STATE OF MISSOURI

BEHAVIORAL HEALTH SERVICES MANUAL

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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

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

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

1.1.A(2) MO HealthNet for Kids

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

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

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

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

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

1.1.A(4) Voluntary Placement Agreement for Children

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

1.1.A(5) State Funded MO HealthNet

ME CODE	DESCRIPTION

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

1.1.A(6) MO Rx

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

1.1.A(7) Women's Health Services

ME CODE	DESCRIPTION

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

1.1.A(8) ME Codes Not in Use

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

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

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

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

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

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

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

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

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

1.2.A FORMAT OF MO HEALTHNET ID CARD

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

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

1.2.B ACCESS TO ELIGIBILITY INFORMATION

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

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

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

58, 59

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

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

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

1.2.C(5) Presumptive Eligibility for Children

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

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

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

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

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

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

ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

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

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

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

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

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

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

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

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

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

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

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

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

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

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

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

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

1.4.A NEWBORN INELIGIBILITY

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

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

1.4.B NEWBORN ADOPTION

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

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

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

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

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

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

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

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

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

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

ME CODE DESCRIPTION

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

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

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

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

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

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

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

- Group 5 consists of uninsured children.

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

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

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

participant, parent or guardian.

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

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

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

1.5.D HOSPICE BENEFICIARIES

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

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

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

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

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

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

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

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

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

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

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

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

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

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

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

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

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

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

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

1.5.G TEMP PARTICIPANTS

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

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

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

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

1.5.G(1) TEMP ID Card

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

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

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

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

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

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

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

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

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

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

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

1.5.I(1) Eligibility Criteria

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

- Screened by a Missouri BCCCP Provider;

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

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

1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

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

1.5.J(3) Premium Payment and Collection Process

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

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

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

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

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

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

1.5.J(4) Termination of Coverage

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

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

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

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

1.5.K(1) Eligibility Determination

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

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

1.5.K(2) MO HealthNet for Kids Coverage

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

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

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

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

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

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

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

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

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

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

- Routine Medical/Dental Care;

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

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

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

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

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

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

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

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

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

1.6.B SPENDDOWN

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

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

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

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

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

1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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

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

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

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

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

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

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

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

1.7.A NEW APPROVAL LETTER

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

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

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

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

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

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

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

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

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

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

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

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

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

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

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

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

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

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

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

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

1.8 TRANSPLANT PROGRAM

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

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

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

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

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

1.8.B PATIENT SELECTION CRITERIA

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

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

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

1.8.C CORNEAL TRANSPLANTS

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

1.8.D ELIGIBILITY REQUIREMENTS

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

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

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

1.8.E MANAGED CARE PARTICIPANTS

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

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

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

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

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

1.8.F MEDICARE COVERED TRANSPLANTS

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

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

END OF SECTION

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

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.

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SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

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

6.2.B(2)(ii) Copy Claim – Original

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

6.2.B(2)(iii) Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

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

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

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

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

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

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

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

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

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

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

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

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

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

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

Service

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

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

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

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

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

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

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

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

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

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

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

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

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

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

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

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

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

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

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

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

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

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

The written request *must* include:

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

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

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

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

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

END OF SECTION

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

9.3 DIAGNOSIS CODE

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

9.4 INTERPERIODIC SCREENS

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

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

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

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

9.5 FULL HCY/EPSDT SCREEN

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

A full HCY/EPSDT screen includes the following:

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

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

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

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

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

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

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

9.6.A DEVELOPMENTAL ASSESSMENT

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

This screen includes the following:

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

9.6.A(1) Qualified Providers

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

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

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

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

PROCEDURE CODE	DESCRIPTION

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

The HCY unclothed physical and history includes the following:

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

9.6.B(1) Qualified Providers

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

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

9.6.C VISION SCREENING

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

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

9.6.C(1) Qualified Providers

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

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

- Optometrist.

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

9.6.D HEARING SCREEN

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

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

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

9.6.D(1) Qualified Providers

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

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

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

9.6.E DENTAL SCREEN

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

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

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

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

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

9.6.E(1) Qualified Providers

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

9.6.F ALL PARTIAL SCREENERS

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

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

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

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

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

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

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

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

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

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

SIGNS AND SYMPTOMS

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

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

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

EXPOSURE PATHWAYS

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

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

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

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

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

9.7.B LEAD RISK ASSESSMENT

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

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

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

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

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

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

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

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

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

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

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

(Capillary specimen or venous blood samples.)

PROCEDURE CODE	DESCRIPTION
83655	Lead, quantitative blood

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

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

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

Recommended Interventions:

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

9.7.E(2) Blood Lead Level 10-19 µg/dL

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

Recommended Interventions:

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

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

9.7.E(3) Blood Lead Level 20-44 µg/dL

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

Recommended Interventions:

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

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

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

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

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

Recommended Interventions:

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

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

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

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

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

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

Recommended Interventions:

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

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

9.7.F COORDINATION WITH OTHER AGENCIES

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

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

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

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

9.7.G(1) Environmental Lead Investigation

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

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

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

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

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

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

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

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

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

9.7.H ABATEMENT

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

9.7.I LEAD CASE MANAGEMENT

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

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

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

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

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

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

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

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

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

Missouri State Public Health Laboratory

Quest Diagnostics

101 Chestnut St,
Jefferson City, MO 65101

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

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

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

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Methodist Medical Center
1200 Pleasant St.
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.

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

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

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

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

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

9.11.A DENTAL SCREENING SCHEDULE

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

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

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

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

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

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

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

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.15 STATE-ONLY FUNDED PARTICIPANTS

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

9.16 MO HEALTHNET MANAGED CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END OF SECTION

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SECTION 10 - FAMILY PLANNING

Family planning services are services relating to elective sterilizations and birth control products including drugs, diaphragms, and IUDs.

Section 10, The Family Planning Section, is *not* applicable to the following manuals:

Adult Day Care Waiver
Adult Day Health Care (NOTE: The Adult Day Health Care Program ends June 30, 2013)
Aged and Disabled Waiver
AIDS Waiver
Ambulance
Comprehensive Day Rehabilitation
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
Hospice
Independent Living Waiver
Medically Fragile Adult Waiver
Nursing Home
Optical
Personal Care
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

END OF SECTION

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SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

MO HealthNet provides health care services to Managed Care eligibles who meet the criteria for enrollment through Managed Care arrangements, as follows:

- Under MO HealthNet's Managed Care Program certain eligible individuals are enrolled with a MO HealthNet Managed Care Health Plan. Managed Care has been implemented statewide, operating in four (4) regions of the state: Eastern (St. Louis area), Central, Southwestern, and Western (Kansas City area)regions.

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

Managed Care eligibles who meet specific eligibility criteria receive services through a Managed Care Health Plan. The Managed Care Program replaces the process of direct reimbursement to individual providers by the MO HealthNet Division (MHD). Participants enroll in a Managed Care Health Plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the Managed Care Program have the opportunity to choose their own Managed Care Health Plan and primary care provider. A listing of the health plans providing services statewide for the Managed Care Program can be found on the MHD website at: http://dss.mo.gov/mhd/participants/mc/managed-care-health-plan-options.htm.

11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Eastern Missouri Managed Care Program (St. Louis area) began providing services to members on September 1, 1995. It includes the following counties: Franklin (036), Jefferson (050), St. Charles (092), St. Louis County (096) and St. Louis City (115). On December 1, 2000, five new counties were added to this region: Lincoln (057), St. Genevieve (095), St. Francois (094), Warren (109) and Washington (110). On January 1, 2008, the following three new counties were added to the Eastern region: Madison (062), Perry (079) and Pike (082).

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),

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

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

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

plan is *not* listed for the participant.

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

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

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

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

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

Managed Care Health Plan members fall into four groups:

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

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

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

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

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

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

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

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

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

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

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

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

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

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

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

- 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

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SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

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

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

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

Total expenditures for MO HealthNet *must* be within the appropriation limits established by the General Assembly. If the expenditures do *not* stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

12.2 BEHAVIORAL HEALTH SERVICES

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

12.3 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.mo.gov/mhd/providers/. 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 RECIPIENT 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 MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

Behavioral Health services are included as a plan benefit in MO HealthNet's Managed Care program for children under the age of 21. Children (category 4) in state care and custody are fee-for-service.

12.6.A MANAGED HEALTH CARE

Under a managed 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

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SECTION 13—BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

The Behavioral Health Services Manual contains policy and procedures for providing behavioral health services to children and adults.

13.1.A CHILDREN AND ADULTS

Medically necessary behavioral health services are available to MO HealthNet (MHD) eligible children under the age of 21 (0-20) and to MHD eligible adults age 21 and over. Medically necessary is defined in Section 22.2 of this manual.

Refer to Section 9 for information concerning the Healthy Children and Youth (HCY) program.

MHD reimburses for services to participants through age 25 who were in Foster Care at age 18 (ME code 38). These individuals receive the same benefit package as they did at age 20 (excluding EPSDT services).

13.2 PARTICIPANT ELIGIBILITY

MHD pays for approved behavioral health services when furnished within the provider's scope of practice. The participant *must* be eligible on the date the service is furnished. Participants may have specific limitations for behavioral health services according to the type of assistance for which they have been determined eligible and their age. It is the provider's responsibility to determine the coverage benefits for a patient based on their type of assistance and age. Prior to performing services, the provider shall ascertain a participant's MHD managed care or other lock-in status. Providers must verify participant eligibility in accordance with methodology outlined in Section1 and Section 3.

13.3 PROVIDER PARTICIPATION REQUIREMENTS

The following providers are eligible to enroll with MHD:

- Licensed and provisional licensed psychologists
- Licensed clinical social workers; licensed master social workers
- Licensed and provisional licensed professional counselors
- Licensed and provisional licensed marital and family therapists
- Psychiatrists
- Psychiatric/mental health nurse practitioners; psychiatric/mental health clinical nurse specialists
- Licensed behavior analysts; licensed assistant behavior analysts
- NCSP credentialed school psychologists (limited to services in school setting)

In order to participate in the MHD Behavioral Health Services Program, the provider *must* satisfy the following requirements:

- Hold a valid license within the state of practice or NCSP credential if a school psychologist rendering services in a school;
- Have a signed and accepted Participation Agreement in effect with the Missouri Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC).

The enrolled MHD provider shall agree to:

Keep any records necessary to disclose the extent of services the provider furnishes to patients, and;

On request, furnish to the Medicaid agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan.

See Section 2 of this provider manual for additional information on provider conditions of participation. Providers interested in enrolling may visit https://mmac.mo.gov/providers/provider-enrollment/

13.3.A PSYCHOLOGISTS, PROVISIONAL LICENSED PSYCHOLOGISTS (PLP) AND PSYCHOLOGY INTERNS

A Psychologist, PLP, or Psychology Intern may provide behavioral health services for children and adults. Psychology Intern services are limited to services provided as part of an APA accredited internship program.

