STATE OF MISSOURI

PHYSICIAN MANUAL

SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION 21
1.1 INDIVIDUALS ELIGIBLE FOR MO HEALTHNET, MANAGED CARE OR STATE FUNDED BENEFITS 21
1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES 21
1.1.A(1) MO HealthNet 21
1.1.A(2) MO HealthNet for Kids 22
1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP) 24
1.1.A(4) Voluntary Placement Agreement for Children 24
1.1.A(5) State Funded MO HealthNet 24
1.1.A(6) MO Rx 25
1.1.A(7) Women's Health Services 25
1.1.A(8) ME Codes Not in Use 26
1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD 26
1.2.A FORMAT OF MO HEALTHNET ID CARD 27
1.2.B ACCESS TO ELIGIBILITY INFORMATION 28
1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES 28
1.2.C(1) MO HealthNet Participants 28
1.2.C(2) MO HealthNet Managed Care Participants 28
1.2.C(3) TEMP 28
1.2.C(4) Temporary Medical Eligibility for Reinstated TANF Individuals 29
1.2.C(5) Presumptive Eligibility for Children 29
1.2.C(6) Breast or Cervical Cancer Treatment Presumptive Eligibility 29
1.2.C(7) Voluntary Placement Agreement 29
1.2.D THIRD PARTY INSURANCE COVERAGE 30
1.2.D(1) Medicare Part A, Part B and Part C 30
1.3 MO HEALTHNET, STATE FUNDED MEDICAL ASSISTANCE AND MO HEALTHNET MANAGED CARE APPLICATION PROCESS 30
1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN 31
1.4.A NEWBORN INELIGIBILITY 32
1.4.B NEWBORN ADOPTION 32
1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT..32
1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS 33
1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE 33
1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN 35
1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS 35
1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program 37
1.5.D HOSPICE BENEFICIARIES 37
1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB) 38
1.5.F WOMEN'S HEALTH SERVICES PROGRAM (ME CODES 80 and 89) 39
1.5.G TEMP PARTICIPANTS 39

1.5.G(1) TEMP ID Card 40
1.5.G(2) TEMP Service Restrictions 41
1.5.G(3) Full MO HealthNet Eligibility After TEMP 41
1.5.H PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) 41
1.5.I MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT 42
1.5.I(1) Eligibility Criteria 42
1.5.I(2) Presumptive Eligibility 43
1.5.I(3) Regular BCCT MO HealthNet 43
1.5.I(4) Termination of Coverage 44
1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM 44
1.5.J(1) Disability 44
1.5.J(2) Employment 44
1.5.J(3) Premium Payment and Collection Process 44
1.5.J(4) Termination of Coverage 45
1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN 45
1.5.K(1) Eligibility Determination 46
1.5.K(2) MO HealthNet for Kids Coverage 46
1.5.L MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION 47
1.5.L(1) MO HealthNet Coverage Not Available 48
1.5.L(2) MO HealthNet Benefits 48
1.5.M VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES 49
1.5.M(1) Duration of Voluntary Placement Agreement 49
1.5.M(2) Covered Treatment and Medical Services 49
1.5.M(3) Medical Planning for Out-of-Home Care 49
1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS 50
1.6.A DAY SPECIFIC ELIGIBILITY 51
1.6.B SPENDDOWN 52
1.6.B(1) Notification of Spenddown Amount 53
1.6.B(2) Notification of Spenddown on New Approvals 53
1.6.B(3) Meeting Spenddown with Incurred and/or Paid Expenses 53
1.6.B(4) Meeting Spenddown with a Combination of Incurred Expenses and Paying the Balance 54
1.6.B(5) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown 54
1.6.B(6) Spenddown Pay-In Option 55
1.6.B(7) Prior Quarter Coverage 55
1.6.B(8) MO HealthNet Coverage End Dates 56
1.6.C PRIOR QUARTER COVERAGE 56
1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS 56
1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE 57
1.7.A NEW APPROVAL LETTER 58
1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals 58

1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter 58
1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice 58
1.7.B REPLACEMENT LETTER 59
1.7.C NOTICE OF CASE ACTION 59
1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS 59
1.7.E PRIOR AUTHORIZATION REQUEST DENIAL 60
1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER 60
1.8 TRANSPLANT PROGRAM 60
1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS 61
1.8.B PATIENT SELECTION CRITERIA 61
1.8.C CORNEAL TRANSPLANTS 61
1.8.D ELIGIBILITY REQUIREMENTS 61
1.8.E MANAGED CARE PARTICIPANTS 62
1.8.F MEDICARE COVERED TRANSPLANTS 62
SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION 64
2.1 PROVIDER ELIGIBILITY 64
2.1.A QMB-ONLY PROVIDERS 64
2.1.B NON-BILLING MO HEALTHNET PROVIDER 64
2.1.C PROVIDER ENROLLMENT ADDRESS 64
2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION 65
2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES 65
2.2 NOTIFICATION OF CHANGES 65
2.3 RETENTION OF RECORDS 66
2.3.A ADEQUATE DOCUMENTATION 66
2.4 NONDISCRIMINATION POLICY STATEMENT 66
2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER 67
2.6 FRAUD AND ABUSE 67
2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS 68
2.7 OVERPAYMENTS 68
2.8 POSTPAYMENT REVIEW 69
2.9 PREPAYMENT REVIEW 69
2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE 70
SECTION 3 - STAKEHOLDER SERVICES 72
3.1 PROVIDER SERVICES 72
3.1.A MHD TECHNICAL HELP DESK 72
3.2 Missouri Medicaid Audit & Compliance (MMAC) 72
3.2.A PROVIDER ENROLLMENT UNIT 73
3.3 PROVIDER COMMUNICATIONS UNIT 73
3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM 73
3.3.A(1) Using the Telephone Key Pad 80

3.3.B MO HEALTHNET SPECIALIST 80
3.3.C INTERNET 81
3.3.D WRITTEN INQUIRIES 82
3.4 PROVIDER EDUCATION UNIT 83
3.5 PARTICIPANT SERVICES 83
3.6 PENDING CLAIMS 84
3.7 FORMS 84
3.8 CLAIM FILING METHODS 84
3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET 84
3.10 Pharmacy & Clinical Services Unit 84
3.11 Pharmacy and Medical Pre-certification Help Desk 85
3.12 Third Party Liability (TPL) 85
SECTION 4 - TIMELY FILING 86
4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING 86
4.1.A MO HEALTHNET CLAIMS 86
4.1.B MEDICARE/MO HEALTHNET CLAIMS 86
4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY 86
4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM 87
4.2.A CLAIMS FILED AND DENIED 87
4.2.B CLAIMS FILED AND RETURNED TO PROVIDER 87
4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT 88
4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT 88
4.5 DEFINITIONS 88
SECTION 5-THIRD PARTY LIABILITY 90
5.1 GENERAL INFORMATION 90
5.1.A MO HEALTHNET IS PAYER OF LAST RESORT 90
5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES 91
5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR 92
5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL 93
5.2 HEALTH INSURANCE IDENTIFICATION 93
5.2.A TPL INFORMATION 94
5.2.B SOLICITATION OF TPR INFORMATION 94
5.3 INSURANCE COVERAGE CODES 95
5.4 COMMERCIAL MANAGED HEALTH CARE PLANS 96
5.5 MEDICAL SUPPORT 96
5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS 97
5.6.A EXCEPTION TO TIMELY FILING LIMIT 97
5.6.B TPR CLAIM PAYMENT DENIAL 98
5.7 THIRD PARTY LIABILITY BYPASS 98
5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4) 99
5.9 LIABILITY AND CASUALTY INSURANCE 99
5.9.A TPL RECOVERY ACTION 100

5.9.B LIENS 100
5.9.C TIMELY FILING LIMITS 100
5.9.D ACCIDENTS WITHOUT TPL 101
5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION 101
5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE 101
5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM 102
5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY 102
SECTION 6-ADJUSTMENTS 105
6.1 GENERAL REQUIREMENTS 105
6.2 INSTRUCTIONS FOR ADJUSTING CLAIMS WITHIN 24 MONTHS OF DATE OF SERVICE 105
6.2.A NOTE: PROVIDERS MUST BE ENROLLED AS AN ELECTRONIC BILLING PROVIDER BEFORE USING THE ONLINE CLAIM ADJUSTMENT TOOL 105
6.2.B ADJUSTING CLAIMS ONLINE 105
6.2.B(1) Options for Adjusting a Paid Claim 105
6.2.B(1)(i) Void 106
6.2.B(1)(ii) Replacement 106
6.2.B(2) Options for Adjusting a Denied Claim 106
6.2.B(2)(i) Timely Filing 106
6.2.B(2)(ii) Copy Claim – Original 107
6.2.B(2)(iii) Copy Claim – Advanced 107
6.2.C CLAIM STATUS CODES 107
6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS 107
6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS 108
SECTION 7-MEDICAL NECESSITY 109
7.1 CERTIFICATE OF MEDICAL NECESSITY 109
7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS 110
7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY 110
SECTION 8-PRIOR AUTHORIZATION 112
8.1 BASIS 112
8.2 PRIOR AUTHORIZATION GUIDELINES 112
8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION 113
8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT 114
8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION (PA) REQUEST FORM 115
8.5.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST 116
8.6 MO HEALTHNET AUTHORIZATION DETERMINATION 117
8.6.A A DENIAL OF PRIOR AUTHORIZATION (PA) REQUESTS 118
8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION 118
8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST 119

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE....119
8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)....120
8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES....120
8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS....121
SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM....122
9.1 GENERAL INFORMATION....122
9.2 PLACE OF SERVICE (POS)....122
9.3 DIAGNOSIS CODE....123
9.4 INTERPERIODIC SCREENS....123
9.5 FULL HCY/EPSDT SCREEN....123
9.5.A QUALIFIED PROVIDERS....125
9.6 PARTIAL HCY/EPSDT SCREENS....125
9.6.A DEVELOPMENTAL ASSESSMENT....126
9.6.A(1) Qualified Providers....126
9.6.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN....127
9.6.B(1) Qualified Providers....127
9.6.C VISION SCREENING....127
9.6.C(1) Qualified Providers....128
9.6.D HEARING SCREEN....128
9.6.D(1) Qualified Providers....128
9.6.E DENTAL SCREEN....129
9.6.E(1) Qualified Providers....129
9.6. F ALL PARTIAL SCREENERS....129
9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)....130
9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS....130
9.7.B LEAD RISK ASSESSMENT....132
9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING....132
9.7.C(1) Risk Assessment....132
9.7.C(2) Determining Risk....132
9.7.C(3) Screening Blood Tests....133
9.7.C(4) MO HealthNet Managed Care Health Plans....133
9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING....134
9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS....134
9.7.E(1) Blood Lead Level <10 µg/dL....134
9.7.E(2) Blood Lead Level 10-19 µg/dL....135
9.7.E(3) Blood Lead Level 20-44 µg/dL....135
9.7.E(4) Blood Lead Level 45-69 µg/dL....135
9.7.E(5) Blood Lead Level 70 µg/dL or Greater....136
9.7.F COORDINATION WITH OTHER AGENCIES....137
9.7.G ENVIRONMENTAL LEAD INVESTIGATION....137

9.7.G(1) Environmental Lead Investigation 137
9.7.H ABATEMENT 138
9.7.I LEAD CASE MANAGEMENT 138
9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER 139
9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING 139
9.7.L OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES 139
9.8 HCY CASE MANAGEMENT 140
9.9 IMMUNIZATIONS 140
9.9.A VACCINE FOR CHILDREN (VFC) 140
9.10 ASSIGNMENT OF SCREENING TIMES 141
9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES 141
9.11.A DENTAL SCREENING SCHEDULE 142
9.11.B VISION SCREENING SCHEDULE 142
9.11.C HEARING SCREENING SCHEDULE 142
9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING 143
9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES) 143
9.13 PARTICIPANT NONLIABILITY 143
9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS 143
9.15 STATE-ONLY FUNDED PARTICIPANTS 143
9.16 MO HEALTHNET MANAGED CARE 144
9.17 ORDERING HCY LEAD SCREENING GUIDE 145
SECTION 10-FAMILY PLANNING 146
10.1 FAMILY PLANNING SERVICES 146
10.2 COVERED SERVICES 146
10.2.A LONG-ACTING REVERSIBLE CONTRACEPTION (LARC) DEVICES 147
10.2.A(1) Intrauterine Device (IUD) 147
10.2.A(2) Non-biodegradable Drug Delivery Implant System 147
10.2.B ORAL CONTRACEPTION (BIRTH CONTROL PILL) 148
10.2.C DIAPHRAGMS OR CERVICAL CAPS 148
10.2.D STERILIZATIONS 148
10.2.D(1) Consent Form 148
10.2.D(2) Informed Consent 149
10.2.D(3) Definitions 151
10.3 SERVICES NOT COVERED UNDER FAMILY PLANNING 152
SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM 153
11.1 MO HEALTHNET'S MANAGED CARE PROGRAM 153
11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 153

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 153
11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 154
11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS 154
11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT 154
11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS155
11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS 155
11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS 157
11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM 157
11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN 160
11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM 160
11.8 QUALITY OF CARE 162
11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS 162
11.9.A NON-BILLING MO HEALTHNET PROVIDER 163
11.10 EMERGENCY SERVICES 163
11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) 163
11.11.A ELIGIBILITY FOR PACE 164
11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE 164
11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS 164
11.11.D PACE COVERED SERVICES 165
12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT 167
12.2 PHYSICIAN SERVICES 167
12.3 DETERMINING A FEE 167
12.3.A ON-LINE FEE SCHEDULE 169
12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS) 169
12.5 PARTICIPANT COST SHARING AND COPAY 170
12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT 170
12.6.A MO HEALTHNET MANAGED HEALTH CARE 170
SECTION 13-BENEFITS AND LIMITATIONS 172
13.1 PROVIDER PARTICIPATION 172
13.2 LOCK-IN PARTICIPANTS 172
13.3 PRESUMPTIVE ELIGIBILITY PROGRAM (TEMP) 173
13.3. A TEMP BENEFIT LIMITATIONS 173
13.3. B FULL MO HEALTHNET ELIGIBILITY AFTER TEMP 173
13.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN 173
13.5 QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM 173

13.5. A HOW THE QMB PROGRAM AFFECTS PROVIDERS 174
13.6 THIRD PARTY LIABILITY (TPL) 174
13.7 SERVICE MODIFIERS 175
13.8 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM, ALSO KNOWN AS EPSDT 175
13.9 LEAD SCREENING AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM 175
13.10 EXPANDED EPSDT/HCY SERVICES 175
13.11 MO HEALTHNET HEALTHY CHILDREN AND YOUTH PAMPHLET 176
13.12 PREVENTIVE MEDICINE SERVICES 176
13.12. A VACCINE FOR CHILDREN (VFC) PROGRAM 177
13.12. A (1) VFC for MO HealthNet Managed Care Participants 177
13.12. A (2) Immunizations Outside VFC Guidelines 178
13.12. A (3) Vaccine Shortages 178
13.12. B ILLNESS CARE 178
13.12. C SCHOOL/ATHLETIC PHYSICALS 178
13.12. D WOMEN, INFANTS AND CHILDREN (WIC) SERVICES 178
13.13 REPORTING CHILD ABUSE CASES 179
13.14 SAFE-CARE EXAMINATIONS 179
13.14. A SAFE-CARE EXAMINATION FORMS 180
13.15 BUREAU OF SPECIAL HEALTH CARE NEEDS: AREA/DISTRICT OFFICES AND COUNTY LISTINGS 181
13.16 PARTICIPANT COPAY 181
13.16. A PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS 181
13.16. B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS 182
13.16. B (1) Copay Amounts 182
13.16. B (2) Exemptions to the Copay Amount 182
13.17 SUPERVISION 184
13.17. A PHYSICIAN'S OFFICE/INDEPENDENT CLINICS 184
13.17. A (1) Physician Assistant 185
13.17. A. (2) Nurse Practitioner Services 187
13.17. A (3) Assistant Physician Services 187
13.17. B RESIDENTS IN TEACHING/CLINICAL SETTING 188
13.17. C MEDICARE PRIMARY CARE EXCEPTION 188
13.17. C (1) Resident Requirements 189
13.17. C (2) Teaching Physician Requirements 189
13.17. C (3) Location of Services 189
13.17 C (4) Billing Guidelines 189
13.17. D PUBLIC HEALTH DEPARTMENT CLINICS AND PLANNED PARENTHOOD CLINICS 190
13.18 DEFINITIONS AND LEVELS OF SERVICE 190
13.19 PLACE OF SERVICE 190

13.20 OFFICE OR OTHER OUTPATIENT SERVICES 191
13.20. A LIMITATIONS TO OFFICE/OUTPATIENT SERVICES....191
13.20. B HISTORY AND EXAMINATION (OUTPATIENT) PRIOR TO OUTPATIENT SURGERY....192
13.21 SPECIAL SERVICES AND REPORTS 192
13.21. A PHYSICIAN SERVICES—AFTER HOURS....192
13.21. B PHYSICIAN SERVICES—SUNDAYS/HOLIDAYS....193
13.21. C CRITICAL CARE SERVICES....193
13.21. C (1) Newborn Care....193
13.21. C (2) Critical Care Services....193
13.21. C (3) Initial Care Services....195
13.22 OFFICE MEDICAL SUPPLY CODES....195
13.23 PRESCRIPTION DRUGS....195
13.23. A PRESCRIBING LONG-TERM MAINTENANCE DRUGS....196
13.23. B INJECTIONS AND IMMUNIZATIONS....196
13.23. C RABIES TREATMENT....198
13.23. D CHEMOTHERAPY....198
13.23. E HERCEPTIN....198
13.23. F EXCEPTIONS TO BILLING ON THE PHARMACY CLAIM....198
13.23. G CLAIM FILING FOR INJECTABLE MEDICATIONS....198
13.23. H INFUSION THERAPY....199
13.23. I INSERTION, REVISION AND REMOVAL OF IMPLANTABLE INTRAVENOUS INFUSION PUMP OR VENOUS ACCESS PORT....199
13.24 EMERGENCY SERVICES....199
13.25 OUT-OF-STATE, NONEMERGENCY SERVICES....200
13.25. A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS201
13.26 CONSULTATIONS....201
13.26. A OFFICE OR OTHER OUTPATIENT CONSULTATIONS....202
13.26. B GUIDELINES FOR THE USE OF CONSULTATIONS....202
13.27 CONCURRENT CARE....203
13.28 ADULT PHYSICALS....203
13.29 MO HEALTHNET MANAGED CARE PROGRAM....203
13.30 HOSPITAL SERVICES....204
13.30. A PHYSICIAN SERVICES....204
13.30. A (1) Hospital Salaried Physicians....204
13.30. B HOSPITAL CARE....204
13.30. C LIMITATIONS....204
13.31 INPATIENT HOSPITAL CERTIFICATION REVIEWS....205
13.32 ANESTHESIA SERVICES....205
13.32. A GENERAL ANESTHESIA FOR CT SCANS....206
13.32. B CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)....207
13.32. B (1) Inpatient Hospital Services....207

13.32. B (2) Outpatient Hospital Services 207
13.32. C MEDICAL DIRECTION BY ANESTHESIOLOGIST 208
13.32. C (1) Concurrent Medical Direction 208
13.32. C (2) Supervision Billing Guidelines 209
13.32. D ANESTHESIOLOGISTS IN A GROUP PRACTICE 209
13.32. E ANESTHESIOLOGIST SERVICES (DENTAL) ASC 210
13.32. F ANESTHESIA SERVICES FOR MULTIPLE SURGERIES 210
13.32. G CALCULATION OF ANESTHESIA SERVICES 210
13.32. H QUALIFYING CIRCUMSTANCES FOR ANESTHESIA 211
13.32. I ANESTHESIA NONCOVERED SERVICES 212
13.32. I (1) Anesthesiologist Assistant (AA) 212
13.33 SURGERY 214
13.33. A ORTHOPEDIC SURGERY—CASTING, REMOVAL, MATERIALS 214
13.33. B ELECTROMAGNETIC TREATMENT OF FRACTURES USING NONINVASIVE OSTEOGENESIS STIMULATOR DEVICE 214
13.33. C ROUTINE FOOT CARE/DEBRIDEMENT OF NAILS 215
13.33. D ASSISTANT SURGEON 215
13.33. E CO-SURGEON'S SERVICES (TWO SURGEONS) 216
13.33. F MULTIPLE SURGICAL PROCEDURES 217
13.33. F (1) Exception to Multiple Surgical Procedures 217
13.33. G ABORTIONS 217
13.33. H HYSTERECTOMIES 218
13.33. H (1) Acknowledgement of Receipt of Hysterectomy Information 219
13.33. I STERILIZATIONS 220
13.33. J MORBID OBESITY TREATMENT 220
13.34 POSTOPERATIVE CARE 221
13.34. A PHYSICIAN SERVICES SUBJECT TO POSTOPERATIVE RESTRICTION 221
13.34. B EXCEPTIONS 222
13.34. C POSTOPERATIVE CARE—OTHER THAN THE SURGEON 223
13.35 SEPARATE/INCIDENTAL PROCEDURES 223
13.36 UNLISTED SERVICE OR PROCEDURE 225
13.37 LIMITING CERTAIN SURGICAL PROCEDURES TO OTHER THAN AN INPATIENT BASIS 225
13.38 NONCOVERED SERVICES 226
13.39 NON-ALLOWABLE SERVICES 228
13.40 RADIOLOGY 229
13.40. A RADIOLOGY SERVICES 229
13.40. A (1) Professional and Technical Component, X-Ray/Nuclear Medicine/EEG/EKG 229
13.40. A (2) Professional Component, X-Ray/Nuclear Medicine/EEG/EKG 230
13.40. A (3) Technical Component, X-Ray/Nuclear, Medicine/EEG/EKG 230
13.40. B PRECERTIFICATION FOR HIGH-TECH AND CARDIAC IMAGING SERVICES 230

13.40. B (1) Initiating Precertification Requests 231
13.40. B (2) Certification Approval Time Frame 231
13.40. C DIAGNOSTIC SITE CERTIFICATION 231
13.40. D PARTICIPANT APPEAL RIGHTS 232
13.40. E COMPLETE RADIOLOGICAL PROCEDURES 232
13.40. F TESTING AGENTS USED DURING RADIOLOGIC PROCEDURES 233
13.40. F (1) Contrast Materials and Radiopharmaceuticals 233
13.40. G MOBILE X-RAY UNIT 233
13.40. H RADIATION ONCOLOGY 233
13.40. H (1) Consultation: Clinical Management (Radiation Oncology) 233
13.40. H (2) Manual Pricing (Radiation Oncology) 234
13.40. H (3) Clinical Treatment Planning (Radiation Oncology) 234
13.40. H (4) Clinical Treatment Management (Radiation Oncology) 234
13.40. H (5) Clinical Brachytherapy 235
13.40. I INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) 235
13.40. I (1) Supervision 236
13.40. I (2) Non-Physician Personnel 236
13.40. I (3) Ordering of Tests 236
13.40. I (4) Multi-State Entities 237
13.40. J NON-COVERED SERVICES 237
13.41 PATHOLOGY AND LABORATORY 237
13.41. A CLINICAL DIAGNOSTIC LABORATORY PROCEDURE REIMBURSEMENT 237
13.41. B CLIA REQUIREMENTS 238
13.41. B (1) Laboratory Test Codes that Include Preparation Only 239
13.41. C LABORATORY SERVICES 239
13.41. C (1) Professional and Technical Component, Lab Service 239
13.41. C (2) Professional Component, Laboratory 239
13.41. C (3) Technical Component, Laboratory 240
13.41. C (4) Billing Codes When the 26/TC Modifiers Do Not Apply 240
13.41. D MULTI-TEST LABORATORY PANELS 240
13.41. E DRUG SCREENING TESTS 241
13.41. F HIV/AIDS TESTING 242
13.41. F (1) Co-Receptor Tropism Assay (Profile) 242
13.41. G LEAD SCREENING 242
13.41. H HEMOSTASIS 242
13.41. I SKIN TESTING 242
13.41. I (1) Tuberculosis (TB) Test 242
13.41. I (2) Allergy Sensitivity Tests 243
13.41. I (3) Allergen Immunotherapy 243
13.41. I (4) Radioallergosorbent Tests 243
13.41. J SMEARS AND CULTURES 243
13.41. K CARCINOEMBRYONIC ANTIGENS (CEA TESTS) 244

13.41. L URINALYSIS 244
13.41. M PAP SMEARS 244
13.41. N CYTOPATHOLOGY 245
13.41. O THERAPEUTIC APHERESIS (PLASMA AND/OR CELL EXCHANGE)....245
13.42 HOSPICE 245
13.42. A ACCESS TO MO HEALTHNET SERVICES FOR HOSPICE ENROLLEES....245
13.42. B IDENTIFICATION OF HOSPICE ENROLLEES 246
13.42. C ATTENDING PHYSICIAN 246
13.43 PHYSICIAN SERVICES IN NURSING HOMES 247
13.43. A TITLE XIX PATIENTS IN NURSING FACILITIES (NF) 247
13.43. B NURSING FACILITY PATIENTS (NOT TITLE XIX)....247
13.44 NURSING FACILITY SERVICES 247
13.45 SCREENING POTENTIAL NURSING HOME PLACEMENTS 248
13.45. A PREADMISSION SCREENING 248
13.45. A (1) Limitations 249
13.46 ADVANCE HEALTH CARE DIRECTIVES 249
13.47 PSYCHIATRY 250
13.47. A BEHAVIORAL HEALTH SERVICES IN A NURSING HOME....250
13.47. B PSYCHIATRIC TREATMENT PLAN....250
13.47. C ELECTROCONVULSIVE THERAPY....250
13.47. D DEFINITION OF PSYCHIATRIC EMERGENCY ADMISSION FOR CHILDREN .250
13.47. E LIMITATIONS 251
13.47. F SERVICES PROVIDED IN GROUP HOME, HOME AND SCHOOL 251
13.48 DIALYSIS 252
13.48. A PHYSICIAN SERVICES (DIALYSIS) 252
13.48. A (1) Monthly End Stage Renal Disease (ESRD) 252
13.48. A (2) Daily ESRD Services 252
13.48. A (3) Hemodialysis/Miscellaneous Dialysis Services 253
13.48. B FREESTANDING DIALYSIS CENTERS 253
13.48. C CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) AND HEMODIALYSIS IN THE HOME....253
13.48. C (1) Reimbursement of Dialysis Facility Training Fee 253
13.48. D DIALYSIS AND HEMODIALYSIS SERVICES IN THE HOME....254
13.48. D (1) Items and Services Included in the Composite Rate 255
13.48. E HOSPITAL-BASED DIALYSIS CLINICS 256
13.48. E (1) Outpatient or Home Services....256
13.49 OPHTHALMOLOGY/OPTICAL 256
13.49. A BILLING OPHTHALMOLOGY SERVICES 257
13.50 OTORHINOLARYNGOLOGY....257
13.50. A VESTIBULAR FUNCTION TESTS....257
13.50. B AUDIOLOGY....257
13.50. B (1) Audiologist Employed by a Physician 257

13.50. B (2) Audiologist in Private Practice 257
13.50. B (3) Diagnostic Audiology Services 258
13.51 CARDIOVASCULAR 258
13.51. A ELECTROCARDIOGRAM (EKG) (ECG) 258
13.51. B CARDIAC REHABILITATION 258
13.52 PHYSICAL MEDICINE 259
13.52. A MODALITIES AND PROCEDURES 259
13.53 NERVOUS SYSTEM 260
13.54 DIGESTIVE SYSTEM 260
13.54. A NUTRITIONAL SUPPLEMENTS 260
13.54. B TOTAL PARENTERAL NUTRITION (TPN) 261
13.54. B (1) TPN for Nursing Facility Residents 261
13.55 OBESITY 261
13.56 CASE MANAGEMENT 262
13.56. A CASE MANAGEMENT ENROLLMENT CRITERIA 262
13.56. B CASE MANAGEMENT FOR PREGNANT WOMEN 263
13.56. B (1) Risk Appraisal 263
13.56. B (2) Procedure Code for Risk Appraisal 264
13.56. B (3) Procedure Codes for Case Management for Pregnant Women 265
13.56. C HEALTHY CHILDREN AND YOUTH (HCY) CASE MANAGEMENT 265
13.56. C (1) Initial Month—HCY Case Management 266
13.56. C (2) Subsequent Months—HCY Case Management 266
13.56. C (3) Prior Authorization Process for HCY Case Management 267
13.56. C (4) HCY Case Management Assessment and Care Plan 267
13.56. D LEAD CASE MANAGEMENT FOR CHILDREN SERVICES 268
13.56. D (1) Documentation of Lead Case Management Services 269
13.56. D (2) Additional Lead Case Management Services 269
13.57 OBSTETRIC SERVICES 270
13.57. A OBSTETRIC PANEL 270
13.57. B ULTRASOUND EXAMS (SONOGRAMS) IN PREGNANCY 270
13.57. B (1) Ultrasound Indication Checklist 270
13.57. B (2) Noncovered Ultrasound Services 271
13.57. C FETAL CONTRACTION STRESS TEST (59020) AND FETAL NON-STRESS TEST (59025) 272
13.57. D "PRENATAL VISIT"—DEFINITION 272
13.57. E RISK APPRAISAL FOR PREGNANT WOMEN 272
13.57. F GLOBAL PRENATAL (59425, 59426) 273
13.57. F (1) Exempted Visits/Consultations 274
13.57. F (2) Global Prenatal/Delivery Transition from Fee-For-Service to MO HealthNet Managed Care 275
13.57. G FETAL MONITORING-INTERNAL (59050) 275
13.57. H GLOBAL PRENATAL/DELIVERY/POSTPARTUM (59400, 59510, 59610, 59618) 275

13.57. I DELIVERY ONLY (59409, 59514, 59612, 59620) 276
13.57. J DELIVERY ONLY INCLUDING POSTPARTUM CARE (59410, 59515, 59614, 59622) 277
13.57. K POSTPARTUM CARE ONLY (59430)....277
13.57. L ANESTHESIA FOR DELIVERY 277
13.57. M MULTIPLE BIRTHS....277
13.57. N SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY 59525—LIST IN ADDITION TO 59510 OR 59515)....277
13.57. O BILLING INSTRUCTIONS....277
13.57.P FREE STANDING BIRTH CENTERS 277
13.57.P(1) Covered Services 278
13.58 MATERNITY STAYS AND POST-DISCHARGE HOME VISITS 278
13.58. A CRITERIA FOR EARLY DISCHARGE FOLLOWING DELIVERY 278
13.58. B COVERAGE OF POST-DISCHARGE VISITS 279
13.59 NEWBORN CARE 279
13.59. A NEONATAL INTENSIVE CARE 280
13.59. B NEWBORN CARE IN THE HOSPITAL 280
13.59. B (1) Initial Hospital/Birthing Center Care 280
13.59. B (2) Subsequent Hospital/Birthing Center Care 280
13.59. B (3) Inpatient Newborn Care (99231TG, 99232TG, 99233TG)....281
13.59. C NEWBORN CARE (OTHER THAN HOSPITAL OR BIRTHING ROOM SETTING) 281
13.59. D NEWBORN ENROLLMENT IN MO HEALTHNET MANAGED CARE HEALTH PLANS....282
13.59. E HOME APNEA MONITORING 282
13.60 DIABETES SELF-MANAGEMENT TRAINING 282
13.60. A DIABETES SELF-MANAGEMENT TRAINING ENROLLMENT CRITERIA....282
13.60. B DIABETES SELF-MANAGEMENT TRAINING SERVICE LIMITATIONS 283
13.60. B (1) Procedure Codes for Diabetes Self-Management Training....284
13.61. B (2) Diabetes Self-Management Training Billing Procedures....284
13.61 HYPERBARIC OXYGEN THERAPY (HBO) (99183) 285
13.62 PODIATRY SERVICES 285
13.62. A PODIATRY LIMITATIONS 285
13.63 CIRCUMCISIONS 285
13.64 VAGUS NERVE STIMULATION 286
13.65 MISSOURI'S BREAST AND CERVICAL CANCER CONTROL PROJECT....286
13.65. A ELIGIBILITY CRITERIA 286
13.65. B PRESUMPTIVE ELIGIBILITY....287
13.65. C MO HEALTHNET COVERAGE....287
13.66 PHARMACY BENEFITS....287
13.66. A LONG-TERM CARE MAINTENANCE DRUG BILLING....287
13.66. B DOSE OPTIMIZATION....287

13.66. C DRUG PRIOR AUTHORIZATION PROCESS 287
13.67 NAME CHANGE.....288
13.68 BILATERAL PROCEDURES (50 MODIFIER).....288
13.69 TELEHEALTH SERVICES.....288
13.69. A COVERED SERVICES.....288
13.69. B ELIGIBLE PROVIDERS 288
13.69. C REIMBURSEMENT 289
13.69. D DOCUMENTATION FOR THE ENCOUNTER.....289
13.70 CHIROPRACTIC MEDICINE – Effective January 1, 2020 289
13.70. A COVERED SERVICES.....289
13.70. B ELIGIBLE PROVIDERS 289
13.70. C ELIGIBLE PARTICIPANTS 289
13.70. D LIMITATIONS.....290
13.71 COMPLEMENTARY HEALTH AND ALTERNATIVES TO CHRONIC PAIN MANAGEMENT 290
13.71. A COVERED SERVICES.....290
13.71. B. PARTICIPANT ELIGIBILITY 290
13.71. C. TREATMENT OPTIONS.....291
13.71. D. LIMITATIONS.....291
13.71. E. PROVIDER REQUIREMENTS 292
13.72 ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT PROGRAM.....292
13.72. A. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTALASSESSMENT PROVIDER ENROLLMENT CRITERIA.....292
13.72. B. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT QUALIFIED ACADEMIC UNIVERSITY-BASED CENTERS 293
13.72. C. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT PROGRAM ELIGIBILITY CRITERIA 293
13.72. D. ASTHMA EDUCATION AND ASTHMA ENVIRONMENTAL ASSESSMENT SERVICE DEFINITIONS.....294
13.72. D (1) Asthma Education Description of Services.....294
13.72. D (2) Asthma Environmental Assessment Description of Services 294
13.72. D (3) Asthma Education and Asthma In-Home Environmental Assessment Program Authorization Limits.....294
13.72. D (4) Asthma Education Services Procedure Codes 295
13.72. D (5) Procedure Codes for Asthma Environmental Assessment Services 295
13.72. D (6) Asthma Education and Asthma Environmental Assessment Billing Procedures .295
13.73 DIABETES PREVENTION PROGRAM SERVICES FOR ADULTS-Effective September 1, 2020.....296
13.73. A DIABETES PREVENTION PROGRAM 296
13.73. B DIABETES PREVENTION PROGRAM SERVICE PROVIDER PARTICIPATION.296
13.73. C DIABETES PREVENTION PROGRAM SERVICES PARTICIPANT CRITERIA ..297
13.74. D LIMITATIONS.....297

