	0907	0912
0913	0916	0917	0942				

NOTE: Any service for which there is no assigned revenue code is considered non-covered.

19.3.D TRANSPLANT REVENUE CODES

Refer to the Transplant manual for revenue codes and proper billing procedures for transplant services.

END OF SECTION

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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 the Provider Communications Unit at (573) 751-2896.

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

20.4.B NON-EMERGENCY EXCEPTION REQUESTS

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

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

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

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.

END OF SECTION

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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

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SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant

	cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.
Basic/Urban/ 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

- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

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

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

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

Fraud

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

Free 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

Provider/Service Type	**Urban Access County**	**Basic Access County**	**Rural Access County**
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100
Infectious Disease	25	50	100
Nephrology	25	50	100

Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100
Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45

Residential mental health treatment providers	20	30	50
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
    - Participant eligibility; and
    - MO HealthNet covered service.

22.7 COPAYMENTS

The participant is required to pay a $2.00 copayment for transportation services. The $2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
    - 03 - Aid to the blind;
    - 12 - MO HealthNet-Aid to the blind; and
    - 15 - Supplemental Nursing Care-Aid to the blind;
    - 18 - MO HealthNet for pregnant women;
    - 43 - Pregnant women-60 day assistance;
    - 44 - Pregnant women-60 day assistance-poverty;
    - 45 - Pregnant women-poverty; and
    - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the

NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.

2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.
5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for

reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare

representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

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SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

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

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

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

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

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.

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UTILIZATION REVIEW PLAN CHECKLIST

UR PLAN CHECKLIST FOR (TITLE XIX) ACUTE CARE FACILITIES

1. Each hospital, furnishing inpatient services to Medicaid (Title XIX) recipients, *must* have a written UR plan that provides for review of each recipient's need for services. The UR plan *must* meet the requirements under §456.101-456.145 and 482.30. (§456.101)
2. The UR plan *must* describe the organization, composition and function of the Utilization Review Committee specifying the frequency of meetings in accordance with §456.105.
3. The Utilization Review Committee *must* be composed of two or more physicians assisted by professional personnel. The committee may *not* include any individual who (1) is directly responsible for the care of the patient whose care is being reviewed or (2) has a financial interest in any hospital. (§456.106)
4. A current list of names and titles of the Utilization Review Committee members is required by DMS/Program Integrity to verify compliance of items 2 and 3. The Division of Medical Services *must* be notified of changes in membership of the committee when they occur.
5. The UR plan *must* provide that each recipient's record includes recipient information as required in §456.111.
6. The UR plan *must* describe the type and frequency of committee records and reports as well as distribution. (§456.112)
7. The UR plan *must* provide that the identities of individual recipients in all UR records and reports are kept confidential. (§456.113)
8. The UR plan *must* state that all Title XIX recipients will have an admission review within one working day of admission date or within one working day after notification of application for Medicaid benefits. (§456.121/456.125)
9. The UR plan *must* provide written medical care criteria to assess the need for admission and continued stay in accordance with §456.122/456.132.
10. The UR plan *must* describe the admission review process. (§456.123)
11. The UR plan *must* state that the notice of adverse decision for admission is sent to: the hospital administrator, the attending physician, the Medicaid agency, the recipient, and if possible the next of kin or sponsor. (§456.124)
12. The UR plan *must* state that notice of an adverse final decision, denying admission, be given within two working days after admission or two working days after notification of application for Medicaid benefits. (§456.126)
13. The UR plan *must* provide for preadmission review and decision. (§456.127)
14. The UR plan *must* provide a description of methods, requirements, criteria and norms (the Medicaid agency uses *Length of Stay by Diagnosis, North Central Region,* 1988 edition)

used in determining the patient's initial and continued length of stay. (§456.128, 456.129, 456.134)