A Psychologist or PLP *must* have and maintain:

- A valid permanent or provisional license issued by the State Committee of Psychologists when practicing in Missouri; or
- A valid permanent or provisional license issued by the psychology licensing authority of the state in which they practice.
- The provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

A Psychology Intern *must* be:

- A doctoral psychology intern in good standing in an internship program that is
  - Accredited by the American Psychological Association, and
  - A member of the Association of Psychology Postdoctoral and Internship Centers
- Under the direct supervision of the MO HealthNet enrolled licensed psychologist responsible for the participant's care

The supervising psychologist for the Psychology Intern must:

- Be enrolled with MO HealthNet as a psychologist

- Supervise and be responsible for the quality of work performed by the psychology intern under his/her direct supervision
- Assure compliance with MO HealthNet rules and regulations
- Retain the name of the participating intern and training dates in the psychology intern's personnel record

NOTE: A PLP *must* only provide services allowed under the provisional licensure. A PLP may *not* operate as an independent practitioner, receive direct payment from MHD, or own his or her own business in the practice as a PLP. PLPs *must* submit a copy of their permanent license to the Missouri Medicaid Audit and Compliance Provider Enrollment Unit upon receipt.

13.3.B LICENSED CLINICAL SOCIAL WORKERS AND LICENSED MASTER SOCIAL WORKERS (LCSW, LMSW)

LCSWs and LMSWs may provide behavioral health services for children and adults.

LCSWs and LMSWs *must* have and maintain:

- A valid license issued by the State Committee for Social Workers if practicing in Missouri; or
- A valid license issued by the social work licensing authority of the state in which they practice;
- The provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

NOTE: An LMSW *must* only provide services allowed under the licensure. An LMSW may *not* operate as an independent practitioner, receive direct payment from MHD or own his or her own business in the practice as an LMSW. LMSW providers *must* submit a copy of the LCSW license to the Missouri Medicaid Audit and Compliance Provider Enrollment Unit upon receipt of license to continue as an MHD provider. LMSWs *must* follow the MHD policy for LCSWs.

13.3.C LICENSED AND PROVISIONAL LICENSED PROFESSIONAL COUNSELORS (LPC, PLPC)

LPCs and PLPCs may provide behavioral health services for children and adults.

LPCs and PLPCs *must* have and maintain:

- A valid permanent or provisional license issued by the State Committee of Professional Counselors if practicing in Missouri; or
- A valid permanent or provisional license issued by the professional counselor licensing authority of the state in which they practice.

- The provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

NOTE: A PLPC *must* only provide services allowed under the provisional licensure. A PLPC may *not* operate as an independent practitioner, receive direct payment from MHD or own his or her own business in the practice as a PLPC. PLPCs *must* submit a copy of their permanent license to the Missouri Medicaid Audit and Compliance Provider Enrollment Unit upon receipt of license to continue as an MHD provider.

13.3.D LICENSED AND PROVISIONAL LICENSED MARITAL AND FAMILY THERAPISTS (LMFT, PLMFT)

LMFTs and PLMFTs may provide behavioral health services for children and adults.

LMFTs and PLMFTs must have and maintain:

- A valid permanent or provisional license issued by the State Committee of Marital and Family Therapists if practicing in Missouri; or
- A valid permanent or provisional license issued by the marital and family therapy licensing authority of the state in which they practice.
- The provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

NOTE: A PLMFT must only provide services allowed under the provisional licensure. A PLMFT may not operate as an independent practitioner, receive direct payment from MHD or own his or her own business in the practice as a PLMFT. PLMFTs must submit a copy of their permanent license to the Missouri Medicaid Audit and Compliance Provider Enrollment Unit upon receipt of license to continue as an MHD provider.

13.3.E LICENSED PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSE SPECIALIST (PCNS), AND PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS (PMHNP)

A Psychiatrist *must* have and maintain:

- A valid permanent license within the state of practice.

A clinical nurse specialist with a specialty in Psychiatry (PCNS) *must* have and maintain:

- A valid RN license AND a valid Document of Recognition with a specialty in Psychiatry within the state of practice.

A mental health nurse practitioner with a specialty in Psychiatry (PMHNP) *must* have and maintain:

- A valid RN license AND Document of Recognition as an adult psychiatric/mental health nurse practitioner, adult psychiatric/mental health clinical nurse specialist,

adult psychiatric/mental health nurse practitioner, family psychiatric/mental health nurse practitioner, family psychiatric/mental health clinical nurse specialist, child-adolescent psychiatric/mental health clinical nurse specialist within the state of practice.

For all provider types listed above, the provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

13.3.F APPLIED BEHAVIOR ANALYSIS (ABA) PROVIDERS: BEHAVIOR ANALYSTS, ASSISTANT BEHAVIOR ANALYSTS, AND ABA QUALIFIED PSYCHOLOGISTS

MHD reimburses Behavior Analysts, Assistant Behavior Analysts and ABA Qualified Psychologists for ABA services provided to participants age 0-20 diagnosed with Autism Spectrum Disorder (ASD).

Behavior Analysts and Assistant Behavior Analysts *must* have and maintain:

- A valid permanent license issued by the Division of Professional Registration, Board of Healing Arts.

MHD reimburses psychologists for ABA services only if they have been approved for the ABA specialty. MHD enrolled psychologists who have ABA in their scope of education, training, and competence may submit documentation of their credentials for consideration. This documentation may be submitted as a provider update via fax to the Provider Enrollment Unit at 573-634-3105. Include the provider's National Provider Identifier (NPI), the name of a contact person, an email address, and a phone number with the required documentation. If not already enrolled, psychologists may submit supporting documentation and request approval for the ABA specialty at the time of enrollment. Psychologists will be notified by email whether they have been approved for the ABA specialty.

An ABA Qualified Psychologist *must* have and maintain:

- A valid license or provisional license issued by the State Committee of Psychologists when practicing in Missouri; or
- A valid license or provisional license issued by the licensing authority of the state in which they practice.
- The provider's NPI must be on file with MHD. Services are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.
- ABA specialty through MMAC Provider Enrollment.

Technicians who provide direct implementation of ABA services under the supervision of a licensed provider must be credentialed by the Behavior Analyst Certification Board as a Registered Behavior Technician™ (RBT). The supervisory relationship must be documented in writing, and the licensed supervisor is responsible for the work performed by the RBT. Services provided by an RBT must be billed by the licensed supervisor using the codes and modifiers specified under Procedure Codes, Limits, and Rates shown below. RBTs are not allowed to enroll as MHD providers.

13.3.G SCHOOL PSYCHOLOGISTS

MHD reimburses for Nationally Certified School Psychologist (NCSP) credentialed School Psychologists for school-based Individualized Education Plan (IEP) Behavioral Health Direct Services. NCSPs who are employed in a duly accredited public or charter school and perform services within the scope of their employment for such school; and within the scope of their education, training, and experience, are eligible to enroll and provide services under this program. Services provided by school psychologists must be billed by the MHD enrolled school district. See section 13.14 for more information about school-based services.

13.3.H NOTIFICATION OF PROVIDER CHANGES

The MMAC Provider Enrollment Section *must* be notified in writing of any changes in provider records within 90 days of the change except for change of ownership, which *must* be reported within 30 days. The notification *must* include the provider's National Provider Identification (NPI), the requested changes, and the provider's signature and *must* be submitted on the Provider Update Request form located online at https://mmac.mo.gov/providers/provider-enrollment/new-providers/provider-enrollment-forms/ . A provider *must* notify the MMAC Provider Enrollment Section promptly of:

- Change of provider address or "pay to" address, if different (necessary to ensure that all correspondence is received promptly). Indication of change of address on a claim form is *not* sufficient.
- Change of ownership of business (*must* be reported within 30 days).
- Change from Social Security number to a Tax Payer I.D. number.
- Change of Employment Address
- Change in EIN, CLIA, Medicare numbers, etc.
- Change in licensure or certification including but *not* limited to status.

Mailing Address:

MMAC Provider Enrollment Section

Missouri Medicaid Audit and Compliance Unit

P. O. Box 6500

Jefferson City, MO 65102

Email address: MMAC.providerenrollment@dss.mo.gov

Refer to Section 2 of this manual for additional information.

13.4 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The requirement to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is stated in the MO HealthNet state regulation (13 CSR 70-3) Conditions of Provider Participation, Reimbursement and Procedure of General Applicability. These requirements are also repeated in the Title XIX Participation Agreement, which is a document signed by all providers upon enrollment as a MO HealthNet provider.

The Code of State Regulation, 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, diagnosis, 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.
- An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:
- First name, and last name, and either middle initial or date of birth of the MO HealthNet participant
- An accurate, complete, and legible description of each service(s) provided
- Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Inpatient hospital services *must* have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical record *must* contain signed and dated physician orders for services billed to MO HealthNet. Services provided by an individual under the direction or supervision are *not* reimbursed by MO HealthNet. Services provided by a person *not* enrolled with MO HealthNet are *not* reimbursed by MO HealthNet
- The name of the referring entity, when applicable
- The date of service (month/day/year)
- For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services identified by the American Medical Association Current Procedural Terminology procedure codes 99291-99292 and targeted case management services administered through the Department of Mental Health and as specified under 13 CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00-4:30 p.m.) *must* be documented

- The setting in which the service was rendered
- The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "non-hospital" patients, the hospital *must* have a written request or requisition slip ordering the tests or procedures
- The need for the service(s) in relationship to the MO HealthNet participant's Treatment Plan
- The MO HealthNet participant's progress toward the goals stated in the Treatment Plan (Progress Notes)

13 CSR 70-3.030(2)(D) states:

"Contemporaneous means at the time the service was performed or within five (5) business days of the time the service was provided. "

Electronic signatures are accepted. Stamped signatures are *not* acceptable.

All documentation *must* be legible and written/submitted in English. As referenced above, documentation *must* be entered in the patient record within five (5) business days of the service delivered.

13.4.A SPECIFIC DOCUMENTATION GUIDELINES FOR PSYCHOTHERAPY SERVICES

Based on 13 CSR 70-3.030(2)(A), the following specific guidance is offered for diagnostic assessments, treatment plans, and progress notes. Documentation must be individualized to the participant receiving services. For diagnostic assessments, it is a best practice recommendation to screen for anxiety, depression, substance use disorder, suicide risk, and trauma at a minimum. Updated documentation templates for diagnostic assessments, treatment plans, and progress notes are available at https://dss.mo.gov/mhd/cs/psych/pages/templates.htm. MO HealthNet provides these templates as examples of acceptable documentation formats, but does not require their use.

13.4.A(1) Diagnostic Assessment

- Diagnostic assessment is a required component in the health record. A diagnostic assessment must include the following elements:
  - First name and last name and either middle initial or date of birth of the participant
  - Referral source, when applicable
  - Date(s) of service and begin and end times
  - Setting in which the service was rendered (e.g., home, office)
  - Presenting problem
  - Statement of needs, goals, and treatment expectations from individual/family requesting services

- Summary of relevant behavioral health (i.e., mental health and/or substance use disorder) treatment history
- Current behavioral health symptoms
- Developmental (if under age 6), family, social, legal, and vocational/educational status and functioning. Historical information related to these domains should also be included if pertinent
- Current medications
- Personal and social resources and strengths, such as family, peers, and other natural supports
- Diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of Mental Disorders (must be supported by symptoms, significant distress or impairment in functioning).
- Provider signature and date

Documentation must support billing in terms of dates and time spent assessing the participant. If the assessment spans multiple days, progress notes may be used to indicate dates of service and start and stop times and to ensure services are documented within 5 business days.