13.74. E DIABETES PREVENTION PROGRAM SERVICES 298
13.74. E (1) Diabetes Prevention Program Core Services Period 298
13.74. E (2) Diabetes Prevention Program Services Ongoing Maintenance Period 299
13.74. E (3) Procedure Codes for Diabetes Prevention Program Services 299
13.74. E (4) Additional Services Request 299
Additional diabetes prevention program services, including core sessions and ongoing maintenance sessions beyond the initial allocation must be requested and will need to go through the prior authorization process and must be deemed medically necessary. 299
13.74. E (5) Diabetes Prevention Program Services Re-enrollment Criteria 299
13.75. F Diabetes Prevention program Services Billing Procedures 300
SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS 301
14.1 REQUIRED ATTACHMENTS 301
14.1.A RESUBMISSIONS 301
14.1.B HOW TO ORDER ATTACHMENTS TO THE CLAIM FORM 301
14.2 CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION 302
14.2.A INSTRUCTIONS FOR COMPLETING THE CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION 302
14.3 ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION 302
14.3.A EXCEPTIONS TO THE ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION 303
14.4 (STERILIZATION) CONSENT FORM 304
14.5 INVOICE FOR MANUALLY PRICED PROCEDURES 304
14.6 CERTIFICATE OF MEDICAL NECESSITY 304
14.6.A WHEN A CERTIFICATE OF MEDICAL NECESSITY IS REQUIRED 305
14.6.A(1) Private Hospital Room 305
14.6.A(2) Sonograms 305
14.6.B A CERTIFICATE OF MEDICAL NECESSITY FORM MAY BE USED INSTEAD OF THE REQUIRED ATTACHMENT 305
14.6.B(1) Definition of Emergency Services 305
14.6.B(2) Lock-In Participants 306
14.6.B(3) Procedures That Require Prior Authorization 306
14.6.C A CERTIFICATE OF MEDICAL NECESSITY MAY NOT BE USED FOR CERTAIN PROCEDURES 307
14.7 ADMISSION CERTIFICATION FORMS 307
14.8 NURSING HOME FORMS 307
14.8.A MISSOURI CARE OPTIONS (PRE-LONG-TERM CARE SCREENING [PLTC]) 307
14.8.A(1) DA-13 307
14.8.B PREADMISSION SCREENING (PASRR) 308
14.8.C LEVEL OF CARE DETERMINATION 308
14.8.C(1) DA-124A/B FORM 308
14.9 RISK APPRAISAL FOR PREGNANT WOMEN 309
SECTION 15-BILLING INSTRUCTIONS 310
15.1 ELECTRONIC DATA INTERCHANGE 310

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION 310
15.3 CMS-1500 AND PHARMACY CLAIM FORMS 311
15.4 PROVIDER COMMUNICATION UNIT 311
15.5 RESUBMISSION OF CLAIMS 311
15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET 311
15.7 CMS-1500 CLAIM FILING INSTRUCTIONS 312
15.8 PLACE OF SERVICE CODES 318
15.9 INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS 322
15.10 INSURANCE COVERAGE CODES 323
15.11 DOSE OPTIMIZATION 323
SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS 324
16.1 GENERAL INFORMATION 324
16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS) 325
16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE 326
16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS 327
16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS 328
16.5 TIMELY FILING 328
16.6 REIMBURSEMENT 328
16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS 328
16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS 329
SECTION 17-CLAIMS DISPOSITION 330
17.1 ACCESS TO REMITTANCE ADVICES 330
17.2 INTERNET AUTHORIZATION 331
17.3 ON-LINE HELP 331
17.4 REMITTANCE ADVICE 331
17.5 CLAIM STATUS MESSAGE CODES 335
17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS 335
17.6 SPLIT CLAIM 336
17.7 ADJUSTED CLAIMS 336
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED) 337
17.9 CLAIM ATTACHMENT STATUS 337
17.10 PRIOR AUTHORIZATION STATUS 338
SECTION 18—DIAGNOSIS CODES 339
18.1 GENERAL INFORMATION 339
SECTION 19-PROCEDURE CODES 340
19.1 ANNUAL NURSING HOME PHYSICAL 340
19.2 CASE MANAGEMENT PROCEDURES 340
19.3 HEALTHY CHILDREN AND YOUTH (HCY) SCREENING CODES 341

19.4 GLOBAL PRENATAL **341**
19.5 SUPPLIES **342**
19.6 X-RAY **342**
19.7 DIABETES SELF-MANAGEMENT TRAINING **342**
SECTION 20-EXCEPTION PROCESS **344**
20.1 EXCEPTION PRINCIPLE **344**
20.2 REQUIREMENTS **344**
20.3 RESTRICTIONS **346**
20.4 REQUESTING AN EXCEPTION **347**
20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS 348
20.4.B NON-EMERGENCY EXCEPTION REQUESTS 348
SECTION 21- ADVANCE HEALTH CARE DIRECTIVES **349**
SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) **350**
22.1 INTRODUCTION **350**
22.2 DEFINITIONS **350**
22.3 COVERED SERVICES **355**
22.4 PARTICIPANT ELIGIBILITY **356**
22.5 NON-COVERED PARTICIPANTS **356**
22.6 TRAVEL STANDARDS **356**
22.7 COPAYMENTS **360**
22.8 MODES OF TRANSPORTATION **361**
22.9 LEVEL OF SERVICE **362**
22.10 ARRANGING TRANSPORTATION **362**
22.11 NON-COVERED SERVICES **362**
22.12 PUBLIC ENTITY REQUIREMENTS **363**
22.13 PROVIDER REQUIREMENTS **364**
22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS **365**
22.15 PARTICIPANT RIGHTS **365**
22.16 DENIALS **366**
22.17 PARTICIPANT GRIEVANCE PROCESS **366**
22.18 STANDING ORDERS **366**
22.19 ANCILLARY SERVICES **367**
22.19.A ANCILLARY SERVICES REQUEST PROCEDURE 368
22.20 WHERE'S MY RIDE? (WMR) **369**
22.21 QUALITY ASSURANCE (QA) PROCEDURE **369**
22.22 FREQUENTLY ASKED QUESTIONS **370**
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING **372**
23.1 CLAIM ATTACHMENT SUBMISSIONS **372**
23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY **373**
MEDICAID CASE MANAGEMENT PROVIDERS - PREGNANT WOMEN AND CHILDREN'S PROGRAMS **374**

MOBILE X-RAY PROCEDURE CODES **382**
VFC ADMINISTRATION CODES **383**

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.

END OF SECTION

TOP OF SECTION

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).

END OF SECTION

TOP OF SECTION

SECTION 3 - STAKEHOLDER SERVICES

3.1 PROVIDER SERVICES

The MHD has various units to assist providers with questions regarding proper claims filing, claims resolution and disposition, payment problems, participant eligibility verification, prior authorization status, coverage inquiries, and proper billing methods and procedures. Additionally, the Missouri Medicaid Audit and Compliance Unit (MMAC) assists providers with enrollment as an MHD provider, enrollment questions and verifications. Assistance can be obtained by contacting the appropriate unit.

3.1.A MHD TECHNICAL HELP DESK

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

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

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

3.2 Missouri Medicaid Audit & Compliance (MMAC)

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

3.2.A PROVIDER ENROLLMENT UNIT

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

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. NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

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

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

3.10 Pharmacy & Clinical Services Unit

This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by 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

TOP OF SECTION

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

TOP OF SECTION

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

TOP OF PAGE

SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

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

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

Service

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

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

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

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

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

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

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

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

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

TOP OF PAGE

SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

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

9.2 PLACE OF SERVICE (POS)

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

03 School
11 Office
12 Home
19 Off Campus Outpatient Hospital
21 Inpatient Hospital
22 On Campus Outpatient Hospital
25 Birthing Center

71 State or Local Public Health Clinic
72 Rural Health Clinic
99 Other

9.3 DIAGNOSIS CODE

The Early Periodic Screening diagnosis code *must* appear as the primary diagnosis on a claim form submitted for HCY screening services.

The appropriate HCY screening procedure code should be used for the initial HCY screen and all other full or partial screens.

9.4 INTERPERIODIC SCREENS

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

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

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

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/behavioral health development;
- Health education (including anticipatory guidance);
- Appropriate immunizations according to age;*
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);*
- Lead screening according to established guidelines;
- Hearing screening;
- Vision screening; and
- Dental screening.

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

It is mandatory that the provider document in the patient's medical record that a preventive screening was provided. The provider can document the screenings in an electronic medical record, written medical record, or use the Bright Futures screening forms. Whether written or electronic, the record must contain all of the components of a full HCY screening.

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they

make them available to appropriate state and federal officials on request. Providers *must* document the screening in the medical record if billing a screening.

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

9.6.A DEVELOPMENTAL ASSESSMENT

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

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

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

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

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

9.6.A(1) Qualified Providers

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

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Speech/language therapist;
- Physical therapist
- Occupational therapist; or

- 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
Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers
Steel welders and cutters
Construction workers
Bridge reconstruction workers
Rubber products manufacturers
Gas station attendants
Battery manufacturers
Chemical and chemical preparation
Manufacturers
Industrial machinery and equipment operators
Firing Range Instructors
ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline

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

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

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

9.7.B LEAD RISK ASSESSMENT

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

If a child is determined by the verbal risk assessment to be high risk, a blood lead level test is required, beginning at six months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter (µg/dL) no further action is required. Subsequent verbal lead risk assessments can change a child's risk category. A verbal risk assessment is required at every visit prescribed in the EPSDT periodicity schedule through 72 months of age and if considered to be high risk *must* receive a blood lead level test, unless the child has already received a blood lead test within the last six months of the periodic visit.

A blood lead test result equal to or greater than 10 µg/dL obtained by capillary specimen (finger stick) *must* be confirmed using venous blood according to the time frame listed below:

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

For future reference and follow-up care, completion of the HCY Lead Risk Assessment Guide is still required at these visits to determine if a child is at risk.

9.7.C(4) MO HealthNet Managed Care Health Plans

The MO HealthNet Managed Care health plans are responsible for mandatory risk assessment for children between the ages of 6 months and 72 months. MO HealthNet Managed Care health plans are also responsible for mandatory blood testing if a child is at risk or if the child is 12 or 24 months of age. MO HealthNet Managed Care health plans *must* follow the HCY Lead Risk Assessment Guide when assessing a child for risk of lead poisoning or when treating a child found to be poisoned.

MO HealthNet Managed Care health plans are responsible for lead case management for those children with elevated blood lead levels. MO HealthNet Managed Care health plans are encouraged to work closely with the MO HealthNet Division and local public health agencies when a child with an elevated blood lead level has been identified.

Referral for an environmental investigation of the child's residence *must* be made to the local public health agency. This investigation is *not* the responsibility of the MO HealthNet Managed Care health plan, but can be reimbursed by the MO HealthNet Division on a fee-for-service basis.

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

When performing a lead risk assessment in Medicaid eligible children, CMS requires the use of the blood lead level test at 12 and 24 months of age and when a child is deemed high risk. The erythrocyte protoporphyrin (EP) test is *not* acceptable as a blood lead level test for lead poisoning. The following procedure code *must* be used to bill the blood lead test:

(Capillary specimen or venous blood samples.)

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

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

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

Missouri State Public Health Laboratory
101 Chestnut St,
Jefferson City, MO 65101

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

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

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

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

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

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

Quest Diagnostics
11636 Administration
St. Louis, MO 63146

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

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

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

Iowa Hygenic Lab

Wallace State Office Building

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Methodist Medical Center
1200 Pleasant St.

Des Moines, IA 50307

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Des Moines, IA 50309

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

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

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.

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

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

Children may be screened at any time the physician, nurse practitioner or nurse midwife* feels it is medically necessary to provide additional screening services. *If it is medically necessary for a full medical screen* (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	3 Years

3-4 Days	4 Years
By 1 Month	5 Years
2 Months	6 Years
4 Months	7 Years
6 Months	8 Years
9 Months	9 Years
12 Months	10 Years
15 Months	11 Years
18 Months	12 Years
24 Months	13 Years
30 Months	14 Years
	15 Years
	16 Years
	17 Years
	18 Years
	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, prior authorization *must* be requested prior to delivering services. Refer to instructions found in Section 13 of the provider manual for information on services requiring prior authorization. Complete the Prior Authorization Request form in full, describing in full detail the service being requested and submit in accordance with requirements in Section 13 of the provider manual.

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

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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 ensuring that Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.

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

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

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

a) A comprehensive unclothed physical examination

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

c) Health education (including anticipatory guidance)

d) Appropriate immunizations according to age

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

f) Lead screen according to established guidelines

g) Hearing screen

h) Vision screen

i) Dental screen

Partial screens which are segments of the full screen may be provided by appropriate providers. The purpose of this is to increase access to care to all children. Providers of partial screens are required to

supply a referral source for the full screen. (For the plan enrollees this should be the primary care physician). A partial screen does *not* replace the need for a full medical screen which includes all of the above components. See Section 9, page 5 through 8 for specific information on partial screens.

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

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 HCY LEAD SCREENING GUIDE

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

END OF SECTION

TOP OF SECTION

SECTION 10-FAMILY PLANNING

10.1 FAMILY PLANNING SERVICES

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

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

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

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

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

10.2 COVERED SERVICES

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

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

10.2.A LONG-ACTING REVERSIBLE CONTRACEPTION (LARC) DEVICES

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

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

MHD currently has a Fiscal Edit in place to prevent duplicate billing of non-oral contraceptive products. Providers are responsible for checking criteria to confirm their patient's eligibility for a LARC device prior to billing MHD. The criteria for non-oral contraceptive products are available at: http://dss.mo.gov/mhd/cs/pharmacy/pdf/non-oral-contraceptives.pdf Login to 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
- 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.

END OF SECTION

TOP OF SECTION

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 PHYSICIAN SERVICES

Reimbursement for physician services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

12.3 DETERMINING A FEE

Under a fee system each procedure, service, medical supply and equipment covered under a

specific program has a maximum allowable fee established.

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

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee;
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.

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

12.3.A ON-LINE FEE SCHEDULE

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

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

Refer to Section 13 for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider. See Section 16 for a detailed explanation of these claims.

12.5 PARTICIPANT COST SHARING AND COPAY

Certain MO HealthNet services are subject to participant cost sharing or copay. The cost sharing amount is paid by the participant at the time services are rendered. Services of the Physician

Program described in this manual are subject to a cost sharing or copay amount. The provider *must*
accept in full the amounts paid by the state agency plus any cost sharing or copay amount required of the participant. Refer to Section 13 for program specific information.

12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

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

12.6.A MO HEALTHNET MANAGED HEALTH CARE

Under a 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 and Section 11 for a detailed description.

END OF SECTION

TOP OF PAGE

SECTION 13-BENEFITS AND LIMITATIONS

This section contains specific information regarding the benefits and limitations of the Physician Program. This section contains specific information regarding the benefits and limitations of the Physician Program. Physicians, physician assistants, assistant physicians, chiropractors (**effective January 1, 2020**), and nurse practitioners are subject to the benefit limitations and coverage restrictions set forth in this manual.

Information regarding provider participation issues such as, nondiscrimination, and retention of records are addressed at length in Section 2.

Participant eligibility and nonliability information is addressed in Section 1. Third party liability is addressed in Section 5. Please refer to these and other general sections for specific information.

13.1 PROVIDER PARTICIPATION

Physicians may participate in the Title XIX Medicaid Program if the following requirements are met:

- The physician holds a valid certificate of registration or licensure within the state of practice (13 CSR 70-3.030(2) (A) 13);
- A Missouri Title XIX participation agreement is completed and approved by the MO HealthNet Division.

Please review Section 2 of this manual for a discussion of provider participation.

13.2 LOCK-IN PARTICIPANTS

"Lock-in" is the term used to describe participants who are restricted to specific providers. When providers verify participant eligibility, the lock-in provider is identified. Section 1 has a more detailed discussion of this policy.

In order 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, completed progress notes from the participant's medical record must be attached to the claim when it is submitted for payment explaining the emergency.
2. Participants are locked-in to another provider for administrative purposes, e.g., abuse, overutilization, etc. These participants *must* be referred by the lock-in provider for services. The PI-118 referral form is to be completed and signed by the Authorized Lock-In Provider when a referral to another provider is medically necessary. The referral is valid for a maximum of 30 days. The referral form *must* be submitted with each claim in order for the

performing provider to receive payment. Provider numbers begin with the provider type of the individual provider, e.g., physician, clinic, pharmacy, etc. For further explanation of the Lock-In Program and a copy and explanation of the Medical Referral Form of Restricted Participant (PI-118) form, refer to Section 1.

Also see Section 13.29, MO HealthNet Managed Care Program, for additional information on restrictions to specific providers as a result of enrollment in a MO HealthNet Managed Care health plan.

13.3 PRESUMPTIVE ELIGIBILITY PROGRAM (TEMP)

Reference Section 1.5.H for information on TEMP participants.

13.3. A TEMP BENEFIT LIMITATIONS

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 1.5.H (2) for information on what is and is *not* covered for TEMP participants.

13.3. B FULL MO HEALTHNET ELIGIBILITY AFTER TEMP

Reference Section 1.5.H (3) for information on MO HealthNet eligibility after TEMP.

13.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

A child born to a woman who is eligible for and receiving 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 until the child's first birthday. Reference Section 1 for detailed information regarding automatic newborn eligibility.

13.5 QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM

Section 301 of the Medicare Catastrophic Coverage Act of 1988 makes individuals who are Qualified Medicare Beneficiaries (QMB) a mandatory coverage group under MO HealthNet for the purpose of paying Medicare deductible and coinsurance amounts on their behalf. Refer to Section 1 for detailed information on QMB participants.

13.5. A HOW THE QMB PROGRAM AFFECTS PROVIDERS

It is 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, MO HealthNet only reimburses providers for Medicare deductible and coinsurance amounts as well as Medicare Part C deductible, coinsurance and copayment amounts for services covered by Medicare, including providers of services *not* currently covered by MO HealthNet such as independent therapists. 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. The medical eligibility code of the participant is "55."
- A QMB and MO HealthNet eligible participant may receive all services (within limitations) covered by MO HealthNet and provided by enrolled providers. MO HealthNet also covers all Medicare deductible and coinsurance amounts as well as Medicare Part C Deductible, coinsurance and copayment amounts for services provided by providers who may or may not participate in MO HealthNet. Reference Section 1 for further information.

13.6 THIRD PARTY LIABILITY (TPL)

It is a federal requirement that MO HealthNet be the payer of last resort for medical services covered under the state plan. Any insurance or other source that is liable for payment of services provided to a participant *must* be utilized before MO HealthNet reimburses for that service.

The purpose of administering a third party liability program is to ensure that federal and state funds are *not* misspent for covered services to MO HealthNet participants when third parties exist who may be legally liable for those services. A claims processing edit denies a claim when no TPL information is shown on the claim, but the participant file indicates other insurance.

Federal regulations at 42 CFR 447.20 prohibit a provider from refusing to furnish services covered by MO HealthNet to an individual who is eligible for MO HealthNet because of a third party's potential liability for the service.

Providers may report changes in insurance coverage directly to the MO HealthNet Program when they learn of them from the participant or the insurance company with the MO HealthNet Insurance Resource Report (TPL-4).

Section 5 of the provider manual explains TPL in detail. Section 15 discusses billing information regarding TPL.

13.7 SERVICE MODIFIERS

Claims submitted to MO HealthNet *must* reflect the appropriate modifier with a procedure code when billing for the services defined below.

MODIFIER	DESCRIPTION
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia service performed personally by anesthesiologist
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
TC	Technical Component
UC	EPSDT Referral for Follow-up Care (required if EPSDT referral is made)

13.8 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM, ALSO KNOWN AS EPSDT

Refer to Section 9 for complete information regarding EPSDT.

13.9 LEAD SCREENING AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM

Reference Section 9 for complete information.

13.10 EXPANDED EPSDT/HCY SERVICES

As a result of the Omnibus Reconciliation Act of 1989 (OBRA 89) mandate, medically necessary items or services that the Social Security Act permits to be covered under MO HealthNet and 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. Some services require prior authorization. For more information, reference the Therapy Manual, Section 13.

Therapy Evaluation Services: Evaluations for physical, occupational and speech therapy are covered services for individuals under age 21. Four hours of evaluation per discipline for a child (per provider) are covered within a twelve-month period.

A prescription is required for physical and occupational therapy evaluation or treatment services. A written referral is required for speech/language evaluation or treatment services.

Therapy Treatment Services: Expanded therapy services, i.e., physical (PT), occupational (OT) and speech/language (ST) therapy treatment services are covered for individuals under age 21. Prior authorization is *not* required but the service *must* be prescribed by an -appropriately licensed healthcare provider, provided to a MO HealthNet eligible participant and billed by a MO HealthNet enrolled provider.

PT, OT and ST treatment services that exceed one hour and fifteen minutes per day or five hours weekly are considered intensive therapy treatment services and require the provider to submit documentation of the medical necessity of the intensive treatment therapy service(s). Reference the Therapy Manual for more information.

Surgeries: Noncovered surgeries and/or procedures in the 10000—69979 range of CPT require prior authorization. When requesting prior authorization of a noncovered procedure for an HCY participant under the age of 21, add the modifier EP to the existing five-digit code and identify the request as an "HCY Request." These requests should be directed to Wipro Infocrossing Healthcare Services.

Psychiatric Services: Reference Section 13.47.

Other HCY services can be referenced in the following manuals: DME, Optical, Hearing Aid, Psychology/Counseling, Dental, etc. Some services that are normally noncovered may be covered; some require prior authorization.

13.11 MO HEALTHNET HEALTHY CHILDREN AND YOUTH PAMPHLET

A copy of the MO HealthNet Healthy Children & Youth Pamphlet may be requested for distribution to patients. Call (573) 751-2896 or the pamphlet may be printed for distribution.

13.12 PREVENTIVE MEDICINE SERVICES

The purpose of the HCY Program is to ensure a comprehensive, preventive health care program for all MO HealthNet eligible individuals who are under the age of 21 years. 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 screenings, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening. Reference Section 9 for additional information on the HCY Program.

13.12. A VACCINE FOR CHILDREN (VFC) PROGRAM

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. Providers may bill for the administration of the free vaccine by using the appropriate VFC Administration Codes. Providers must not use any additional administration procedure code. The MO HealthNet reimbursement for the administration is $5.27 per component. The administration fee(s) may be billed in addition to a Healthy Children and Youth (HCY) screen, a preventive medicine service, or in addition to an office visit if a service other than administration of a vaccine was provided to the child. Providers enrolled as Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) *must not* bill an additional administration fee for any vaccine.

For more information regard the specific guidelines of the VFC Program contact the following:

Department of Health and Senior Services
Bureau of Immunization of Assessment and Assurance
PO Box 570
Jefferson City, MO 65109
(800) 219-3224 or (573) 526-5220

13.12. A (1) VFC for MO HealthNet Managed Care Participants

MO HealthNet Managed Care health plans and their providers *must* use the VFC vaccine for MO HealthNet Managed Care participants. The health plans do *not* receive an additional administration fee as reimbursement is included in the health plan's capitation payment. Health plans may have different payment arrangements with their providers and the VFC administration fee may be included in the

capitation payment from the health plan to the provider. However, the health plan reimbursement to public health departments should be $5.27 per vaccine component unless otherwise regulated. Providers should contact the appropriate MO HealthNet Managed Care health plan for correct billing procedures.

13.12. A (2) Immunizations Outside VFC Guidelines

If an immunization is given to a MO HealthNet participant who does *not* meet the VFC guidelines, use the standard procedure for billing injections. Providers should bill on the Pharmacy Claim form using the national drug code (NDC). Refer to Section 13.23.B for additional billing information.

13.12. A (3) Vaccine Shortages

In cases of vaccine shortages, providers are notified by bulletin and given further instructions.

13.12. B ILLNESS CARE

If an abnormality is detected during a preventive medicine examination and follow-up care or treatment is required, diagnosis codes should reflect the abnormality or condition for which the follow-up care or treatment is indicated, such as anemia, respiratory problems, heart murmur, underweight, overweight, infections, etc. In these situations, the appropriate Office/Outpatient procedure code is used, rather than the Preventive Medicine codes.

13.12. C SCHOOL/ATHLETIC PHYSICALS

A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis codes Z00.121 or Z00.129, should be used. This also applies for other school physicals when required as conditions for entry into or continuance in the educational process. Use the appropriate Preventive Medicine code with the appropriate modifiers. Reference Section 9.5 for the appropriate modifiers.

13.12. D WOMEN, INFANTS AND CHILDREN (WIC) SERVICES

WIC agencies with MO HealthNet NPIs for the agency and the performing provider may bill for a minimal office visit (CPT code 99211) and for a hemoglobin lab (CPT code 85018) performed during a certification or re-certification of MO HealthNet eligible WIC clients, only if the agency is able to substantiate its costs exceed any amounts received from other sources of funding. Costs associated with the WIC services are non-reimbursable costs for Federally Qualified Health Centers (FQHCs). If the WIC provider cannot substantiate that its costs do not exceed funds received from other sources, then the agency cannot bill MO HealthNet for the WIC services.

13.13 REPORTING CHILD ABUSE CASES

State Statute 210.115 RSMo (Cum. Supp. 1992) requires physicians, hospitals and other specified personnel to report possible child abuse cases to the Family Support Division Child Abuse Hot Line, (800) 392-3738.

13.14 SAFE-CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services (DHSS) are covered by the MO HealthNet Division. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis.

It is extremely important for MO HealthNet enrolled providers furnishing SAFE-CARE examinations to identify children who are eligible for MO HealthNet or MO HealthNet Managed Care benefits. In order to maximize funding, claims for these children should be submitted to MO HealthNet for processing. Do *not* send claims for these children to the Family Support Division (FSD) or to the local county FSD offices for reimbursement.

Eligibility may be verified by contacting the county FSD office in which the child resides, by logging onto the Internet at www.emomed.com or by calling the MO HealthNet Division interactive voice response system at (573) 751-2896. To use the interactive voice response system the provider needs either the child's MO HealthNet or MO HealthNet Managed Care ID number, the child's Social Security Number and date of birth, or the mother's MO HealthNet or MO HealthNet Managed Care ID number and the child's date of birth. Refer to Section 1 for more information on eligibility.

The examination for sexual or physical abuse for MO HealthNet Managed Care and fee-for-service MO HealthNet children *must* be billed using one of the following procedure codes, when provided by a MO HealthNet enrolled SAFE trained provider:

PROC CODE	DESCRIPTION
99205U7	SAFE, Sexual Assault Findings Examination
99205U752	CARE, Child Abuse Resource Education Examination

NOTE: It is *not* allowable to bill both a SAFE *and* a CARE examination for the same child on the same day.

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):

57420 U7	57452 U7	81025 U7	86317 U7	86592 U7	86631 U7
86632 U7	86687 U7	86688 U7	86689 U7	87076 U7	87077 U7
87110 U7	87210 U7	87390 U7	87391 U7	87534 U7	87535 U7
87536 U7	87537 U7	87538 U7	87539 U7	99170 U7	

Claims for laboratory tests **performed by someone other than the SAFE-CARE provider** require the referring physician information on the professional claim. The performing laboratory need *not* be authorized as a SAFE-CARE provider to perform and receive reimbursement for the testing.

Laboratory tests for SAFE-CARE exams are *not* restricted to the tests listed above and may include any medically necessary tests ordered by the SAFE-CARE provider. The specific tests listed above are excluded from the MO HealthNet Managed Care plan's responsibility and should be billed to the MO HealthNet Program as fee-for-service. However, laboratory tests *not* included on this list but ordered by the SAFE-CARE provider **are** the responsibility of the MO HealthNet Managed Care plan for a participant enrolled in that program.

13.14. A SAFE-CARE EXAMINATION FORMS

Providers may obtain the SAFE-CARE (Sexual Assault Forensic Examination/Child Abuse Resource and Education) Network Medical Examination form by calling the program administrator, at (573) 526-4405 or by faxing a request to (573) 526-5347. The request may also be sent in writing to:

SAFE-CARE Network
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102

The SAFE-CARE examination form is also available at
http://health.mo.gov/living/families/injuries/safecare/pdf/ExamForm.pdf

SAFE-CARE providers may use the electronic form instead of the paper form. This eliminates the need for providers to send paper copies to the Missouri Department of Health

and Senior Services (DHSS) for data collection. For additional information on the electronic system, please contact the SAFE-CARE Network at (573) 526-4405.

13.15 BUREAU OF SPECIAL HEALTH CARE NEEDS: AREA/DISTRICT OFFICES AND COUNTY LISTINGS

Reference the Bureau of Special Health Care Needs Area Offices map and the BSHCN Area Office County Listing.

13.16 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. This amount is referred to as copay. The copay amount is paid by the participant at the time services are rendered. Some services of the Physician Program described in this manual are subject to a copay amount. The provider *must* accept in full the amounts paid by the state agency plus any copay amount required of the participant.

When the MO HealthNet Maximum Allowed Amount for an office visit is equal to or less than the copay amount, the provider should charge the lesser amount of the Maximum Allowed Amount or the copay.

13.16. A PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS

Providers are responsible for collecting the copayment amounts from the MO HealthNet participant. 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. The MO HealthNet Program shall *not* increase its reimbursement to a provider to offset an uncollected copayment from a participant. The provider shall collect a copayment from a participant at the time each service is provided or at a later date. A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant’s statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copay amounts collected and of the copay amount due but uncollected because the participant did *not* make payment when the service was rendered.

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

13.16. B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS

Unless otherwise exempted (Refer to Section 13.16.B (2)) it is the responsibility of the participant to pay the required copay amount due. Whether or not the participant has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service.

13.16. B (1) Copay Amounts

Unless an exemption applies, each provider providing treatment for each date of service on which the participant receives services shall charge the following copayments:

Physician, MD or DO	$1.00
Nurse Practitioner	$1.00
Physician Assistant	$1.00
Assistant Physician	$1.00
Independent Clinic	$. 50
FQHC	$2.00
Independent X-ray	$1.00
Independent Laboratory	$1.00
CRNA/AA	$ .50
Case Management	$1.00
Public Health Department Clinic	$ .50
Teaching Institution	$ .50

13.16. B (2) Exemptions to the Copay Amount

The following participants or conditions are exemptions to the participant's responsibility for the cost sharing amount:

- Services provided to participants under 19 years of age; or participants receiving MO HealthNet under the following categories of assistance: ME codes 06, 33, 34, 36, 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 MO HealthNet under the following categories of assistance: ME codes 23 and 41;

- Services provided to participants who have both Medicare and MO HealthNet, if Medicare covers the service and provides payment for it; or participants receiving MO HealthNet 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 a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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; serious impairment of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or others due to an alcohol or drug abuse emergency, injury to self or bodily harm to others, or 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;
- 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 MO HealthNet 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 MO HealthNet under the following categories: ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Services identified as medically necessary through an EPSDT screen;
- Services provided to persons receiving MO HealthNet under a category of assistance for the blind: ME codes 02, 03, 12, and 15;
- Services provided to 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;
- MO HealthNet 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 the person's physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility or skilled nursing facility.

The exemption to the copay amount is identified by MHD when processing the claim. The italicized information shown in parenthesis below are claim form identifiers that *must* be included on the claim form in order for the exemption to apply:

- Services related to an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen. *(Diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129 or an EPSDT condition code must appear on the claim form and/or the participant must be age 18 and under on the date of service.)*
- Emergency services (*Condition Code AJ & Emergency Indicator)*;
- Drugs and services specifically identified as relating to family planning services *(Drug class or family planning indicator and/or family planning diagnosis codes)*;
- Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy *(pregnancy diagnosis code)*;
- Therapy services in an emergency room or outpatient hospital setting. (Physical therapy, Chemotherapy, Radiation therapy, Psychology/ Counseling and Renal Dialysis) (Condition code AJ and exempt therapy procedure codes).

13.17 SUPERVISION

13.17. A PHYSICIAN'S OFFICE/INDEPENDENT CLINICS

Services and supplies rendered in a private practice setting are considered incidental to a physician's professional services (and therefore billable by the physician) only when there is direct personal supervision by the physician. This rule applies to services of auxiliary personnel *employed by* the physician and working under the physician's supervision such as nurses, technicians, therapists, physician assistants and other aides.

Direct personal supervision in the office setting does *not* mean that the physician *must* be present in the same room with the auxiliary personnel. However, the physician *must* be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel are performing services. Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

If auxiliary personnel perform the services outside the office setting, the services are likewise covered as incidental to the physician services only if there is direct personal supervision by the physician. For example, if a nurse accompanies the physician on house calls and administers an injection, the injection is covered; if the same nurse makes the call alone and administers the injection, the service is *not* covered since the physician is *not* providing direct personal supervision.

13.17. A (1) Physician Assistant

Physician assistant services billed by a collaborating physician must be billed using modifier AR (Physician provider services in a physician scarcity area/physician assistant services). Physician assistant services will also be reimbursed when provided in a hospital setting. The services must also be billed using modifier AR by a collaborating physician.

For dates of service on or after August 17, 2015, physician assistants may enroll as a MO HealthNet provider and submit claims for service reimbursement. A physician assistant shall only practice at a location where a physician routinely provides patient care, except existing patients of the collaborating physician in the patient's home. The collaborating physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Appropriate supervision shall require the collaborating physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. A collaborative practice agreement shall limit a physician assistant to practice only at locations with a geographic proximity to be determined by the board of registration for the healing arts. For physician assistants working in certified community behavioral health clinics, RHCs or FQHCs, no supervision requirements, in addition to the federal law, shall be required.

A physician assistant must be licensed by the Missouri Board of Healing Arts as set forth in 20 CSR 2150-7 and must practice within their scope of practice referenced in Section 334.735 of the Missouri Revised Statutes, which includes:

- Taking patient histories;
- Performing physical examinations of a patient;
- Performing or assisting in the performance of routine office laboratory and patient screening procedures;
- Performing routine therapeutic procedures;
- Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;
- Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a licensed physician;
- Assisting the collaborating physician in institutional settings, including reviewing of treatment plans, ordering of tests, diagnostic laboratory and radiological services, and ordering of therapies using procedures reviewed and approved by a licensed physician;
- Assisting in surgery, however physician assistants cannot be assistant surgeons;
- Performing such other tasks not prohibited by law under the supervision of a licensed physician; and
- Physician assistants shall not perform or prescribe abortions.