15. The UR plan *must* state the continued stay review process and review dates in accordance with §456.132-456.135.
16. The UR plan *must* state that the notice of adverse decision for continued stay is sent to: the hospital administrator, the attending physician, the Medicaid agency, the recipient and if possible the next of kin or sponsor. (§456.136)
17. The UR plan *must* state that notice of adverse final decision, denying continued stay, be given within two working days after the review date or within two working days after the date of decision. (§456.137)
18. The UR plan *must* include requirements for medical care evaluation studies outlining content and data sources for the studies. (§456.141, 456.142, 456.143, and 456.144)
19. The UR plan *must* state that at least one MCE study will be completed each year and at least one will be in progress at all times. (§456.145)
20. The UR plan *must* state that records will be kept for 5 years (see provider agreement).
21. The UR plan and/or revision *must* be signed and dated by the appropriate hospital authority so that DMS can monitor current plans on file.

NOTE: (Copies of reference upon request)

Please refer to 42 CFR 456.60 and 456.80, which are certification of need and plan of care requirements. These may be included in the UR plan. However, compliance *must* be evident in the medical record documentation.

For SNF facilities refer to 42 CFR 456 Subpart E; ICF-Subpart F.

UR PLAN CHECKLIST FOR (TITLE XIX) PSYCHIATRIC FACILITIES

1. Each mental hospital, furnishing inpatient services to Medicaid (Title XIX) recipients *must* have a written UR plan that provides for review of each recipient's need for services. The UR plan *must* meet the requirements under §456.201-456.245 and 482.30. (§456.201)
2. The UR plan *must* describe the organization, composition and function of the Utilization Review Committee specifying the frequency of meetings in accordance with §456.205.
3. The Utilization Review Committee *must* be composed of two or more physicians, one of whom is knowledgeable in diagnosis and treatment of mental diseases, assisted by professional personnel. The committee may *not* include any individual who (1) is directly responsible for the care of the patient whose care is being reviewed or (2) has a financial interest in any hospital. (§456.206)
4. A current list of names and titles of the Utilization Review Committee members is required by DMS/Program Integrity in order to verify compliance of items 2 and 3. Also, the

Division of Medical Services *must* be notified of changes in membership of the committee when they occur.

5. The UR plan *must* provide that each recipient's record includes recipient information as required in §456.211.
6. The UR plan *must* describe the type and frequency of committee records and reports as well as distribution. (§456.212)
7. The UR plan *must* provide that the identities of individual recipients in all UR records and reports are kept confidential. (§456.213)
8. The UR plan *must* provide written medical care criteria to assess the need for continued stay in accordance with §456.231 and 456.232.
9. The UR plan *must* provide that the initial and subsequent continued stay review dates be assigned as required in §456.233 and 456.234.
10. The UR plan *must* provide a description of methods, requirements, criteria and norms (the Medicaid agency uses *Length of Stay by Diagnosis, North Central Region,* 1988 edition) used in determining the patient's continued length of stay. (§456.235)
11. The UR plan *must* state the continued stay review process and review dates in accordance with §456.236.
12. The UR plan *must* state that the notice of adverse decision for continued stay is sent to: the hospital administrator, the attending physician, the Medicaid agency, the recipient and if possible the next of kin or sponsor. (§456.237)
13. The UR plan *must* state that the notice of adverse final decision denying continued stay, be given within two working days after the review date or within two working days after the date of decision. (§456.238)
14. The UR plan *must* include requirements for medical care evaluation studies outlining content and data sources for the studies. (§456.241, 456.242, 456.243, and 456.244)
15. The UR plan *must* state that at least one MCE study will be completed each year, and at least one will be in progress at all times. (§456.245)
16. The UR plan *must* state that records will be kept for 5 years (see provider agreement).
17. The UR plan and/or revision *must* be signed and dated by the appropriate hospital authority in order that DMS can monitor current plans on file.

NOTE: (Copies of reference upon request)

Please refer to 42 CFR 456.160, 456.170, 456.171, 456.172 and Subpart G 456.480-456.482 (Inpatient Psychiatric Services/Under 21), which are Utilization Control and certification requirements (for auditing purposes). These may be included in the UR plan. However, compliance *must* be evident in the medical record documentation.
For SNF facilities refer to 42 CFR 456 Subpart E; ICF-Subpart F.

END OF SECTION

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