If the participant needs further services, the diagnostic assessment should form the basis for a treatment plan. Providers should update the diagnostic assessment annually for adults and adolescents (age 13 to 20) or within six months for children under 13.

13.4.A(2) Treatment Plan

A treatment plan is a required document in the overall record of the participant.

The treatment plan must reflect the participant's unique needs and goals and must include:

- Measurable goals or outcomes;
- Services, supports, and actions to accomplish each goal/outcome. For example, provider interventions, action steps for participant, other family or social supports or resources.
- Projected time frame for the completion of each goal/outcome not to exceed 12 months;
- Estimated completion/discharge date; and
- Provider signature and date.

Providers must update the treatment plan annually for adults and adolescents (age 13 to 20) or within six months for children under 13.

The treatment plan is a working document, and providers should incorporate updates into the plan as needed on an ongoing basis. For example, the treatment plan should reflect when goals are met or revised, when new goals are added, and when interventions are added or updated.

13.4.A(3) Progress Notes

Providers must document each treatment encounter with an individualized progress note that includes the following elements:

- First and last name of participant;
- The specific service rendered (e.g., group therapy) or the procedure code;
- The date (month/date/year) and the actual begin and end time (e.g., 4:00-4:30 p.m. of the face-to-face service;
- The setting in which the service was rendered;
- Description of the immediate issue(s) addressed in therapy;
- Participant's report of recent symptoms and/or behaviors related to diagnosis and treatment plan goals;
- Therapist intervention(s) and participant response;
- Progress toward treatment goal(s)
- For family therapy, identify each family member present;
- For group therapy, the number of group members present;
- Provider's name, signature and date.

13.4.B RETENTION OF RECORDS

MO HealthNet providers *must* retain for six (6) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Program, and *must* furnish or make the records available for inspection or audit by the Department of Social Services (DSS) or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program 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.

13.5 PATIENT COST SHARING AND COPAY

Patients 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 patient at the time services are rendered. Services of the Behavioral Health Services 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 patient.

13.5.A PROVIDER RESPONSIBILITY TO COLLECT COPAYMENT

Providers of service *must* charge and collect the copay amount. Providers of service may *not* deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the patient'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 patient'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 patient did *not* make payment when the service was rendered.

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

13.5.B PATIENT RESPONSIBILITY TO PAY COPAY

It is the responsibility of the patient to pay the required copay amount due. Whether or not the patient 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. The copay only applies to identified services and patients with certain ME codes.

13.5.B(1) Uncollected Copay Amount

If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copays under this practice. However, a provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected copay. If a provider is not willing to provide services to a MO HealthNet participant with uncollected copay, the provider must give the participant advance notice and a reasonable opportunity to arrange care with a different provider before services are discontinued.

13.5.C SERVICES REQUIRING A COPAY

Adults receiving a limited benefit package are required to pay a copay for some behavioral health services. Provider types required to collect a copay and the copay amounts are listed below.

TYPE OF PROVIDER	COPAY AMOUNT
Physician, M.D.	$1.00
Physician, D.O.	$1.00
Nurse Practitioner	$1.00
Psychologist	$2.00
Independent Clinic/FQHC	$2.00
Independent Clinic	$0.50
Teaching Institution Department	$0.50
Teaching Institution	$0.50
Rural Health Clinic	$2.00

Copay is applied once regardless of how often the procedure code is billed to get the total allowed units per date of service.

The copay amount is deducted from the MHD Maximum Allowable amount for fee-for-service claims reimbursed by MO HealthNet.

13.5.D EXEMPTIONS TO THE COPAY REQUIREMENTS

The following exemptions apply to the MO HealthNet copay requirements:

- Services provided to participants under nineteen (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, and 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 services provided in an outpatient clinic or emergency room after the sudden onset of a medical or behavioral health condition manifesting itself by acute symptom of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
    1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
    2. Serious impairment to bodily functions; or
    3. Serious dysfunction of any bodily organ or part; or
    4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
    5. 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.
- Services provided to pregnant women who are receiving MO HealthNet under the following categories of assistance only: ME Code 18, 43, 44, 45, 58, 59, and 61;
- Services provided to foster care participants who are receiving MO HealthNet under the following categories of assistance: ME Codes 07, 08, 28, 29, 30, 37, 38, 49, 50, 51, 63, 66, 67, 68, 69, and 70;
- Services identified as medically necessary through an Early Periodic Screening, Diagnostic and Treatment (EPSDT) screen;
- Services provided to persons receiving 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;
- Behavioral 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 use disorder facility or as a child-servicing agency within the comprehensive children's mental health service system.

13.5.E PROVIDER PARTICIPATION PRIVILEGES

Participation privileges in the MO HealthNet program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any copay amount required of the participant. Provider of services in the program areas affected by the copay requirement must charge copay as specified at the time the service is provided to retain their participation privileges in the MO HealthNet program. Providers must

maintain records of copay amounts for six (6) years and must make those records available to the Department of Social Services upon request.

13.6 PATIENT NONLIABILITY

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

13.7 EMERGENCY SERVICES

Emergency services are required when there is 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 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.

13.8 OUT-OF-STATE, NONEMERGENCY SERVICES

All non-emergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet patients 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 Prior Authorization 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

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

The written request *must* include:

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

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

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

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

1. All Medicare/Medicaid crossover claims.
2. All children in Foster Care living outside the State of Missouri. However, non-emergency services or services that routinely require precertification continue to require precertification by out-of-state providers even though the service was provided to a child in Foster Care.
3. Emergency ambulance services.
4. Independent laboratory services.

13.9 PRECERTIFICATION

Prior to requesting precertification, a provider may deliver fourteen hours of psychotherapy services to a participant for whom they have not precertified services within the last rolling year. The fourteen hours may include any combination of individual therapy, family therapy without patient present, family therapy, or group therapy (90832, 90834, 90837, 90846, 90847, or 90853). The fourteen hours applies to the group practice if services are provided in a clinic setting, not to each individual performing provider of that group practice. Prior to delivering additional services (beyond the initial 14 hours), a provider must request precertification. The patient *must* meet eligibility requirements on the date of service, and the provider *must* be enrolled and eligible to bill for the services. Precertification of services is *not* a guarantee of payment.

The number of hours precertified is based on the patient's age, diagnosis, type of therapy, and ME Code. Refer to Section 13.11 for hours issued for adults (ages 21 and over) and Section

13.12 for hours issued for children (ages 0 through 20 and ME code 38 ages 21 through 25). The default precertification period is 12 months.

Providers should use diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders to establish diagnosis. Providers must use the corresponding diagnostic code from the current edition of the International Classification of Diseases when requesting precertification and submitting claims (required for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Please refer to section 18.3 of the Behavioral Health Services Manual.

With the exception of psychiatric diagnostic evaluation (90791, 90792), all covered behavioral health services for patients age birth through 2 years (i.e., psychological testing, family therapy) require precertification.

If psychotherapy services are required beyond the initial fourteen hours, the provider must request precertification prior to delivering additional services. To request precertification the provider or designated staff may make the request online through CyberAccess, by fax, mail, or via telephone.

- To become a CyberAccess[SM] user, contact the Conduent help desk at (888) 581-9797 or (573) 632-9797, or send an email to CyberAccessHelpdesk@Conduent.com. Conduent staff will set up individual training sessions with each provider site that requests access to the Web tool.

- Written requests must include the current version of the Behavioral Health Services Request for Precertification form and may be faxed to (573) 635-6516 or mailed to MO HealthNet Division, PO Box 4800, Jefferson City, MO 65102.

- For telephone requests, call the Behavioral Health Services help desk at (866) 771-3350. It is recommended that providers complete the Behavioral Health Services Request for Precertification form prior to calling as the information on the form is required to complete the request.

If the therapist is part of a clinic or group, the precertification should be requested using the clinic/group NPI. If the provider is not part of a group or clinic (solo practice), the precertification should be requested using the individual NPI. Precertification for services being delivered by a member of an FQHC, RHC, or CMHC must be requested by using the FQHC, RHC, or CMHC NPI.

Precertification is required even when third party insurance coverage exists. Medicare is not considered third party insurance; however, if Medicare does not cover the service, a precertification is required for payment by MO HealthNet.

Precertification is required for patients residing in a nursing home, but behavioral health services cannot be provided at the nursing home aside from diagnostic evaluation provided by a psychiatrist or advanced practice psychiatric nurse.

All precertification requests must be complete in order to be processed. A precertification cannot be processed if the participant or provider identifying information is incomplete or inaccurate (including Provider NPI, DCN, etc.). The Behavioral Health Services Help Desk makes every attempt to reconcile any incorrect/inaccurate information with providers; however, it remains the provider's responsibility to provide complete and accurate information when submitting a request for precertification.

A participant may have an open precertification with one provider for individual therapy and/or family therapy and a second precertification open with the same or different provider for group therapy.

If a provider needs to change a precertification, the provider may call or fax in the change request. A request to change the precertification requires the participant's name, DCN, type of therapy, current precertification, and a description of the desired change.

If the participant is changing providers, the provider listed on the current precertification must end that precertification before the new provider can obtain a precertification. If the current provider refuses to close the precertification, the new provider must submit a signed release from the participant, or participant's guardian, requesting a change in provider. The signed release must include the participant DCN, type of therapy to be closed, the number of hours used, and the name of the therapist whose authorization is to be closed. When a participant changes providers any available units may be transferred from the closed precertification to the new provider's approved precertification if requested. The new provider does not receive an additional allotment of therapy hours, but rather the portion of therapy hours remaining for the current precertification period.

When precertification requests are denied partially or in full, the participant receives a letter outlining the reason for denial and their appeal rights. The provider does not receive a copy of the denial letter. The participant's denial letter contains the telephone number for the participant to call for assistance if needed.

MO HealthNet does not cover psychotherapy services provided by someone other than the enrolled provider, except for doctoral psychology interns under the supervision of a psychologist (see section 13.3.B of this manual) or psychiatry residents under the supervision of a teaching psychiatrist (see section 13.17.B of the physician provider manual).

13.9.B CLINICAL EXCEPTIONS

MO HealthNet recognizes there are instances when participants may need behavioral health services that exceed the program limits defined in this manual. For example, a provider may request a clinical exception to exceed daily, monthly, or annual limits for specific services for an individual due to medical necessity. To do so, a provider must submit, in advance of providing services, a completed Behavioral Health Services Request for Precertification form, a letter with clinical rationale, and any available supporting documentation via fax to the Behavioral Health Help Desk at (573) 635-6516. A clinical consultant will review all exception requests for medical necessity, and the provider will receive a faxed response indicating whether medical necessity is met. Providers may call the help desk with questions at (866) 771-3350.