Physician assistants shall not prescribe nor dispense any drug, medicine, device or therapy unless pursuant to a physician collaborative practice agreement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing and dispensing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a physician assistant collaborative practice agreement which is specific to the clinical conditions treated by the collaborating physician and the physician assistant shall be subject to the following:

- A physician assistant shall only prescribe controlled substances in accordance with section 334.747;
- The types of drugs, medications, devices or therapies prescribed or dispensed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the collaborating physician;

- All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the collaborating physician;
- A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request, receive and sign for noncontrolled professional samples and may distribute professional samples to patients;
- A physician assistant shall not prescribe any drugs, medicines, devices or therapies the collaborating physician is not qualified or authorized to prescribe; and
- A physician assistant may only dispense starter doses of medication to cover a period of time for seventy-two hours or less.

13.17. A. (2) Nurse Practitioner Services

Nurse practitioner services billed by a collaborating physician are only billable when there is direct personal supervision by the physician. Direct personal supervision does not mean that the physician must be present in the same room with the auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the nurse practitioner is performing the service. Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

Nurse practitioners may enroll as providers with MHD. Nurse practitioners are subject to the benefit limitations and coverage restrictions set forth in the Physician's Manual. The policy above is only for those nurse practitioner services billed by a supervising physician.

13.17. A (3) Assistant Physician Services

An assistant physician (AP) is a medical school graduate who has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination within the three-year period immediately preceding application for licensure as an AP, or within three years after graduation from a medical college or osteopathic medical college, whichever is later. An AP has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding three-year period, unless when such three-year anniversary occurred he or she was serving as a resident physician in an accredited residency in the United

States and continued to do so within thirty days prior to application for licensure as an AP.

An AP must have a collaborative practice arrangement with a licensed physician as referenced in Section 334.037 of the Missouri Revised Statutes. The collaborating physician is responsible at all times for the oversight of the AP and accepts all responsibility for the primary care services provided by the AP.

An AP may only provide primary care services and vaccines within the scope of a collaborative practice arrangement. Primary care services are those identified by the following Current Procedural Terminology (CPT) codes:

- 99201 through 99215 for new and established patient office or other outpatient evaluation and management (E/M) visits;
- 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services; and
- 99341 through 99350 for new and established patient home E/M visits.

Collaborative practice arrangements, which shall be in writing, may delegate to an AP the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the AP, and is consistent with that AP's skill, training, and competence and the skill and training of the collaborating physician.

13.17. B RESIDENTS IN TEACHING/CLINICAL SETTING

In order for a teaching physician to bill for services of a resident, the teaching physician *must* be physically present during the key portion of the service. The teaching physician *must* personally document, in the medical record, his/her presence and participation in the service. MO HealthNet does not provide reimbursement for medical direction or supervision of students in a teaching, training or other setting.

13.17. C MEDICARE PRIMARY CARE EXCEPTION

MO HealthNet recognizes the Medicare Primary Care Exception. Under this exception, MO HealthNet may be billed for reasonable and necessary low to mid-level Evaluation and Management (E/M) services when provided by a resident without the presence of a teaching physician.

13.17. C (1) Resident Requirements

Residents providing the billable patient care service without the physical presence of a teaching physician *must* have completed at least six months of a Graduate Medical Education (GME) approved residency program. Centers *must* maintain the documentation under the provisions at 42 CFR 413.86 (i).

Residents generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include acute care for ongoing conditions, coordination of care furnished by other physicians and providers, and comprehensive care *not* limited by organ system or diagnosis.

13.17. C (2) Teaching Physician Requirements

Teaching physicians submitting claims under this exception may *not* supervise more than four residents at a time and *must* be immediately available if needed. The teaching physician *must* have no other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident. The teaching physician *must* have the primary medical responsibility for patients cared for by the residents, ensure that the care provided was reasonable and necessary, review the care provided by the resident during or immediately after each visit, and document the extent of his/her own participation in the review and direction of the services furnished to each patient.

13.17. C (3) Location of Services

The services *must* be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by the residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is *not* met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a non-hospital entity, verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86 (f) (4) (ii).

13.17 C (4) Billing Guidelines

The GE modifier *must* be used to denote services provided under the primary care exception. The primary care exception applies only to specific low and mid-level E/M codes for both new and established patients. The new patient Current Procedural Terminology Codes (CPT) codes to which the exception applies are

99201, 99202, and 99203. The established patient CPT codes are 99211, 99212, and 99213.

13.17. D PUBLIC HEALTH DEPARTMENT CLINICS AND PLANNED PARENTHOOD CLINICS

The physician's presence is *not* required onsite in Public Health Department and Planned Parenthood Clinic settings when a written protocol is developed, implemented and evaluated by the physician and the registered nurse. The facility *must* ensure the protocols are current. The physician *must* ensure the services are appropriate and medically necessary.

A copy of this protocol *must* be located in each individual clinic. Clinic staff *must* furnish or make this protocol available for inspection by the Department of Social Services upon request.

This policy applies only to the services provided in a clinic setting as typically maintained by Public Health Department clinics and Planned Parenthood clinics. **This policy does *not* apply in individual physician offices or independent clinics.** The policy in those situations continues to require that the physician be onsite and render direct personal supervision. This policy also does *not* apply to psychiatric services wherever provided. The policy in those situations continues to require that the services be personally provided by the physician.

All services *must* be billed by the clinic on a professional claim. The provider number of the enrolled physician assuming responsibility for these services through a written protocol *must* be shown in the appropriate field on the claim for each service billed.

13.18 DEFINITIONS AND LEVELS OF SERVICE

Services billed to the MO HealthNet Program as rendered for a given diagnosis should *not* exceed the level of service defined for new or established patients. Definitions are described in the “Guidelines” section of the CPT book. Please refer to the definitions and explanation given for the use of codes when determining the level of service to be used for each patient. The CPT definitions and levels pertain to office or other outpatient services, hospital, inpatient services, consultations, home services, etc.

13.19 PLACE OF SERVICE

Physician services may be provided in settings such as the physician's office, the participant's home or other place of residence, the hospital, or settings such as a clinical facility, ambulatory surgical care facility, or school.

Two-digit numeric place of service (POS) codes *must* be used when filing claims to MO HealthNet. A listing of POS codes and definitions is located in Section 15, Billing Instructions.

13.20 OFFICE OR OTHER OUTPATIENT SERVICES

The procedure codes to be used to report evaluation and management services provided in the physician's office, an outpatient hospital facility, or other ambulatory facilities are found in the CPT book. A patient is considered an outpatient until inpatient admission to a health care facility occurs. Non-emergency services provided in an emergency room should be considered clinic (outpatient) place of service (POS) for billing purposes.

13.20. A LIMITATIONS TO OFFICE/OUTPATIENT SERVICES

- Office/outpatient services are to be used for "illness" care and are limited to one visit per participant per provider per day. Additional medically necessary visits on the same day may be covered if a properly completed Certificate of Medical Necessity form is attached to the claim and approved by the medical consultant. (See Section 7 for instructions on completion of the Certificate of Medical Necessity form.)
- An office/outpatient physician visit includes, but is *not* limited to, the following:
    - Examining the patient and obtaining a medical history for symptoms or indications of an illness or medical condition. For children's examinations as required for school education purposes, reference Section 13.12.C. Reference Section 9 for information on Healthy Children and Youth (HCY) screenings;
    - Administering injections;
    - Preparing bacterial, fungal and cytopathology smear(s) and cultures;
    - Obtaining specimens (urine, blood, etc.);
    - Using any instrument to examine and/or diagnose the illness or condition;
    - Fitting a diaphragm;
    - Furnishing supplies (e.g., gowns, drapes, gloves, urine cups, swabs, etc.) (Reference Section 19.5 for billable supplies);
    - Preparing medical records and all required forms.
- An office/outpatient service may *not* be billed on the same date of service as a home visit, subsequent hospital visit, consultation, preventive medicine services, HCY screening, or nursing home visit. (An office visit may be billed on the same date of service as a hospital admission if the office visit is not related to the hospital admission. All office/outpatient services provided by the admitting physician in conjunction with the admission are considered part of the initial hospital care.)
- An office/outpatient visit may *not* be billed on the same date of service as any of the psychotherapy visits. (Reference Section 13.47 for information on psychiatric services)

- An office visit is *not* covered if the only service is to obtain a prescription, the need for which has been determined previously.
- An office/outpatient visit may only be billed on the same date of service as a physical medicine modality or procedure when an office/outpatient visit service is provided. (If planned therapy is the only service received, an office/outpatient visit should *not* be billed in addition to the therapy procedure.)
- Procedure code 99201 (new patient) or 99211 (established patient) may be billed for the administration of an injection if the injection does *not* have an administration procedure code.
- "New patient" office/outpatient services are limited to one per provider for each participant. Visits subsequent to the "new patient" office/outpatient services *must* be coded as "established patient" office/outpatient services as defined in the CPT procedural coding book.
- Healthy Children and Youth (HCY), also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT), full and partial screenings are covered in accordance with the periodicity schedule and procedures outlined in Section 9 of this manual.
- A "new patient," office/outpatient, for a physician in a group or clinic is defined as one that has *not* been seen by another member of the group who has the same specialty. Subsequent services *must* be coded as "established patient" services.

13.20. B HISTORY AND EXAMINATION (OUTPATIENT) PRIOR TO OUTPATIENT SURGERY

Procedure codes 99201-99215 may be used in the outpatient setting (POS 22) for the initial history and physical workup prior to outpatient surgery.

13.21 SPECIAL SERVICES AND REPORTS

13.21. A PHYSICIAN SERVICES—AFTER HOURS

Procedure code 99050, "Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed," may be billed in addition to the appropriate procedure code for the service, for those services provided before or after the physician's designated office hours. "Designated office hours" are defined as those hours known and understood by the public as times the office is regularly open for business.

"After hours" designation may only be applied to those unusual circumstances occurring outside the regular/designated office hours as represented to the public, and during which the physician is not normally on-site. This policy is applicable only to physician office/clinic services and RHC/FQHC services.

13.21. B PHYSICIAN SERVICES—SUNDAYS/HOLIDAYS

For those physician office/clinic services requested on Sundays or on one of the following specified holidays, the physician may bill procedure code 99051 "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours", in addition to the appropriate procedure code for the service performed.

The following holidays are recognized:

- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- New Year's Day

13.21. C CRITICAL CARE SERVICES

13.21. C (1) Newborn Care

See **Section 13.59**.

13.21. C (2) Critical Care Services

Critical care services represent delivery of medical services by a team of skilled professionals, directed by an appropriately trained physician or physicians, for a critically ill or injured patient. A critical illness or injury connotes a high likelihood of imminent or life-threatening deterioration in the patient's condition and the risk of organ failure requiring the immediate availability of skilled health care providers who can continuously monitor the patient's condition, as well as recognize and treat organ system failure. Some conditions that require critical care services include, but are not limited to: hemorrhagic, hypovolemic, cardiogenic or septic shock, cardiac, respiratory, hepatic or renal failure, and life threatening post-operative complications. Critical care services require an extensive and specialized medical knowledge base, advanced and complex medical decision-making, and considerable technical expertise.

When services are provided to a critically ill neonate or young child in an intensive care unit that does *not* provide 24 hour direct physician supervision (*not* a Pediatric Intensive Care Unit (PICU) or a Neonatal Intensive Care Unit (NICU)) procedure codes 99291-99292 should be used to report the actual minutes spent in direct care.

Procedure codes 99471-99472 are used to report physician services provided in a PICU by a physician directing the care of a critically ill infant or young child from 29 days of postnatal age up through 24 months of age. Codes 99468-99469 report services provided by a physician directing the care of a neonate 28 days or less in a NICU. Codes 99478-99480 are used to report services subsequent to the day of admission provided by a physician directing the continuing intensive care of the low birth weight or very low birth weight infant who no longer meets the definition of critically ill. Procedure codes 99471-99480 are used when the health care team is under 24-hour direct physician supervision and may only be reported once a day.

Critical care is usually, but *not* always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit or the emergency care facility. The supervising physician assumes complete responsibility for the direct provision of critical care services and/or the supervision of the team providing these services at all times. When the supervising physician is not immediately available at the bedside, it is required that the supervising physician maintains constant awareness of the experience, skills, and capabilities of those skilled medical professionals immediately available to the bedside pending his or her physical presence. It is likewise incumbent upon the skilled team members immediately available to the patient to ensure that the supervising physician is made aware of changes in the patient's condition that might necessitate his or her physical presence.

All members of the critical care services team must be credentialed to provide critical care services and the procedures necessary to accomplish those services by their institution and state licensing boards. The team composition will vary by setting, patient age and diagnosis and may include: certified neonatal nurses, physician assistants, residents, fellows, and neonatal nurse practitioners, hospitalist physicians, pediatric intensivists, or attending neonatologists. Every health care setting is strongly encouraged by the MO HealthNet Division to ensure a minimum level of competency for all medical professionals serving in areas where critical care services are provided, and in particular for those periods when the supervising physician is not immediately available to the bedside.

The following services are included in the reimbursement for critical care when performed during the critical period by the physician: the interpretation of cardiac output measurements; chest x-rays; pulse oximetry, blood gases and information data stored in computers, e.g., ECGs, blood pressures, hematologic data; gastric intubation; temporary transcutaneous pacing; ventilator management; pulse oximetry; and vascular access procedures. Any services performed which are *not* listed above may be reported separately.

13.21. C (3) Initial Care Services

Procedure code 99291 is to be used only for initial care for the first 30 to 74 minutes (maximum quantity is 1) and procedure code 99292 is used for each additional 30 minutes up to a maximum of eight units per day (4 additional hours per day). Reference the CPT Book for descriptions of the procedure codes.-check units

Services for a patient who is *not* critically ill but who is in a critical care unit should be reported using subsequent hospital care codes (99231-99233).

Hospital visits may *not* be billed on the same date of service, by the same physician, as any of the critical care procedure codes.

Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the critical care time, even when they are performed in the critical care unit at a patient's bedside.

13.22 OFFICE MEDICAL SUPPLY CODES

Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit. Appropriate supplies may be billed by the provider with the appropriate procedure code. Refer to Section 19.5 for a list of supply and material procedure codes. Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may *not* be billed separately. Providers may *not* bill for any reusable supplies.

An invoice of cost showing the cost and the description of the supply *must* be submitted with the claim when procedure code 99070 is billed.

An electronic invoice of cost attachment is available to providers through the billing website at www.emomed.com.

13.23 PRESCRIPTION DRUGS

All drug products produced by manufacturers that have entered into a rebate agreement with the Federal Government are reimbursable under the MO HealthNet Pharmacy Program, with the exception of Drug Efficacy Study Implementation (DESI) drugs and drugs falling outside the definition of a covered outpatient drug, as defined in Section 1927(k) (2), (k) (3) and (k) (4) of the Social Security Act, which are excluded from coverage.

A list of manufacturers that have entered into a rebate agreement with the Federal Government (along with the first five digits of the NDC number by which products may be identified), can be found in Drug Company Contact Information. Products for which the first five digits of NDC numbers are *not* included on the list are *not* reimbursable under the MO HealthNet Pharmacy

Program and are *not* available through any prior authorization program. The federal Centers for Medicare & Medicaid Services (CMS) have required that participating manufacturers identify products which are affected by the Drug Efficacy Study Implementation (DESI). CMS has instructed state Medicaid programs that products identified as such are *not* subject to federal financial participation and are therefore *not* reimbursable under the MO HealthNet Pharmacy Program.

To comply with the Deficit Reduction Act of 2005 (DRA) states must now collect the 11-digit National Drug Codes (NDC) on all outpatient drug claims submitted to the MO HealthNet program for rebate purposes. Providers are required to submit their claims for all medications administered in the clinic or outpatient hospital setting, with the exact NDC that appears on the product dispensed or administered. Should a dispute arise between MO HealthNet utilization data and a manufacturer's estimation of product sold, data is supplied to the manufacturer to resolve the dispute. If necessary, zip code or provider-specific utilization data is provided. Should data indicate that a provider is billing fraudulently by using NDCs other than those identifying the actual product dispensed, the information is referred to the Missouri Medicaid Audit & Compliance (MMAC) Unit and may result in legal action, provider sanctions and possible termination from the program.

13.23. A PRESCRIBING LONG-TERM MAINTENANCE DRUGS

Maintenance medications are drugs taken on a regular basis for an ongoing condition such as but not limited to diabetes, high blood pressure, cholesterol or asthma. Maintenance medications are required to be prescribed for no less than a one-month supply when, in the prescriber's professional judgment, the patient's diagnosis has been established, the condition stabilized, and the drug has achieved the desired effect and may be safely prescribed ongoing. Pharmacy providers are to dispense in the manner prescribed. Regardless of the dispensing system utilized, long term care and all maintenance medications may be billed no more frequently than one time per month. The MO HealthNet Pharmacy Program will not allow refill of medications for weekend passes, leaves of absence or utilization of reserve days. There will be no exceptions for these circumstances beyond those required to implement a change in the prescribed dosage.

13.23. B INJECTIONS AND IMMUNIZATIONS

Injections are covered only if administered by a physician, a physician assistant, advanced practice nurse or by a nurse or other qualified health care provider under the physician's supervision. Injections that are *not* considered by accepted standards of medical practice to be a specific or effective treatment for the particular diagnosis for which they are given are *not* covered.

Injections that exceed the frequency or duration indicated by accepted standards of medical practice and are *not* justified by extenuating circumstances are *not* covered.

Providers may bill procedure code(s) 90460-90461 or 90471-90472 for the administration of vaccines/toxoids. If a significant separately identifiable Evaluation and Management (E/M) service is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration code. Rural Health Clinics (RHCs) (provider based) and Federally Qualified Health Centers (FQHCs) may *not* separately bill for the administration of an injection regardless of whether or not there is an encounter with a core service provider. The costs for these services are to be included in the RHC and FQHC cost reports. These procedure codes do *not* apply to the immunizations included in the Vaccine for Children (VFC) Program. Providers should use the appropriate VFC Administration Codes to bill for the administration of VFC immunizations.

When vaccines are furnished at no cost to the practitioner by the Department of Health and Senior Services, Centers for Disease Control and Prevention, the vaccines *cannot* be billed to MO HealthNet. Refer to Section 13.12.A for information on the Vaccine for Children (VFC) Program

MO HealthNet pays for allergen immunotherapy (95120-95134 and 95165) performed in the office. (An office visit may *not* be billed in addition to these codes unless another identifiable service was provided at that time—in addition to allergen immunotherapy.) Reference Section 13.41.H (3) for additional information.

Physicians *must* bill for injectables administered in their offices on an electronic Pharmacy Claim form. Non-retail pharmacy claim submissions are limited to a one day supply unless specifically noted otherwise in this manual. This method of billing provides physicians with a broader range of products to select from in treating their patients. All FDA approved products are accessible and no diagnosis-based limitations apply.

Reimbursement for injectables billed on the Pharmacy Claim is made on the basis of the lower of the following:

1. Applicable Wholesaler Acquisition Cost (WAC), plus 10%,
2. Applicable Missouri Maximum Allowable Cost (MAC),
3. Applicable Federal Upper Limit,

   or

4. Usual and customary charge.

Products administered *must* be identified on the Pharmacy Claim using the precise 11 digit National Drug Code (NDC) found on the product package.

The Omnibus Budget Reconciliation Act of 1990 provides that a rebate *must* be paid for products of manufacturers participating in the National Rebate Agreement. These rebates are paid by the manufacturer to state Medicaid programs on the basis of NDC specific utilization

data. Therefore, it is essential that providers submit claims utilizing the precise 11 digit NDC found on the package from which the product is administered.

13.23. C RABIES TREATMENT

Physicians *must* bill on the Pharmacy Claim form using the National Drug Code (NDC) for rabies vaccine administered in an office setting. Refer to Section 15 for billing information.

13.23. D CHEMOTHERAPY

Chemotherapy injections are covered for the treatment of malignancies. Providers bill for the drug using the appropriate NDC on the Pharmacy Claim. Chemotherapy administration services 96401 through 96425 are covered in an office setting. Infusion therapy services provided in an inpatient or outpatient setting are *not* separately billable services.

13.23. E HERCEPTIN

Herceptin is administered in the physician's office and may be billed on the Pharmacy Claim using the national drug code (NDC). Herceptin is packaged in a multiple dose (440 milligram) powder-filled vial. This drug is unique as it should be billed by MILLIGRAM rather than vial. The appropriate office visit may be billed in addition to the drug.

13.23. F EXCEPTIONS TO BILLING ON THE PHARMACY CLAIM

The following exceptions apply in specific instances:

- Ambulatory Surgical Centers (Specialty B5) *must NOT* bill separately for injections, as the facility payment includes all supplies and equipment.
- Mental Health Regional Centers

(Specialty 56) are restricted to annual assessments and daily specialized services only.

- Public Health Department Clinics *must* bill on the professional claim in accordance with special instructions for vaccines provided by the Centers for Disease Control and Prevention (CDC). Contact the Provider Relations Communication Unit at (573) 751-2896 for more information. All other (purchased) vaccines *must* be billed on the Pharmacy Claim.

13.23. G CLAIM FILING FOR INJECTABLE MEDICATIONS

The Pharmacy Claim is significantly different from the professional claim used for billing other MO HealthNet covered physician services. The quantity to be billed for injectable medications dispensed to MO HealthNet participants *must* be calculated as follows:

- Containers of medication in solution (for example, ampules, 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 for example: Copaxone Pegasys.
- The product Herceptin, by Genentech, *must* be billed by milligram rather than by vial.
- Immunizations and vaccines *must* be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

13.23. H INFUSION THERAPY

The following infusion therapy procedures are covered in the office setting and require the presence of the physician *during* the infusion. They are *not* to be used for intradermal, subcutaneous, intramuscular or routine IV drug injections. Physicians may bill a maximum of eight units of IV services using procedure code 96361 in addition to one hour of 96360 making a total of nine units of IV therapy.

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. I INSERTION, REVISION AND REMOVAL OF IMPLANTABLE INTRAVENOUS INFUSION PUMP OR VENOUS ACCESS PORT

The surgeon bills for the actual insertion of the pump. If performed on an inpatient basis, the hospital includes the cost of the pump in its ancillary charges. If done in the outpatient facility, the pump should be billed by the hospital using the outpatient supply code.

13.24 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 means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, 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 participant is stabilized in order to maintain the stabilized conditions or to improve or resolve the participant's condition.

13.25 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 the Participant Services Unit:

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 for any covered service. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

13.25. 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.
5. All border state providers

13.26 CONSULTATIONS

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. It is ***not*** a referral of a patient to another physician for care and treatment.

The request for a consultation from the attending physician or other appropriate source and the need for consultation *must* be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed *must* also be documented in the patient's medical record and communicated to the requesting physician or appropriate source.

Consultations are *not* appropriate when the consultant and the attending physician "concurrently" continue to monitor, treat and prescribe on an ongoing basis. In these situations hospital or office visits should be used, being especially aware of the *diagnosis* for which each physician is providing treatment. (Reference Section 13.27).

There are two subcategories of consultations: office or other outpatient consultations, initial inpatient.

13.26. A OFFICE OR OTHER OUTPATIENT CONSULTATIONS

Follow-up visits in the consultant's office or other outpatient facility that are initiated by the consultant are *not* to be reported as consultations. These services are to be reported using office visit codes for established patients (99211-99215).

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

13.26. B GUIDELINES FOR THE USE OF CONSULTATIONS

MO HealthNet has established the following guidelines concerning consultations:

- A consultation may be provided in any setting: inpatient or outpatient hospital, office/clinic, emergency room or home.
- Subject to existing limitations, a confirmatory consultation provided by a physician of any specialty related to the diagnosis and performed prior to surgery is payable, regardless of whether or not the consulting physician performed the surgery.
- A confirmatory consultation by a surgeon is payable even if the recommendations for surgery do *not* agree or if surgery is *not* performed.
- Only one consultation is allowed by the same provider per participant, per hospital stay for the same diagnosis.
- Consultations by more than one provider specialist may be allowed for multiple diagnoses.
- Follow-up hospital visits by the consulting physician *assuming patient management* on subsequent days are payable.
- If the consultant continues to monitor treatment of a patient on an ongoing basis, hospital or office visits should be billed instead of a consultation.
- An *office* consultation and hospital admission on the same date of service is allowed.
- A *hospital* consultation is *not* allowed following a hospital admission by the same physician.
- A consultation is *not* allowed by the same provider on the same date of service as any of these procedures: office/outpatient visit, home visit, emergency room visit, subsequent inpatient hospital visit, nursing home visit, psychiatric service, psychotherapy, infant/child/adolescent care, physical therapy procedures, HCY/EPSDT screening.

- Consultation services *must* be documented in the appropriate office/hospital records.
- A consultation report *must* be attached to the claim when billing the highest level of office/outpatient consult codes (99245) and the highest level of inpatient consult (99255).

13.27 CONCURRENT CARE

Concurrent care is defined as medical care rendered by more than one physician to a seriously ill patient during the course of an illness when the patient's condition requires the special skills of more than one physician (e.g., neurologist following surgery involving brain and spinal cord; cardiologist following open-heart surgery; internist following amputation of a limb for participant with diabetes).

Payment is made for concurrent care visits by more than one physician specialist or subspecialist on the same date of service only when the medical need is clearly documented by the nature of the diagnosis and the description of the service provided.

Routine concurrent care visits made at the request of the patient or family or made as a matter of personal interest in a continuing patient/physician relationship are *not* covered.

13.28 ADULT PHYSICALS

One adult "preventive" examination/physical, including a well woman exam (ages 21 and older) per 12 months is covered by MO HealthNet. Physicals are also covered when required as a condition of employment. Diagnosis codes Z00.00 or Z00.01 or diagnosis codes Z01.411 or Z01.419, should be used and billed under the appropriate preventative medicine procedure code (99385-99387 or 99395-99397).

13.29 MO HEALTHNET MANAGED CARE PROGRAM

MO HealthNet eligibles who meet specific eligibility criteria receive services through a managed health care plan known as the MO HealthNet Managed Care program. Participants enroll in a health plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the MO HealthNet Managed Care Program have the opportunity to choose their own health plan and primary care provider. Most physician services are included in the Managed Care program.

Providers are advised to verify MO HealthNet eligibility prior to delivering a service because MO HealthNet eligibility can and often does change. If the patient is a participant in the managed care program, specific procedures *must* be followed before a service can be rendered. For information on identifying MO HealthNet Managed Care participants, reference Section 1.2.C (2). For complete information on the MO HealthNet Managed Care programs, reference Section 11.

13.30 HOSPITAL SERVICES

13.30. A PHYSICIAN SERVICES

All physician services provided in hospital inpatient, outpatient or emergency room setting *must* be billed on the professional claim. This policy includes the professional components of radiology and pathology. (Reference Section 15 for further billing instructions.)

MO HealthNet enrolled physicians who are *not* hospital salaried or contractually compensated by the hospital may bill for their own services, or the group/clinic with whom the physician is associated may bill for the physician services, identifying the performing provider on the professional claim. All services billed by the physician/clinic using the individual provider number *must* have been performed by the billing provider and there *must* be documentation in the patient's medical record for each service billed.

13.30. A (1) Hospital Salaried Physicians

Services provided in the hospital or a clinic that is considered by Medicare as part of the hospital must be billed using the All Department provider identifier in the billing field and the individual who performed the service in the performing field.

All physicians and advanced practice providers who provide services to MO HealthNet participants must enroll individually.

If there are clinics that are considered part of the hospital then all of the individual practitioners providing services in the clinic(s) must also enroll individually.

A hospital may enroll their departments separately only if they have a separate Medicare identifier and NPI for each department.

13.30. B HOSPITAL CARE

Evaluation and Management services on the same date provided in sites other than the hospital that are related to the admission should *not* be reported separately by the admitting physician, as they are considered part of the initial hospital care. The inpatient care level of service reported by the admitting physician should include the services related to the admission that the physician provided in the other sites of service as well as those in the inpatient setting.

13.30. C LIMITATIONS

- Inpatient hospital lengths of stay are limited to the lesser of:
    - the number of medically necessary days billed by the hospital; or
    - the number of days approved through admission and continued stay reviews based on the diagnosis/age/surgery limitations.

- For infants less than 1 year of age at admission, all medically necessary days are paid.
- For admissions exempt from admission and continued stay reviews, the 75th percentile of the *Length of Stay by Diagnosis and Operation, North Central Region, 1988*, applies.
- Daily hospital visits are limited to one per provider per day for each participant.
- Hospital discharge day management (99238-99239) is a covered service to report the physician's final examination, continuing care instructions, etc., and can only be billed by the admitting physician. Do *not* bill these procedure codes for completion of the discharge summary only.
- A hospital visit may *not* be billed on the same date of service as hospital discharge day management (99238).
- A hospital visit for the same patient on the same day as another medical procedure (non-visit type of service) billed by that physician is noncovered.
- Services provided in an inpatient or outpatient hospital setting by nursing and/or hospital personnel are *not* billable services by a physician, for example, starting of IVs, catheterizations, etc.

NOTE: For planning purposes, physicians should be aware of established and special lengths of stay when admitting patients.

13.31 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's inpatient review authority will receive all the appropriate information necessary to review admissions subject to admission certification. Reference Section 13.28 of the Hospital Manual for more information on Inpatient Hospital Certification Reviews.

13.32 ANESTHESIA SERVICES

Anesthesia services are covered when performed by an Anesthesiologist, Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA). Medical direction of anesthetists by an anesthesiologist is also a covered service.

Services involving administration of anesthesia are reported by the use of the anesthesia CPT procedure codes (00100-01999) plus the following modifier codes:

AA - Anesthesia service performed personally by anesthesiologist

QX - CRNA/AA service with medical direction by a physician

QZ - CRNA service without medical direction by a physician

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.

The service for which anesthesia is billed *must* be a covered service. The provider of anesthesia services is required to ensure the procedure is a covered service.

Administration of local infiltration, digital block or topical anesthesia by the operating surgeon or obstetrician is included in the surgery or delivery fee, and a separate charge for administration is non-allowed.

An epidural performed as a separate procedure is reimbursable at 100% of the MO HealthNet allowable fee, whether a physician or a CRNA performs the service. Injections of anesthetic substance (e.g., epidural), *must* be billed using the appropriate CPT procedure code (i.e., 62311 or 62319). Providers may only bill using a unit of 1. Spinal anesthesia is *not* covered with modifiers AA, QK, QX and QZ.

Local anesthesia is *not* covered as a separate service. It is included in the procedure/surgery charge if provided in a physician's office; included in the facility charge if provided in an ambulatory surgical center (ASC) or outpatient department of a hospital; or included in the accommodation charge for the facility if provided on an inpatient basis.

Anesthesia agents or supplies used in the physician's office prior to the performance of other surgical procedures may be billed by using supply code 99070. An invoice showing the cost and the description of the supply *must* be submitted with the claim.

Anesthesia services include the usual preoperative and postoperative visits; the anesthesia care during the procedure; the administration of fluids and/or blood; and the usual monitoring procedures; e.g., monitoring of blood gases, cardiac monitoring, etc. *Do not* bill MO HealthNet separately for services that are included in the anesthesia service.

Moderate (Conscious) Sedation includes: assessment of the patient, establishment of IV access, administration of agent(s), maintenance of sedation, monitoring of oxygen saturation, heart rate, and blood pressure, and recovery. The following codes are payable by MO HealthNet:

99143 99144 99145 99148 99149 99150

Insertion of an intra-arterial, central venous or Swan-Ganz catheter is *not* included in routine monitoring and may be billed separately.

13.32. A GENERAL ANESTHESIA FOR CT SCANS

There may be an occasional need for anesthesia during CT scan services as a result of medically necessary circumstances, e.g., hyperactive child, intellectually disabled individual, etc. Procedure code 76499, unlisted diagnostic radiologic procedure, may be billed. A copy

of the anesthesia report is required and is manually priced by the state medical consultant. Procedure code 01922, with the appropriate modifier may be billed.

Payment for anesthesia services is determined within the system and is based on minutes of use, the Anesthesia Relative Value and the conversion factor for the anesthesiologist or CRNA.

13.32. B CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

MO HealthNet recognizes qualified CRNAs as independent providers with the capability for direct billing of medical or surgical services if they are allowed to furnish these services under Missouri state law. Payments may be made directly to the CRNA or to the hospital or physician employing or contracting the CRNA.

The CRNA *must* have a valid license as a registered nurse and maintain current certification from the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

Noncovered CRNA Procedures: MO HealthNet does *not* reimburse CRNAs for the critical care codes 99291-99292, as these procedures are payable only to a physician. However, procedures such as insertion of a Swan-Ganz catheter by a CRNA during a critical care visit are payable.

13.32. B (1) Inpatient Hospital Services

CRNAs whose services are billed on a professional claim should enroll as MO HealthNet providers. Teaching Department Hospitals may bill with their NPI and enter the CRNA MO HealthNet provider identifier as the performing provider.

13.32. B (2) Outpatient Hospital Services

All CRNA services provided in the outpatient department of a hospital *must* be billed on a professional claim. Hospital-based or contractually compensated CRNAs should be enrolled as MO HealthNet providers in order to bill for their services. Reimbursement is on a fee-for-service basis.

The billing provider may be the hospital if the CRNA is hospital salaried or contractually compensated. If the CRNA is employed by a physician, the physician may bill for those services using the appropriate modifier. CRNAs who are self-employed and have no financial compensation from the hospital may bill for outpatient hospital services under their own provider identifier, also using the appropriate modifier.

13.32. C MEDICAL DIRECTION BY ANESTHESIOLOGIST

MO HealthNet covers reimbursement to *anesthesiologists* for medical direction of qualified and licensed anesthetists, i.e., Certified Registered Nurse Anesthetists (CRNA)* and Anesthesiologist Assistants (AA) **. CRNAs may or may *not* be independently enrolled in order for an anesthesiologist to qualify for medical direction.

Regardless of the employment/contractual relationship that may exist between the CRNA/AA physician/ anesthesiologist/ hospital, the criteria/protocols present in each facility that dictate the presence of and medical direction by, an anesthesiologist is accepted, if criteria as stipulated in this manual have been/are being met.

MO HealthNet does *not* provide reimbursement for medical direction or supervision of students in a teaching, training or other setting.

13.32. C (1) Concurrent Medical Direction

The concurrent medical direction of at least two, but *not* more than four, anesthetists may be reimbursed if the following additional requirements are met:

For each patient, the physician:

- performs and documents a pre-anesthetic examination and evaluation;
- prescribes the anesthesia plan;
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergency;
- ensures that any procedures in the anesthesia plan that the physician does *not* perform are performed by a qualified individual;
- monitors the course of anesthesia administration at frequent intervals;
- remains physically present and available for immediate diagnosis and treatment of emergencies; and
- provides indicated post-anesthesia care.

A physician who is concurrently directing the administration of anesthesia should ordinarily *not* be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area or periodic monitoring of an obstetrical patient does *not* substantially diminish the scope of control exercised by the physician. However, if the physician leaves the immediate area of the operating suite for other than a short duration or devotes extensive time to other patients or situations, medical direction ends.

13.32. C (2) Supervision Billing Guidelines

- All physician claims for anesthesia medical direction are one-line claims limited to anesthesia services provided to individual participants and containing the adjusted total number of minutes of anesthesia rendered to the specific patient.
- The modifier to be used for medical direction is QK.
- Medical direction is payable to physicians with provider specialty 05 (anesthesiology).
- Bill the anesthesia procedure code for the major procedure on the professional claim.
- Procedure codes to be used are the CPT anesthesia procedure codes (00100-01999).
- When the anesthesiologist and anesthetist are both involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist, and the procedure should then be billed using modifier AA. No separate payment is allowed for supervision, nor for the anesthetist's service, regardless of whether or not the anesthetist (i.e., CRNA) is independently enrolled as a MO HealthNet provider. *A separate payment for the CRNA is only payable if documentation is attached showing that it was medically necessary for both the anesthesiologist and the CRNA to be involved.* If the CRNA service was *not* medically necessary, recoupment of the CRNA service may be made.
- Medical direction of two, three or four anesthetists is allowed by *billing for the adjusted total number of minutes representing the entire procedure(s) appropriate to each participant* (regardless of the number of concurrent procedures performed on each participant) as no percentage reductions are made for concurrent procedures. Billing for concurrent medical direction *must* be adjusted to accurately reflect only that portion of time during which medical direction, as defined, continues to be provided.
- Medical direction by a surgeon may *not* be billed to MO HealthNet.

13.32. D ANESTHESIOLOGISTS IN A GROUP PRACTICE

For those anesthesiologists in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another furnishes the other component parts of the anesthesia service. However, the medical record *must* indicate that the services were furnished by physicians and identify the physicians who rendered them.

13.32. E ANESTHESIOLOGIST SERVICES (DENTAL) ASC

MO HealthNet covers certain dental services in a freestanding ambulatory surgical care (ASC) facility for those patients who are unable to cooperate in the conventional dental setting due to age, disability or behavioral health problems.

These services include tooth extraction, removal of wisdom/impacted teeth and pedodontic restoration (may include one or more of the following: complete clinical examination, prophylaxis, fluoride treatment, restorations, extractions, removal of wisdom/impacted teeth, pulpotomies, root canals and crowns). Adults with a limited benefit package have restricted dental benefits. Please reference the Dental Provider Manual.

When anesthesia services are performed in an ASC facility for any of the aforementioned types of dental procedures, the anesthesiologist *must* bill procedure code 00170 (Anesthesia for intraoral procedures, including biopsy; not otherwise specified). The code is limited to one per participant per date of service using the appropriate anesthesia modifier and place of service 24, Ambulatory Surgical Center. Enter the total number of minutes on the professional claim. *An operative report and anesthesia report are required.*

13.32. F ANESTHESIA SERVICES FOR MULTIPLE SURGERIES

Anesthesia providers may only bill for one procedure per operative setting using the appropriate anesthesia modifier. When anesthesia is administered for multiple surgical procedures for the same participant (same operative setting/date of service), only the major surgical procedure may be billed. Anesthesia time for *all* of the procedures should be calculated into total minutes and billed using the major procedure code only. Services may *not* be billed separately for the other procedures performed. Refer to Section 13.32. G for additional instructions on calculating the time.

If the participant was taken back to surgery because of medical complications, a Certificate of Medical Necessity form or Anesthesia Report *must* be attached documenting surgery performed during another time frame.

13.32. G CALCULATION OF ANESTHESIA SERVICES

Base Rate (Relative Value x Conversion Factor) + Time (Time Unit(s) x Conversion Factor) = Maximum Allowable Fee.

- The **base rate** (the **relative value** x the **conversion factor** appropriate for the provider type) is reflected as the "payment amount" in the pricing file**. This is *not* the total reimbursement amount, but is used in the calculation**.
- **Anesthesia time unit(s):** Each 15-minute unit of anesthesia is equal to a time unit of 1. For instance, an anesthesia service (i.e., administration or supervision) of one hour

constitutes a unit value of 4. **However, the total number of minutes of anesthesia (60) *must* be shown on the professional claim. The system converts into units.**

- **Increments less than 15 minutes** are priced at a percentage of the conversion factor and added to the total amount payable.

1-5 minutes over 1 unit = 25%

6-9 minutes over 1 unit = 50%

10-13 minutes over 1 unit = 75%

14-15 minutes over 1 unit = 100%

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

If more than 15 minutes elapse between the operating room (OR) time and the start of surgery, an explanation should be provided. The industry standard for the amount of time between transferring the patient to the recovery room and the anesthesia stop time is five to 15 minutes. If it is longer than this, the documentation should clearly explain the reasons for the prolonged anesthesia time.

The professional claim *must* reflect the appropriate anesthesia procedure code, modifier and the actual anesthesia time in minutes.

The system calculates the reimbursement amount based on the above information. This *must* be entered correctly in order for the correct payment to be made.

13.32. H QUALIFYING CIRCUMSTANCES FOR ANESTHESIA

Many anesthesia services are provided under particularly difficult circumstances depending on factors such as the extraordinary condition of the patient, notable operative conditions or unusual risk factors. The following qualifying circumstances significantly impact on the character of the anesthetic service provided. These procedures are *not* reported alone but are reported in addition to the appropriate anesthesia procedure code and appropriate modifier.

PROC CODE	DESCRIPTION

99100.....	Anesthesia for patient of extreme age, under one year and over seventy.
99116.....	Anesthesia complicated by utilization of total body hypothermia.
99135.....	Anesthesia complicated by utilization of controlled hypotension.
99140.....	Anesthesia complicated by emergency conditions (specify).

An emergency is defined in Section 13.24.

When reporting one of the above procedure codes, the maximum quantity is always 1, as reimbursement is based on a fixed maximum allowable amount. Do *not* use the anesthesia modifiers, AA, QK, QC or QZ *when billing for these specific procedures.*

Anesthesia services for surgical procedures requiring Certification of Medical Necessity for Abortion, (Sterilization) Consent Form or Acknowledgement of Receipt of Hysterectomy Information form *must* be accompanied by these documents, properly executed, to be allowed (See Section 14).

13.32. I ANESTHESIA NONCOVERED SERVICES

Any surgical procedure listed as noncovered for surgery is also noncovered for anesthesiology.

Anesthesiologist monitoring telemetry in the operating room is a noncovered service.

Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.

Anesthesiologist, CRNA/AA services are *not* covered in the recovery room.

13.32. I (1) Anesthesiologist Assistant (AA)

MO HealthNet allows an Anesthesiologist Assistant (AA) to enroll as a MO HealthNet provider. An AA is a person who works under the supervision of a licensed anesthesiologist and provides anesthesia services and related care. They *must* be licensed by the Missouri Board of Healing Arts as set forth in 20 CSR 2150-9 and submit a copy of the license to the MO HealthNet Division. The AA *must* also submit the name and mailing address of the supervising anesthesiologist.

An AA shall practice only under the direct supervision of an anesthesiologist who is physically present or immediately available. A supervising anesthesiologist shall be allowed to supervise up to four AAs concurrently

An AA *must* practice within their scope of practice referenced in Section 334.402 of the Missouri Revised Statutes. This includes:

- Obtaining a comprehensive patient history, performing relevant elements of a physical exam and presenting the history to the supervising anesthesiologist;
- Pretesting and calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and monitors, in consultation with an anesthesiologist;
- Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques;
- Establishing basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support;
- Administering intermittent vasoactive drugs, and starting and adjusting vasoactive infusions;
- Administering anesthetic drugs, adjuvant drugs and accessory drugs;
- Assisting the supervising anesthesiologist with the performance of epidural anesthetic procedures, spinal anesthetic procedures and other regional anesthetic techniques;
- Administering blood, blood products, and supportive fluids;
- Providing assistance to a cardiopulmonary resuscitation team in response to a threatening situation;
- Participating in administrative, research, and clinical teaching activities as authorized by the supervising anesthesiologist; or
- Performing other tasks *not* prohibited by law under supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to perform.

An AA is prohibited from the following:

- Prescribing any medications or controlled substances;
- Administering any drugs, medicines, devices, or therapies the supervising anesthesiologist is *not* qualified or authorized to prescribe;
- Practicing or attempting to practice without the supervision of a licensed anesthesiologist or in any location where the supervising anesthesiologist is *not* immediately available for consultation, assistance, and intervention.

The provider of anesthesia services is required to ensure the procedure is a covered service. An AA and a CRNA are *not* allowed to bill for the same anesthesia services.

When the anesthesiologist personally performs a service, the procedure should be billed using the AA modifier. No separate payment is allowed for supervision by the anesthesiologist, nor for the AA's service, regardless of whether or not the AA is independently enrolled as a MO HealthNet provider. A separate payment for the AA is only payable if documentation is attached showing that it was medically necessary for both the anesthesiologist and the AA to be involved. If the AA service was *not* medically necessary, recoupment of the AA service may be made.

Reference the MO HealthNet fee schedule for coverage and reimbursement information at www.dss.mo.gov/mhd. AA codes are listed under Anesthesia-Certified Registered Nurse Anesthetist/AA.

13.33 SURGERY

Surgical services under the MO HealthNet Program are covered as described in this manual, and are also subject to certain restrictions, limitations, exclusions and requirements, as specified.

13.33. A ORTHOPEDIC SURGERY—CASTING, REMOVAL, MATERIALS

Application of casts, strapping and splints (29000-29590) are replacement procedures only to be used during the 30-day postoperative period if the casting is performed due to a complication (e.g., patient fell and broke cast, wound infection, etc.) or after the 30-day postoperative period. Subsequent visits are payable only if additional services were provided at the time of cast application.

Codes for cast removal (29700-29715) should be used only for casts applied by another physician.

Reference the appropriate HCPCS codes for cast supplies.

13.33. B ELECTROMAGNETIC TREATMENT OF FRACTURES USING NONINVASIVE OSTEOGENESIS STIMULATOR DEVICE

CPT procedure code 20974—Electrical stimulation to aid bone healing; noninvasive (non-operative) is a covered service for treatment of:

- nonunion of long bone fractures (1 cm or less);
- failed fusion;
- congenital pseudoarthrosis.

This procedure requires prior authorization.

The patient's history, general medical information, prior orthopedic history, present diagnosis and condition and prescription measurements *must* be visible on the corporate (supplier) orthopedic prescription form signed by the prescribing physician. The prescription form and a Prior Authorization Request form *must* be submitted for review by the state medical consultant and returned to the supplier dispensing the stimulator, indicating approval or denial. Refer to Section 8 for information on prior authorization request procedures.

The fee includes x-ray evaluation and consultation by the physician's medical staff, fabrication and loan (6 months or more) of a treatment unit calibrated to the patient's site specifications, shipping, and any necessary servicing or technical support.

13.33. C ROUTINE FOOT CARE/DEBRIDEMENT OF NAILS

MO HealthNet does not cover routine foot care. This involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement or reduction), and other hygienic or preventive maintenance.

Foot care is *not* considered routine when the claim indicates the participant has a diagnosis of diabetes mellitus or other peripheral vascular disease (e.g., diabetes with peripheral circulatory disorders, Raynaud's Syndrome, thromboangiitis obliterans and other specified peripheral vascular disease).

When coding unilateral or bilateral debridement of nails, procedure code 11720 (debridement of nail(s) any method, one to five) or procedure code 11721 (same, six or more), the number of units of service (quantity) should be one for each procedure code.

Refer to Section 13.62 for information on limitations for certain podiatry services.

13.33. D ASSISTANT SURGEON

MO HealthNet adheres to the guidelines set by Centers for Medicare & Medicaid Services (CMS) for assistants at surgery. The services of an assistant surgeon are billed with modifier 80. Reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the assistant surgeon column of the database instruct carriers how to reimburse for services. The fee schedule can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

NOTE: Not all codes in the listing are covered by MO HealthNet; refer to the MO HealthNet fee schedule.

An assistant surgeon's fee is payable at 20% of the surgeon's fee for the surgical procedure. Only one assistant surgeon can be paid for those procedures that warrant an assistant.

If the surgeon's claim is systematically priced, the assistant surgeon's claim is also systematically priced. If the surgeon's claim is manually priced, the assistant surgeon's claim is also manually priced, and an operative record *must* be attached to the claim for payment.

Follow-up care provided by the assistant surgeon is subject to the 30-day postoperative policy as described in this manual. Reference Section 13.34.

Only physicians may be considered assistant surgeons.

The surgeon and assistant surgeon *must* each submit separate professional claims for services provided, using his/her individual provider number.

MO HealthNet does *not* reimburse for the services of an assistant surgeon when a co-surgeon is used.

A clinic may submit a single professional claim for the surgeon and assistant surgeon, using the clinic's provider number and *must* also include each individual provider's number as the performing provider.

NOTE: For assisting at cesarean deliveries, the appropriate procedure code for the delivery only *must* be billed, regardless of whether or not the surgeon billed the global procedure. A "global" delivery indicates that the prenatal care, delivery and postpartum care are provided by a single physician; therefore global delivery procedure codes may *not* be billed by the assistant surgeon.

13.33. E CO-SURGEON'S SERVICES (TWO SURGEONS)

"Co-surgeons" are defined as two primary surgeons working simultaneously to perform distinct parts of a total surgical service during the same operative session. Reimbursement is based on 100% of the major procedure for the primary surgeon and 62.5% for the secondary surgeon.

MO HealthNet adheres to guidelines set by CMS for co-surgeons. Reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the co-surgeon column of the database instruct carriers how to reimburse for services. The fee schedule can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

NOTE: Not all codes in the listing are covered by MO HealthNet; refer to the MO HealthNet fee schedule.)

The surgeon and co-surgeon *must* file separate claims, each using his/her own individual MO HealthNet provider number. The surgical procedure code together with modifier 62 (Two

Surgeons) should be shown on both claims. The name of both surgeons *must* appear on the claim form in the "description" area.

13.33. F MULTIPLE SURGICAL PROCEDURES

When multiple surgical procedures are performed for the same body system through the same incision, the major procedure is considered for payment at 100% of the allowable fee for the procedure. (No reimbursement is made for incidental procedures.)

Multiple surgical procedures performed on the same participant, on the same date of service, by the same provider, for the same or separate body systems through separate incisions *must* be billed in accordance with the following guidelines:

- The major, secondary and tertiary procedures should be indicated on the claim form using appropriate CPT codes. The major, secondary and tertiary procedures are usually determined by the allowed amount of the procedure code. The procedure with the highest allowed amount is considered the major procedure.
- A copy of the Operative Report may be attached to claims for multiple surgeries to provide additional information. If *not* attached, a copy may be requested to assist with the claim processing.

Claims for multiple surgeries are allowed according to the following:

- 100% of the allowable fee for the major procedure.
- 50% of the allowable fee for the secondary procedure.
- 25% of the allowable fee for the tertiary procedure.

13.33. F (1) Exception to Multiple Surgical Procedures

An exception to the multiple surgical procedure policy is diagnostic endoscopies. When more than one diagnostic endoscopy is performed on the same day with the same or different approaches, but *different instruments*, both are reimbursable at 100% of the allowable fee for the procedure.

When more than one diagnostic endoscopy is performed on the same day using the same approach and the *same instrument,* only the major procedure is payable.

13.33. G ABORTIONS

In accordance with Public Law 115-245 (2018), 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. Reference Section 14.

For missed or spontaneous abortions (miscarriages) see Certificate of Medical Necessity form in the forms section of the provider manuals.

NOTE: Abortions are *not* to be reported as family planning services.

13.33. H HYSTERECTOMIES

In accordance with Federal Regulations 42 CFR 441.251, 42 CFR 441.252, 42 CFR 441.255 and 42 CFR 441.256 regarding Sterilization by Hysterectomy:

A. A hysterectomy *is not* a MO HealthNet covered service if:

- the hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- if there was more than one purpose to the procedure, it would *not* have been performed except for the purpose of rendering the individual permanently incapable of reproducing.

B. A hysterectomy *is* a MO HealthNet covered service if:

- the conditions in paragraph A of this section do *not* apply;
- the person who secured authorization to perform the hysterectomy has informed the individual and her representative (e.g., legal guardian, husband, etc.), if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing; and
- the individual or her representative, if any, has signed a written Acknowledgement of Receipt of Hysterectomy Information form prior to surgery. The completed form *must* be attached to the MO HealthNet claim at the time the claim is submitted for payment.

C. 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 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 acknowledgment 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 retroactive to this time. 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 to one of the following situations:
    - 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.

13.33. H (1) Acknowledgement of Receipt of Hysterectomy Information

Refer to the MO HealthNet fee schedule for procedures that require an Acknowledgement of Receipt of Hysterectomy Information form.

All providers (surgeon, assistant surgeon, anesthesiologist, hospital) *must* present all required documentation. It is the secondary provider's responsibility to obtain the necessary certification from the performing physician.

Requirements concerning hysterectomies apply to an individual of any age.

Hysterectomies are *not* to be reported as family planning services.

The (Sterilization) Consent Form may *not* be used in lieu of the Acknowledgement of Receipt of Hysterectomy Information form. (See Section 14.)

13.33. I STERILIZATIONS

Sterilization is defined as any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

For family planning purposes, sterilization 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.

See Family Planning, Section 10, for detailed information regarding program coverage, required consent and other guidelines. Refer to the MO HealthNet fee schedule for procedures requiring a (Sterilization) Consent Form.

13.33. J MORBID OBESITY TREATMENT

Morbid obesity, as defined by the American Medical Association (AMA) is a Body Mass Index (BMI) greater than 40. The treatment of obesity is covered by MO HealthNet (MHD) when the treatment is an integral and necessary course of treatment for a concurrent or complicating medical treatment. The following codes for bariatric surgery, gastric bypass, gastroplasty, and laparoscopy are covered codes by MHD for patients when one **or** two of the following criteria, **and** number three must be met:

1. BMI greater than 40 with or without a co-morbid condition, **or**

2. BMI of 35-40 and at least one of the following co-morbid conditions:

- Secondary diabetes mellitus;
- Diabetes mellitus;
- Essential hypertension;
- Hypertensive heart disease;
- Hypertensive chronic kidney disease;
- Hypertensive heart and chronic kidney disease;
- Secondary hypertension.

3. Must be non-smoker/tobacco user or provide evidence of smoking/tobacco-cessation.

These services must be prior authorized. Refer to section 8 of the physician's manual to review MHD's prior authorization policy.

43644 43645 43659 43770 43775 43845 43846 43847 43848

The following are covered codes by MHD for patients if the above criteria are met, but do not require a prior authorization request.

43771 43772 43773 43774

13.34 POSTOPERATIVE CARE

Postoperative care includes 30 days of routine follow-up care for those surgical or diagnostic procedures having a MO HealthNet reimbursement amount of $75.00 or more. For counting purposes, *the date of surgery is the first day.*

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

Pain management is considered part of postoperative care. Visits for the purpose of postoperative pain control are *not* separately reimbursable.

Physician services are audited against claims that have already been paid as well as against those claims currently in process.

Supplies necessary for providing the follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures that meet the postoperative care policy, may be billed under the appropriate supply code (Reference Section 19.5). Attach an invoice if applicable.

13.34. A PHYSICIAN SERVICES SUBJECT TO POSTOPERATIVE RESTRICTION

The following procedures are subject to the postoperative editing when billed within 30 days after the date of a surgical procedure. These services are included in the postoperative care and are *not* billable as separate services.

Office or Other Outpatient Services

99201	99202	99203	99204	99205	99211
99212	99213	99214	99215	99217	99218
99219	99220				

Home Medical Services

99341 99342 99343 99344 99345 99347
99348 99349 99350

Hospital Inpatient Services

99231 99232 99233 99234 99235 99236
99238 99239

Nursing Facility Care

99304 99305 99306 99307 99308 99309
99310 99315 99316 99318

Residential Care Facility I (RCF-I) and Residential Care Facility II (RCF-II)

99324 99325 99326 99327 99328 99334
99335 99336 99337

Emergency Department Services

99281 99282 99283 99284 99285

Unlisted Evaluation and Management Services

99499

Preventive Medicine Services

99381 99382 99383 99384 99385 99386
99387 99391 99392 99393 99394 99395
99396 99397

Ophthalmologist

92002 92004 92012 92014

Special Services Codes

99050 99051 99053 99056 99058

13.34. B EXCEPTIONS

Exceptions to the postoperative care policy may be reimbursed for complications or extenuating circumstances that have been documented and determined to be exempt by the

state medical consultant. In addition, the following services are exempted from the postoperative policy limitations:

- Initial hospital visits (procedure codes 99221, 99222 and 99223) to allow payment for physician services when a patient is admitted to the hospital on the same date of service as a surgery;
- Consultations (procedure codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255);
- Renal dialysis codes (procedure codes 90935, 90937);
- Physician services provided *prior* to the date of surgery (For deliveries, if billing the global delivery code, this *includes* all routine *prenatal* care, in addition to 30-day postoperative care.);
- All surgeries or procedures billed having a reimbursement amount of less than $75.00;
- Newborn care (procedure codes 99460, 99461, 99462 and 99465);
- Suture removal:
    - If the sutures are removed by the same physician who performed the surgery, the charge is included in the surgical fee and is *not* paid separately.
    - If another physician removes the sutures, use code 99201 or 99211.

13.34. C POSTOPERATIVE CARE—OTHER THAN THE SURGEON

- Postoperative care is noncovered when rendered by another member of a group or corporation to which the operating surgeon belongs when the second physician's specialty is the same as the operating surgeon.
- Postoperative care by another member of a group or corporation whose specialty is different from the surgeon is payable.
- Postoperative care by a physician other than the surgeon is payable if:
    - the diagnosis treated is *not* related to the surgery.
    - the illness would have required hospitalization in its own right.
    - the surgeon would *not* be expected to handle the condition.

13.35 SEPARATE/INCIDENTAL PROCEDURES

Some procedures are commonly carried out as an integral part of a total service and as such do *not* warrant a separate identification. However, when such a procedure is performed independently of, and is *not* immediately related to other services, it may be listed as “separate procedure.” Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a

specific purpose, it may be considered to be a separate procedure. Attach copies of the operative report(s) for the medical consultant's review.

Examples: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue is removed or when debridement is carried out separately without immediate primary closure (11040 - 11044).

Simple ligation and exploration of blood vessels, nerves or tendons in an open wound is part of wound closure and is *not* paid separately.

Surgeries considered incidental to, or a part of another surgical procedure, performed on the same day, are *not* paid separately, but rather are included in the fee for the major procedure.

The following are examples of procedures that are included in the reimbursement and *not* paid separately when incidental to other specified services.

- Anoscopy, proctosigmoidoscopy, sigmoidoscopy, prior to diagnostic or therapeutic colonoscopy.
- Application of cast with open or closed reduction of a fracture.
- Application of dressing, casts and/or splints with tendon repair.
- Biopsy of breast prior to a mastectomy.
- Biopsy of mesentery, omentum and peritoneum when performed with another abdominal surgery.
- Control of postoperative bleeding (e.g., tonsillectomy, removal of prostate (TUR), hemorrhoidectomy, hysterectomy, etc.)
- Debridement (simple) of an open wound prior to skin graft or repair of laceration.
- Diagnostic dilation and curettage (uterus), salpingo-oophorectomy prior to hysterectomy, same day.
- Diagnostic endoscopy; preceding surgery, same day, using the same approach and the same instruments.
- Exploratory laparotomy when it is the route of entry for another abdominal surgery.
- Insertion of T-tube, Penrose drain, Foley catheter, chest tube, hemivac, etc., during surgery and removal after.
- Iridotomy or iridectomy when performed with cataract extraction.
- Laminotomy, craniotomy or thoracotomy, preceding surgery, same approach, same day.
- Laparoscopy preceding laparotomy.
- Local or regional anesthesia by surgeon or obstetrician.

- Lysis of abdominal adhesions, when another abdominal surgery (e.g., colon resection, hysterectomy, etc.) is performed.
- Mobilization of the intestine during abdominal surgery.
- Obtaining a donor graft.
- Pharyngoscopy, laryngoscopy, tracheoscopy, when performed with bronchoscopy or esophagoscopy with upper gastrointestinal endoscopy.
- Removal of packs (e.g., nasal, uterine, etc.) after insertion.
- Urethral catheterization and calibration preceding cystourethroscopy.
- Ureteral endoscopy preceding renal endoscopy through established nephrostomy.

13.36 UNLISTED SERVICE OR PROCEDURE

A service or procedure *not* listed in the CPT book may be considered for payment. However, the procedure *must* be related to an unusual or complicating situation involving a *MO HealthNet covered service,* as identified in the CPT book or MO HealthNet Provider Manual. When reporting such a service, the appropriate "Unlisted Procedure" code *must* be used to indicate the service, identifying it by "Special Report." Pertinent information attached to the claim for payment should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. All claims are manually reviewed by the state medical consultant for appropriateness and payment.

An unlisted procedure code is *not* to be used when a code is already available in CPT book or is otherwise described in the manual.

Not all services contained in the CPT book are covered by MO HealthNet. Some codes, although defined and contained in the CPT book as updates, additions, deletions or revisions may *not* yet be on file and are, therefore, noncovered. *Procedures that are not covered or are not on file, are noncovered and should not be billed through the use of any of the "Unlisted" or "99" codes.*

13.37 LIMITING CERTAIN SURGICAL PROCEDURES TO OTHER THAN AN INPATIENT BASIS

Many minor surgeries/procedures are such that they are considered "office" procedures. Others, while more difficult, can be performed in an adequately staffed and equipped office, an ambulatory surgical center (ASC) or outpatient department of the hospital.

Inpatient hospital admissions *must* be certified as medically necessary and appropriate before MO HealthNet will reimburse for inpatient services. MO HealthNet has generally adopted those procedures identified by Medicare that can be performed safely in an ambulatory surgical center as outpatient procedures. MO HealthNet currently provides facility payment to MO HealthNet enrolled ASC facilities for procedures identified by Medicare as ASC procedures.

The criteria used takes into account risk factors, existing co-morbidities, the planned course of treatment on admission and other factors that justify inpatient admission for performance of the procedure. Reference Section 13 of the Hospital Manual.

13.38 NONCOVERED SERVICES

Noncovered services may be billed to the participant. (Reference also "non-allowed" services, Section 13.39, which *may not* be billed to the participant.)

Services beyond those normally covered under the MO HealthNet Program may be approved for those participants under the age of 21 who are eligible for EPSDT/HCY services, based on the medical necessity of the service/procedure. These services may require prior authorization. (Reference Section 9, Healthy Children and Youth Program, for more information.)

To determine whether or not a service is covered by MO HealthNet, contact the Provider Communications Unit at (573) 751-2896.

Although it is *not* possible to list every situation or procedure that is noncovered through the Physician Program, the following list has been compiled:

- Abortions (except as specifically outlined in Section 13.33.G);
- Acupuncture;
- Ambulance service to the physician's office;
- Autopsy (postmortem examination);
- Ballistocardiogram;
- Biofeedback services;
- Clinical studies, trials, testing, experimental and investigational medical procedures, drugs, equipment, etc;
- Contact lenses;
- Cosmetic surgery directed at improving appearance (e.g., augmented mammoplasty, face lifts, rhinoplasty, etc.);
- Ear piercing;
- Foot care (routine) (Foot care for diabetes mellitus and other peripheral vascular diseases are *not* considered routine and are covered);
- Garter belts, elastic stockings, Jobst and pressure garments for hand and arms, Spenco boots and other foot coverings;
- Hair transplants;
- Implantation of nuclear-powered pacemaker;
- Keloids, excision of (unexposed areas of body);

- Necropsy (Autopsy);
- Occupational therapy services (age 21 and over);
- Orthopedic shoes or supportive devices for the feet for ages 21 and over (orthopedic shoes when an integral part of the brace may be obtained through the Durable Medical Equipment Program);
- Penile prostheses or insertion of;
- Personal comfort items;
- Preparation of special reports sent to insurance companies;
- Psychiatric reports for court evaluation or juvenile court;
- Reimbursement for medical direction or supervision of students in a teaching, training or other setting;
- Salpingoplasty;
- Services by psychologists, social workers or other mental health workers, for ages 21 and over, even when performed under the supervision of a psychiatrist;
- Services rendered anywhere when a physician is *not* in attendance and in direct supervision of the service except where exempt as stated in Section 13.17;
- Sex therapy;
- Speech therapy (except as training in use of an artificial larynx) (age 21 and over);
- Tattoos, removal of;
- Treatment of infertility;
- Surgical procedures for gender change such as:
    - Hysterectomy
    - Mammoplasty
    - Mastectomy
    - Orchiectomy
    - Penectomy
    - Penile construction
    - Release of vaginal adhesions
    - Revision of labia
    - Vaginal dilation
    - Vaginal reconstruction
    - Vaginoplasty;

- Treatment of impotence;
- Tuboplasty vasovasostomy (sterilization reversal);
- Vials of insulin (covered under Pharmacy Program);
- Vitamin injections (Reference Section 13.23.F for exceptions);
- Weight control unless criteria in Section 13.33.J is met.

13.39 NON-ALLOWABLE SERVICES

The following services are included in the MO HealthNet provider's reimbursement for the procedure/surgery and are *not* separately allowable, billable to the participant or to the MO HealthNet Program as office/outpatient visits, or in any other manner:

- Administration of medication/injection (if the patient is examined/treated as the service is included in the office/outpatient visit or other procedure performed);
- Assistant surgery fees for surgeries/procedures identified by Medicare as non-payable;
- Canceled or "no show' practitioner appointments;
- Cast removal when the cast was applied by the same physician;
- Catheterization for a urine specimen in the office;
- Claim filing;
- Debridement of a laceration and abrasion with immediate primary closure of wound;
- Drawing fees;
- Follow-up visits for interpretation of tuberculin tests, PPD or Tine (office visit within two to five days of the test);
- Handling and/or conveyance of specimen to an independent laboratory for interpretation;
- Hospital visits for the same patient, same date of service as another medical procedure billed by that physician;
- Incidental surgical procedures performed through the same incision;
- Incorrect billing;
- Intralesional injections;
- Local anesthesia;
- Medical testimony;
- Office visits to obtain a prescription, the need of which had already been ascertained;
- Postage;
- Professional fees for "Clinical Diagnostic Laboratory Procedures";

- Removal or placement of sutures by the operating physician/surgeon;
- Routine postoperative care following a surgery or procedure;
- Services *not* directly related to the participant's diagnosis, symptoms or medical history, or services in excess of those deemed medically necessary to treat the patient's condition;
- Services considered part of a MO HealthNet covered service/procedure;
- Services or supplies covered through another MO HealthNet Program;
- Services or supplies furnished free of charge by any governmental body (e.g., injectable material, etc.);
- Telephone calls;
- Venipuncture for the purpose of obtaining a blood specimen.

13.40 RADIOLOGY

Providers may bill the MO HealthNet Program only for those covered procedures requested by the patient's attending physician or other medical professional. A medical professional is a person who is authorized by State licensure law to order hospital services for diagnosis or treatment of a patient.

A written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation.

When billing for radiology services, the following guidelines should be used. These indicate the services (professional, technical or professional and technical components) involved, any particular restrictions that apply to physicians, independent diagnostic testing facilities (IDTF), independent x-ray services or independent radiologists.

Effective for dates of service on or after January 1, 2018, claims billed by a provider based rural health clinic (RHC) for the technical component of a laboratory or radiology service will deny. Provider based RHCs, owned and operated by a hospital, may bill MHD for these services using the hospital's NPI on the UB-04 billing form. The provider based RHC may also bill with an active Clinic/Group NPI using the CMS-1500 billing form. Providers will be reimbursed according to the MHD fee schedule.

13.40. A RADIOLOGY SERVICES

13.40. A (1) Professional and Technical Component, X-Ray/Nuclear Medicine/EEG/EKG

- *Must* be billed on a professional claim;
- May *never* be billed with inpatient or outpatient POS;

- May be billed by physician, clinic, FQHC, Provider Based RHC, Independent Diagnostic Testing Facility (IDTF), independent radiologist or independent x-ray service;
- Referring physician must be reported if the billing provider is an independent radiologist, IDTF or is a provider with a specialty of radiology/radiation therapy.

13.40. A (2) Professional Component, X-Ray/Nuclear Medicine/EEG/EKG

- *Must* be billed on a professional claim;
- May be billed by physician, clinic, FQHC, Provider Based RHC, IDTF, independent x-ray, or independent radiologist;
- Referring physician must be reported if the billing provider is an independent radiologist, IDTF or is a provider with a specialty of radiology/radiation therapy.

13.40. A (3) Technical Component, X-Ray/Nuclear, Medicine/EEG/EKG

- *Must* be billed on a professional claim for physician or IDTF billing;
- *Must* be billed on UB-04 claim for outpatient hospital billing;
- Technical component may *never* be billed by the physician for services provided on an inpatient or outpatient hospital basis;
- May be billed by a physician, hospital, clinic, FQHC, IDTF, independent radiologist or independent x-ray service;
- Referring physician required if biller is independent radiologist, IDTF or is a provider with a specialty of radiology/radiation therapy.

13.40. B PRECERTIFICATION FOR HIGH-TECH AND CARDIAC IMAGING SERVICES

High-tech and cardiac imaging procedure codes require precertification. 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

13.40. B (1) 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 - Cyber Access 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 DiagnositicSite 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 Type of Provider (Taxonomy Codes) match the facility location where the procedure is to be performed. When searching for the performing provider, search only by the NPI number

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 onto the MO HealthNet Web portal at www.emomed.com.

13.40. B (2) Certification Approval Time Frame

All radiological precertifications are issued for a 30-day period. Approved procedures *must* be performed within 30 days from the date for which approval is issued. This approval time frame applies to all radiological procedures which require precertification.

13.40. C DIAGNOSTIC SITE CERTIFICATION

All enrolled MO HealthNet providers that perform any of the procedures listed on HealthHelp's Web portal at https://portal.healthhelp.com/mohealthnet must complete a DiagnosticSite questionnaire. Starting February 1, 2016, providers can complete their DiagnosticSite certification online at: https://portal.healthhelp.com/radsitenet/registration.aspx This questionnaire must be completed by each provider location that will be performing and billing for any of the above mentioned high-tech and/or cardiac imaging procedures for MO HealthNet eligible participants. The goal of the DiagnosticSite questionnaire 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 DiagnosticSite questionnaire, within their submitted scope of practice.

If you have questions regarding this questionnaire, please contact SiteSupport@HealthHelp.com or call 1-800-546-7065.

13.40. D 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 90 days of the date of the denial letter to request a hearing. After 90 days, requests to appeal are denied.