13.9.C PRECERTIFICATION EXEMPTIONS

Psychotherapy services provided during inpatient hospital stays, evaluation and management services, narcosythesis, electroconvulsive therapy, tobacco cessation counseling, psychiatric diagnostic evaluation, psychological testing, and health and behavior assessment and intervention are exempt from the precertification process.

Psychotherapy for crisis is exempt from the precertification process. The presenting problem for this service is severe enough to pose a threat to the participant's wellbeing or a danger to self or others and requires immediate attention to a patient in high distress.

13.9.D RESIDENTIAL TREATMENT FACILITY EXEMPTIONS

Services provided in a residential treatment facility setting are exempt from the precertification process.

Services provided in residential treatment facilities are identified by the following place of service codes:

14 – Group Home

33 – Custodial Care Facility

56 – Psychiatric Residential Treatment Center

Providers must report correct place of service codes on claims submitted to MO HealthNet.

In addition, services provided to children with an ME Code of 07, 08, 37, or 88 who are residing in or are under the care of a residential treatment facility are exempt from the precertification process if the services are provided at a site other than the residential treatment facility. The TJ modifier should be used to indicate that the services were provided to a child residing in or under the care of a residential treatment facility at a site other than the facility (office, outpatient hospital, home, etc.). The TJ modifier should not be used for services provided at the facility. The place of service codes above exempt those services from the precertification process.

NOTE: All services, except assessment, for patients age birth through 2 years do require precertification, regardless of the child's placement.

13.9.E PARTICIPANT APPEAL RIGHTS

When a precertification request is denied, the participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The State Fair Hearings Process may be requested by the participant, in writing, to the MO HealthNet Division, Participant Services Unit (PSU), and P.O. Box 6500, Jefferson City, MO 65102. The Participant Services Unit may also be called toll-free at 1-800-392-2161. The participant must contact PSU within 90 days of the date of the denial letter if they wish to request a hearing. After 90 days, requests to appeal are denied.

13.10 COVERED PSYCHOTHERAPY SERVICES – ADULTS AND CHILDREN

Covered psychotherapy services for adults and children are described in detail below. See section 13.12 for precertification requirements and section 13.13 for specific procedure codes.

13.10.A PSYCHIATRIC DIAGNOSTIC EVALUATION (90791, 90792)

A Psychiatric Diagnostic Evaluation *must* include direct patient contact and, for a child, may include the following types of activities (include only face to face (in person or via telehealth) contact with child and/or parent in units billed, due to MHD time-based unit):

- Interview with child (includes topics of family, peers, school relationships, behavior, emotions, observation of social skills, developmental level of planning skills and informal assessment of overall development)
- Interview with parent
- Report from teachers or other collateral contacts

This procedure is limited to six half-hour units per patient, per provider, per rolling year.

13.10.B PSYCHOLOGICAL TESTING

Psychologists, provisional licensed psychologists, qualified doctoral level psychology interns, and psychiatrists may provide psychological testing services in addition to diagnostic assessment when warranted for proper evaluation. Psychological testing (including any combination of the below procedures) is limited to a maximum of four hours per participant, per provider, per rolling year.

MHD reimburses for the following testing services:

- Procedure code 96130 - Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s), or caregiver(s), when performed; first hour.

- Procedure code 96131 – Psychological testing evaluation services, each additional hour (List separately in addition to code for primary procedure)

- Procedure code 96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes.

- Procedure code 96137 – Psychological or neuropsychological test administration and scoring, Each additional 30 minutes (List separately in addition to code for primary procedure)

- Procedure code 96146 - Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.

- Procedure code 96105 – Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.

- Procedure code 96112 - Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes.

- Procedure code 96113 - Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes.

- Procedure code 96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour.

- Procedure code 96121 – Neurobehavioral status exam, each additional hour (List separately in addition to code for primary procedure).

The patient record must include the clinical justification for conducting the test as well as the intended purpose of the results. Testing services (including any combination of the above procedures) are limited to a maximum of four hours per patient, per provider, per rolling year.

13.10.C INDIVIDUAL PSYCHOTHERAPY

Per CPT, the psychotherapy service codes include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. 90832, 90834 and 90837 describe psychotherapy for the individual patient; times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service.

- **90832 –Psychotherapy**, approximately 16 to 37 minutes face-to-face with the patient.
- **90834 –Psychotherapy**, approximately 38 to 52 minutes face-to-face with patient.
- **90837 –Psychotherapy,** 53 or more minutes face-to-face with patient.

The codes listed above do not differentiate between inpatient and outpatient settings.

Individual Psychotherapy is limited to 1 unit per day/5 units per month.

Individual Psychotherapy in the inpatient setting is limited to one unit per day. Monthly limits do *not* apply when in an Inpatient Hospital setting.

13.10.D SPECIAL CONSIDERATIONS FOR YOUNG CHILDREN

EVIDENCE-BASED PRACTICE AND FAMILY THERAPY ENCOURAGED

Whenever possible, providers are encouraged to utilize evidence-based practices that address the specific clinical issues and demographic characteristics of the individual(s) being treated. Many evidence-based practices for children actively involve parents/caregivers in the intervention. Providers are encouraged to involve parents/caregivers in the interventions (e.g., providing family therapy), especially when treating younger children. In addition to incorporating family therapy, most evidence-based practices for children 0 – 5 years of age are hybrid treatments that incorporate cognitive behavior therapy, play, and/or other treatment strategies.

COMPETENCE IN TREATING YOUNG CHILDREN

Consistent with the ethical standards for behavioral health, providers are expected to practice within the boundaries of their competence. This applies equally to services for the early childhood population as it does to services for other age groups. If providers do not have the knowledge and skills to work with a particular clinical population, they are urged to seek learning experiences to gain the necessary knowledge and skills or refer the child to a competent provider.

CONSIDERATION OF THE DEVELOPMENTAL LEVEL OF THE CHILD

Providers treating young children are expected to base their plan of intervention on a comprehensive and individualized assessment that takes into consideration, among other factors, the developmental level of the child and the specific clinical issues being treated. When working with young children who have behavioral health concerns, best practice is to screen development to determine if developmental delays play a role in socio-emotional difficulties and to guide developmentally appropriate treatment planning. If developmental delays are found or suspected, providers should refer clients for further assessment and treatment as needed. One developmental consideration is that a young child may not have the expressive language skills to explain his/her symptoms and response to treatment, or the receptive language skills to understand the clinician if she or he were to use ordinary adult language. Treatments for young children typically incorporate activities, pictures, drawing, role-playing, books, play, etc. to facilitate communication, make therapeutic concepts and skills concrete, build the therapeutic relationship, and help the child change.

PLAY THERAPY GUIDELINES

Play therapy includes a variety of treatment techniques that may be effective with young children. The appropriate CPT® code used to capture an intervention that incorporates play therapy techniques depends on the specific therapeutic approach used and could be individual therapy or family therapy. Documentation should clearly reflect how the play therapy techniques were utilized in a therapeutic manner to address the issue(s) being treated. Please note that observing children playing in a playroom, playing on playground

equipment, playing at daycare, or playing at home in their normal routine is not play therapy and is not reimbursable by MHD.

DOCUMENTATION

Regardless of the treatment approach used (e.g., trauma-focused cognitive-behavioral therapy, parent-child interaction therapy, or play therapy), the treatment plan should include the billable service in the "services, supports and actions to accomplish each goal" section. The treatment plan should also describe specific planned interventions, strategies and actions. If specific techniques are planned they may be included, but a specific strategy (e.g., play therapy) alone is not a sufficient description of an intervention. The same considerations apply to progress notes. Progress notes must include the specific MO HealthNet billable services rendered.

13.10.E FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than as individual patients. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill family therapy for each family member. - Parental issues may not be billed and family therapy is only billable when defined in the treatment plan as necessary on behalf of the identified patient.

Only one precertification per household is approved and open at a time for family therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient, then the oldest child's DCN must be used for precertification and billing purposes. When a specific child is identified as the primary patient, that child's DCN must be used for precertification and billing purposes. Providers should not request more than one family therapy precertification per household.

A family may be defined as biological, foster, adoptive or other family configuration. A family is not a group and providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.

13.10.F GROUP THERAPY

Group therapy must consist of at least 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient group therapy sessions also.

Group therapy may not be billed on the same date of service as family therapy (90846 or 90847) unless the patient is inpatient, in a residential treatment facility, or custodial care facility. Services must be provided at the facility location.

Group therapy in a group home is billed with Place of Service Code 14. Group therapy in a residential/custodial facility is billed with Place of Service Code 33. Group therapy in a homeless shelter is billed with Place of Service Code 04.

13.10.G PSYCHOTHERAPY FOR CRISIS

Psychotherapy for crisis is used to offer immediate, short-term help to patients who experience an event that produces emotional, mental, physical, and behavioral distress or problems. A crisis can refer to any situation in which the patient perceives a sudden loss of the ability to use effective problem-solving and coping skills. Psychotherapy for crisis aims to reduce the intensity of the patient's emotional, mental, physical and behavioral reactions to a crisis and help the patient return to their level of functioning before the crisis. Psychotherapy for crisis is appropriate for children, adolescents, and younger and older adults. Elements of psychotherapy for crisis include helping the individual understand the crisis and their response to it as well as becoming aware of and expressing feelings, such as anger and guilt. A major focus of psychotherapy for crisis is exploring coping strategies.

Psychotherapy for crisis (90839) must be a face-to-face contact to diffuse a situation of immediate crisis. The situation must be severe enough to pose a threat to the patient's well-being or danger to him/herself or others. Psychotherapy for crisis services cannot be scheduled in advance.

13.10.H TOBACCO CESSATION COUNSELING

MHD reimburses for both behavioral and pharmacologic interventions for tobacco cessation for MHD eligible participants. Both individual (99406, 99407) and group counseling (90853) are covered for tobacco cessation. See Section 13.13 for more information on procedure codes, limits, and modifiers.

The pharmacologic intervention is reimbursed through the MHD Pharmacy Program. As of January 1, 2020, MHD Managed Care Health Plans cover the behavioral tobacco cessation interventions for their members. For dates of service prior to January 1, 2020, members of an MHD Managed Care Health Plan received the smoking cessation behavioral intervention on a fee-for-service basis outside of the MHD managed care benefit package.

MHD covers unlimited quit attempts per lifetime, including behavioral and pharmacologic interventions.