13.40. E COMPLETE RADIOLOGICAL PROCEDURES

When a procedure is performed by *two physicians*, the radiologic portion of the procedure is designated as "radiological supervision and interpretation" and should be billed by the physician providing the radiology service. The intravenous/intra-arterial procedure code(s) found in the "Surgery" section of the CPT book and the injection if applicable, *must* be billed separately by the provider performing the service.

When a *single physician* performs the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series (reference the Surgery Section of the *Physicians' Current Procedural Terminology (CPT)*), *must* be used in addition to the appropriate "radiological supervision and interpretation" procedure code. Payment to a single physician for interventional radiologic procedures or diagnostic studies involving injection of contrast media includes all unusual pre-injection and post-injection services; e.g., necessary local anesthesia, placement of needle or catheters, injection of contrast media, supervision of the study and interpretation of results.

The Radiological Supervision and Interpretation codes are *not* applicable to the Radiation Oncology codes. (Refer to Section 13.40.H Radiation Oncology for additional information.)

13.40. F TESTING AGENTS USED DURING RADIOLOGIC PROCEDURES

13.40. F (1) Contrast Materials and Radiopharmaceuticals

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.

13.40. G MOBILE X-RAY UNIT

The services of a mobile x-ray unit, procedure code R0070 (transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; one patient seen), are covered when medically necessary. The participant *must* be non-ambulatory as a result of a fall, illness, etc. However, only one trip fee is allowed per trip regardless of the number of patients seen in a nursing facility, custodial care facility or the MO HealthNet participant's home or other place of residence. If more than one participant receives radiologic services, bill for the mobile x-ray unit trip fee for the first participant seen. For example, only one fee for a trip to the nursing facility is payable even if multiple patients are x-rayed. The specific radiologic service provided to each participant may be billed using the appropriate participant's name and MO HealthNet number. Refer to Mobile X-ray Procedure Codes for a list of covered procedures.

Mobile x-ray units should bill the technical component using modifier TC.

13.40. H RADIATION ONCOLOGY

Procedure codes for therapeutic radiology for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services and clinical treatment management procedures. Services include normal follow-up care during the course of treatment and for three months following completion of the therapeutic radiology.

13.40. H (1) Consultation: Clinical Management (Radiation Oncology)

Preliminary consultation, evaluation of the patient prior to the decision to treat or full medical care (in addition to treatment management) when provided by the therapeutic radiologist, may be identified by the appropriate procedure codes from the Evaluation and Management, Medicine or Surgery Sections of the current year's CPT book.

13.40. H (2) Manual Pricing (Radiation Oncology)

When a service or procedure is performed that *must* be manually priced by the state medical consultant (for example 77299, 77399, 77499 or 77799), the description of the procedure, area of body treated and type of therapy (e.g., kilovoltage, megavoltage, radium, isotopes, etc.) is reviewed. To expedite processing of manual pricing of radiation oncology claims, providers are encouraged to attach "By Report" information or an operative report to the claim. Such "By Report" information assists the state medical consultant in determining whether payment can be made and, if so, in determining the reimbursement amount. Claims without sufficient information are denied for additional information.

13.40. H (3) Clinical Treatment Planning (Radiation Oncology)

The clinical treatment planning process is a complex service including interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of appropriate treatment devices and other procedures.

13.40. H (4) Clinical Treatment Management (Radiation Oncology)

Clinical treatment management codes are used when a patient's treatment requires daily or weekly management treatments. The codes are based on five fractions or treatments delivered, comprising one week, regardless of the time interval separating the delivery of treatments. "Weekly" does *not* mean a calendar week, but five treatment sessions. If two treatments are performed (for instance A.M. and P.M.) on the same day, the service counts as two fractions.

Providers must bill MO HealthNet only one weekly management code for every five fractions administered. *Enter a unit of "1" using the date of the fifth fraction as the date of service.*

At the end of each course of treatment, three or four fractions are considered another week of treatment using the date of the last fraction as the date of service.

If the remainder is one or two days, the provider is *not* reimbursed and the provider may *not* bill MO HealthNet or the participant for these days. This equalizes over a period of time.

If the total course is only one or two treatments, use code 77431. Code 77431 should *not* be used to fill in several left over treatments after a long course of therapy.

Weekly Clinical Treatment Management includes all of the following related professional functions:

- Supervision of patient treatment and technologist activities;
- Consultation with physicist regarding ongoing quality control of treatment activity;
- Ongoing consultation with attending medical and surgical oncologists and personal physicians as needed;
- Direct patient examination and care as needed on a timely basis;
- Special setups by physicians when needed (vaginal cone, eyeshields, etc.);
- Prescribing of medications;
- Ordering, review and interpretation of laboratory and radiological studies;
- Review and interpretation of periodic portal films;
- Completion of insurance reports;
- Family contacts and consultation with social workers, pastoral counselors; telephone contacts with patient and family after hours;
- Necessary changes, interruptions in treatment course;
- End of treatment conference(s) with patient/family including complete assessment of response and status at that time;
- Summary report to all referring and attending physicians and appropriate institutions; patient's permission obtained;
- Definitive arrangements for follow-up with the treating radiation oncologist and all other physicians with legitimate role in care of patient; and
- First follow-up visit with radiation oncologist.

13.40. H (5) Clinical Brachytherapy

Clinical brachytherapy requires the use of either natural or man-made radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation is performed solely by the therapeutic radiologist. Clinical brachytherapy services include admission to the hospital and the daily visit(s).

13.40. I INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

Diagnostic tests performed in an independent diagnostic testing facility (IDTF) are covered when medically necessary. The tests *must not* be for screening purposes, in the absence of a known disease, injury, or malformed body part.

13.40. I (1) Supervision

An IDTF *must* have one or more supervising physicians who are responsible for the direct and ongoing oversight of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of non-physician personnel who use the equipment. This level of supervision is the requirement for general supervision. Each supervising physician does *not* have to be responsible for all of these functions. The basic requirement is that all the supervisory physician functions be properly met at each location, regardless of the number of physicians involved. Supervisory physicians do *not* have to be employees of the IDTF. They can be contracted physicians for each location served by an IDTF.

The supervising physician may *not* order tests to be performed by the IDTF, unless the supervising physician in question had a relationship with the beneficiary prior to the performance of the testing and is treating the patient for a specific medical problem.

The supervising physician *must* evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF.

In the case of a procedure requiring the direct or personal supervision of a physician, the IDTF supervising physician *must* personally furnish this level of supervision whether the procedure is performed in the IDTF, or, in the case of mobile services, at the remote location.

13.40. I (2) Non-Physician Personnel

Any non-physician personnel used by the IDTF to perform tests *must* demonstrate the basic qualifications to perform the tests and have training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician *must* be certified by an appropriate national credentialing body. Non-physician practitioners may *not* supervise diagnostic testing performed by others. The IDTF *must* maintain documentation available for review that the requirements are met.

13.40. I (3) Ordering of Tests

All procedures performed by the IDTF *must* be specifically ordered in writing by the physician who is treating the patient. The order *must* specify the diagnosis or other basis for the testing. The supervisory physician for the IDTF may *not* order tests unless the supervisory physician is the patient's treating physician with a prior relationship with the patient. An IDTF may *not* add any procedures without a written order from the treating physician.

13.40. I (4) Multi-State Entities

The supervising physician *must* be licensed to practice in the state where the diagnostic tests are performed.

An IDTF that operates across state boundaries *must* maintain documentation that its supervising physicians and technicians are licensed and certified in each of the states in which it is furnishing services. An IDTF *must* comply with applicable laws of any state in which it operates.

13.40. J NON-COVERED SERVICES

Services performed for screening purposes, in the absence of known disease, injury or malformed body part, and are non-covered.

All services *not* appropriately supervised are deemed to be of uncertain reliability, *cannot* be considered reasonable and necessary for the diagnosis of disease, injury, or malformation of a body member, are non-covered.

Services *not* ordered in writing by the treating physician are non-covered.

All services *not* documented in the medical record are non-covered.

13.41 PATHOLOGY AND LABORATORY

13.41. A CLINICAL DIAGNOSTIC LABORATORY PROCEDURE REIMBURSEMENT

Section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369) contains guidelines for reimbursement for certain clinical diagnostic laboratory services and is applicable to physicians (individual or group practice), independent laboratories and outpatient hospitals. These guidelines contain a requirement that MO HealthNet reimbursement may *not* exceed the national limitation amount.13.41.A (1) 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.

Clinical diagnostic laboratory services billed by the hospital are paid from the Outpatient Lab Fee Schedule rather than a percentage of the billed charge in order to comply with the Deficit Reduction Act of 1984 (DEFRA). For reporting purposes, services reimbursed on a fee schedule basis shall *not* be included as allowable MO HealthNet costs in cost settlement.

13.41. B CLIA REQUIREMENTS

Under the Clinical Laboratory Improvement Amendments Act (CLIA) of 1988, all laboratory sites, including independent laboratories, hospitals, physician offices, nursing homes, etc., as defined at 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; or be exempt by virtue of the fact that the lab is licensed by an approved state program.

CLIA requires all laboratories to meet quality standards, to be certified by the Department of Health and Senior Service's Bureau of Hospital Licensing and Certification, and hold the proper certificate for the tests performed. Providers *must* have the appropriate CLIA certification on their MO HealthNet provider file to allow accurate claims processing. A copy of the certificate(s) is required to ensure that the provider files contain all of the necessary information.

The CLIA number is a ten digit number. Laboratories are initially issued either a registration certificate or a certificate of waiver as appropriate. The registration certification is valid for a period of two years, or until the lab is inspected or accredited as meeting CLIA standards. The schedule for inspections is based on the number of tests a laboratory performs. Regulations mandate biannual onsite surveys. The goals are to ensure safe and accurate laboratory work, to preserve patient access to clinical tests and to encourage technological innovation.

MO HealthNet uses the Categorization of Tests found on the Centers for Medicare and Medicaid (CMS) Web site for codes subject to CLIA edits, codes exempt from CLIA edits, list of CLIA Waived tests, list of Physician Performed Microscopy Procedures (PPMP) and the Clinical Diagnostic Laboratory Tests. Links to lists of these codes is available at www.cms.gov/CLIA/10_Categorization_of_Tests.asp.

13.41. B (1) Laboratory Test Codes that Include Preparation Only

Claims submitted for special stains, technical component or preparation only are *not* subject to CLIA requirements. However, providers billing only the professional component or the technical and professional components combined are subject to the CLIA requirements and *must* be registered with the CLIA program.

13.41. C LABORATORY SERVICES

The following information provides billing guidelines for laboratory services. A physician order must be retained by the billing laboratory for each service billed. Physician orders must be individualized; standing orders are not acceptable.

13.41. C (1) Professional and Technical Component, Lab Service

- *Must* be billed on a professional claim only;
- May only be billed by the provider who processes and interprets the specimen;
- May never be billed in inpatient or outpatient place of service;
- May be billed by physicians/clinics (including FQHCs and Provider Based RHCs) and independent laboratories with CLIA Certificates;
- Referring physician's NPI is required when billed by independent laboratory;
- Diagnosis required.

13.41. C (2) Professional Component, Laboratory

- *Must* be billed on a professional claim;
- May only be billed by provider interpreting the specimen;
- May be billed by physician/clinics (including FQHCs and Provider Based RHCs) or independent laboratory (when CLIA certified);
- Referring physician's NPI is required if provider is independent laboratory;
- Diagnosis required.

13.41. C (3) Technical Component, Laboratory

- When billing for clinical diagnostic laboratory procedures, the technical component is the only appropriate component to bill;
- *Must* be billed on a professional claim for physician billing;
- May only be billed by provider who processes the specimen;
- *Must* be billed on UB-04 claim form for outpatient hospital billing;
- The technical component may never be billed for services provided on an inpatient basis;
- May be billed by physician/pathologist or independent laboratory (when CLIA certified);
- Referring physician's NPI is required when biller is independent laboratory;
- Diagnosis required.

13.41. C (4) Billing Codes When the 26/TC Modifiers Do Not Apply

Some codes listed for professional/technical component modifiers have indicators that the concept of a professional/technical component does not apply. When procedure codes have these indicators, the codes should be billed without a modifier. For the complete listing of indicators refer to the 26/TC indicator column on the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The fee schedule can be found at www.wpsmedicare.com/j5macpartb/fees/physician_fee_schedule/index.shtml.

13.41. D MULTI-TEST LABORATORY PANELS

Refer to the CPT book for the appropriate procedure codes for multi-test laboratory panels. The panel components are *not* intended to limit the performance of other tests. If medically necessary additional tests are performed in addition to those specifically indicated for a particular panel, those tests may be billed separately in addition to the panel code.

In order to bill a panel procedure code, it is required that *all* indicated components in a panel test be performed on the same date of service. If all components of a specific panel are performed on the same date of service, each test *must not* be unbundled and billed separately. The panel procedure code *must* be billed. Any laboratory tests performed on the same date of service that are included in the panel *must not* be billed in addition to the panel procedure code. The laboratory *must* have the appropriate CLIA certificate for all laboratory tests performed.

13.41. E DRUG SCREENING TESTS

Qualitative (presumptive) and semi-quantitative drug screening tests are covered by the MO HealthNet Program. Refer to the CPT book for appropriate procedure codes to reflect testing on single or multiple drug classes. A drug screen test reports what drug classes (e.g., tricyclic antidepressants, phenothiazines, amphetamines, benzodiazepines, barbiturates, cannabinoids, methadone, opiates) are present (qualitative) and may provide an estimate (semi-quantitative) of the concentration. An initial drug screen or preliminary test that yields qualitative or semi-quantitative results must be reported with an appropriate drug testing procedure code categorized as such in the CPT book. Codes in the Therapeutic Drug Assay or Chemistry Sections of the CPT book may not be used to report qualitative (presumptive) or semi-quantitative drug screening and preliminary test results.

The MO HealthNet program only covers **quantitative** (definitive) or "confirmative" tests (i.e., procedure codes from the Therapeutic Drug Assay or Chemistry sections of the CPT book) if there is a positive screen for the drug class to be quantified **and** if the physician has documented the medical necessity in the patient medical record..

Physician offices may bill for initial drug screens performed at point of care (e.g., by use of CLIA waived test devices) or independent and/or hospital laboratories may bill for screenings they performed. Both providers cannot bill for the same date of service for the same participant.

The ordering physician has certain responsibilities:

- The ordering physician must coordinate the billing of the drug screen tests with the performing laboratory.
- The ordering physician must document medical necessity in the patient medical record when ordering quantification of a drug class or a confirmatory drug test.
- The ordering physician must sign each order for drug screening tests by signing a paper order, or by electronic signature that conforms with the requirements of 13 CSR 65-3.050. The requirements state that an electronic signature means a computer data compilation of any symbol or series of symbols executed, adopted, or authorized by an individual with the intent to be the legally binding equivalent of the individual's handwritten signature. The use of biometrics does not constitute an electronic signature; however, biometrics may be used as part of electronic signature verification. A signature stamp does not constitute an electronic signature;

The performing laboratory has certain responsibilities:

- The performing laboratory must ensure the physician has provided documentation of medical necessity when requesting quantification of a drug class or a confirmatory drug test.
- The performing laboratory must not perform quantification of a drug class or a confirmatory drug test without documentation of medical necessity.

13.41. F HIV/AIDS TESTING

HIV/AIDS testing is a covered service when the participant's physician has reason to believe that tests should be performed to rule out AIDS. Some indications for AIDS testing include frequent drug use, hemophilia, patients who are sexually active and those having frequent blood transfusions.

13.41. F (1) Co-Receptor Tropism Assay (Profile)

Patient diagnosed with AIDS who have evidence of viral replication may be screened with Profile testing to receive a new class of drugs. This blood test determines whether a patient will respond to the drugs classified as CCR5 antagonists. The test is billed using modifier 22 "Increased procedural service" with procedure code 87999 "Unlisted microbiology procedure". The Trofile test must be done to determine the necessity for the CCR5 antagonist drug Selzentry® (maraviroc). If the Trofile test is not performed, Selzentry® (maraviroc) will not be covered without additional justification for medical necessity. Clinical criteria for Selzentry® (maraviroc) can be found at www.dss.mo.gov/mhd/cs.

13.41. G LEAD SCREENING

Lab tests for blood lead levels are covered by MO HealthNet for all ages and are reimbursed in addition to the office visit and/or HCY screening. Procedure code 83655 is payable to the laboratory processing the specimen. Reimbursement for obtaining the specimen (drawing fee) is included in the reimbursement for the office visit and/or HCY screening and must *not* be billed to the patient.

Reference Section 9 for more information regarding HCY lead screening and lead assessments.

13.41. H HEMOSTASIS

Prothrombin time, prothrombin consumption, thrombin time, clotting time, bleeding time, thromboplastin (PTT), platelet count, etc., are covered for the diagnostic and/or therapeutic approach to disorders of hemostasis. Anticoagulation therapy (Heparin, Coumadin) *must* be documented in the diagnosis box of the claim form "on anti-coagulant," except when billing for an independent laboratory.

13.41. I SKIN TESTING

13.41. I (1) Tuberculosis (TB) Test

Tuberculosis (TB) intradermal test is a covered MO HealthNet service. This procedure is exempt from the CLIA requirements. Providers *must* bill for the

medication used during the test through the Pharmacy Claim form on the Web portal at www.emomed.com, or other electronic equivalent, using the national drug code (NDC). The test itself is billed with the appropriate CPT code.

13.41. I (2) Allergy Sensitivity Tests

Allergy sensitivity tests are selective cutaneous and mucous membrane tests in correlation with the patient's history, physical examination and other observations. The number of tests performed should be based upon the history, physical findings and clinical judgment. All patients should *not* necessarily receive the same tests nor the same number of sensitivity tests.

When billing for allergy testing, indicate on the professional claim the number of individual tests performed, since these procedures instruct the biller to "specify number of tests."

13.41. I (3) Allergen Immunotherapy

Office visit codes may be billed in addition to allergen immunotherapy only if other identifiable services are provided on the same date.

- Stinging insect venom, single dose vials are covered.
- Services billed using the unlisted allergy/clinical immunologic service or procedure code is reviewed and manually priced by a state medical consultant. Clinical documentation must be attached to the claim.
- Syringes used for self-administration must be billed with a unit of one using the appropriate supply procedure code. An invoice showing the cost, description and quantity *must* be submitted with the professional claim.

NOTE: An invoice is *not* required for the therapeutic allergen.

13.41. I (4) Radioallergosorbent Tests

Use the appropriate procedure code that represents the radioallergosorbent testing provided. The number of tests provided should be reflected in the number of units billed.

13.41. J SMEARS AND CULTURES

The following identifies covered and non-covered services:

- Covered for the diagnosis and treatment of acute infection.
- Bacterial, fungi, microplasma, endotoxin, tissue, virus, tubercle cultures, etc., are covered.

- Sensitivity studies are covered.
- Wet and dry mount smears are covered.
- Thayer-Martin used in venereal disease testing is *not* covered.
- Bacterial smear and cultures of the same area on the same date of service are non-covered. Only the culture is payable.

13.41. K CARCINOEMBRYONIC ANTIGENS (CEA TESTS)

CEA tests are payable only for cancer of the colon, stomach, pancreas, or lung.

The test employing the reagent *must* be used with other tests that are acceptable for diagnosing cancer or a test for tumor growth recurrence in patients who have had a tumor irradiated or removed surgically.

13.41. L URINALYSIS

Clinical pathology urinalysis codes *must* be consistent with the diagnosis (disease, procedure).

A clean-catch kit to collect a clean-voided midstream specimen for culture is covered in the physician's office by billing the appropriate supplies and materials procedure code. An invoice showing the cost and the description of the supply *must* be submitted with the claim.

Routine urinalysis is non-covered except for monthly prenatal visits and new patient examinations (when applicable). When billing the global prenatal codes or global prenatal/delivery codes, the fee for this procedure *includes* all urinalysis testing during the prenatal period and is *not* covered separately.

Simple catheterization of the urethra to collect a urine specimen is included in the fee for the office visit and is *not* separately covered.

Culture media (e.g., agar, broth egg base, Thayer-Martin, culturette, etc.) are part of the culture and are *not* paid separately.

When microscopy and urinalysis are performed on the same date of service, use the urinalysis procedure code only. Do *not* bill separately.

13.41. M PAP SMEARS

Pelvic examinations and obtaining the specimen for a Pap smear are included in the reimbursement for the office visit. Processing and interpreting the Pap smear are only payable to a CLIA certified facility employing a pathologist (cytologist).

13.41. N CYTOPATHOLOGY

Procedure code for cytopathology services *must* be performed by a pathologist. Therefore, these procedures and types of service are appropriate only in settings with appropriate CLIA registration certificates.

A unit of service for these codes is the specimen and is defined as tissue or tissues submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. The diagnosis(es) is/are required. Two or more such specimens from the same patient (e.g., separately identified endoscopic biopsies, skin lesions, etc.) are each appropriately assigned an individual procedure code reflective of the proper level of service.

Any unlisted specimen should be assigned to the code that most closely reflects the physician work involved when compared to other specimens assigned that code. Reference the CPT book for a full explanation of specimens within each level.

13.41. O THERAPEUTIC APHERESIS (PLASMA AND/OR CELL EXCHANGE)

Therapeutic apheresis is a medical procedure utilizing specialized equipment to remove selected blood constituents (plasma or cells) from whole blood and return the remaining components to the person from whom the blood was taken. Other supplies, e.g., IV fluids, *must* be billed on the Pharmacy Claim form using the national drug code (NDC).

13.42 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.

Refer to the MO HealthNet Hospice Manual, Section 13 for specific program information.

13.42. A ACCESS TO MO HEALTHNET SERVICES FOR HOSPICE ENROLLEES

When a participant elects hospice services, the hospice provides or arranges for all care, supplies, equipment and medicines related to the terminal illness. MO HealthNet reimburses the hospice provider who then 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. In this instance the provider of the service is reimbursed directly by the MO HealthNet Program.

13.42. B 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 provider. Eligibility may be verified by calling (573) 751-2896, which is answered by an interactive voice response (IVR) system, or the provider may use the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 for more information.

When a participant's hospice election begins, the participant *must* present the MHD Hospice Enrollment Computer-Generated Letter to the provider, along with their ID card, new approval letter or replacement letter. This is necessary to alert other providers of medical services, e.g., ambulance, durable medical equipment, home health, hospital, nursing home, personal care and pharmacy providers of the restrictions on billing. Non-hospice providers are encouraged to contact the hospice indicated on the IVR or POS terminal when they have questions about whom to bill for a specific service.

If the participant disenrolls from hospice services, the MO HealthNet Division issues a letter to the participant acknowledging the disenrollment that the participant *must* present, along with the ID card, to providers in order to obtain services that can be billed directly to the MO HealthNet Program.

13.42. C ATTENDING PHYSICIAN

The attending physician is a doctor of medicine or osteopathy and is identified by the individual at the time the individual elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care. The attending physician is the participant's physician of choice who participates in the establishment of the plan of care and works with the hospice team in caring for the patient. The attending physician *must* certify that the patient is terminally ill with a life expectancy of 6 months or less. The physician *must* sign the Physician Certification of Terminal Illness form within eight days of the date of the hospice election. The physician continues to give the medical orders and may have privileges in the hospice inpatient care.

MO HealthNet reimburses the hospice participant's attending physician directly if the physician is *not* employed by the hospice provider. The services are reimbursed at the lower of the physician's billed charges or the MO HealthNet maximum allowable amount.

13.43 PHYSICIAN SERVICES IN NURSING HOMES

The following is a summary of physician services required for MO HealthNet residents in a Title XIX facility and are usually performed in the nursing home. It includes both federal and state licensing requirements. For more information, reference Section 13 of the Nursing Home Manual.

13.43. A TITLE XIX PATIENTS IN NURSING FACILITIES (NF)

- A thorough medical history and physical examination (assessment) of each resident *must* be performed and entered into the resident's record within four days of admission to a MO HealthNet bed.
- The physician *must* see the resident every thirty days for the first ninety days and at least every ninety days thereafter.
- The physician *must* review and sign the medical orders when the physician sees the resident. State rules require that physician orders *must* be signed every other calendar month.
- There *must* be an assessment performed at least annually with the portion of it pertaining to the medical condition of the resident established by the physician. In addition, an assessment *must* be done whenever there is a significant change in the resident's condition.
- All physician telephone orders *must* be signed within seven days.

13.43. B NURSING FACILITY PATIENTS (NOT TITLE XIX)

- There *must* be a medical examination at the time of admission or within 30 days prior to admission, then annually thereafter.
- There *must* be physician certification at the time of admission or prior to MO HealthNet payment that Nursing Facility services are necessary.
- There *must* be a physician recertification of need for these services every 12 months.
- There *must* be a written plan of care established by a team of professionals, of which the physician is a member. The plan of care *must* be reviewed every 90 days by the team.
- All orders prescribed by the physician *must* be signed. Telephone orders *must* be countersigned within 2 days.
- All orders *must* be renewed in writing every 90 days.

13.44 NURSING FACILITY SERVICES

Two subcategories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Both subcategories apply to new or

established patients. Comprehensive assessments may be performed at one or more sites in the assessment process: the hospital, office, nursing facility, domiciliary/non-nursing facility or patient's home.

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care and place of service (POS) 32 “nursing facility” should be entered on the professional claim as the POS.

The (single) level of service reported by the admitting physician should include all services related to the admission the physician provided in the other site(s) of service as well as in the nursing facility setting, except for hospital discharge services, which may be reported separately.

The annual nursing facility assessment (99318) is to be billed only once per rolling year.

For those participants who have both Medicare and MO HealthNet coverage, the annual nursing facility assessment may be billed directly to MO HealthNet. Procedure code 99318 is exempt from the “Medicare Suspect” edit.

13.45 SCREENING POTENTIAL NURSING HOME PLACEMENTS

A pre-long-term-care screening (PLTCS) for a preliminary evaluation of level of care and a discussion of alternative services *must* be provided to any MO HealthNet or potential MO HealthNet individual considering care in a MO HealthNet certified nursing home bed. With certain exceptions, the screening *must* be provided prior to admission to the nursing facility.

Referrals for the PLTCS screening may be made by a physician, hospital, family member, nursing facility, ombudsman, etc., by calling the Department of Health and Senior Services at (800) 392-0210.

Missouri Long-Term-Care-Option Program: The LTACS Client Report (DA-13)/LCDE (LTACS Client Data Entry) form is the screening to identify mentally ill, intellectually disabled or developmentally disabled individuals.

Nursing Home Assessments: Potential nursing home placements are screened and informed of community long-term-care options.

13.45. A PREADMISSION SCREENING

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.

For additional information, forms DA-13, DA-124A/B and DA-124C can be found in Section 14 of this manual.

13.45. A (1) Limitations

- Only one new patient visit is allowed per participant per provider regardless of the place of service.
- Only one annual nursing facility (NF) assessment (99318) is allowed per participant per rolling year. If a participant had a physical while a resident of an RCF or Assisted Living Facility (ALF) and is transferred to an NF, another physical is *not* payable within that rolling year.
- Nursing Home Visits are limited to one visit per participant per provider per month. The medical record must clearly document the medical necessity of any additional visits.
  - The NF, RCF or ALF annual physical (99318) are restricted to one per rolling year.

13.46 ADVANCE HEALTH CARE DIRECTIVES

OBRA 90, Section 4715(1) (58), requires each state to develop a written description of the law of the state concerning advance directives. An advance directive allows participants to designate a person to make certain health decisions for them at a future time in which the participant may be incapacitated.

The following MO HealthNet providers who receive Title XIX (Medicaid) payments are subject to the OBRA 90 requirements concerning advance health care directives:

1. Hospitals;
2. Nursing facilities;
3. Home health care providers;
4. Personal care service providers;
5. Hospice providers; and
6. Health Maintenance providers.

These providers are required to follow certain rules and procedures. For a complete explanation of the advance health care directives, reference Section 21.

13.47 PSYCHIATRY

Psychiatric services are those services rendered by a physician (psychiatrist), a Psychiatric Clinical Nurse Specialist (CNS), or a Psychiatric Mental Health Nurse Practitioner (PMHNP), who deals with the study, treatment and prevention of mental illness.

Documentation for each service provided *must* be contained in each participant's medical record at the specific location the services were rendered. All time based services require documentation of start and stop times. For information on guidelines and limitations for psychotherapy, please refer to the Behavioral Health Services Provider Manual.

13.47. A BEHAVIORAL HEALTH SERVICES IN A NURSING HOME

MO HealthNet does *not* cover behavioral health services, with the exception of 90791 and 90792 (Psychiatric Diagnostic Evaluation) when performed by a psychiatrist, PCNS, or PMHNP for nursing facility residents when those services are provided in a nursing home. This is the policy regardless of any arrangement a physician may have with a nursing facility concerning the leasing of office space within the nursing home. If behavioral health services are provided in the long term care facility itself, there is no MO HealthNet coverage afforded a participant. Any costs incurred by a facility for the provision of these services are *not* an allowable cost on the nursing facility's MO HealthNet cost report.

13.47. B PSYCHIATRIC TREATMENT PLAN

A treatment plan is a plan of action developed by the provider using information gathered during the assessment and/or testing. The treatment plan *must* include the psychosocial information, scope, frequency, duration of services, short-term goals, long-term goals, and discharge plan. A separate reimbursement is *not* allowed for the development of a treatment plan.

13.47. C ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) is covered as a second or third line treatment for major depressive disorder and bipolar depression and is limited to a series of two sessions per week for a three to five week period in conjunction with drug management. A Certificate of Medical Necessity form attached to the claim is necessary if a third ECT per week is required.

13.47. D DEFINITION OF PSYCHIATRIC EMERGENCY ADMISSION FOR CHILDREN

It is important for psychiatric hospitals serving children and youth 20 years of age and under to determine whether or not an admission is an emergency. The type of admission determines if the certification of need for inpatient services and the medical/psychiatric/social evaluation

must be made by an independent team or by the hospital's interdisciplinary team. Information may be requested from the attending physician as part of this review.

A psychiatric emergency is defined as a condition requiring immediate psychiatric intervention as evidenced by:

- impairment of mental capacity whereby a person is unable to act in their own best interest; or
- behavior that is by intent an action dangerous to others; or
- behavior and action that are dangerous to self.

13.47. E LIMITATIONS

- Telephone consultations are non-allowable.
- Team management/staffing are non-allowable.
- Only one of the following is covered on a single date of service:
  - office/outpatient visit;
  - home visits (including residential care facility and school);
  - hospital visit;
  - psychotherapy (individual or group);
  - psychiatric diagnostic;
  - electroconvulsive therapy;
  - narcosynthesis.
  - Psychiatric services are *not* covered for diagnoses relating to intellectual disabilities.
- Subsequent hospital visits, using the appropriate level of service, may be allowed on the days that the patient is actually seen but therapy is not done.
- Group therapy (90853) may *not* be billed on the same date of service as family therapy (90846 or 90847) unless the participant is inpatient, in a residential treatment facility or custodial care facility.

13.47. F SERVICES PROVIDED IN GROUP HOME, HOME AND SCHOOL

A group home is a child care facility, which approximates a family setting, provides access to community activities and resources and provides care to no more than 2-12 children. When providing therapy to a group of children in a group home, 90853 is billed with place of service 14.

Group therapy is *not* covered in the home (place of service 12) for a family unit living under the same roof. If therapy is provided to a family unit, family therapy *must* be billed. Settings

which do *not* necessarily approximate a family setting, but whose purpose is to provide one shelter for a group of individuals (home or pregnant teens), group therapy is billed instead of family therapy with a place of service 14.

Services provided in a public school *must* be billed using place of service 03. Services provided in a private school setting *must* be billed using place of service 99.

Modifier U8 *must* be used when submitting claims for place of service 12 (home) or 99 (other). The U8 modifier is *not* appropriate when billing 90853, regardless of place of service.

13.48 DIALYSIS

Hemodialysis and peritoneal dialysis services are covered through the MO HealthNet Program.

Hemodialysis is a process of removing waste products, toxins and excess fluids from the blood. The patient's blood is diverted from a blood vessel by way of a cannula into a dialyzer, or dialyzer machine, where it is treated and then returned to the patient's circulation by another tube inserted into a different blood vessel.

An Evaluation and Management code (99221-99233) may be billed on the same day that an inpatient dialysis treatment was provided as long as a significant, separately identifiable service is rendered. All Evaluation and Management services related to the patient's end stage renal disease that are rendered on a day when dialysis is performed and all other patient care services that are rendered during the dialysis procedure are included in the dialysis procedure.

13.48. A PHYSICIAN SERVICES (DIALYSIS)

13.48. A (1) Monthly End Stage Renal Disease (ESRD)

Procedure codes 90951 through 90962 (based on the patient's age) are used for the monthly supervision of ESRD patients. The appropriate code should be used for ongoing monitoring of the patient, regardless of whether a service is rendered on every day of the month. When billing for monthly supervision, identify only the first date of the month as the date of service and "1" for the number of units. The Monthly ESRD procedure codes are reported ONCE per month and should *not* be used if the patient is hospitalized during the month.

13.48. A (2) Daily ESRD Services

If the physician is *not* involved in continuous supervision of the patient, or becomes involved late in the month, daily visits *must* be billed. When billing supervision for less than a full month (procedure code 90951-90967, based on the patient's age), identify the first day of dialysis to the last day of dialysis. The

number of units *must* equal the number of days within the range of dates. If treatment periods within a month are interrupted (i.e., hospitalization), bill on separate lines for each continuous period using these same guidelines. Daily visits are *not* to be billed for ongoing/monthly supervision.

Example: Patient is admitted to the hospital as an inpatient on July 11 and discharged on July 27, which is 17 days of hospitalization. The appropriate daily ESRD dialysis procedure code is billed as July 1- July 10 = 10 days and July 29 - July 31 = 3 days, for a total of 13 days billed.

Example: Patient is in the hospital on July 1 and discharged on July 3, which is 3 inpatient days for July. The appropriate daily ESRD procedure code is billed from July 4 - July 31 = 28 days billed.

Daily visits are *not* to be billed for ongoing/monthly supervision.

Please note monthly and daily supervision are *not* to be billed in the same month.

13.48. A (3) Hemodialysis/Miscellaneous Dialysis Services

Procedure codes 90937 (hemodialysis procedure requiring repeated evaluations...), and 90947 (dialysis procedure other than hemodialysis requiring repeated evaluations...) are only acceptable when performed on an inpatient hospital basis.

Procedure codes 90935 (hemodialysis) and 90945 (dialysis procedure other than hemodialysis) may be performed on an inpatient basis, in freestanding dialysis centers located within the premises of the hospital or in freestanding dialysis centers located outside the premises of the hospital.

13.48. B FREESTANDING DIALYSIS CENTERS

The technical component of dialysis provided in a freestanding dialysis clinic *must* be billed on the professional claim using procedure code 90999 SU.