Providers can access the educational videos on “Discussing Treatment of Tobacco Use with Patients” and “Improving Tobacco Cessation Counseling Skills” and earn free continuing education credits:

- www.mimhtraining.com/qi-improving-tobacco-knowledge
- www.mimhtraining.com/qi-tobacco-cessation

Providers also are encouraged to review the evidence and recommendations outlined in Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guideline, sponsored by the United States Department of Health and Human Services, which can be

found at:http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html

Based on the evidence, this document recommends:

- "The 5 A's," a brief intervention for the primary care setting:
  - Ask about tobacco use – All patients should be screened for tobacco use at every visit.
  - Advise to quit – All physicians should strongly advise every patient who smokes to quit.
  - Assess willingness to quit – Once identified as a smoker, willingness to quit should be assessed.
  - Assist in quit attempt – offer medication and provide or refer for additional treatment; for patients unwilling to quit, provide interventions designed to increase future quit attempts (e.g., motivational interviewing).
  - Arrange follow-up – For patients willing to quit, arrange follow-up contacts, beginning the first week after quit date; for patients unwilling to quit, address tobacco dependence and willingness to quit at next visit.
- Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit.
- The combination of behavioral intervention and medication is more effective than either alone.
- Behavioral interventions should include both support/encouragement and practical counseling, such as problem-solving skills/skills training.
- Even behavioral counseling lasting less than 3 minutes increases abstinence rates
- Longer behavioral counseling sessions increase abstinence rates further.
- Providing four or more sessions of behavioral counseling is especially effective in increasing abstinence rates.
- Use of telephone quit lines is effective in increasing abstinence rates.
- Use of educational materials tailored to the individual, both print and web-based, appear to be effective in increasing abstinence rates.
- Missouri offers free help to smokers who want to quit using tobacco.
- Smoking cessation information, including educational materials for youth, pregnant women, and other adults, is available at: http://health.mo.gov/living/wellness/tobacco/smokingandtobacco
- The Missouri Tobacco Quitline provides counseling, information, and referrals. In order to register to talk to a trained quit coach, individuals can call the Quitline number at 1-800-QUIT-NOW (1-800-784-8669) or register online at: www.quitnow.net/missouri.

- Live people answer Missouri's Quitline 24 hours a day, 7 days a week, and quit coaches are on duty 24 hours a day, seven days a week.

Healthcare professionals can call the Quitline for information about the service. They can learn about proper use and dosing of nicotine replacement therapy. They can also learn about written materials covering a broad range of topics related to tobacco cessation.

13.10.H(1) DIAGNOSIS CODES FOR TOBACCO CESSATION

In order to be reimbursed by MHD, the claim for the behavioral intervention must contain a diagnostic code in one of the following ranges: F17200-F17209, F17210-F17219, F17220-F17229, F17290-F17299, O0900-O0903, O0910-O0913, O09211-O09219, O09291-O09299, O0930-O0932, O0940-O0943, O99330-O99335, Z331, Z3400-Z3403, Z3480-Z3483, Z3490-Z3493.

Reimbursement is limited to one session per day. The behavioral intervention must be face-to-face with the patient (in person or via telehealth).

The behavioral intervention is included in the global fee for prenatal/delivery/post-partum care billed by physicians and nurse midwives and should not be billed separately.

13.10.I HEALTH AND BEHAVIOR ASSESSMENT AND INTERVENTION (HBAI) SERVICES

MHD reimburses for medically necessary HBAI services. Covered practitioners include:

- Licensed psychologists, provisional licensed psychologists, psychology interns;
- Licensed clinical social workers, licensed master social workers;
- Licensed professional counselors, provisional licensed professional counselors (as of January 1, 2020);
- Licensed marital and family therapists, provisional licensed marital and family therapists (as of January 1, 2020).

HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable the participant to overcome the perceived barriers to self-management of his/her chronic condition(s).

HBAI services are not to be used for the treatment of a behavioral health condition. These services are specifically intended to address any or all of the following barriers to disease self-management of a chronic physical condition:

- Cognitive

- Emotional
- Social
- Behavioral functioning

13.10.I(1) ELIGIBILITY CRITERIA FOR HBAI SERVICES

- The participant must have an underlying physical illness or injury.
- There must be indications that there are biopsychosocial factors that may be affecting treatment or self-management of the condition.
- The participant must be alert, oriented, and have the capacity to understand and respond to information related to the condition.
- The behavioral health provider must have medical records documenting the specific physical health condition diagnosed by a physician, nurse practitioner, physician assistant, or assistant physician. This requirement may be met through an integrated health record or through records or correspondence containing a diagnosis received from the medical provider.

Please refer to Section 13.13 for more information on procedure codes and limitations. Precertification is not required for HBAI services. HBAI services are covered for both children and adults. Psychologists and PLPs must bill with the AH modifier. Supervisors billing for psychology intern services must bill with the HL and AH modifier. LCSWs and LMSWs must bill with the AJ modifier. LPCs and PLPCs must bill with the UD modifier. LMFTs and PLMFTs must bill with the HE modifier.

13.11 PRECERTIFICATION GUIDELINES – ADULTS

Individual, group, and family therapy services (beyond the first fourteen hours) provided to adults (21 years of age or older) must be precertified. See Section 13.13 for procedure codes and modifiers.

See Section 13.9 for additional information regarding the precertification process.

Providers are expected to establish a participant's diagnosis using diagnostic criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The corresponding diagnostic code from the current edition of the *International Classification of Diseases (ICD)* must be used when requesting precertification and submitting claims (required for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Please refer to Section 18.3 of the Behavioral Health Services Manual.

Precertifications for psychotherapy services for adults are issued for a maximum of ten (10) hours per rolling year for adjustment disorder, Z-code, or unspecified current version ICD diagnostic codes. For all other covered diagnosis codes, refer to the table below for the maximum hours issued for a twelve-month period. All precertifications expire twelve months from the date requested. Requests for continued services beyond the 12-month precertification must include (1) a completed Behavioral Health Services Request for Precertification form, (2) a letter explaining the rationale for continued services, and (3) supporting clinical documentation (assessment, treatment plan, and most recent three progress notes). A clinical consultant will review all continued service requests for medical necessity. These requests must be submitted via fax to the Behavioral Health Services Help Desk at (573) 635-6516.

13.11.A Adults: Maximum Hours Precertified per 12 months

	Individual* 90832 / 90834/90837	Family* 90847	Family without patient 90846	Group 90853
Max Hours	15	10	10	25

**Note: Provider may precertify up to 25 hours of individual, or family, or a combination.*

13.12 PRECERTIFICATION GUIDELINES - CHILDREN AND YOUTH

Precertification is required for family, individual, and group psychotherapy (beyond the first fourteen hours) for children and youth, ages 3 through 20 years, who are *not* in state custody and for children and youth in foster care (ME Codes 07, 08, 37, and 38), not residing in a residential treatment facility. With the exception of diagnostic evaluation, precertification is required for all covered services (i.e., psychological testing and family therapy) provided to children age birth through 2 years, regardless of the ME code or placement of the child.

Providers are expected to establish a participant's diagnosis using diagnostic criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The corresponding diagnostic code from the current edition of the *International Classification of Diseases (ICD)* must be used when requesting precertification and submitting claims (required for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Please refer to section 18.3 of the Behavioral Health Services Manual.

Precertifications for psychotherapy services for children and youth are issued for a maximum of ten (10) hours per rolling year for adjustment disorder, Z-code, or unspecified current version ICD diagnostic codes. For all other covered diagnosis codes, refer to the table below for the maximum hours issued for a twelve month period. All precertifications expire twelve months from the date requested. Requests for continued services beyond the 12-month precertification must include (1) a completed Behavioral Health Services Request for Precertification form, (2) a

letter explaining the rationale for continued services, and (3) supporting clinical documentation (assessment, treatment plan, and most recent three progress notes). A clinical consultant will review all continued service requests for medical necessity. These requests must be submitted via fax to the Behavioral Health Services Help Desk at (573) 635-6516.

Multiple therapies are the treatment of the individual with more than one therapy, such as Individual and Family, within the same authorization period. The Treatment Plan *must* document the need for more than one therapy.

If a child's age changes during the precertification period, the precertification continues as authorized. However, if the child turns 21 during the authorization period, the policy for services provided to adults applies.

Only one precertification per household is approved at any given time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient, the oldest child's DCN must be used for precertification and billing purposes. Family therapy may be provided without the primary patient present; however, documentation should clearly state the reason the primary patient was not present. When a specific child is identified as the primary patient, that child's DCN must be used for precertification and billing purposes. **Providers should not request more than one family therapy precertification per household.**

Please refer to Section 13.9 for additional information regarding precertification.

13.12.A PRECERTIFICATION FOR CHILDREN AND YOUTH BY AGE GROUP – CHILDREN NOT IN STATE CUSTODY

Family therapy is the preferred modality for children through age 12 due to the evidence base regarding the effectiveness of actively involving parents in the therapy process.

Children Not In State Custody: Maximum Hours Precertified per 12 Months:

Age	Testing*	Individual 90832/90834/90837	Family 90847	Family without Patient 90846	Group 90853
0-2	4	N/A	20	10	N/A
3	N/A	5	15	10	N/A
4	N/A	15	15	10	N/A
5-12	N/A	16	37	10	13
13-17	N/A	27	26	10	13
18-20	N/A	37	16	10	13

**Note: Precertification not required for testing unless under age 3. Annual limit for testing is listed.*

13.12.B PRECERTIFICATION FOR CHILDREN AND YOUTH BY AGE GROUP – FOSTER CARE (ME CODE 07, 08, 37, AND 38)

Children in Foster Care: Maximum Hours Precertified per 12 Months

Age	Testing*	Individual 90832/90834/90837	Family 90847	Family without Patient 90846	Group
0-2	4	N/A	50	10	N/A
3	N/A	15	35	10	N/A
4	N/A	35	35	10	N/A
5-12	N/A	37	37	10	36
13-17	N/A	37	37	10	36
18-20	N/A	37	37	10	36
21-25	N/A	37	37	10	36

**Note: Precertification not required for testing unless under age 3. Annual limit for testing is listed.*

MHD recognizes there are instances with children and youth in foster care when additional family therapy services may be required. If a child in foster care requires family therapy sessions with the foster parent and separate family therapy sessions with the biological parent/parents, the provider should obtain one family therapy precertification for the child.

The provider must develop an integrated treatment plan for the family therapy with objectives and outcomes for therapy with the foster family and biological family. The hours may be split between the two families, i.e. family therapy sessions with foster parents and separate family therapy sessions with the biological parent(s). Hours will be issued in accordance with the guidelines above. Hours required beyond these guidelines may be requested through the Clinical Exception process, as outlined in Section 13.9.B. Requests for additional hours of family therapy for separate sessions with the biological and foster families must be recommended by the Family Support Team.

Providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly, yearly limits are not reimbursed unless approved in advance through the clinical exception process.

Foster families that consist of several unrelated children should request one family therapy precertification per family. Rare circumstances may arise when each unrelated child in a foster family requires a separate family therapy session with the foster parent. Requests for multiple family therapy precertifications per foster family will only be considered through the clinical exceptions process as stated in Section 13.9.B. Requests for multiple precertifications within the same household must be recommended by the Family Support Team.

13.13 PROCEDURE CODES FOR PSYCHOTHERAPY SERVICES – ADULTS AND CHILDREN

The current reimbursement amount may be accessed at the MO HealthNet Fee Schedule at http://dss.mo.gov/mhd/providers/pages/cptagree.htm.

13.13.A PSYCHOTHERAPY SERVICES REQUIRING PRECERTIFICATION – ADULTS AND CHILDREN

CPT® CODE	CPT® CODE DESCRIPTION, UNIT, AND LIMITATIONS
90832	Psychotherapy, 30 minutes with patient (approx 16 to 37 minutes face-to-face with the patient) Maximum of 1 unit per day, 5 units per month, per patient, per provider
90834	Psychotherapy, 45 minutes with patient (approx 38 to 52 minutes face-to-face with the patient) Maximum of 1 unit per day, 5 units per month, per patient, per provider
90837	Psychotherapy, 60 minutes with patient (53 or more minutes face-to-face with the patient) Maximum of 1 unit per day, 5 units per month, per patient, per provider
90846	Family psychotherapy (without patient present), 50 minutes Maximum of 1 unit of 90846 or 90847 per day, 5 units of 90846 or 90847 or combination per month, per patient, per provider

90847	Family psychotherapy (conjoint psychotherapy), 50 minutes Maximum of 1 unit of 90846 or 90847 per day, 5 units of 90847 or 90847 or combination per month, per patient, per provider
90853	Group psychotherapy (other than a multi-family group) (MHD defined 30 minute unit) Maximum of 3 units per day, 15 units per month, per patient, per provider

Regardless of precertification, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly, yearly limits are *not* reimbursed unless approved in advance through the clinical exception process.

13.13.B - PSYCHOTHERAPY SERVICES NOT REQUIRING PRECERTIFICATION – ADULTS AND CHILDREN

CPT® CODE	CPT® CODE DESCRIPTION, UNIT, AND LIMITATIONS
90791	Psychiatric diagnostic evaluation (MHD defined 30 minute unit) Maximum of 6 units per patient, per provider, per rolling year
90792	Psychiatric diagnostic evaluation with medical services (MHD defined 30 minute unit) Maximum of 6 units per patient, per provider, per rolling year
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g. sodium amobarbital (Amytal) interview) (MHD defined 30 minute unit)
90870	Electroconvulsive therapy (includes necessary monitoring) (MHD defined 30 minute unit)

90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes (MHD defined 60 minute unit)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s), or caregiver(s), when performed; first hour. (60 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96131	Psychological testing evaluation services, each additional hour (List separately in addition to code for primary procedure). (60 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes. (30 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96137	Psychological or neuropsychological test administration and scoring, each additional 30 minutes (List separately in addition to code for primary procedure) (30 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)

96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only. (untimed) Maximum of 4 units per day
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour (60 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes (60 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes (30 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per provider)
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour. (60 minute unit) Maximum of 4 hours of testing (any combination of 96130, 96131, 96136, 96137, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per

	participant, per provider)
90839	Psychotherapy for crisis (60 minute unit)
Tobacco Cessation Counseling Procedures	
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes Maximum of 1 unit per day
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes Maximum of 1 unit per day
HBAI Procedures	
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making) Limit of 1 unit per day, 2 per rolling year.
96158	Health and behavior intervention, individual, face-to-face; initial 30 minutes Limit of 1 unit per day, 8 units per rolling year.
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service) Limit of 1 unit per day, 12 units per rolling year, per participant
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes

	Limit of 1 unit per day, 12 units per rolling year.
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) Limit of 2 units per day, 24 per rolling year.
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes Limit of 1 unit per day, 9 units per rolling year.
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) Limit of 1 unit per day, 18 per rolling year.

13.13.C PSYCHOTHERAPY PROCEDURE CODES BY PROVIDER SPECIALTY

Psychiatrists and advanced practice nurses should utilize ***either*** the appropriate Evaluation and Management (E & M) code ***or*** the appropriate psychotherapy code listed below. The billing of a combination of psychotherapy and E & M code is not allowed. Please refer to the current CPT® manual for specific guidelines.

The U8 Modifier should be used for services billed with place of service 12 (home). The appropriate modifiers *must* be used for all codes. The procedure codes and modifiers are listed by provider type below.

The AH modifier must be included when billing claims for psychologists or PLPs.

The AJ modifier must be included when billing claims for LCSWs or LMSWs.

The UD modifier must be included when billing claims for LPCs or PLPCs.

The HE modifier must be included when billing claims for LMFTs or PLMFTs.

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CPT® Code	CPT® Code Description	CPT® Code & Modifier by Provider Specialty							Precert Req
		Psychiatrist	PCNS PMHNP	Psychologist PLP	Psychology Intern	LCSW LMSW	LPC PLPC	LMFT PLMFT	
90791	Psychiatric Diagnostic Evaluation	90791	90791 SA	90791 AH	90791 HL AH	90791 AJ	90791 UD	90791 HE	No
90792	Psychiatric Diagnostic Evaluation with Medical Services	90792	90792 SA	N/A	N/A	N/A	N/A	N/A	No
90832	Psychotherapy, 30 min	90832	90832 SA	90832 AH	90832 HL AH	90832 AJ	90832 UD	90832 HE	Yes
90834	Psychotherapy, 45 min	90834	90834 SA	90834 AH	90834 HL AH	90834 AJ	90834 UD	90834 HE	Yes
90837	Psychotherapy, 60 min	90837	90837 SA	90837 AH	90837 HL AH	90837 AJ	90837 UD	90837 HE	Yes
90839	Psychotherapy for Crisis, 60 minutes	90839	90839 SA	90839 AH	90839 HL AH	90839 AJ	90839 UD	90839 HE	No
90846	Family Psychotherapy without Patient, 50 min	90846	90846 SA	90846 AH	90846 HL AH	90846 AJ	90846 UD	90846 HE	Yes
90847	Family Psychotherapy with Patient, 50 min	90847	90847 SA	90847 AH	90847 HL AH	90847 AJ	90847 UD	90847 HE	Yes
90853	Group Psychotherapy	90853	90853 SA	90853 AH	90853 HL AH	90853 AJ	90853 UD	90853 HE	Yes
90865	Narcosynthesis	90865	90865 SA	N/A	N/A	N/A	N/A	N/A	No
90870	Electroconvulsive therapy (includes monitoring)	90870	90870 SA	N/A	N/A	N/A	N/A	N/A	No
90880	Hypnotherapy	90880	90880 SA	90880 AH	90880 HL AH	N/A	N/A	N/A	No
90885	Psychiatric evaluation of records	90885	90885 SA	90885 AH	90885 HL AH	N/A	N/A	N/A	No
96130	Psych testing evaluation services,	96130	N/A	96130 AH	96130 HL AH	N/A	N/A	N/A	No

	first hour								
96131	Psych testing evaluation services, each additional hour	96131	N/A	96131 AH	96131 HL AH	N/A	N/A	N/A	No
96136	Psych test admin and scoring by professional, first 30 min	96136	N/A	96136 AH	96136 HL AH	N/A	N/A	N/A	No
96137	Psych test admin and scoring by professional, each additional 30 min	96137	N/A	96137 AH	96137 HL AH	N/A	N/A	N/A	No
96146	Single automated test with automated result only	96146	N/A	96146 AH	96146	N/A	N/A	N/A	No
96105	Assessment of aphasia	96105	N/A	96105 AH	96105 HL AH	N/A	N/A	N/A	No
96112	Developmental testing, first hour	96112	N/A	96112 AH	96112 HL AH	N/A	N/A	N/A	No
96113	Developmental testing, each additional 30 min	96113	N/A	96113 AH	96113 HL AH	N/A	N/A	N/A	No
96116	Neurobehavior status exam, first hour	96116	N/A	96116 AH	96116 HL AH	N/A	N/A	N/A	No
96121	Neurobehavior status exam, each additional hour	96121	N/A	96121 AH	96121 HL AH	N/A	N/A	N/A	No
99406	Tobacco cessation counseling, 3-10 min	99406	99406 SA	99406 AH	99406 HL AH	99406 AJ	99406 UD	99406 HE	No
99407	Tobacco cessation counseling, greater than 10 min	99407	99407 SA	99407 AH	99407 HL AH	99406 AJ	99407 UD	99407 HE	No
96156	Health behavior	N/A	N/A	96156 AH	96156 HL AH	96156 AJ	96156 UD	96156 HE	No

	assessment or re-assessment								
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	N/A	N/A	96158 AH	96158 HL AH	96158 AJ	96158 UD	96158 HE	No
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	N/A	N/A	96159 AH	96159 HL AH	96159 AJ	96159 UD	96159 HE	No
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	N/A	N/A	96164 AH	96164 HL AH	96164 AJ	96164 UD	96164 HE	No
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	N/A	N/A	96165 AH	96165 HL AH	96165 AJ	96165 UD	96165 HE	No
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	N/A	N/A	96167 AH	96167 HL AH	96167 AJ	96167 UD	96167 HE	No
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	N/A	N/A	96168 AH	96168 HL AH	96168 AJ	96168 UD	96168 HE	No

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13.14 BEHAVIORAL HEALTH SERVICES IN A SCHOOL SETTING

MHD reimburses for behavioral health services provided in a school setting, and billing procedures vary depending on whether or not services are part of an Individualized Education Program (IEP). Behavioral health services not included in an IEP for a child who is MHD eligible, may be billed by an MHD enrolled provider or by the school district. Providers must use place of service code 03 for all behavioral health services provided in a school setting, including services provided in a school-based health center.

School districts cannot bill for non-IEP services under the same national provider identifier (NPI) and taxonomy as IEP services. In order to bill for non-IEP services, school districts must obtain either a new NPI or a new taxonomy for their current NPI. Once the school district obtains the new NPI or taxonomy, it must complete a web-based enrollment application at https://peu.momed.com/peu/momed/presentation/commongui/PeHome.jsp.

The following guidelines apply to non-IEP behavioral health services provided in school:

- School districts are encouraged to establish a formal agreement with any provider who will provide services on school property. The school district has discretion over which providers are allowed to provide services on school property.
- Providers must be enrolled as MHD fee-for-service program providers or with a particular Managed Health Care Plan depending on the child's MHD coverage.
- MHD Managed Care Health Plans are responsible for all MHD covered services provided within schools that are not part of an IEP under the IDEA. This includes services provided at a school-based health clinic.
- All behavioral health services provided by a MHD and/or MCO enrolled provider, to an otherwise eligible child with the intent to bill MHD, require parental/legal guardian consent, except in those cases referenced in RSMo 431.061 & RSMo 431.056.
- Providers must contact the child's respective MHD Managed Care health plan to obtain coverage guidelines and limitations for children whose services are covered through the Managed Care Program.
- Each child must have a treatment plan and the plan must specify how a parent/legal guardian will be engaged in the behavioral health services provided to the child.
- School personnel designated by the district must approve and coordinate time and place for services within the school.
- Non-IEP services are not billed with the TM modifier. Services must be billed with the modifier corresponding to the performing provider (see section 13.13.C). For services provided by school psychologists, modifier AH must be used.

13.14.A SCHOOL-BASED IEP DIRECT SERVICES

MO HealthNet Behavioral Health services are included in the school based services program for public and charter schools. The program allows the school district to receive

the federal match portion of the funds allocated for certain medical services. Only the services identified in the -IEP- and up to the amount and duration identified in the IEP are reimbursable. All Behavioral Health services guidelines and limitations, including precertification requirements and daily, monthly, and annual limits, apply to school based services.

School based Behavioral Health services are medically necessary behavioral health services that consist of diagnostic assessment, psychological testing, individual therapy, family therapy, and group therapy.