13.48. C CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) AND HEMODIALYSIS IN THE HOME

Continuous Ambulatory Peritoneal Dialysis (CAPD) is a MO HealthNet covered service. This method of treatment frees patients from the confinement of a machine and from the dietary restrictions associated with intermittent hemodialysis or peritoneal dialysis.

13.48. C (1) Reimbursement of Dialysis Facility Training Fee

A training fee of $507.50 per patient (regardless of the length of training), is payable to the dialysis facility that has responsibility for furnishing training to the patient. Dialysis and hemodialysis training services and supplies include personnel

services (including home visits, if necessary), dialysis supplies, parenteral items routinely used in dialysis, training manuals and materials and routine laboratory tests.

Procedure code 90989 “Dialysis training, patient including helper where applicable, any mode, completed course” *must* be billed by the dialysis facility using place of service 65, with a quantity of 1. Each patient trained *must* be billed using the individual’s MO HealthNet ID number. The date of service to be used is the first day of training. This is a one-time-only procedure and covers all training provided by the facility.

Procedure code 90993 "Dialysis training, patient, including helper where applicable, any mode, course *not* completed, per training session" *must* be billed by the dialysis facility using place of service 65, and the number of training sessions completed as the quantity.

Please note procedure code 90993 *must* never be billed if reimbursement has been made for procedure 90989.

13.48. D DIALYSIS AND HEMODIALYSIS SERVICES IN THE HOME

Hemodialysis and peritoneal dialysis services may be performed in the following places of service:

12-Home

31-Skilled Nursing Facility

32-Nursing Facility

33-Custodial Care Facility

54-Intermediate Care Facility/Mentally Retarded

The maximum allowable reimbursement for home dialysis/hemodialysis services is $1.599.00 per month regardless of the frequency of the treatments. Reimbursement for claims processed over this dollar amount is reduced or denied. The following guidelines provide specific billing information:

PROC CODE	DESCRIPTION	MAXIMUM UNITS
S9335	Hemodialysis Procedure, with Single Physician Evaluation, in the Home	13
S9339	Dialysis other than Hemodialysis, with Single Physician Evaluation, in the Home	31

Providers may bill for hemodialysis services on the professional claim using a separate line for each date of service and a unit of one. More than one date of service may be billed on each claim. The provider number of the supervising physician *must* be shown as the performing provider on the professional claim.

Providers may bill "From-Thru" dates for consecutive days of dialysis provided ***within the same month***. However, care *must* be taken to assure that the days billed match the number of units billed on the professional claim. If dates of service are *not* consecutive or are *not* within the same month, separate lines *must* be used for each non-consecutive date of service and for consecutive dates that span more than one month. The provider number of the supervising physician *must* be shown as the performing provider on the professional claim.

13.48. D (1) Items and Services Included in the Composite Rate

The following items and services are covered and included in the composite rate and *must* be furnished by the facility, either directly or through arrangements, to all of its MO HealthNet dialysis patients. Items and services include, but are *not* limited to:

- medically necessary home dialysis equipment;
- home dialysis support services, which include the delivery, installation, maintenance, repair and testing of home dialysis and support equipment;
- purchase and delivery of all necessary home dialysis supplies including things such as weight scales, sphygmomanometer, IV stand and dialysate heaters; and consumable and disposable supplies such as dialysate, tubing and gauze pads;
- all dialysis services furnished by the facility's staff; and
- ESRD related laboratory tests at the frequencies specified below. Any test furnished in excess of the frequency listed, or any test furnished that is *not* listed is covered only if there is documentation of its medical necessity.

Every Month

BUN	Total Protein
Creatinine	Albumin
Sodium	Alk. Phosphatase
Potassium	LDH
C02	SGOT
Calcium	Hct

Magnesium	Hgb
Phosphate	Dialysate Protein

Every 3 Months

WBC

RBC

Platelet count

Every 6 Months

Residual renal function	Bone mineral density
24-hour urine volume	MNCV
Chest x-ray	EKG

Other examples (but *not* an all-inclusive list) of items and services that are covered in the composite rate and may *not* be billed separately when furnished by a dialysis facility are:

- staff time used to administer blood;
- de-clotting of shunts and any supplies used to de-clot shunts;
- oxygen and the administration of oxygen; and
- staff time used to administer separately billable parenteral items.

Medications are *not* included in the composite rate and may be billed separately.

13.48. E HOSPITAL-BASED DIALYSIS CLINICS

13.48. E (1) Outpatient or Home Services

REVENUE CODE	DESCRIPTION
0821	Hemodialysis
0831	Peritoneal Dialysis
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD)
0851	Continuous Cycling Peritoneal Dialysis (CCPD)

13.49 OPHTHALMOLOGY/OPTICAL

Physicians (M.D. or D.O.) *must* use 92002 -92499 when billing for eye examinations or special ophthalmological services.

Physicians who also dispense eyeglasses or artificial eyes *must* obtain an optical provider number to receive reimbursement for optical services.

13.49. A BILLING OPHTHALMOLOGY SERVICES

- To bill general ophthalmological services use 92002-92014.
- To bill special ophthalmologic services use 92015-92140.
- To bill hospital, emergency department and other institutional medical services, use the codes from the Evaluation and Management Services section (99221-99233 and 99281-99285) unless specific ophthalmological codes (92002-92499) are more appropriate.
- To report surgical services, see surgery, eye and ocular adnexa (65091, etc.).

13.50 OTORHINOLARYNGOLOGY

13.50. A VESTIBULAR FUNCTION TESTS

CPT procedure codes 92531-92548 and 92700 should be used for billing these services.

13.50. B AUDIOLOGY

13.50. B (1) Audiologist Employed by a Physician

If an audiologist is employed by a physician and works in the same office suite as the physician, audiological services covered through the MO HealthNet Physician Program may be billed under the physician's MO HealthNet number In this instance, the provisions of Section 13.17, Supervision, apply which state in part:

"Direct personal supervision in the office setting does *not* mean that the physician *must* be present in the same room with the auxiliary personnel. However, the physician *must* be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel is performing services." Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

13.50. B (2) Audiologist in Private Practice

When an audiologist works in a different location than the physician and receives referrals from a physician, the audiologist *must* become MO HealthNet enrolled and bill under the hearing aid MO HealthNet provider number.

A referral by a physician is required for an adult patient who has a pre-existing medical condition that would be adversely affected without these services. The referral must include the referring physician's name and NPI number, type of

services needed and medical condition. The diagnosis must be related to a medical condition and supporting documentation must be retained in the patient's file.

13.50. B (3) Diagnostic Audiology Services

Procedure codes 92552 (Pure tone audiometry, threshold; air only), 92553 (Pure tone audiometry, threshold; air and bone), 92556 (Pure tone audiometry, threshold; with speech recognition), 92557 (Comprehensive audiometry threshold evaluation and speech recognition, 92553 and 92556 combined), 92567 (Typanometry, impedance testing), and 92568 (Acoustic reflex testing; threshold) is covered for individuals 21 and over when performed by an audiologist (provider type 33). These procedure codes must be billed with an SC modifier (Medically necessary service or supply) and must be ordered by a physician.

13.51 CARDIOVASCULAR

13.51. A ELECTROCARDIOGRAM (EKG) (ECG)

Electrocardiograms *must* be consistent with the diagnosis/medical condition for which care is received; e.g., angina, chest pain, congestive heart failure, tachycardia, bradycardia, myocardial infarction, etc.

ECGs are noncovered; e.g., prior to each hospital admission or surgery or when performing physical examinations, etc., unless medically indicated.

Interpretation of an ECG (93010) in the hospital or nursing home is paid to the consulting physician, *not* to the attending physician.

A cardiovascular stress test (93015) and an electrocardiogram (93000) are *not* payable for the same participant on the same date of service. Only the cardiovascular stress test (93015) is payable.

An echocardiogram and electrocardiogram may be allowed for the same participant on the same date of service.

EKG monitoring by an anesthesiologist during surgery should *not* be billed separately.

13.51. B CARDIAC REHABILITATION

Cardiac rehabilitation is a covered service through the outpatient department of the hospital. Procedure codes 93797 and 93798 cover the equipment and personnel needed to provide outpatient hospital services. A facility code may *not* be billed by the hospital on the same date of service unless a physician provided services on that day.

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:

1. have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
2. have had coronary bypass surgery; and/or
3. have stable angina pectoris.

13.52 PHYSICAL MEDICINE

The following guidelines apply to all eligible participants unless the therapy is identified as medically necessary as a result of an HCY/EPSDT screening for participants under age 21.

Physical medicine codes 97012 - 97799 are provided to assist in the diagnosis, recovery and rehabilitation of patients with neuromuscular, orthopedic and other disabilities, when prescribed by a physician.

Physical medicine services may be performed in the office, a clinic, in the home or outpatient department of the hospital. Physical medicine services performed on an inpatient basis are *not* separately reimbursable but rather are included in the hospital's per diem rate.

Payment for 97010 (application of a modality to one or more areas; hot or cold packs) is bundled into the payment for all other services including, but *not* limited to, office visits and physical therapy. The patient *cannot* be billed separately for this service.

Physical medicine modalities or procedures *must* be performed by or supervised by a physician. Physical medicine codes 97012-97799 are no longer covered for adults receiving a limited benefit package.

13.52. A MODALITIES AND PROCEDURES

- A limited level of service (99211) may be billed on the same date of service for follow-up therapy.
- A “special report” describing the procedure *must* accompany the claim for procedure code 97039, unlisted modality (specify) and 97139, unlisted procedure (specify).
- Diathermy (97024) is noncovered for the treatment of asthma, bronchitis, etc.
- Spinalator treatment is noncovered.
- Massage therapy (97124) is only paid if used in conjunction with another physical therapy procedure.
- Electrical stimulation (97014) is covered for the treatment of spasticity, incapacitating muscle spasm and semiparesis.
- Manipulation of spine requiring anesthesia, any region (22505), does *not* include evaluation and management services (99201-99215 or 99221-99233).

- Procedure code 97010 (application of hot or cold packs) is *not* covered. Payment for application of hot and cold packs is bundled into payment for all other services including, but *not* limited to, office visits and physical therapy. The patient *cannot* be billed separately for this service.

13.53 NERVOUS SYSTEM

Transcutaneous Electrical Nerve Stimulator (TENS) rental and/or purchase and the application of the battery-operated portable TENS unit are *only* covered by MO HealthNet under the HCY Program. Referrals for these services should be made to a durable medical equipment provider.

Procedure code 64550 "Application of surface (transcutaneous) neurostimulator" is a MO HealthNet covered service.

Physical therapy modalities and procedures (97000 series) as listed in the CPT book, may be used for treatment. Procedure code 97010 (application of hot or cold packs) is *not* covered. Payment for application of hot and cold packs is bundled into payment for all other services including, but *not* limited to, office visits and physical therapy. The patient *cannot* be billed separately for this service.

Referrals for these services should be made to participating DME providers.

13.54 DIGESTIVE SYSTEM

13.54. A NUTRITIONAL SUPPLEMENTS

There are many patients who, because of chronic illness or trauma, *cannot* ingest enough food orally to support healing and maintain normal activities of daily life. These people *must* use an alternative method of nutritional therapy, either parenteral nutrition or enteral tube nutrition, depending upon the particular patient's medical condition. Long term enteral therapy via a feeding tube (eg. gastrostomy or jejunostomy tube) is covered under the MO HealthNet Physician Program. See appropriate CPT code for surgery.

- Nutritional Supplements/Enteral Feedings—Age 21 and Over: Nutritional supplements such as Ensure, and Sustacal are non-covered for participants age 21 and over. Non-covered services may be requested through the MO HealthNet exception process. (Reference Section 20.) For participants residing in nursing facilities, these supplements are included in the nursing facility per diem.
- Nutritional Supplements/Enteral Feedings—Age 0-20: Nutritional supplements such as Ensure, Sustacal, infant formula, and PKU nutrition are MO HealthNet covered services for individuals age 0-20 through the Healthy Children and Youth (HCY) Program. Please refer to Section 19 of the Durable Medical Equipment manual for the restriction guidelines.

13.54. B TOTAL PARENTERAL NUTRITION (TPN)

Cutdown placement of central venous catheter, for the parenteral administration of greater than customary amounts of nutrients into a large central vein for those patients who *cannot* eat, and a constant vascular access for those patients requiring venipuncture(s) who have no peripheral access available, are covered services under the Physician Program.

Total parenteral nutrition (TPN) and supplies used to administer TPN are covered services under the Durable Medical Equipment (DME) Program. Please refer to Section 13 of the Durable Medical Equipment manual for policy guidelines.

13.54. B (1) TPN for Nursing Facility Residents

TPN is covered under the Durable Medical Program for participants in the nursing home. Please refer to Section 13 of the Durable Medical manual for policy guidelines.

13.55 OBESITY

The treatment of obesity is noncovered unless the treatment is an integral and necessary part of a course of treatment for a concurrent or complicating medical condition.

Procedures for bariatric surgery (43770) gastroplasty, laparoscopic sleeve gastrectomy (43775), stomach (43659) and gastric bypass for morbid obesity (43846, 43847 and 43848) are covered surgical procedures when one **or** two of the following criteria, **and** number three must be met:

1. BMI greater than 40 with or without a co-morbid condition, **or**

2. BMI of 35-40 and at least one of the following co-morbid conditions:

   - Secondary diabetes mellitus;
   - Diabetes mellitus;
   - Essential hypertension;
   - Hypertensive heart disease;
   - Hypertensive chronic kidney disease;
   - Hypertensive heart and chronic kidney disease;
   - Secondary hypertension.

3. Must be non-smoker/tobacco user or provide evidence of smoking/tobacco-cessation.

A Prior Authorization Request form and supporting documentation, if appropriate, *must* be submitted to the fiscal agent, Wipro Infocrossing Healthcare Services, for processing. Refer to Section 8 for additional information.

Bariatric surgery procedure codes 43771, 43772, 43773 and 43774 do not require prior authorization.

When billing MO HealthNet for any services related to obesity, the primary diagnosis *must* be for a concurrent or complicating medical condition. The claim should reflect obesity as a secondary diagnosis.

NOTE: Procedure code 43659 is *not* always used for the treatment of obesity.

13.56 CASE MANAGEMENT

Case management is an activity under which responsibility for locating, coordinating and monitoring a group of necessary services for a participant rests with a designated person or organization in order to promote the effective and efficient access to necessary comprehensive health services. Case management seeks to promote the good health of participants and includes referral to various agencies for other needed services, such as Women, Infant and Children (WIC).

13.56. A CASE MANAGEMENT ENROLLMENT CRITERIA

To provide and bill for case management services, a provider *must* be approved and enrolled as a case management provider with MO HealthNet. Upon approval, a specialty code of Case Management, or Targeted Case Management—Children EPSDT, is added to the existing provider file.

In order to be eligible for participation as a MO HealthNet case management provider, the entity *must*:

- have at least two years experience in the development and implementation of coordinated individual maternal and child health plans.
- be able to demonstrate the ability to assure that every pregnant woman and infant/child being case managed has access to comprehensive health services.
- have a minimum of one year experience in the delivery of public health or community health care services including home visiting.
- employ licensed registered nurses (R.N.); licensed clinical social workers with a minimum of 1 year experience as medical social work, certified nurse practitioners, physician assistants or licensed physicians (M.D. or D.O.) case managers who have

  knowledge of:

  - federal, state and local entitlement and categorical programs related to children and pregnant women such as Title V, WIC, Prevention of Mental Retardation, Children With Special Health Care Needs, etc.;
  - individual health care plan development and evaluation;
  - community health care systems and resources; and
  - perinatal and child health care standards (ACOG, AAP, etc.)

and the ability to:

- interpret medical findings;
- develop an individual case management plan based on an assessment of client health, nutritional status and psycho/social status and personal and community resources;
- reinforce client responsibility for independent compliance;
- establish linkages among service providers;
- coordinate multiple entity services to the benefit of the client;
- evaluate client progress in accessing appropriate medical care and other needed services; and
- educate clients regarding their health conditions and implications of risk factors.

HCY case management services may *not* duplicate any targeted case management services provided by the Department of Mental Health, the Jackson County Foster Care Alternative Care Medical Plan, or case management provided under a waiver, e.g., AIDS Waiver.

13.56. B CASE MANAGEMENT FOR PREGNANT WOMEN

Case management services are available for MO HealthNet eligible pregnant women who are "at risk" of poor pregnancy outcomes and are intended to reduce infant mortality and low birth weight by encouraging adequate prenatal care and adherence to the recommendations of the prenatal caregiver.

13.56. B (1) Risk Appraisal

A risk appraisal is a set of criteria to be used in identifying pregnant women who are at risk of poor pregnancy outcomes, and children who have or are at risk of developing, physical, psychosocial and/or developmental problems.

All appropriate MO HealthNet participating providers are urged to perform risk appraisals on pregnant women during the initial visit and as changes in the patient's medical condition indicate. Completion of the Risk Appraisal for Pregnant Women is mandatory in order to establish the "at risk" status of the patient and to bill the global prenatal or global delivery procedure code. No additional payment is made for performing the risk appraisal as it is included in the global reimbursement for prenatal care or delivery. The Risk Appraisal for Pregnant Women form *must* be sent directly to the enrolled MO HealthNet Case Management Provider of the patient's choice and a copy filed in the patient's medical record.

Any eligible pregnant woman who meets any one of the identified risk factors, as determined by the administration of the Risk Appraisal for Pregnant Women, is eligible for prenatal case management services and a referral should be made to a MO HealthNet participating prenatal case management provider. The medical care provider should inform "at risk" pregnant women of prenatal case management benefits available to her and her unborn child.

Only MO HealthNet participating providers who meet the prenatal case management criteria, as established by the MO HealthNet Division, (reference Section 13.56. A) are eligible for reimbursement of prenatal case management services for participants considered "at risk" as a result of the appraisal.

A list of prenatal case management providers can be found in MO HealthNet Case Management Providers-Pregnant Women And Children's Programs. Providers who are interested in becoming case managers should contact the Provider Enrollment Unit for more information at:

Missouri Medicaid Audit & Compliance (MMAC) Provider Enrollment Unit
P.O. Box 6500
Jefferson City, MO 65102-6500
mmac.providerenrollment@dss.mo.gov

13.56. B (2) Procedure Code for Risk Appraisal

The following procedure code should be used when billing the Risk Appraisal for Pregnant Women when it is provided separately and apart from a global prenatal service.

PROC CODE	DESCRIPTION
H1000	Risk Appraisal, Pregnant Women

The Risk Appraisal for Pregnant Women is included in the following procedure codes and may *not* be billed separately:

59400	59425	59426	59510	59610	59618
99204	99204EP	99205	99205EP	99214	99214EP
99215	99215EP				

13.56. B (3) Procedure Codes for Case Management for Pregnant Women

PROC CODE	DESCRIPTION
H1001TS.....	Prenatal care, at risk enhanced service; antepartum management; follow up service
H1001	Prenatal care, at risk enhanced service; antepartum management Limited to one per participant per provider per calendar month.
H1004	Prenatal care, at risk enhanced service; follow-up home visit Limited to one per participant per provider per calendar month.
H1001TS52.....	Prenatal care, at risk enhanced service; antepartum management; follow-up, reduced service
G9012	Other specified case management service *not* elsewhere classified

The date of the last menstrual period (LMP) *must* be shown on the professional claim when billing a code for initial case management for pregnant women.

Case management services are exempt from cost sharing.

*The initial visit *must* be provided prior to the date of delivery.

13.56. C HEALTHY CHILDREN AND YOUTH (HCY) CASE MANAGEMENT

Medically necessary case management services under Section 1905(a) of the Social Security Act are covered for persons under the age of 21 through the Healthy Children and Youth (HCY) Program. (Refer to Section 9 for information about the HCY Program.)

Healthy Children and Youth (HCY) case management is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate services for a participant rests with a specific individual or organization. It centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history and activating the examination/diagnosis/ treatment “loop.”

HCY case management may be used to reach out beyond the bounds of the MO HealthNet Program to coordinate access to a broad range of services, regardless of the source of funding for the services to which access is gained. The services to which access is gained *must* be found by the MO HealthNet Program to be medically necessary for the child. HCY case management services are intended to assist MO HealthNet eligible individuals in gaining access to needed medical, social, educational and other services. However, MO HealthNet *cannot* pay for social, educational and other services that are *not* medical in nature even though the case management service that assists the individual in accessing these services is covered.

Health care providers should be aware of this service so that patients who have a medical need for such services can be referred to a case management entity. HCY Case Management services require prior authorization, unless otherwise stated and are limited as follows:

13.56. C (1) Initial Month—HCY Case Management

A separate procedure code and reimbursement have been established for the first month that HCY case management services are provided. This includes the assessment and development of the care plan, and a face-to-face encounter that includes an educational component.

PROC CODE	DESCRIPTION	RESTRICTIONS
T1016EP	Case Management, Child, Month with initial visit	Prior authorization required and limited to one per child per provider

13.56. C (2) Subsequent Months—HCY Case Management

Subsequent months of case management should be billed using the following procedure code.

PROC CODE	DESCRIPTION	RESTRICTIONS
T1016EPTS	Case Management, HCY	Prior authorization required

Procedure Code T1016EPTS *cannot* be billed during the same month as the initial case management visit.

13.56. C (3) Prior Authorization Process for HCY Case Management

Prior Authorization Requests for HCY case management are processed by the Department of Health and Senior Services, Bureau of Special Health Care Needs (BSHCN). The Prior Authorization Request should be submitted on the yellow Prior Authorization Request form and mailed to:

Department of Health and Senior Services
The Bureau of Special Health Care Needs
P.O. Box 570
Jefferson City, MO 65102-0570.

Emergency requests may be faxed or telephoned to the Bureau of Special Health Care Needs.

FAX Number: (573) 751-6237
Telephone Number: (573) 751-6246

The Prior Authorization Request *must* be initiated by the provider who will be performing the HCY case management services.

For information on completing the Prior Authorization Request form, reference Section 8.

13.56. C (4) HCY Case Management Assessment and Care Plan

The individual's need for case management services *must* be assessed and a care plan *must* be developed. The plan *must* indicate the date of the full/partial/interperiodic screen that resulted in the establishment of the medically necessary case management services and the date of the most recent full HCY screen. *If the child has not received a full screen, the case management provider must make arrangements for a full screen and follow up that the screen was obtained, including all age-appropriate immunizations and lead screening if indicated.* The plan *must* contain the type of interventions, frequency of visits, if home visits are necessary and an end date. The care plan *must* be maintained in the patient's medical record. All HCY case management services *must* be documented in the patient's record. Maintenance of a condition-specific protocol by the case management entity is *not* accepted instead of individual client records.

Contact the MO HealthNet Provider Communications Unit at (573) 751-2896 for more information.

13.56. D LEAD CASE MANAGEMENT FOR CHILDREN SERVICES

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. The following procedure codes have been established for billing lead case management. Prior authorization is *not* required:

PROC
CODE DESCRIPTION

T1016UA .....Lead Case Management, with Initial Visit

T1016UATS...Lead Case Management, Subsequent Months

- T1016UA—Lead Case Management, with Initial Visit

  For admission to case management within two weeks of receiving confirmatory blood-lead level. This includes client/family assessment, establishes a Plan of Care and reinforces education provided by health care providers. The client/family is provided the case manager's name and telephone number. (The higher the blood lead level, the more timely the initial visit should occur.)

- T1016UATS—Lead Case Management, Subsequent Months

  Three month encounter following initial encounter to assess progress of affected child and review and reinforce client/family education and medical regime.

  AND

  At six to seven months after initial encounter which includes discharge counseling regarding lead status and ongoing nutrition and environmental maintenance. Discharge is contingent upon the following three conditions being met:

  - 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

  Other reasons for discharge may include:

  - Blood lead level remains below 20 µg/dL for 1 year. This closure reason is intended for use in cases where all efforts to reduce a child's blood lead level have been made (i.e, hazards in the home environment have been reduced, personal hygiene, nutritional, and housekeeping behaviors have been appropriately modified, etc.), yet the child's body burden of lead

causes the child's blood lead level to consistently remain between 15-20 µg/dL.

- Refusal of service
- The child is older than 72 months of age
- Unable to locate

A minimum of three client/family case management encounters, all face-to face, are mandatory. If more than three case management fees are billed per participant, documentation of medical necessity and copies of progress notes are required for the additional visits and *must* be attached to the claim. These encounters *must* be at two to three month intervals, all being face-to-face.

13.56. D (1) Documentation of Lead Case Management Services

The following information *must* be included in the client record:

- Admission progress notes made to include blood-lead level, assessment of client/family, Plan of Care and any interventions by the case manager.
- Follow-up visit (second visit) to include lab results, client status, any interventions by case manager and progress to goals.
- Exit discharge contact documentation to include reason for discharge, lab results, client status, exit counseling, and the status of goal completion (to include telephone number for questions and assistance).

13.56. D (2) Additional Lead Case Management Services

- Case management of children with elevated blood levels greater than 20 µg/dL may be continued beyond the minimum of 3 encounters until 2 acceptable blood-lead levels are documented.
- Encounters *must* be at two- to three-month intervals, all being face to face.
- Documentation *must* be attached to the claim to include validation of the blood-lead level and significant interaction. Procedure code T1016UATS should be billed.

Reference the Bureau of Special Health Care Needs Area Offices map, which are MO HealthNet enrolled case management agencies. If a case management provider *cannot* be located for the child, contact the area Bureau of Special Health Care Needs (BSHCN) office located on the BSHCN Area Office County Listing for case management assistance.

13.57 OBSTETRIC SERVICES

13.57. A OBSTETRIC PANEL

The Obstetric Panel (80055) *must* include the tests listed in the *Current Procedural Terminology (CPT)* book. Billing for these procedures individually or in addition to the obstetric panel (80055) is *not* allowed, regardless of the procedure code or method used. However, these panel components are *not* intended to limit the performance of other medically necessary tests, which when performed in addition to those specifically indicated for a particular panel may be reported separately. Refer to Section 13.41.D for additional laboratory panel information.

13.57. B ULTRASOUND EXAMS (SONOGRAMS) IN PREGNANCY

Routine ultrasounds are *not* indicated in normal pregnancies. However, MO HealthNet reimbursement is available for up to three ultrasound procedures during any one rolling year when reasonable and necessary based on medical indication(s).

Ultrasounds provided in excess of three during any one rolling year *must* be medically necessary. All services *must* be adequately recorded in the patient's record and *must* demonstrate appropriateness of use in proper diagnosis, 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 include information regarding the patient's diagnosis for use by the billing provider.

Failure of medical records to adequately document and support the utilization of ultrasonography procedures shall result in the recovery of all payments made for these services at the provider's liability.

This policy of limitation applies only to program reimbursement for the service. It does *not* apply to the exercise of medical judgment as to need.

13.57. B (1) 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-feto Protein (MSAFP) screen;
- Fetal malpresentation;
- Suspected abruptio placenta;
- Suspected oligo/polyhydramnios;
- Suspected macrosomia;
- Preeclampsia;
- Preterm labor;
- Premature rupture of membrane (PROM);
- Suspected placenta previa;
- Post-date pregnancy;
- Suspected fetal anomaly;
- Other (requires definition).

13.57. B (2) Noncovered Ultrasound Services

- Routine screening of *all* pregnant women.
- Use of any apparatus in auscultation of fetal heart tones.

13.57. C FETAL CONTRACTION STRESS TEST (59020) AND FETAL NON-STRESS TEST (59025)

The total component (both the professional and technical components of the procedure) for fetal stress and non-stress procedures are covered when performed in an office/clinic setting.

Use the 26 modifier when only the professional component is performed in an inpatient, outpatient or office/clinic setting.

Modifier TC is used when only the technical component is performed in an outpatient or office/clinic setting. If performed inpatient, payment for this charge is included in the per diem rate paid to the hospital.

13.57. D "PRENATAL VISIT"—DEFINITION

A "prenatal visit" is defined as a face-to-face visit with the pregnant MO HealthNet participant at which time all of the following services *must* be performed:

- Patient's weight
- Blood pressure
- Urine check
- Fetal heart tone (FHT) attempt
- Fundal height
- Interim history

A telephone call is *not* a prenatal visit/contact, nor is a WIC referral or other visit for any other reason *not* directly related to the pregnancy, e.g., treatment for cold, allergy shot, etc.

13.57. E RISK APPRAISAL FOR PREGNANT WOMEN

The Risk Appraisal for Pregnant Women is included in the following procedure codes and may *not* be billed separately:

59400	59510	59425	59426	59610	59618
99204	99204EP	99205	99205EP	99214	99214EP
99215	99215EP				

PROC CODE	DESCRIPTION
H1000.....	Risk Appraisal, Pregnant Women

This procedure code should be used when billing the Risk Appraisal for Pregnant Women when it is provided separately and apart from a global prenatal/delivery/postpartum service.

A risk appraisal is a set of criteria to be used in identifying pregnant women who are at risk of poor pregnancy outcomes, and children who have or are at risk of developing, physical, psychosocial and/or developmental problems.

All appropriate MO HealthNet participating providers are urged to perform risk appraisals on pregnant women during the initial visit and as changes in the patient's medical condition indicate. Completion of the Risk Appraisal for Pregnant Women is mandatory in order to establish the "at risk" status of the patient and to bill the global prenatal or global delivery procedure code. No additional payment is made for performing the risk appraisal as it is included in the global reimbursement for prenatal care or delivery. The Risk Appraisal for Pregnant Women form *must* be filed in the patient's medical record.

Any eligible pregnant woman, who meets any one of the identified risk factors, as determined by the administration of the Risk Appraisal for Pregnant Women, is eligible for prenatal case management services and a referral should be made to a MO HealthNet participating prenatal case management provider. The medical care provider should inform "at risk" pregnant women of prenatal case management benefits available to her and her unborn child.

Only MO HealthNet participating providers who meet the prenatal case management criteria, as established by the MO HealthNet Division, (reference Section 13.56.A) are eligible for reimbursement of prenatal case management services for participants considered "at risk" as a result of the appraisal.

A list of prenatal case management providers can be found in MO HealthNet Case Management Providers-Pregnant Women and Children's Programs. Providers who are interested in becoming case managers should contact the Provider Enrollment Unit for more information at:

Missouri Medicaid Audit & Compliance (MMAC)
Provider Enrollment Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

13.57. F GLOBAL PRENATAL (59425, 59426)

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, vaginitis, and a "Risk Appraisal for Pregnant Women".

If the risk appraisal determines the pregnant woman to be at risk, a referral should be made to an approved case management provider. (Reference Risk Appraisal Section 13.56.B (1).)

Only one prenatal care code, 59425 (4-6 visits) or 59426 (7 or more visits) may be billed per pregnancy. The provider *must* have seen the MO HealthNet eligible participant for four or more prenatal visits, and performed all of the "prenatal visit" services (at each visit) as defined. If a provider does more than 3 visits but the participant goes to another provider for the rest of her pregnancy, all visits *must* be billed using the appropriate office visit procedure codes, except for exempted visits/consultations as described in Section 13.57.F(1). Women with complicating conditions should be referred for consultations or specialty care, as indicated.

The global prenatal fee is reimbursable when one physician or physician group practice provides all of the patient's obstetric prenatal care. For this purpose, a physician group is defined as an obstetric clinic, there is one patient medical record, and each physician/physician assistant/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal care services provided within the clinic under the primary care physician's provider number as the performing provider.

When fewer than four complete prenatal visits were performed, providers *must* bill for individual dates of service, using the appropriate Evaluation and Management (E/M) code.

The date of the delivery is the date of service to be used when billing the global prenatal codes.

Providers *must* enter the date of last menstrual period (LMP) on the professional claim form when billing this procedure.

13.57. F (1) Exempted Visits/Consultations

1. Entry into Care: A total of two visits may be paid by MO HealthNet to allow the initial provider (*not* providing ongoing care) to perform an initial examination, diagnose the pregnancy and make a referral to a second provider. The second provider, who then provides the remainder of the prenatal care, may bill for global prenatal/global delivery, as appropriate, if all other conditions applicable to the global billing and delivery of service are met.
2. Consultations: In addition, two consultations by referral to another MO HealthNet provider may be paid and still permit billing of the global

prenatal or global delivery (by the referring physician) if all other conditions applicable to the global billing and delivery of service are met.

3. Services for High-Risk Patients: For those pregnant women who develop a high-risk condition for which more than two consultative visits by an obstetrician are required, MO HealthNet allows payment for the consultative visits in addition to the global prenatal care code billed by a previous provider. The consultative services must be medically necessary and properly documented. This policy is an effort to assure adequate and appropriate prenatal services for high-risk pregnant women.

4. If the prenatal care is transferred to the consulting physician, global payment is not allowed for either provider.

13.57. F (2) Global Prenatal/Delivery Transition from Fee-For-Service to MO HealthNet Managed Care

When the obstetrical care begins under a fee-for-service setting and continues into a MO HealthNet Managed Care health plan, and the Managed Care health plan reimburses the provider a global fee, the provider *must not* bill any visits to MO HealthNet fee-for-service. If a global fee is *not* received from the Managed Care health plan, the provider may bill MO HealthNet fee-for-service for each visit provided.

13.57. G FETAL MONITORING-INTERNAL (59050)

The attachment of electrodes to the scalp or buttocks during the first stage of labor (the period from the onset of regular uterine contractions to full dilation and effacement of the cervix) is part of the delivery and should *not* be billed separately. During the first stage of labor, the obstetrician may be informed of severe variable decelerations and may request a consultation. The consultant may be reimbursed for this procedure.

Fetal monitoring during labor by a consultant is a MO HealthNet covered service. This procedure may only be performed on an inpatient hospital basis by a consultant.

13.57. H GLOBAL PRENATAL/DELIVERY/POSTPARTUM (59400, 59510, 59610, 59618)

The fee for the global prenatal/delivery/postpartum care includes all prenatal visits, routine urinalysis testing during the prenatal period, subsequent care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, vaginitis, and a Risk Appraisal for Pregnant Women. The fee also includes the initial hospital visit, the delivery and postpartum care. If a provider does more than 3 visits but the participant goes to another provider for the rest of

her pregnancy, the global prenatal/delivery/postpartum care procedure codes *cannot* be billed. Each date of service *must* be billed separately.

If the risk appraisal determines that the pregnant woman is high risk, either medically or socially, a referral should be made to a case manager of the participant's choice. Reference Section 13.56.B for information concerning Case Management for Pregnant Women.

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all of the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, there is one patient medical record, and each physician/physician assistant/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal, delivery and postpartum care services provided within the clinic, using the primary care physician's provider number as the performing provider.

NOTE: Last menstrual period (LMP) is required on all claims for global and/or prenatal/delivery services.

When billing for this service, the date of delivery is the service date to be entered on the professional claim form.

A delivery diagnosis code *must* be used.

It is inappropriate to bill global delivery when the pregnancy terminates at or prior to twenty weeks gestation. Services are to be billed using the appropriate Evaluation and Management Services code(s) and/or medical/surgical procedure(s) performed.

13.57. I DELIVERY ONLY (59409, 59514, 59612, 59620)

The delivery only, procedure codes are used when more than one provider is involved in the prenatal care and delivery, and the physician at delivery:

- has provided no prenatal care;
- does *not* provide postpartum care
- elects to bill fee-for-service; or
- elects to bill global prenatal for prenatal services and delivery.

Providers *must* enter the date of the last menstrual period (LMP) on the professional claim. The date of service is the delivery date. A delivery diagnosis code *must* be used.

It is inappropriate to bill a delivery code when the pregnancy terminates at or prior to 20 weeks gestation. Services are to be billed using the appropriate Evaluation and Management Services code(s) and/or medical/surgical procedure(s) performed.

13.57. J DELIVERY ONLY INCLUDING POSTPARTUM CARE (59410, 59515, 59614, 59622)

The delivery only including postpartum care procedure codes are used when more than one provider is involved in the prenatal care and delivery and the physician at delivery:

- has provided no prenatal care and;
- provides the delivery and postpartum care

13.57. K POSTPARTUM CARE ONLY (59430)

The postpartum care only procedure is used when the physician provides postpartum care only.

13.57. L ANESTHESIA FOR DELIVERY

The anesthesiologist, CRNA and anesthesiologist providing medical direction for general anesthesia *must* bill for services using the appropriate CPT anesthesia procedure code.

13.57. M MULTIPLE BIRTHS

When it is medically necessary to perform a cesarean section on a subsequent delivery after a child has been delivered vaginally, reimbursement is 100% for both deliveries. Documentation *must* be kept in the patient's file indicating the need for both procedures.

13.57. N SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY 59525—LIST IN ADDITION TO 59510 OR 59515)

This procedure requires the Acknowledgement of Receipt of Hysterectomy Information form.

13.57. O BILLING INSTRUCTIONS

For those situations in which services are provided in a clinic setting (e.g., public health, family planning or other group practice), caution *must* be used to assure that duplicate billing does *not* occur by the clinic provider and physician of record. When this occurs, duplicate payments may be made, resulting in subsequent recovery of the overpayments.

13.57.P FREE STANDING BIRTH CENTERS

Effective for dates of service on or after December 22, 2019, the MO HealthNet Division (MHD) will enroll free standing birth centers as MO HealthNet providers. A free standing birth center is defined as a facility, not licensed as part of the hospital, which provides maternity care away from the mother's usual residence and where low risk births are planned following a normal uncomplicated pregnancy.

13.57.P(1) Covered Services

The free standing birth center facility payment includes all room charges for the mother and baby, equipment and supplies. Providers will use Current Procedural Terminology (CPT) code 59409 with modifier SU to bill for facility services provided in a birthing center. If labor was begun in a birthing center, but the woman had to be transferred to a hospital for the birth, the birthing center may bill CPT code S4005. Birthing center facility services are limited to one per participant per pregnancy

The physician or certified nurse midwife must submit separate claims for their professional services. Services provided before and after the delivery, such as antepartum and postpartum care are included in the professional payment for the physician or certified nurse midwife.

13.58 MATERNITY STAYS AND POST-DISCHARGE HOME VISITS

Coverage through the MO HealthNet Program is available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly born child. A shorter length of hospital stay for services related to maternity and newborn care may be approved if the shorter stay meets with the approval of the attending physician after consulting with the mother. In which case, post-discharge care is required.

13.58. A CRITERIA FOR EARLY DISCHARGE FOLLOWING DELIVERY

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

- The antepartum, intrapartum and postpartum courses for both mother and baby are uncomplicated;
- Term (38-42) weeks with birth weight appropriate for gestational age;
- Vital signs for baby are normal and stable for at least 12 hours: heart rate 100-160/minute, respiratory rate <60/minute, and axillary temperature 97 to 98 degrees Fahrenheit in an open crib with appropriate clothing;
- Two successful feedings with coordinated sucking, swallowing and breathing while feeding;

- No evidence of excessive bleeding at the circumcision site for at least two hours;
- Physician examination reveals no abnormalities that require continued hospitalization;
- There is no evidence of significant jaundice in the first 24 hours;
- The mother has received instruction regarding: bottle or breast feeding, adequacy of breast feeding assessed by latch-on and swallowing, urine and stool frequency, cord, skin and infant genital care, recognition of signs of illness, common problems, jaundice, infant safety (car seat and position for sleeping) and mother verbalizes/demonstrates her knowledge, ability and confidence;
- Support person(s) available in the home to assist the mother;
- No unresolved family, environmental or social risk factors present such as: untreated parental substance abuse, history of child abuse or neglect, mental illness of parent in the home, no fixed home, untreated domestic violence, especially during this pregnancy;
- Mother has stable vital signs and is able to ambulate without vertigo;
- Initial hepatitis B vaccine is administered or appointment made for administration within the first week of life;
- Initial newborn screenings performed prior to discharge, if performed before 24 hours of milk feeding, a repeat is ordered or scheduled during the follow-up visit;
- Follow-up care within 48 hours with result reported to physician on the same day.

13.58. B COVERAGE OF POST-DISCHARGE VISITS

MO HealthNet reimburses up to two post-discharge skilled nurse visits in the home within two weeks of an early inpatient discharge for a stay of less than 48 hours for a vaginal delivery and for a stay of less than 96 hours for a cesarean section delivery when provided by a home health agency. Visits *must* be physician ordered and included in a plan of care. The criteria for an early inpatient discharge and the post-discharge visits *must* be met.

The first post-discharge visit shall be provided within 48 hours of an inpatient discharge unless otherwise ordered by a physician and the second post-discharge visit, if appropriate (e.g., breast feeding *not* well established) shall be provided within two weeks of an inpatient discharge. These services are exempt from the home-bound requirement. The post discharge visit(s) covers both the mother and newborn.

13.59 NEWBORN CARE

Initial examinations have been identified as HCY screenings. The newborn's medical record *must* document that all aspects of a full HCY examination were performed. Future screenings should be

billed under the appropriate screening codes according to the HCY periodicity schedule. Reference Section 9.

13.59. A NEONATAL INTENSIVE CARE

Procedure codes 99468-99469 are used to report services provided by physicians directing the care of a critically ill neonate or infant in a neonatal intensive care unit (NICU). These codes represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered critically ill, the codes for Subsequent Hospital Care (99231-99233) should be utilized.

These NICU codes are to be used in addition to codes 99360 and 99465 or 99464 as appropriate, when the physician is present for the delivery and newborn resuscitation is required.

Care rendered includes management; monitoring and treatment of the patient including nutritional, metabolic and hematologic maintenance; pharmacologic control of the circulatory system; case management services; parent counseling; and personal direct supervision of the health care team.

13.59. B NEWBORN CARE IN THE HOSPITAL

13.59. B (1) Initial Hospital/Birthing Center Care

The following procedure code should be used for the initial (normal) newborn examination only. This is a one-time-only code and should be billed using the infant's MO HealthNet ID number (DCN) and the date of birth as the date of service.

PROC CODE	DESCRIPTION
99460.....	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant. This code should also be used for birthing room deliveries.

13.59. B (2) Subsequent Hospital/Birthing Center Care

This procedure code should be used for subsequent examinations performed in the hospital on days following the date of birth.

PROC
CODE DESCRIPTION

99462 .....Subsequent hospital care, per day, for evaluation and management of normal newborn.

For illness or critical care, the hospital inpatient services, neonatal intensive care or critical care codes should be used. The procedure and diagnosis *must* support the use of these service codes. Reference Section 13.21.C (2).

13.59. B (3) Inpatient Newborn Care (99231TG, 99232TG, 99233TG)

These procedure codes are limited to services provided to newborns/infants for the specific diagnosis codes listed below.

A40.0	A40.1	A40.3	A40.8
A40.9	A41.01	A41.02	A41.1
A41.2	A41.3	A41.4	A41.50
A41.51	A41.52	A41.53	A41.59
A41.81	A41.89	A41.19	A42.7
P07.00	P07.01	P07.02	P07.03
P07.10	P07.14	P07.15	P07.16
P07.17	P22.0	P36.0	P36.10
P36.19	P36.2	P36.30	P36.39
P36.4	P36.5	P36.8	P36.9

13.59. C NEWBORN CARE (OTHER THAN HOSPITAL OR BIRTHING ROOM SETTING)

PROC CODE DESCRIPTION

99461 ..... Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center. This is a one-time-

only code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service.

99463 ..... Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date. This is a one-time code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service.

13.59. D NEWBORN ENROLLMENT IN MO HEALTHNET MANAGED CARE HEALTH PLANS

A child born to a participant enrolled with a health plan is automatically enrolled with the mother's plan effective on the date of birth if the child is determined to be eligible on the date of birth.

When providing services to a newborn whose mother is enrolled with a health plan, providers are urged to contact the health plan immediately regarding any incurred charges for the child. (Reference Section 11, Managed Health Care Delivery System.)

13.59. E HOME APNEA MONITORING

A home apnea monitor is covered through the Durable Medical Equipment Program for MO HealthNet eligible infants with symptoms of Sudden Infant Death Syndrome (SIDS). A Certificate of Medical Necessity form completed and signed by the physician is required every six months. The rental of the monitor is manually reviewed. The monitor *must* be prescribed by an M.D. or D.O.

13.60 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 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 self-management training services are *not* available to adults receiving a limited benefit package.

13.60. A DIABETES SELF-MANAGEMENT TRAINING ENROLLMENT CRITERIA

To provide and bill for diabetes self-management training, a provider *must* be approved and enrolled as a diabetes self-management provider with MO HealthNet. Following are the requirements to enroll as a provider under the Diabetes Self-Management Training program:

Certified Diabetes Educator (CDE): *Must* hold a permanent Missouri license as a registered nurse, physician assistant or physician. CDE *must* also hold current certification from the National Certification Board for Diabetes Educators (NCBDE) through the American Association of Diabetes Educators (AADE). CDEs practice under the Scope of Practice for Diabetes Educators developed by AADE.

Registered Dietician (RD): *Must* hold a permanent Missouri license as a registered nurse, physician assistant, physician, social worker, pharmacist, registered dietician or other health care professional. When the RD is licensed by Missouri, the RD *must* submit a copy of the license as an RD. The RD *must* also hold current certification from the Commission on Dietetic Registration through the American Dietetic Association (ADA). RDs practice under American Dietetic Association Standards of Professional Practice by the ADA.

Registered Pharmacist (RPh): *Must* hold a permanent Missouri license as licensed pharmacist and *must* have completed the National Community Pharmacists Association (NCPA) "Diabetes Care Certification Program" **OR** completed the American Pharmaceutical Association (APhA)/AADE certification program "Pharmaceutical Care for Patients with Diabetes."

Diabetes education providers employed/contracted with federally qualified health centers (FQHCs) or rural health clinics (RHCs) bill with their individual diabetes self-management training provider number with payment designated to the FQHC or RHC.

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.

13.60. B DIABETES SELF-MANAGEMENT TRAINING SERVICE LIMITATIONS

Diabetes self-management training services are limited to any of the following circumstances with documentation of the need for services maintained in the provider's file:

- Initial diagnosis of diabetes;
- Any significant change in the patient's symptoms, condition or treatment.

Diabetes self-management training *must* be prescribed by a physician or health care provider with prescribing authority to the CDE, RD or RPh.

An initial assessment is reimbursed once per lifetime. The initial assessment *must* be performed by a physician or a CDE.

The initial assessment should include but *not* be limited to information from the patient on the following:

- Health and medical history;
- Use of medications;
- Diet history;
- Current mental health status;
- Use of health care delivery systems;
- Life-style practices;
- Physical and psychological factors;
- Barriers to learning; family and social supports; and
- Previous diabetes education, actual knowledge and skills.

Two subsequent visits are reimbursed per rolling year. The two subsequent visits may be individual, group or a combination of individual and group.

Any additional visits require a Certificate of Medical Necessity form from a physician or health care provider with prescribing authority documenting the need for any additional visits be kept in the patient's file.

The diabetes self-management training services for patients enrolled in MC+ are the responsibility of the health plan.

13.60. B (1) Procedure Codes for Diabetes Self-Management Training

PROC CODE	DESCRIPTION
99205U9 ..	Initial Assessment–Comprehensive Diabetes Education–Minimum 1 hour
G0108	Diabetes Education–Subsequent Visit–Minimum 30 minutes
G0109	Diabetes Education–Group Subsequent (No more than 8 persons)–Minimum 30 minutes

13.61. B (2) Diabetes Self-Management Training Billing Procedures

The diabetes self-management training services *must* be billed on a professional claim, with the appropriate procedure code.

The place of service (POS) code *must* be one of the following: 03 (School); 11 (Office); 12 (Home); 21 (Inpatient Hospital); 22 (Outpatient Hospital); or 99 (Other Unlisted Facility).

Training provided by a CDE, RD or RPh *not* employed by the hospital, *must* be billed using POS 21 (Inpatient Hospital) or 22 (Outpatient Hospital) using their own diabetes self-management training provider number.

13.61 HYPERBARIC OXYGEN THERAPY (HBO) (99183)

Physician attendance and supervision of hyperbaric oxygen therapy (HBO), per session) is a covered MO HealthNet service for the professional component. Evaluation and Management services and/or procedures (e.g., wound debridement) provided in conjunction with HBO should be reported separately.

13.62 PODIATRY SERVICES

Podiatrists *must* follow policy and procedure as stated in the Physician Manual. Podiatrists are limited to the services identified below:

- services that podiatrist are legally authorized to perform in the state where they are licensed;
- medical, surgical and mechanical services for the foot or any area *not* above the ankle joint.

NOTE: A podiatrist does *not* charge a copay when the service is an outpatient visit. Refer to Section 13.16 for information on cost sharing and copay.

13.62. A PODIATRY LIMITATIONS

The following podiatry services are not covered for adults receiving a limited benefit package:

11719—Trimming of nondystrophic nails, any number

11720—Debridement of nail(s) by any method(s); one to five

11721—Debridement of nail(s) by any method(s); six or more

11750—Excision of nail and nail matrix, partial or complete

29540—Strapping of ankle and/or foot

13.63 CIRCUMCISIONS

MO HealthNet pays for elective circumcisions for all newborn infants less than 28 days old using Current Procedural Terminology (CPT) codes 54150 and 54160. Procedure codes 54161, 54162, 54163 and 54164 require Prior Authorization. Documentation from a physician that a disease,

pathology or other abnormality exists that requires a medically therapeutic circumcision *must* be attached to the Prior Authorization Request.

13.64 VAGUS NERVE STIMULATION

Vagus nerve stimulation is covered for patients with medically refractory partial onset epileptic seizures for whom surgery is *not* recommended or for whom surgery has failed.

The procedure is performed in the hospital and usually requires an overnight stay. Surgeons should code the implant procedure as electrode placement and neurostimulator placement. In addition, a physician (usually a neurologist) typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant. The physician should bill the following CPT codes:

95970 95974 95975

These analysis and programming procedure codes may also be billed periodically to test and reprogram the device.

The device is included in the hospital per diem if the surgery is performed in an inpatient hospital setting. If the surgery is performed in an outpatient hospital setting, the device is billable under the outpatient supply code.

13.65 MISSOURI'S BREAST AND CERVICAL CANCER CONTROL PROJECT

Missouri women who are diagnosed with breast or cervical cancer under the state's Breast and Cervical Cancer Control Project may be eligible to receive treatment through the MO HealthNet Program.

Uninsured women under the age of 65 who have been screened through Missouri's Breast and Cervical Control Project and are in need of treatment for breast or cervical cancer may qualify for full MO HealthNet coverage. This includes treatment of certain precancerous conditions and early stage cancer.

13.65. A ELIGIBILITY CRITERIA

To qualify for Medical Assistance based on the need for Breast or Cervical Cancer Treatment all the following criteria *must* be met:

- Screened by Missouri Breast or Cervical Cancer Treatment Provider
- Need for treatment for breast or cervical cancer including certain precancerous conditions
- Under the age of 65 years old
- Have a Social Security Number

- Citizenship or alien status
- Uninsured, or have health coverage that does *not* cover breast or cervical cancer treatment
- A Missouri resident

13.65. B PRESUMPTIVE ELIGIBILITY

Presumptive eligibility determinations are made by Breast and Cervical Cancer Control Project MO HealthNet providers. When a Breast and Cervical Cancer Control Project MO HealthNet provider determines a woman is eligible for presumptive eligibility, they issue her a MO HealthNet approval letter. MO HealthNet coverage under presumptive eligibility begins on the date the Breast and Cervical Cancer Control Project provider determines the woman is in need of treatment.

13.65. C MO HEALTHNET COVERAGE

MO HealthNet coverage under Breast and Cervical Cancer Treatment begins on the first day of the month of an approved application and continues until the last day of the month that the regular MO HealthNet application is approved or Breast and Cervical Cancer Treatment is no longer required, whichever is later.

Services can be obtained from enrolled MO HealthNet providers on a fee-for-service basis. Participants eligible based on the need for Breast and Cervical Cancer Treatment are *not* enrolled in managed care.

Presumptive eligibility, Breast and Cervical Cancer Treatment and regular MO HealthNet eligibility provide full MO HealthNet benefits.

For additional information and to learn where the closest Breast and Cervical Cancer Control Project provider is located call the Cancer Information Service at 1-800-CANCER which translates to (800) 422-6227.

13.66 PHARMACY BENEFITS

13.66. A LONG-TERM CARE MAINTENANCE DRUG BILLING

Reference Pharmacy Manual Section 13.

13.66. B DOSE OPTIMIZATION

Reference Pharmacy Manual Section 13.

13.66. C DRUG PRIOR AUTHORIZATION PROCESS

Reference Pharmacy Manual Section 13.

13.67 NAME CHANGE

Documentation *must* accompany claims for a participant whose name changes after a form is completed, (i.e., sterilization). For example, a letter of explanation should be submitted to document a name change due to marriage or divorce.

13.68 BILATERAL PROCEDURES (50 MODIFIER)

MO HealthNet covered procedures that are performed bilaterally and are identified by Medicare Services as appropriate bilateral procedures, *must* be billed using the 50 modifier and quantity of 1. For bilateral procedures identified by Medicare Services, please reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the bilateral surgery column of the database instruct carriers how to reimburse for services. The fee schedule can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

Note: Not all codes in the listing are covered by MO HealthNet; refer to the MO HealthNet fee schedule.

13.69 TELEHEALTH SERVICES

Telehealth Services are health care services provided through information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site.

Telehealth offers participants, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.

13.69. A COVERED SERVICES

Services provided through telehealth must meet the standard of care that would otherwise be expected should such services be provided in person.

Prior to the delivery of telehealth services in a school, the parent or guardian of the child shall provide authorization for such service. The authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year.

13.69. B ELIGIBLE PROVIDERS

Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person.

To be reimbursed for telehealth services health care providers treating patients in this state, utilizing telehealth, must be fully licensed to practice in this state and be enrolled as a MO HealthNet provider prior to rendering services.

13.69. C REIMBURSEMENT

Reimbursement to the health care provider delivering the medical service at the distant site is equal to the current fee schedule amount for the service provided. Use the appropriate CPT code for the service along with place of service 02 (telehealth).

Distant site services provided on school grounds should be billed with place of service 03 and a GT modifier.

The originating site is only eligible to receive a facility fee for the Telehealth service. Claims should be submitted with HCPCS code Q3014 (Telehealth originating site facility fee). Procedure code Q3014 is used by the originating site to receive reimbursement for the use of the facility while Telehealth services are being rendered.

13.69. D DOCUMENTATION FOR THE ENCOUNTER

A health care provider is required to keep a complete medical record of a Telehealth service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.030.

13.70 CHIROPRACTIC MEDICINE – Effective January 1, 2020

13.70. A COVERED SERVICES

Chiropractic services are limited to examinations, diagnoses, adjustments, manipulations and treatments of malpositioned articulations, and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice.

13.70. B ELIGIBLE PROVIDERS

To be eligible for participation in the MO HealthNet Chiropractic Program, a provider must be licensed to practice chiropractic by complying with the provisions of Chapter 331, RSMo and shall have signed a participation agreement to provide chiropractic services under the MO HealthNet program.

13.70. C ELIGIBLE PARTICIPANTS

Any person who is eligible for Title XIX benefits from the Family Support Division and who is found to be in need of chiropractic services in accordance with the procedures described in this rule shall be deemed eligible to receive these services.

13.70. D LIMITATIONS

Participants may receive up to 20 visits per year for chiropractic services.

13.71 COMPLEMENTARY HEALTH AND ALTERNATIVES TO CHRONIC PAIN MANAGEMENT

MO HealthNet has developed a structured Complementary Health and Alternative to Chronic Pain Management program to help decrease the use, misuse and prescribing of opioid medications for chronic pain.

13.71. A COVERED SERVICES

Complementary Health and alternative therapies include a combination of newly covered services including physical therapy, chiropractic therapy, and acupuncture, along with current coverage of cognitive-behavioral therapy (CBT) for chronic pain and non-opioid medication therapy.

13.71. B. PARTICIPANT ELIGIBILITY

Before starting use of opioid medications for chronic pain, treatment goals should be discussed with the participant, alternative options will be provided and a treatment plan will be initiated. Nonpharmacologic therapy and non-opioid therapy are preferred for chronic pain. MO HealthNet has established guidelines for providing complementary and alternative therapy for participants with chronic pain. These services will be available to MO HealthNet participants that meet established criteria. Therefore, MO HealthNet will reimburse for complementary health and alternative therapies for chronic pain provided pursuant to the preventative benefit Social Security Act 1905 (a)(1) and Social Security Act 1905 (a)(B) and 42 CFR 440.130(c). The patient must meet the following criteria:

- be MO HealthNet eligible; **and**
- be 21 years of age or older, **and**
- have one of the following conditions:
    - chronic, non-cancer neck and/or back pain; or
    - chronic pain post traumatic injury such as traumatic injury resulting from a motor vehicle collision; and
- have a qualifying chronic pain diagnosis as determined by MO HealthNet Division.

The program is not intended for participants with active cancer therapy, end of life, or palliative care.

13.71. C. TREATMENT OPTIONS

Assessment is to be provided upon initial office visit to establish plan of care. Reassess evidence of improvement and risks of therapy benefits when considering discontinuing or requesting further treatment.

Complementary health and alternative therapy services for qualified adult participants requires a determination by the prescribing physician of a combination of physical therapy, chiropractic therapy, acupuncture, and non-opioid medication therapy, as clinically appropriate.

Non-opioid and opioid therapy includes initiating the first line of treatment, alternative pain therapy as well as establishing treatment goals. Treatment will be determined on a risk level of low or medium to high.

Over-the-counter, prescription, and opioid medications are provided based on best practice and evidence based guidelines. Non-opioid medication (such as NSAIDS, acetaminophen, and/or muscle relaxer medication) is to be considered as first line of treatment, length of treatment based on best practice and evidence-based guidelines.

13.71. D. LIMITATIONS

Complementary Health and Alternatives to Chronic Pain program requires a physician's referral as well as prior authorization to be eligible for the program. The prescribing physician must prescribe the service in the participant's plan of care during a regular office visit. Recommendations will be granted based on best practice and evidence-based guidelines.

The combination of physical therapy, chiropractic therapy and acupuncturist's services are subject to an annual maximum limit of thirty (30) visits or one hundred twenty (120) units of service per year with one (1) unit equaling fifteen (15) minutes. Additional complementary and alternative therapy requests beyond the initial allocation must be deemed medically necessary. The prescribing physician shall reassess evidence of the adult participant's improvement and the risks of complementary health and alternative therapy when considering discontinuing or requesting further coverage of complementary health and alternative therapies for chronic pain.

MHD enrolled behavioral health providers may deliver CBT via individual, family, or group modalities and may report either psychotherapy codes (90832-90853) or health and behavior assessment and intervention codes (96150-96154). Individual (90832, 90834, 90837), family (90846, 90847), and group psychotherapy (90853) require precertification and may be provided for diagnosis codes of F45.41 and F45.42. Health and behavior assessment and intervention services do not require precertification and may be provided for physical health

conditions. For additional information about these services, refer to the Behavioral Health Services Manual at http://manuals.momed.com/collections/collection_psy/print.pdf.

To obtain pre-certification, enrolled providers can call 800-392-8030, Option 6, 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@conduent.com.

13.71. E. PROVIDER REQUIREMENTS

In order to refer or provide complementary health and alternative therapy, the prescribing physician and the complementary health and alternative therapy provider must be currently enrolled as a MO HealthNet provider and currently licensed in Missouri or a bordering state to provide therapy. MO HealthNet shall provide reimbursement for complementary and alternative therapy for treatment provided to participants with chronic pain by a qualified provider who meets the outlined criteria.

13.72 ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT PROGRAM

Evidence has shown that the combined approach of asthma education and environmental assessments leads to better health outcomes in the pediatric population.

13.72. A. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTALASSESSMENT PROVIDER ENROLLMENT CRITERIA

To provide and bill for asthma education and asthma environmental assessment services, a provider must be approved and enrolled as an asthma education provider and/or asthma environmental assessment provider with MO HealthNet. Following are the requirements to enroll as a provider under the Asthma Education and Asthma Environmental Assessment program:

Asthma Education Providers must hold either a National Asthma Educator Certification (AEC) or a state certification. State certification programs are accredited training programs, such as a university, within the state that provide an accredited training program and certificate incorporating similar guidelines as the national certification; upon successful completion of the training a certificate must be provided. A certificate means that the student has successfully completed the training program and is competent to provide asthma education services. Eligibility criteria for admission into the certification programs are determined by the administrator of the program. Providers must be enrolled as a MO HealthNet Provider and will bill under the Disease Management provider type with an Asthma Education Specialty.

Asthma Environmental Assessors must hold either a National Environmental Health Association (NEHA) Healthy Home Specialist; or Building Performance Institute (BPI) Healthy Home Evaluator Micro-Credential; or a state certification. State certification programs are accredited training programs, such as a university, within the state that provide an accredited training program and certificate incorporating similar guidelines as the national certification; upon successful completion of the training a certificate must be provided. A certificate means that the student has successfully completed the training program and is competent to provide asthma in-home assessment services. Eligibility criteria for admission into the certification programs are determined by the administrator of the program. Providers must be enrolled as a MO HealthNet Provider and will bill under the Disease Management provider type with an In-Home Environmental Assessor Specialty.

13.72. B. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT QUALIFIED ACADEMIC UNIVERSITY-BASED CENTERS

Qualifying Academic University-Based Centers will evaluate, certify, and track physician referrals; and will function to assist with physician referrals for asthma education and environmental home assessment statewide.

The qualified academic university-based centers will be responsible for maintaining verification for that current asthma education and asthma in-home environmental assessment providers have maintained national and/or state certification.

The qualified academic university-based centers must maintain a website with an up-to-date provider list for physicians and their offices to utilize to consult asthma educators and asthma in-home environmental assessors to provide services to participants once a prior authorization has been approved.

An up-to-date provider list must also be available to providers on the Department of Social Services' website https://dssapp.dss.mo.gov/providerlist/sprovider.asp.

13.72. C. ASTHMA EDUCATION AND ASTHMA IN-HOME ENVIRONMENTAL ASSESSMENT PROGRAM ELIGIBILITY CRITERIA

Asthma education and asthma in-home environmental assessment services require a referral and/or a prescribed service in the participant's plan of care by a physician for a participant to be eligible for the services. For participants to be eligible for asthma education and asthma environmental assessment services the individual must meet the following criteria:

- The participant must be currently enrolled in MO HealthNet, and
- Be younger than twenty-one (21) years of age, and
- Have a primary diagnosis of asthma, and

- Have had one of the following events as a result of asthma in the last twelve (12) months:
    - One (1) or more Inpatient hospital stays related to asthma, or
    - Two (2) or more emergency department visits related to asthma, or
    - Three (3) or more urgent care visits related to asthma, or
- A high utilization of rescue inhalers (short-acting inhaled beta-2 agonists defined as four (4) or more prescription refills, or underutilization of inhaled corticosteroids (ICS) defined as missing four (4) or more refills based on their enrollment months, and at least one (1) emergency department or urgent care visit.

13.72. D. ASTHMA EDUCATION AND ASTHMA ENVIRONMENTAL ASSESSMENT SERVICE DEFINITIONS

13.72. D (1) Asthma Education Description of Services

Asthma education, preventive medicine counseling, and self-management education may include but are not limited to increasing adherence to the inhaled corticosteroid (ICS) regimen, optimizing inhalation technique, supporting trigger reduction in indoor environment (home, school and work), identifying and reducing impairment and reducing and managing the risks of asthma exacerbation, increasing compliance with asthma action plans, measurement of lung function, counseling on the findings of the environmental assessment, management of co-morbid conditions, health-promoting, promotion of non-pharmacologic behaviors, and education on nasal hygiene.

13.72. D (2) Asthma Environmental Assessment Description of Services

Asthma in-home environmental assessments may include but are not limited to activities that assist in identifying and support the reduction of disease causing agents in the home leading to medical complications of asthma. Asthma in-home environmental assessments do not include remediation of issues identified in the home.

13.72. D (3) Asthma Education and Asthma In-Home Environmental Assessment Program Authorization Limits

Asthma Education and Asthma In-Home Environmental Assessment services require a referral and/or a prescribed service in the participant's plan of care by a physician. All asthma education and in-home environmental assessment services require a prior authorization with MO HealthNet.

Asthma education and asthma environmental assessment services may be performed by nationally or state certified asthma educators and nationally or state certified asthma environmental assessors.

Annual limit of asthma education visits will be dependent on the codes used, but shall not exceed one (1) hour per year with the exception of one (1) ninety- (90-) minute self-management session and two (2) in-home environmental assessments that are allowed annually. Any additional asthma education and environmental in-home assessments will need to go through the prior authorization process and be deemed medically necessary.

13.72. D (4) Asthma Education Services Procedure Codes

PROC CODE	DESCRIPTION
S9441	Asthma education non-physician (30 minute unit)
99401	Preventive medicine counseling, individual, (15 minute unit)
99402	Preventive medicine counseling, individual, (30 minute unit)
98960	Self-management education using standardized effective curriculum, individually, either incident to a clinical encounter or as preventive service, (90 minute unit)

13.72. D (5) Procedure Codes for Asthma Environmental Assessment Services

PROC CODE	DESCRIPTION
S9441 SC	Asthma environmental assessment, non-physician

13.72. D (6) Asthma Education and Asthma Environmental Assessment Billing Procedures

The asthma education and asthma environmental assessment services must be billed on a professional claim, with the appropriate procedure code.

The place of service (POS) code must be the following: 12 (Home).

13.73 DIABETES PREVENTION PROGRAM SERVICES FOR ADULTS- Effective September 1, 2020

Diabetes Prevention Program (DPP) Services for adult participants are covered through the MO HealthNet Program. The intent of these services is to utilize the Center for Disease Control and Prevention's (CDC's) National Diabetes Prevention Program guidelines to provide structured medically necessary services recommended by a licensed practitioner authorized to prescribe within their scope of practice either directly or by protocol consistent with their scope of practice under state law to prevent or delay the onset of type 2 diabetes for participants ages twenty-one (21) years of age and older who are at risk for diabetes or have indications of prediabetes, in accordance with 42 CFR 440.130 (c). The goal of these services is to improve health outcomes for the adult population at risk for developing diabetes by managing obesity and associated co-morbidities. Participants receiving DPP services are not eligible to receive concurrent authorization for other MO HealthNet reimbursed weight reduction services.

13.73. A DIABETES PREVENTION PROGRAM

Diabetes Prevention Program (DPP) is a structured, lifestyle change program specifically developed and recognized by the Centers for Disease Control and Prevention (CDC) to prevent or delay type 2 diabetes. The program is intended for people who have prediabetes or are at risk for type 2 diabetes, but who do not already have diabetes, to promote lifestyle changes that decrease the progression to type 2 diabetes. The program services include a variety of behavioral and nutritional intervetions identified as evidence based by clinical research studies and/or nationally recognized organizations specializing in disease control and prevention. DPP services are provided during sessions that occur at regular periodic intervals over the course of one year, and, if eligible based upon individual measurable health-outcomes, additional ongoing maintenance sessions at regular, periodic intervals for another year.

13.73. B DIABETES PREVENTION PROGRAM SERVICE PROVIDER PARTICIPATION

DPP service providers must have pending, preliminary, or full recognition status from the CDC's Diabetes Prevention Recognition Program, https://www.cdc.gov/diabetes/prevention/index.html. The CDC regulates the standards needed for recognition. DPP service providers must be enrolled as MO HealthNet providers.

DPP service providers use lifestyle coaches for delivery of DPP services to participants. The lifestyle coaches must have completed nationally recognized training for delivery of DPP services. Lifestyle coaches may be:

- Physicians
- Licensed nonphysician practitioners

- Unlicensed practitioners under the supervision of a DDP services provider or a licensed MO HealthNet practitioner.

For DPP services delivered by unlicensed lifestyle coaches, the supervising MO HealthNet provider will assume professional liability for care of the patient and furnish services within its scope of practice according to the law.

All lifestyle coaches must complete a minimum of 12 hours of training in DPP services from an organization recognized by the CDC for DPP.

13.73. C DIABETES PREVENTION PROGRAM SERVICES PARTICIPANT CRITERIA

Any person who is eligible for Title XIX benefits a determined by the Family Support Division, and who also meets the following criteria shall be deemed eligible to receive these services:

- Be twenty-one (21) years old or older;
- Not currently pregnant;
- Have, as of the date of attendance at the first core session, a BMI equal to or greater than twenty-five (25) or twenty-three (23) if of Asian descent;
- Have no previous diagnosis of type one (1) or two (2) diabetes with the exception of gestational diabetes; and
- Have, within the last twelve (12) months:
    - Hemoglobin A1C test with a value of five and seven-tenths percent (5.7%) to six and four-tenths percent (6.4%);
    - A fasting plasma glucose of one hundred (100) mg/dl to one hundred twenty-five (125) mg/dl; or
    - Two (2) hour plasma glucose of one hundred forty (140) to one hundred ninety-nine (199) mg/dl after the seventy-five (75) oral glucose tolerance test.

13.74. D LIMITATIONS

The prescribing provider will need to seek prior authorization for the first twelve (12) months of the diabetes prevention program from the MO HealthNet Division prior to starting the program. A prescribing provider is defined as a licensed practitioner authorized to prescribe within their scope of practice either directly or by protocol consistent with their scope of practice under State Law.

For participants that are eligible for the ongoing maintenance sessions, the prescribing provider must seek an additional prior authorization from the MO HealthNet Division for the additional twelve (12) months of ongoing maintenance sessions.