To participate in the MO HealthNet school-based Behavioral Health Services Program, the billing provider of the services must be a Department of Elementary and Secondary Education recognized public or charter school district in the State of Missouri. The school district is considered the billing provider and all services included in the school based Behavioral Health Services Program must be billed by the school district. School districts must contract with a Behavioral Health Services provider enrolled with MO HealthNet to provide behavioral health services. The arrangements made by the school district with the behavioral health service providers are between the school district and the provider. The Behavioral Health Services provider delivering the school based behavioral health service is considered the performing provider and can only be shown as the performing provider on the school district's claim submitted to MO HealthNet for reimbursement of school based services. An individually enrolled MO HealthNet Behavioral Health Services program provider cannot bill directly for MO HealthNet school based behavioral health services.

The child receiving school based Behavioral Health services must be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made. The child must be under the age of 21 years. All services rendered to a child must be billed under the child's individual MO HealthNet identification number.

Services provided as documented in an IEP are reimbursed at the Federal Financial Participation Rate (FFP). The remainder of the allowed amount is the responsibility of the school district originating the IEP. The MO HealthNet maximum allowable fee for each code can be found on the Internet at http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm.

The school district must bill the actual cost of providing the service.

The school district and the Behavioral Health Services provider must maintain a copy of the official public school generated IEP and the treatment plan in the child's record to document the service as an IEP service.

Children enrolled in a MO HealthNet managed care health plan receive school based Behavioral Health services that are identified in an IEP on a fee-for-service basis outside of the MO HealthNet managed care benefit package.

13.14.B PROVIDER ENROLLMENT – SCHOOL-BASED SERVICES

Each school district interested in billing MO HealthNet for school based services must enroll as a MO HealthNet provider. Each individual performing provider that provides Behavioral Health services for a school district MUST also enroll with MO HealthNet. For all enrollment information, go to http://peu.momed.com/momed/presentation/commongui/PeHome.jsp.

School districts currently enrolled for therapy services who wish to expand to include other school based services must contact Provider Enrollment to request each service be added to the provider file. This request can be e-mailed to MMAC.providerenrollment@dss.mo.gov or mailed to Missouri Medicaid Audit and Compliance, Attn: Provider Enrollment, PO Box 6500, Jefferson City, MO 65102, or faxed to 573-526-2054.

If the school district is not actively enrolled with MO HealthNet to provide school based therapy services, a provider application must be completed online at the MHD website, www.dss.mo.gov/mhd, for any or all of the expanded services. Enrollment applications are not available on paper.

Information provided on the enrollment application must agree with the information on file with the Department of Elementary and Secondary Education.

The following providers are eligible to perform school-based IEP behavioral health direct services:

- Licensed clinical social workers (LCSW), licensed master social workers (LMSW)
- Licensed professional counselors (LPC), provisionally licensed professional counselors(PLPC)
- Licensed marital and family therapists, and provisional licensed marital and family therapists
- Licensed psychologists, provisionally licensed psychologists (PLP)
- NCSP credentialed school psychologists
- Psychiatric clinical nurse specialists (PCNS)
- Psychiatric Mental health nurse practitioners (PMHNP)
- Psychiatrists

13.14.C TREATMENT PLAN – SCHOOL-BASED IEP DIRECT SERVICES

A provider-signed treatment plan must be maintained at the facility where services are performed and must be made available for audit purposes at any time. The MO HealthNet Division does not require a standardized treatment plan format.

Services must be provided as indicated in the IEP and treatment plan. A child's treatment plan must be evaluated at regular intervals.

The treatment plan must specify:

- the diagnosis;
- the desired outcome;
- the nature of the treatment;
- the frequency of treatment (number of minutes per day/per week/per month); and
- The duration (weeks or months) of services.

The child or his/her family may not be charged for development of the treatment plan. MO HealthNet does not reimburse the school district or the Behavioral Health Services provider to participate in IEP meetings or when developing a treatment plan for a child.

The child's treatment record must also include all components, including adequate documentation as required in 13 CSR 70-98.

13.14.D PROCEDURE CODES FOR SCHOOL-BASED IEP DIRECT SERVICES

The following procedure code/modifier combinations are the allowable codes for the school based services program and must be utilized within the provider's scope of practice and in accordance with applicable licensure standards. See also Section 13.23 of this manual regarding use of modifiers.

Service	Psychiatrist, PCNS, PMHNP	Psychologist, PLP	LCSW, LMSW	LPC, PLPC	LMFT, PLMFT
Psychiatric Diagnostic Evaluation	90791 TM	90791 TM AH	90791 TM AJ	90791UD TM	90791 TM HE
Psychiatric Diagnostic Evaluation with Medical Services	90792 TM	N/A	N/A	N/A	N/A
Psychotherapy, 30 min	90832 TM	90832 TM AH	90832 TM AJ	90832 UD TM	90832 TM HE
Psychotherapy, 45 min	90834 TM	90834 TM AH	90834 TM AJ	90834 UD TM	90834 TM HE
Family Psychotherapy without Patient	90846 TM	90846 TM AH	90846 TM AJ	90846 UD TM	90846 TM HE
Family Psychotherapy with Patient	90847 TM	90847 TM AH	90847 TM AJ	90847 UD TM	90847 TM HE
Group Psychotherapy	90853 TM	90853 TM AH	90853 TM AJ	90853 UD TM	90853 TM HE
Psychotherapy for Crisis, 60 minutes	90839 TM	90839 TM AH	90839 TM AJ	90839 UD TM	90839 TM HE

Psych testing evaluation service, first hour	* 96130 TM	96130 TM AH	N/A	N/A	N/A
Psych testing evaluation service, each additional hour	*96131 TM	96131 TM AH	N/A	N/A	N/A
Test admin and scoring by professional, first 30 min	*96136 TM	96136 TM AH	N/A	N/A	N/A
Test admin and scoring by professional, each additional 30 min	*96137 TM	96137 TM AH	N/A	N/A	N/A
Single automated test with automated result	* 96146 TM	96146 TM AH	N/A	N/A	N/A
Assessment of aphasia	* 96105 TM	96105 TM AH	N/A	N/A	N/A
Developmental testing, first hour	* 96112 TM	96112 TM AH	N/A	N/A	N/A
Developmental testing, each additional 30 min	*96113 TM	96113 TM AH	N/A	N/A	N/A
Neurobehavior status exam, first hour	* 96116 TM	96116 TM AH	N/A	N/A	N/A
Neurobehavior status exam, each additional hour	*96121	96121 TM AH	N/A	N/A	N/A

* These procedure codes cannot be billed by PCNS or PMHNP.

13.15 TIME-BASED SERVICE LIMITATIONS

The provider *must* choose the code that most accurately describes the service provided.

Psychotherapy times, as defined in the CPT®, are for face-to-face services with patient and/or family member. The patient must be present for all or a majority of the service. In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832, 38-52 minutes for 90834, 53 or more minutes for 90837). Do not report psychotherapy of less than 16 minutes duration.

The CPT® definition of diagnostic assessment (90791, 90792) and group therapy (90853) is *not* time limited. MHD defines a unit of service as 30 minutes for these procedure codes. In order to be reimbursed by MHD, the services *must* be provided in full 30-minute units.

Crisis Intervention (90839) is defined in the CPT® as a one hour service.
Travel time is *not* reimbursed and *must not* be included as part of the scheduled appointment time.

13.16 NATIONAL CORRECT CODING INITIATIVE

MHD incorporates the Medicaid National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits in its claims processing system. Providers can find the current NCCI PTP edits online at: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html

13.17 POSTPAYMENT REVIEW

All services reimbursed through the MHD Behavioral Health Services Program are subject to post payment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in recoupment according to State Regulation 13 CSR 70-3.030(5) and the provider may be subjected to prepayment review on all MHD claims. Continued non-compliance may result in termination of the provider enrollment agreement.

13.18 PREPAYMENT REVIEW PROCESS

Services that are on prepayment review *must* be billed on a paper claim form (CMS-1500 or the approved claim form at the time of submission). The required documentation must be attached. For Behavioral Health Services procedure codes, the current Diagnostic Assessment, Treatment Plan, and Progress Note must be attached to the claim form for review to determine if the services were medically necessary and billed correctly. For the required elements of a Diagnostic Assessment, Treatment Plan, and Progress Note, please refer to Section 13.4.

13.19 APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

In order to be eligible for ABA services, participants must be under 21 and have a diagnostic evaluation performed by a licensed physician or licensed psychologist, resulting in a diagnosis of Autism Spectrum Disorder (ASD), and recommending ABA services as medically necessary. The diagnostic evaluation should be performed in accordance with *Autism Spectrum Disorders: Missouri Best Practice Guidelines for Screening, Diagnosis, and Assessment,* published by the Missouri Autism Guidelines Initiative. These guidelines can be found at: http://autismguidelines.dmh.mo.gov/pdf/Guidelines.pdf.

Participants enrolled in an MHD managed care health plan will receive ABA services on a fee-for service basis, outside of the MHD managed care benefit package.

13.19.A ABA ELIGIBLE PROVIDERS

The following providers are eligible to provide ABA services:

- Licensed psychologists with education and experience in ABA
- Licensed behavior analysts
- Licensed assistant behavior analysts
- Registered behavior technicians™

Provisional licensed providers are not eligible to enroll. MHD will reimburse psychologists for ABA services only if they have been approved for the ABA specialty. MHD enrolled psychologists who have ABA in their scope of education, training, and competence may submit documentation of their credentials for consideration.
This documentation may be submitted as a provider update via fax to the Provider Enrollment Unit at 573-634-3105. Include the provider's National Provider Identifier (NPI), the name of a contact person, an email address, and a phone number with the required documentation. If not already enrolled, psychologists may submit supporting documentation and request approval for the ABA specialty at the time of enrollment. Psychologists will be notified by email whether they have been approved for the ABA specialty.

Technicians who provide direct implementation of ABA services under the supervision of a licensed provider must be credentialed by the Behavior Analyst Certification Board as a Registered Behavior Technician™ (RBT). The supervisory relationship must be documented in writing, and the licensed supervisor is responsible for the work performed by the RBT. Services provided by an RBT must be billed by the licensed supervisor using the codes and modifiers specified in section 13.19.B. RBTs are not allowed to enroll as MHD providers.

13.19.B ABA PROCEDURE CODES BY PROVIDER SPECIALTY

The following table includes procedure codes and modifiers billable by behavior analysts, assistant behavior analysts, and ABA qualified psychologists when provided directly by the licensed provider. The table also includes procedure codes and modifiers billable by behavior analysts, assistant behavior analysts, and ABA qualified psychologists for services provided by registered behavior technicians™ (RBT). The HM modifier must be used to indicate services provided by RBT. In addition, the licensed supervisor must use the appropriate modifier for his or her specialty (e.g., HO for Behavior Analyst or Psychologist; HN for Assistant Behavior Analyst). Psychologists should not use the AH modifier with these codes.

Services may be provided in Place of Service 11 (office), 12 (home) or 99 (other). The U8 modifier should be used for services billed with a Place of Service 12 (home) or 99 (other). Psychologists should not use the AH modifier with these codes.