To obtain prior authorization, enrolled providers can call 800-392-8030, Option 7, 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@conduent.com

13.74. E DIABETES PREVENTION PROGRAM SERVICES

DPP Services are structured medically necessary services that include ongoing nutrition or behavior-counseling focusing on weight reduction and lifestyle changes, physical activity and fitness assessments. A prescriber provider's referral, utilizing the eligibility criteria set forth by the CDC, is required for the participant to be eligible for this program. The prescribing provider will need to prescribe the service in the participant's plan of care during a regular office visit. A prescribing provider is defined as a physician or other licensed practitioner of healing arts within the scope of authorized practice under State law.

13.74. E (1) Diabetes Prevention Program Core Services Period

DPP core services period includes a twelve (12) month period of intervention with a minimum of twenty-two (22) sessions and a maximum of twenty-six (26) sessions. DPP core services period include, but are not limited to, weight monitoring and tracking, physical activity tracking, and caloric intake tracking as required.

During months one (1) through six (6) of the DPP core services period DPP service providers will be required to provide a minimum of sixteen (16) weekly sessions utilizing CDC-approved DPP core module curriculum.

This curriculum provides counseling that focuses on, but is not limited to, information about Type Two (2) Diabetes and how to prevent it; self-monitoring weight and food intake; healthy eating; introduction to physical activity; dealing with lifestyle changes; developing lasting lifestyle changes; and stress management.

During months seven (7) through twelve (12) of the DPP core services period DPP service providers will be required to provide a minimum of six (6) monthly sessions utilizing CDC-approved DPP core maintenance module curriculum.

This curriculum provides counseling that focuses on maintaining long-term dietary changes, increased physical activity, and behavior change strategies for continued weight loss.

13.74. E (2) Diabetes Prevention Program Services Ongoing Maintenance Period

DPP ongoing maintenance period includes access to one (1) year of ongoing maintenance sessions to eligible participants.

The ongoing maintenance sessions are done in three-month intervals for a maximum of four (4) sessions during months thirteen (13) through twenty-four (24).

In order to qualify for the ongoing maintenance sessions after the initial twelve (12) month program the participant must achieve and maintain a minimum weight loss of five percent (5%) at the end of the first twelve (12) months.

13.74. E (3) Procedure Codes for Diabetes Prevention Program Services

PROCEDURE CODE	DESCRIPTION
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized DPP curriculum, provided to individuals in a group setting, minimum sixty (60) minutes, per day.
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 minutes.

13.74. E (4) Additional Services Request

Additional diabetes prevention program services, including core sessions and ongoing maintenance sessions beyond the initial allocation must be requested and will need to go through the prior authorization process and must be deemed medically necessary.

13.74. E (5) Diabetes Prevention Program Services Re-enrollment Criteria

A participant that is unable to meet and/or maintain the criteria for the additional twelve (12) months of ongoing maintenance sessions has the option, after twelve (12) months, to

re-enroll in the diabetes prevention program starting with the first twelve (12) months if the participant meets the established criteria and has an approved prior authorization.

13.75. F Diabetes Prevention program Services Billing Procedures

DPP services must be billed on a professional claim, with the appropriate procedure code. Diabetes Prevention Program services are beyond the scope of those services covered under the Rural Health Clinic and/or FQHC designation. These services must be separately billed (as appropriate) under the appropriate performing provider furnishing the services, using their active *non-RHC* Clinic and/or *non-FQHC* provider number.

END OF SECTION

TOP OF PAGE

SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require prior authorization or medical necessity. Reference Section 14.6 for specific requirements on medical necessity. Reference Section 7, Medical Necessity, and Section 8, Prior Authorization, 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 requirement for the code with the modifier. Refer to the MO HealthNet fee schedule, for a list of 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/MO HealthNet Crossover Claims, for further information. Refer to Sections 1-11 and 20 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).
- check that the name of the participant is the same on both the attachment and the claim.
- attach a legible copy if *not* submitting an original.
- check that all required information and signatures appear on the attachment.
- check that the dates of service are consistent with dates on the attachment.

14.1.A RESUBMISSIONS

When a claim requiring an attachment is resubmitted, *the provider must include a legible copy of the attachment with the resubmitted claim*. The fiscal agent *cannot* match the new submission to the attachment sent with the previous claim.

14.1.B HOW TO ORDER ATTACHMENTS TO THE CLAIM FORM

Required attachments to the claim form may be requested by completing the Forms Request.

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 13.40.G 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.

To order a supply of the Certification of Medical Necessity for Abortion forms, use the Forms Request or contact the Provider Relations Unit at (573) 751-2896.

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 13.40.H. 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.

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 it *must* be signed by the individual or her representative prior to the surgery, but there are no time limits. The Centers for Medicare & Medicaid (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 TO THE ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

There are exception situations in which the Acknowledgement of Receipt of Hysterectomy Information form is *not* required; however, other physician certification is required in these situations, e.g., the Certificate of Medical Necessity form.

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 acknowledgment 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 MO HealthNet 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 (STERILIZATION) CONSENT FORM

A (Sterilization) Consent Form *must* be attached to a claim whenever a voluntary sterilization procedure is performed. The (Sterilization) Consent Form has five copies. The bottom of the form shows the distribution. The physician should attach the white copy or a legible copy of the form to the claim. Refer to the MO HealthNet fee schedule for the procedures that require this attachment.

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.

14.5 INVOICE FOR MANUALLY PRICED PROCEDURES

An invoice should be attached to the claim for payment of certain procedures 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 procedures that require attachments.

The following are examples of procedures that *must* include an invoice.

PROC CODE	DESCRIPTION
J7190	Factor VIII (non-heat treated)
	Always indicate "1" unit on the claim form and attach invoice showing the actual number of units.
J7194	Factor IX
	Always indicate "1" unit on the claim form and attach invoice showing the actual number of units
A4261	Medical and Surgical Supplies (IUD/Diaphragm only)
A4641	Provision of Diagnostic Radionuclide(s)
A9699	Provision of Therapeutic Radionuclide(s)

Procedure codes ending in "99" are always manually priced and *must* include the information necessary for pricing by the state medical consultant.

14.6 CERTIFICATE OF MEDICAL NECESSITY

Certain services, procedures or circumstances require that a Certificate of Medical Necessity form be attached to a claim when it is submitted for payment. The service may be payable, if the Certificate

of Medical Necessity form supports the need for the service or why another policy could *not* be followed.

Section 7 of this manual provides a full explanation of the purpose of this form, including instructions for completion and a sample form.

14.6.A WHEN A CERTIFICATE OF MEDICAL NECESSITY IS REQUIRED

The following *circumstances* require a Certificate of Medical Necessity form. Refer to the MO HealthNet fee schedule, for *procedures* that require a Certificate of Medical Necessity form.

14.6.A(1) Private Hospital Room

A private room is covered if there is a medical justification (e.g., infection control). A Certificate of Medical Necessity form *must* be completed by the physician and attached to the hospital claim explaining why a private room was necessary.

A private room is also covered if all patient rooms in a facility are private. The hospital provider *must* contact the Provider Enrollment Unit if all its rooms are private rooms. The attachment of a Certificate of Medical Necessity form is *not* required in this instance.

A private room is *not* covered if requested by the patient solely for the patient's convenience.

14.6.A(2) Sonograms

Claims for obstetrical sonograms exceeding three per participant, per rolling year *must* be accompanied by a properly completed Certificate of Medical Necessity form documenting the necessity of the additional procedures.

14.6.B 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 cannot 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.

14.6.B(1) Definition of Emergency Services

Emergency medical condition means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, 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 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.

14.6.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 that details the nature of the emergency as well as a copy of the progress notes *must* accompany the claim when it is submitted for payment. Lock-in information is available on the interactive voice response (IVR) system or at www.emomed.com and should be verified along with the other eligibility information.

14.6.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.

14.6.C A CERTIFICATE OF MEDICAL NECESSITY MAY NOT BE USED FOR CERTAIN PROCEDURES

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 Section 14.3 and 14.4.

14.7 ADMISSION CERTIFICATION FORMS

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's inpatient review authority will receive all the appropriate information necessary to review admissions subject to admission certification. Reference Section 13.28 of the Hospital Manual for more information on Inpatient Hospital Certification Reviews.

14.8 NURSING HOME FORMS

The information on nursing home forms is important to physicians that *must* consider nursing home placement in the discharge plans of patients.

14.8.A MISSOURI CARE OPTIONS (PRE-LONG-TERM CARE SCREENING [PLTC])

There *must* be a PLTC screening for all admissions to a MO HealthNet bed for MO HealthNet eligible participants or MO HealthNet applicants. This screening can be as brief as a telephone call or as detailed as a face-to-face interview. A PLTC number *must* be requested from the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure.

14.8.A(1) DA-13

Field #13 in Section A of the DA-124A/B *must* have a valid Pre-Long-Term-Care screening (PLTC) number entered there, which can be found on the DA-13. If the resident does *not* have a DA-13 form with that number when he/she is admitted to the facility, the nursing home *must* contact the Central Office Medical Review Unit (COMRU) at the Division of Regulation and Licensure, (573) 526-8609. They give a PLTC number if one has already been assigned or begin the screening process in order to assign a number. The Family Support Division *cannot* authorize nursing home benefits if a screening number has *not* been assigned. If the nursing home admits a resident before a screening has taken place and an exemption is *not* met, the nursing home authorization for payment may be delayed.

14.8.B PREADMISSION SCREENING (PASRR)

Section 13 discusses in detail the purpose and process of preadmission screening. Briefly, nursing homes are required to screen all applicants to Title XIX certified beds to determine if the individual is known or suspected to be mentally ill (MI), developmentally disabled (DD) or intellectually disabled (ID). If the applicant is known or suspected to be MI, DD or ID and no special admissions category applies, he/she *cannot be admitted* to the certified bed until a determination on 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, DD or ID. The DA-124C form should be used to do 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, DD, or ID, he/she 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, DD or ID, form DA-124A/B *must* be completed.

  The DA-124A/B and DA-124C *must* be sent to: COMRU, Division of Regulation and Licensure, P.O. Box 570, Jefferson City, MO 65102. *The person cannot be admitted* until a Level II screening is done, unless a special admissions category applies.

  If a Level II evaluation is needed, the Notice to the Applicant *must* be given to the individual or his representative.
- An applicant who is inappropriately admitted to a nursing facility according to the PASRR process *cannot* be held liable.

Instructions appear on the back of the form.

14.8.C LEVEL OF CARE DETERMINATION

14.8.C(1) 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 19 CSR 30-81.030 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.

If providers have any questions concerning how to complete the forms, they may contact the COMRU Unit at the Division of Regulation and Licensure, (573) 526-8609. Forms that are *not* completed fully may be returned to the entity that submitted them.

14.9 RISK APPRAISAL FOR PREGNANT WOMEN

See Section 13 of the Physician's Manual for information on the Risk Appraisal for Pregnant Women.

END OF SECTION

TOP OF PAGE

SECTION 15-BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12 Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12 Version v5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12 Version v5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference www.dss.mo.gov/mhd/providers for further information. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, Version 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

15.3 CMS-1500 AND PHARMACY CLAIM FORMS

The CMS-1500 claim form is always used to bill MO HealthNet for professional services and the Pharmacy Claim form for pharmacy services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 and the Pharmacy Claim forms 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 of the Physician Provider Manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any claim or line item on a claim that resulted in a zero payment or incorrect payment can be retrieved and resubmitted at the billing website at www.emomed.com 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 retrieve and resubmit electronically or on a CMS-1500 or a Pharmacy Claim form. An example of a correctable error is the use of an invalid procedure code. A provider may also void a previously billed and paid claim at this site.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, the units field (Field #24g) on the CMS-1500 claim form is blank and the system automatically plugs a 1, but the number of units provided should have been 5, the claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct the payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a patient has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payor. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, a paper claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice attached indicating the denial. The claim may also be submitted through the Internet at www.emomed.com or through the 837 electronic claims transmission. Reference Section 16.5 of this manual for instructions for submission of claims to MO

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date, the claim *must* be filed through the Internet at www.emomed.com or through the 837 electronic transmission. Reference Section 16 for billing instructions.

MO HealthNet applies editing to Medicare/MO HealthNet crossover claims very similar to that used to process MO HealthNet only claims. The claims processing system can only process 25 edits or less on one claim. A crossover claim will deny with Remittance Advice Remark Code MA130 if processing of the claim results in more than 25 edits. The following edits will post to every line of a claim: timely filing, duplicate claim submission, third party liability, and spendown. The provider may bill a smaller claim to Medicare to avoid the 25 edit limit when claims crossover from Medicare.

15.7 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed, check the Medicaid box and if the patient has both Medicare and MO HealthNet, check both boxes.
*1a. Insured's I.D. Number	Enter the patient's eight-digit MO HealthNet number (DCN) as shown on the patient's ID card.
*2. Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card.
3. Patient's Birth Date, Sex	Enter month, day, and year of birth, mark

	appropriate box.
**4. Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13.
5. Patient's Address	Enter address and telephone number if available.
**6. Patient's Relationship to Insured	Mark appropriate box if there is other insurance.
**7. Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available.
8. Reserved for NUCC Use	Leave Blank.
**9 Other Insured's Name	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2.
**9a. Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. 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.
9b. Reserved for NUCC Use	Leave Blank.
9c. Reserved for NUCC Use	Leave Blank.
**9d. Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. 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.
**10a.-10c. Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank.
10d. Claim Codes (Designated by NUCC)	Leave Blank.
**11. Insured's Group Policy or FECA	Enter the primary policyholder's insurance

Number	policy number or group number, if the insurance is through a group, such as an employer, union, etc. 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.
**11a. Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. 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.
**11b. Other Claim ID (Designated by NUCC)	Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
**11c. Insurance Plan Name or Program Name	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. 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.
**11d. Other Health Benefit Plan	Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9, 9a and 9d with the secondary insurance information. 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.
12. Patient's or Authorized Person's	Leave blank.

Physician Signature	
**13. Insured's or Authorized Person's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
**14. Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15. Other Date	Leave blank.
16. Dates Patient Unable to Work	Leave blank.
**17. Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider
**17a. Other ID #	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)
**17b. NPI	Enter the NPI number of the referring, ordering, or supervising provider.
**18. Hospitalization Dates	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.
19. Additional Claim Information (Designated by NUCC)	Providers may use this field for additional remarks/descriptions.
**20. Outside Lab	If billing for laboratory charges, mark appropriate box. The referring physician may not bill for lab work that was referred out.
*21. Diagnosis	Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative

	description in this field. Enter the ICD diagnosis code in the same order on all pages of claims with multiple lines. The ICD indicator is not used.
**22. Resubmission Code	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank.
*24A. Date(s) of Service	Enter the date of service under "from" in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.
*24B. Place of Service	Enter the appropriate place of service code in the unshaded area of the field:
**24C. EMG-Emergency	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
*24D. Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field #19 may be used for remarks or descriptions.)
*24E. Diagnosis Pointer	Enter A, B, C, D from Field #21in the unshaded area of the field. Do not enter the

	actual diagnosis code.
*24F. Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
*24G. Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a "1" if the field is left blank. **Anesthesia:** Enter the total number of minutes of anesthesia. **Consecutive visits**—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in Field #24a. **Injections:** Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is "2."
**24H. EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E". If the service is family planning related, enter "F". If the service is both an EPSDT/HCY and Family Planning enter "B".
**24I. ID Qualifier	Enter in the shaded area of 24I the qualifier indentifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shaded area.
**24J. Rendering Provider ID	The individual rendering the service is reported in this field. Enter the NPI number of the provider in the unshaded area of the field. This field is required for a clinic, radiology, teaching institution, or a group practice only.
25. Federal Tax ID Number	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.

27. Accept Assignment	Leave Blank.
*28. Total Charge	Enter the sum of the line item charges.
29. Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field.
30. Reserved for NUCC Use	Leave Blank.
31. Provider Signature	Leave Blank.
**32. Service Facility Location Information	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
**32a. NPI #	Enter the NPI number of the service facility location in 32.
**32b. Other ID#	Enter number.
*33. Provider Name/ Number/Address	Affix the billing provider label or write or type the information exactly as it appears on the label.
**33a. NPI #	Enter the NPI number of the billing provider in 33.
**33b. Other ID #	Enter number.

15.8 PLACE OF SERVICE CODES

CODE	DEFINITION
03 School	A facility whose primary purpose is education.
11 Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an

		ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do *not* require hospitalization or institutionalization.
23	Emergency Room Hospital	The portion of a hospital in which emergency diagnosis and treatment of illness or injury are provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who

		require medical, nursing, or rehabilitative services that does *not* provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and that does *not* include a medical component.
34	Hospice	A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families is provided. NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service should be used.
49	Independent Clinic	A location, *not* part of a hospital and *not* described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Clinic (FQHC)	A facility approved by the federal government to provide health care services in generally low income areas.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program

		for patients who do *not* require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does *not* provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).
55	Residential Substance Abuse Treatment Facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do *not* require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology,

		social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End Stage Renal Disease Treatment Facility	A facility other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility that is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service *not* identified above.

15.9 INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.missouri.gov/mhd/ 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.

15.10 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on the interactive voice response (IVR) system, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability.

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Division's participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 of the Physician Provider Manual for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PATIENT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.

15.11 DOSE OPTIMIZATION

Pharmacy claims submitted are subject to edits to identify claims for pharmacy services that fall outside expected patterns of use for certain products. Overrides to these edit denials are processed through a help desk at (800) 392-8030. The help desk is available seven days a week, 8:00 a.m. to 9:00 p.m. Monday-Friday and 8:00 a.m. to 6:00 p.m. Saturday and Sunday. A menu directs callers to select options based on the nature of the call. Justification for utilization outside expected patterns, such as FDA approved labeling, is required for approval of such an override.

Reference the MO HealthNet Dose Optimization Edit list of drug products initially subject to the edit as well as patterns that are allowed without requiring an override to the edit.

END OF SECTION

TOP OF PAGE

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

TOP OF SECTION

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.

END OF SECTION

TOP OF PAGE

SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

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

The diagnosis code *must* be entered on the claim form exactly as it appears in the current ICD (International Classification of Disease) book.

Diagnosis codes are *not* included in this section. The current ICD book should be used as a guide in the selection of the appropriate diagnosis code.

END OF SECTION

TOP OF PAGE

SECTION 19-PROCEDURE CODES

Procedure codes used by MO HealthNet are identified as HCPCS codes (Health Care Procedure Coding System). The HCPCS is divided into three subsystems, referred to as level I, level II and level III. 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. Level III codes have been developed by Medicaid State agencies for use in specific programs. NOTE: Replacement of level III codes is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should reference bulletins for code replacement information.

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 930876
Atlanta, GA 31193-0876
Telephone Number: (800) 621-8335
AMA Members (312) 262-3211
Fax Orders: (312) 464-5600
https://catalog.ama-assn.org/Catalog/home.jsp

19.1 ANNUAL NURSING HOME PHYSICAL

PROC
CODE DESCRIPTION

99318.....Annual Physical (NF)

19.2 CASE MANAGEMENT PROCEDURES

H1000.....Prenatal care, at-risk assessment

H1001TS……Prenatal care, at risk enhanced service; antepartum management; follow-up service.

H1001……Prenatal care, at risk enhanced service; antepartum management.

G9012..... Other specified case management service not elsewhere classified.

H1004.....Prenatal care, at risk enhanced service; follow-up home visit.

H1001TS52..... Prenatal care, at risk enhanced service; antepartum management; follow-up; reduced service

T1016UATS.....Lead Case Management

T1016UA ..... Lead Case Management, Month with Initial Visit

19.3 HEALTHY CHILDREN AND YOUTH (HCY) SCREENING CODES

Reference Section 9 for Healthy Children and Youth (HCY) screening codes.

19.4 GLOBAL PRENATAL

PROC CODE DESCRIPTION

59425.....Antepartum care only; 4-6 visits

59426..... Antepartum care only; 7 or more visits

59400.....Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510..... Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59618.....Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59610..... Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

19.5 SUPPLIES

PROC CODE	DESCRIPTION
99070	Supplies and Materials (except Spectacles), Provided by the Physician Over and Above Those Usually Included
A4300	Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal)
A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
A4565	Slings
A4261	Medical and Surgical Supplies (Cervical cap for contraceptive use)
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)

19.6 X-RAY

PROC CODE	DESCRIPTION
R0070	Mobile X-Ray (trip fee)

19.7 DIABETES SELF-MANAGEMENT TRAINING

PROC CODE	DESCRIPTION
99205U9	Initial Assessment–Comprehensive Diabetes Education–Minimum 1 Hour
G0108	Diabetes Education–Subsequent Visit–Minimum 30 minutes
G0109	Diabetes Education–Group Subsequent (no more than 8 persons)–Minimum 30 Minute Session

END OF SECTION

TOP OF PAGE

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

TOP OF PAGE

SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

Adult Day Health Care
Aged and Disabled Waiver
Ambulance
Ambulatory Surgical Centers
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
ID/DD Waiver
Nurse Midwife
Optical
Pharmacy
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

END OF SECTION

TOP OF SECTION

SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

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.

END OF SECTION

TOP OF SECTION

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.

END OF SECTION

TOP OF PAGE

MEDICAID CASE MANAGEMENT PROVIDERS - PREGNANT WOMEN AND CHILDREN'S PROGRAMS

Adair County Health Dept.
1001 South Jamison
Kirksville, MO 63501

Audrain Co Health Dept
605 E Promenade P.O. Box 957
Mexico, MO 65265

Barry County Health Dept.
65 Main, P.O. Box 207
Cassville, MO 65625

Barton County Health Dept
1301 East 12th Street
Lamar, MO 64759

Benton County Health Department
1234 Commercial St, Box 935
Warsaw, MO 65355

Bollinger County Health Center
107 Hwy 51 N, P.O. Box 409
Marble Hill, MO 63764

Butler County Health Department
1619 North Main
Poplar Bluff, MO 63901

Cabot Westside Clinic
1810 Summit Street
Kansas City, MO 64108

Caldwell County Health Department
PO Box 66, 255 West Main
Kingston, MO 64650

Callaway County Health Department
4950 County Road 304
Fulton, MO 65251

Cape Girardeau County Public Health Center
1121 Linden Street, P.O. Box 1839
Cape Girardeau, MO 63702

Physician

Carter County Health Department
1611 Health Center Road, P.O. Box 70
Van Buren, MO 63965

Cedar County Health Department
1317 South Highway 32
El Dorado Springs, MO 64744

Christian County Health Department
301 East Brick, P.O. Box 340
Ozark, MO 65721

Clinton County Health Department
106 Bush Street Highway 116 West
Plattsburg, MO 64477

Columbia-Boone County Health Department
600 East Broadway, P.O. Box 6015
Columbia, MO 65205

Community Health-In-Partnership Services
2431 North Grand Avenue
St Louis, MO 63106

Crawford County Nursing Service
202 West Main Street, P.O. Box 367
Steelville, MO 65565

Dallas County Health Department
1011 West Main, P.O. Box 199
Buffalo, MO 65622

Daviess County Health Dept
609 A South Main Street
Gallatin, MO 64640

Dent County Health Department
601 South Macarthur
Salem, MO 65560

Douglas County Health Dept
603 Northwest 12th Ave, P.O. Box 940
Ava, MO 65608

Dunklin County Health Department
410 Teaco Road
Kennett, MO 63857

Physician

Family Health Center
1500 Vandiver, Suite 110
Columbia, MO 65202

Family Care Health Centers (Forest Park)
401 Holly Hills Avenue
St Louis, MO 63110

Family Care Health Centers (Carondelet)
6313 Michigan Avenue
St Louis, MO 63111

Franklin County Health Services
15 South Oak
Union, MO 63084

Freeman Maternity Clinic
3401 McIntosh Circle, Suite 102
Joplin, MO 64804

Gasconade County Health Department
300 Schiller Street
Hermann, MO 65041

Grace Hill Neighborhood Health Center
2600 Hadley Street
St Louis, MO 63106

Grundy County Health Department
1716 Lincoln Street
Trenton, MO 64683

Harrison County Health Department
1700 Bethany Highway 136 West, P.O. Box 425
Bethany, MO 64424

Henry County Health Department
306 South Second Street
Clinton, MO 64735

Hickory County Health Department
P.O. Box 21, Cedar at Dallas
Hermitage, MO 65668

Holt County Health Department
PO Box 438, 113 West Nodaway Street
Oregon, MO 64473

Physician

Howell County Health Department
411 Garfield Avenue
West Plains, MO 65775

Iron County Health Department
606 West Russell
Ironton, MO 63650

Jasper County Health Department
105 Lincoln
Carthage, MO 64836

Jefferson County Health Department
405 Second Street, P.O. Box 437
Hillsboro, MO 63050

Johnson County Community Health Services
429 Burkarth Road
Warrensburg, MO 64093

Knox County Health Department
217 North First Street
Edina, MO 63537

Lawrence County Health Department
105 West North Street
Mount Vernon, MO 65712

LE Cox Medical Center
Family Medical Care Center
1423 North Jefferson

Lewis County Health Department
P.O. Box 96
Monticello, MO 63457

Linn County Health Department
635 South Main, P.O. Box 280
Brookfield, MO 64628

Macon County Health Department
503 North Missouri Street
Macon, MO 63552

Madison County Health Department
806 West College Avenue
Fredericktown, MO 63645

Physician

Marion Co Health Department
3105 Route W, P.O. Box 1378
Hannibal, MO 63401

McDonald County Health Department
500 Olin Street, P.O. Box 366
Pineville, MO 64856

Mercer County Health Department
305 West Main
Princeton, MO 64673

Mississippi County Health Department
1200 East Marshall
Charleston, MO 63834

Missouri Bootheel Regional Consortium
46 Highway 162E
Portageville, MO 63873

Monroe County Health Department
310 North Market Street
Paris, MO 65275

Montgomery County Health Department
400 North Salisbury
Montgomery City, MO 63361

Morgan County Health Department
104 West Lafayette
Versailles, MO 65084

Myrtle Hilliard Davis Comp Health Center Inc
5471 Dr Martin L King Dr
St Louis, MO 63112

New Madrid County Health Department
406 Highway 61
New Madrid, MO 63869

Newton County Health Department
812 W Harmony, P.O. Box 447
Neosho, MO 64850

Nurses for Newborns
7259 Lansdowne Suite 100
St. Louis, MO 63119

Physician

Oregon County Health Department
P.O. Box 189
Alton, MO 65606

Ozark County Health Center
#4 Market Street, P.O. Box 180
Gainesville, MO 65655

Pemiscot County Health Center
810 East Reed, P.O. Box 531
Hayti, MO 63851

Peoples Health Centers
5701 Delmar Boulevard
St Louis, MO 63112

Perry County Health Department
406 North Spring Suite 1
Perryville, MO 63775

Pettis County Community Health Center
911 East 16th Street
Sedalia, MO 65301

Phelps County Health Department
200 North Main Street
Rolla, MO 65401

Pike County Health Department
5 East Church Street
Bowling Green, MO 63334

Pulaski County Health Department
101 12th Street
Crocker, MO 65452

Putnam County Health Department
1613 Grant
Unionville, MO 63565

Ralls County Health Department
405 West First Street, Box 434
New London, MO 63459

Reynolds County Health Department
Buford & Green

Physician

P.O. Box 40
Centerville, MO 63633

Ripley County Health Center
1003 East Locust Street
Doniphan, MO 63935

Saline County Health Office
353 South Lafayette Avenue
Marshall, MO 65340

Samuel U. Rodgers Health Center
825 Euclid Avenue
Kansas City, MO 64124

Schuyler County Health Department
275 South Green, P.O. Box 387
Lancaster, MO 63548

Scotland County Health Department
Route 1, Box 55-A
Memphis, MO 63555

Scott County Health Department
P.O. Box 70
Benton, MO 63736

Shannon County Health Center
110 Grey Jones Drive, P.O. Box 788
Eminence, MO 65466

Shelby County Health Department
104 East Main, P.O. Box 240
Shelbyville, MO 63469

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

St Charles Co Dept Of Community Health & Environment
1650 Boonslick Road
St Charles, MO 63301

St Clair County Health Center
530 Arduser Drive
Osceola, MO 64776

Physician

St Francois County Health Center
1025 West Main St, P.O. Box Q
Park Hills, MO 63601

St Joseph-Buchanan County Health Department
904 South 10th Street
St Joseph, MO 64503

St Louis County Department Of Health
111 South Meramec
Clayton, MO 63105

Ste. Genevieve County Health Department
115 Basler Drive, P.O. Box 49
Ste. Genevieve, MO 63670

Stoddard County Health Center
1001 North Highway, P.O. Box 277
Bloomfield, MO 63825

Sullivan County Health Department
#1 Hawthorne Drive, P.O.Box 129
Milan, MO 63556

Swope Parkway Health Center
AFDC Clerk
3801 Blue Parkway
Kansas City, MO 64130

Taney County Health Department
15479 Us Hwy 160, P.O. Box 369
Forsyth, MO 65653

Texas County Health Department
402 South First Street
Houston, MO 65483

Tri County Health Department
302 North Park
Stanberry, MO 64489

University Physicians
P.O. Box 7687
Columbia, MO 65205

Physician

Vernon County Health Department
301 N Washington, Box 486
Nevada, MO 64772

Washington County Health Department
520 Purcell Drive
Potosi, MO 63664

Webster County Health Unit
233 East Washington
Marshfield, MO 65706

Wright County Health Department
Highway 5, P.O. Box 97
Hartville, MO 65667

END OF SECTION

TOP OF PAGE

MOBILE X-RAY PROCEDURE CODES

70100	70110	70120	70130	70140	70150	70160
70210	70220	70250	70260	70328	70330	71010
71020	71100	71101	71110	71111	71120	71130
72010	72020	72040	72070	72080	72100	72110
72170	72190	72200	72202	72220	73000	73010
73020	73030	73060	73070	73080	73090	73100
73110	73120	73130	73140	73500	73510	73520
73550	73560	73562	73590	73592	73600	73610
73620	73630	73650	73660	74000	74010	74020
74022						

93005	93012	93041	93224	93225	93226	93230
93231	93232	93235	93236			

END OF SECTION

TOP OF PAGE

VFC ADMINISTRATION CODES

Vaccines provided through the VFC Program include:

DT	**Administration Procedure Code 90702SL** • Provided to VFC-eligible children if pertussis vaccine is contraindicated and the child is younger than seven years of age.
DTaP	**Administration Procedure Code 90700SL** • Recommended for all doses in the DTP series.
DTaP/Hep B/IPV	**Administration Procedure Code 90723SL** • Licensed for the 3-dose primary series.
DTaP/Hib/IPV (Pentacel)	**Administration Procedure Code 90698SL** • Provided to all VFC- eligible children 6 weeks through 4 years of age.
DTaP/IPV (Kinrix)	**Administration Procedure Code 90696SL** • Booster dose provided to all VFC-eligible children 4 through 6 years of age.
e-IPV	**Administration Procedure Code 90713SL** • Provided to all VFC-eligible children 6 weeks through 18 years of age.
Hep A	**Administration Procedure Code 90633SL** • Provided to VFC-eligible children who are at least 2 years of age through 18 years of age.
Hep B	**Administration Procedure Code 90744SL** • Provided to all VFC-eligible children 0 through 18 years of age.
Hib	**Administration Procedure Codes 90647SL or 90648SL** • Provided to all VFC-eligible children 6 weeks of age to 59 months of age.
Human Papilloma Virus (HPV)	**Administration Procedure Code 90649SL, 90650 SL, 90651SL** • Provided to all VFC- eligible children and adolescents age 9 years through 18 years.

Influenza	**Administration Procedure Code 90656SL** • Provided for all VFC-eligible children 3 years through 18 years. **Administration Procedure Code 90685SL** • Provided for all VFC-eligible children 6 months through 35 months. **Administration Procedure Code 90686SL** • Provided for all VFC-eligible children 3 years through 18 years. **Administration Procedure Code 90688SL** • Provided for all VFC-eligible children 3 years through 18 years. **Administration Procedure Code 90672SL** • Provided for all VFC-eligible children 2 years through 18 years. **Administration Procedure Code 90674SL** • Provided for all VFC-eligible children 4 years through 18 years.
Measles, Mumps, Rubella and Varicella (MMRV)	**Administration Procedure Code 90710SL** • Provided for children and adolescents age 1 year through 12 years.
Meningococcal	**Administration Procedure Code 90734SL** • Provided for children and adolescents age 2 years through 18 years.
Meningococcal B	**Administration Procedure Code 90620SL** • Provided for VFC-eligible adolescents 16-18 years of age and VFC-eligible children 10-18 years of age at increased risk of a Meningococcal disease outbreak. Series includes 2 doses.
Meningococcal B	**Administration Procedure Code 90621SL** • Provided for VFC-eligible adolescents 16-18 years of age and VFC-eligible children 10-18 years of age at increased risk of a Meningococcal disease outbreak. Series includes 3 doses.
Meningococcal/Hib	**Administration Procedure Code 90644SL** • Provided for VFC-eligible infants 2-15 months of age at increased risk of a meningococcal disease outbreak.
MMR	**Administration Procedure Code 90707SL** • Provided to all VFC-eligible children 12 months through 18 years of age. Series includes 2 doses; 2nd dose provided at least 24 days after the first dose.
Pneumococcal 23-valent	**Administration Procedure Code 90732SL**

(Polysaccharide)	• Provided only to VFC-eligible children 2 years through 18 years who have functional or anatomical asplenia, immunocompromising illness or medications, chronic illness (as specified above), who are Alaskan Native or American Indian, or who have received a bone marrow transplant.
Pneumococcal 13-valent (Conjugate)	**Administration Procedure Code 90670SL** • All infants and children at least 6 weeks of age through 59 months old. Groups identified by ACIP as being at highest risk include infants, toddlers through 24 months old, children with sickle cell disease or anatomical asplenia, chronic illnesses, immunocompromising conditions, or HIV infection. Groups at moderate risk include toddlers 24-35 months old, children of African American, American Indian, and Alaskan Native descent, and children who attend out of home child care between 35 and 59 months of age.
Rotavirus (Rotarix)	**Administration Procedure Code 90680SL** • Provided to all VFC- eligible children who are 6 weeks through 32 weeks of age. Series includes a three dose vaccine.
Rotavirus (Rotarix)	**Administration Procedure Code 90681SL** • Provided to all VFC- eligible children who are 6 weeks through 32 weeks of age. Series includes a two dose vaccine.
Td	**Administration Procedure Code 90714SL** • Booster recommended for 11-18 year old children if 5 years have elapsed since the previous booster dose. • Tetanus and diptheria (Td) adsorbed, preservative free, for use in children age 7 years or older, for intramuscular use.
Tetanus, Diphtheria Toxoids and Acellular Pertussis (Tdap)	**Administration Procedure Code 90715SL** • Provided for children and adolescents age 11 years through 18 years.
Varicella	**Administration Procedure Code 90716SL** • Provided to VFC-eligible children who are at least 12 months of age through 18 years.

END OF SECTION

TOP OF PAGE