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CPT® Code	CPT® Code Description	CPT® Code & Modifier by Provider Specialty			Precert Required
		Behavior Analyst/ABA Qualified Psychologist	Assistant Behavior Analyst	Behavior Analyst, Assistant Behavior Analyst, And ABA Qualified Psychologist for Registered Behavior Technician™ (RBT) Services	
97151	Behavior identification assessment, each 15 min	97151 HO	N/A	N/A	Yes
97152	Behavior identification – supporting assessment, each 15 min	97152 HO	97152 HN	97152 HM and (HO or HN)	Yes
0362T	Behavior identification – supporting assessment admin by professional with two or more techs, each 15 min	0362T HO	N/A	N/A	Yes
97153	Adaptive behavior treatment by protocol administered by technician, each 15 min	97153 HO	97153 HN	97153 HM and (HO or HN)	Yes
97155	Adaptive behavior treatment with protocol modification administered by physician or other qualified healthcare professional, each 15 min	97155 HO	97155 HN	N/A	Yes
97156	Family adaptive behavior treatment guidance, each 15 min	97156 HO	97156 HN	N/A	Yes
97158	Group adaptive behavior treatment with protocol modification, each 15 min	97158 HO	97158 HN	N/A	Yes
0373T	Adaptive behavior treatment with protocol modification admin by professional with two or more techs, each 15 min	0373T HO	N/A	N/A	Yes

13.19.C PRECERTIFICATION OF ABA SERVICES

All ABA services require precertification. When requesting precertification of ABA services, fax the completed Request for Applied Behavior Analysis (ABA) Precertification form and required documentation to the Behavioral Health Help Desk at (573) 635-6516. This form is available at http://manuals.momed.com/manuals/presentation/forms.jsp. The following table lists the additional documentation required according to the service for which precertification is being requested.

PRECERTIFICATION BEING REQUESTED:	REQUIRED DOCUMENTATION:
ABA Assessment for Intervention Planning	Diagnostic Evaluation
ABA Intervention (initial)	Assessment for Intervention Planning, Intervention Plan
ABA Intervention (continued)	Current Intervention Plan, Progress, Data/Graphs

ABA intervention may be precertified for a period of up to six months from the start date. If continued services are needed beyond the six month period, additional precertification is required. Providers will receive a faxed response indicating the number of hours allowed, as well as precertification start and end dates.

13.19.D DOCUMENTATION REQUIREMENTS

All services provided *must* be adequately documented in the medical record. The obligation to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is required by the following documents:

- Missouri regulation (13 CSR 70-3.030).
- The Title XIX Provider Participation Agreement, which is signed by all providers upon enrollment as a MO HealthNet provider.

The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) defines “adequate documentation” and “adequate medical records” as follows:

- Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.
- Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, 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.

13.20 EPSDT/HCY SERVICES

Behavioral health services are covered when the need for treatment is a result of a complete, partial, or interperiodic Healthy Children and Youth (HCY) screening and the service is medically necessary. See Section 9 of this provider manual for additional information on Healthy Children and Youth (HCY) Screening services.

13.20.A PARTIAL EPSDT/HCY SCREENS

Partial EPSDT/HCY screens for Developmental Mental Health Assessment may be performed by a Psychiatrist, PCNS, PMHNP, Psychologist, PLP, LCSW, LMSW, LPC, PLPC, LMFT, or PLMFT. Other providers who may perform Developmental Mental Health Assessments are listed in Section 9.

A Developmental Mental Health Assessment includes:

Assessment of personal, social and language development.

Assessment of fine and gross motor skill development.

Assessment of emotional and psychological status.

Age appropriate guides can be found in the HCY Screening Guide included in Section 9.

The diagnosis code of "Z00110, Z00111, Z00121 or Z00129" *must* appear as the primary diagnosis in Field #23A on the CMS-1500 claim form when billing for HCY developmental screening service.

Developmental partial screens (99429 59 and 99429 59 UC) are covered for children under the age of 21 in the HCY Behavioral Health Services program. It is the provider's responsibility to encourage the child/youth to have an HCY examination to facilitate total health care that establishes the need for the treatment services.

13.20.A(1) EPSDT/HCY Partial Screen for Developmental Assessment

PROC CODE	DESCRIPTION
99429 59	Developmental/mental health partial screen
99429 59 UC	Developmental/mental health partial screen with referral

13.20.A(2) Partial Screeners

The provider of a partial medical screen should have a patient referral source for the remaining required components of the screen. Examples of partial screeners may include but are *not* limited to:

- Public Health Departments
- Early Childhood Programs
- School Districts

13.21 NONCOVERED SERVICES

Services that are performed to treat individuals over 21 associated with an EPSDT/HCY child are *not* covered. If it is determined that the parent/guardian or other individual is in need of service, the appropriate referral should be made.

The following services are *not* covered under the Behavioral Health Services Program such as but not limited to:

- Biofeedback therapy
- Auditory Therapy

Non-covered services may be billed to the patient.

13.21.A NON-ALLOWED SERVICES

The following services are non-allowed under the Behavioral Health Services Program and may *not* be billed to a Medicaid patient:

- Courtesy calls such as patient drop in visits to give a progress report that was *not* scheduled, and no therapy services were rendered
- Missed appointments or failure to show
- Additional payment is *not* made for services that are performed after regularly scheduled office hours, on holidays, or on weekends
- Participation in Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) meeting
- Telephone calls
- Court appearances
- Mental health services that are performed to treat the parent of an MHD eligible child who is *not* in MC+ are *not* covered on a fee-for-service basis. If it is determined that the parent/guardian is in need of mental health services, the appropriate referral *must* be made.
- Testing when performed by a PCNS, PMHNP, LCSW, LMSW, LPC, PLPC, LMFT, or PLMFT.
- Telephone consultations
- Add-on therapy and interactive codes (90833, 908336, 90785, 90840)
- Add-on psychotherapy code for E&M service (90838)
- Services that require precertification, but were performed without a precertification

- Travel time is *not* reimbursed and *must not* be included as part of the scheduled appointment time.

13.21.B BEHAVIORAL HEALTH SERVICES IN A NURSING HOME

MHD does *not* cover behavioral health services provided by a psychologist, Psychology Intern, LCSW, LMSW, LPC, PLPC, LMFT, or PLMFT to nursing facility residents when those services are provided in the nursing home setting. This is the policy regardless of any arrangement a provider 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 facility itself, there is no MHD coverage afforded a patient. Any costs incurred by a facility for the provision of these services are *not* allowable costs on the nursing facility's MHD cost report.

MHD does allow a psychiatric diagnostic evaluation (procedure codes 90791 and 90792) for participants in a skilled nursing facility (nursing home) when performed by a psychiatrist, PCNS, or PMHNP. The psychiatric diagnostic evaluation includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

Please see Sections 13.10.A and 13.4.A(1) for more information about psychiatric diagnostic evaluation, including specific documentation requirements.

13.22 TELEHEALTH SERVICES

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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.

Please refer to Section 8.9 of the Behavioral Health Services manual for out-of-state, non-emergency services.

13.22.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.

13.22.B ELIGIBLE PROVIDERS

Any licensed health care provider may 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 via telehealth must be fully licensed to practice in this state and be enrolled as a MO HealthNet provider prior to rendering services.

13.22.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.

13.22.D PRECERTIFICATION AND UTILIZATION REVIEW

All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made.

Certain procedures or services can require precertification from the MO HealthNet Division or its authorized agents. Services for which a precertification was obtained remain subject to utilization review at any point in the payment process. A service provided through Telehealth is subject to the same precertification and utilization review requirements which exist for the service when not provided through Telehealth.

13.22.E 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 70-3.020 and 13 CSR 70-98.015.

13.23 MODIFIERS

Claims *must* be submitted using the appropriate modifier(s).

The specialty modifier is always required.

- AH – Psychologist (Do not use AH modifier with ABA codes), PLP
- AJ – Licensed Clinical Social Worker, Licensed Master Social Worker
- HL AH – Psychology Intern
- UD – Licensed Professional Counselor, PLPC
- HE – Licensed Marital and Family Therapist, PLMFT

The following modifiers are required when appropriate:

- U8 – in home (12). The U8 modifier is *not* appropriate when billing 90853, regardless of POS.
- CR – Catastrophe/Disaster Related. The CR modifier is used to track services provided to patients identified as a catastrophe/disaster victims in any part of the country. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with the use of this modifier.
- TM – used when billing School Based Behavioral Health services (see Section 13.14)
- The appropriate NCCI modifier should be used when appropriate. (see Section 13.16)

13.24 FREQUENTLY USED PLACE OF SERVICE CODES

02 – Telehealth

03 – Public School

04 – Homeless Shelter

11 – Office

12 – Home

14 – Group Home

21 – Inpatient Hospital

22 – Outpatient Hospital

33 – Custodial Care Facility

50 – FQHC

51 – Inpatient Psychiatric Facility

55 – Residential Substance Use Disorder Treatment Facility

56 – Psychiatric Residential Treatment Facility

61 – Comprehensive Inpatient Rehabilitation Facility

72 – Rural Health Clinic

99 – Other Place of Service (Other place of service not identified above)

13.24.A PLACE OF SERVICE CODE

Services provided in a public school setting must be billed with place of service 03.

Place of service 99 *cannot* be used for therapy provided in a public setting. A public setting includes but is *not* limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers *must* use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may *not* be billed to MHD. Although there is a place of service 15 for mobile unit, MHD does *not* cover services provided in this setting.

Place of service 11 (office) may be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) have defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

Services provided to children who reside in a Residential Treatment Center and who are under the care and custody of the Children's Division *must* use place of service code 33 when the services are provided at the Residential Treatment Center.

Group therapy services are *not* covered in place of service "12", home.

When providing therapy to a group of children in a group home, group therapy (90853) is billed with a place of service group home (POS 14) (Documentation *must* show the reason for providing services in the home.).

13.25 REFERRAL SERVICES

Services for parent(s)/guardian(s) and/or the family unit that are medically necessary but beyond the scope of the HCY Behavioral Health Services Program may be obtained through the adult Behavioral Health Services Program or by a referral to other programs. Medically necessary Behavioral Health services are also available through the Department of Mental Health's Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation (CPR) Program, or in an FQHC/RHC setting; however, these services are available under specific guidelines.

MHD provides for Behavioral Health services to patients without regard to age when medically necessary. These services are covered only when performed by a Psychiatrist, PCNS, PMHNP, Psychologist, or PLP.

13.26 THIRD PARTY LIABILITY (TPL)

When a MHD patient has a third party resource (TPR) that may be liable for the payment of all or a portion of the service, it *must* be submitted to the insurance company before MHD considers the claim for payment. See Section 5 of this provider manual for further instructions on how to submit claims affected by a TPR.

Federal regulation 42 CFR 447.20 states the following: "A provider may *not* refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s)."

13.26.A TPL BYPASS

Certain services are eligible to bypass Third Party Liability (TPL) editing in the MHD payment system. Those claims involve preventative pediatric services (including EPSDT services), prenatal care, and those that the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division. Federal regulation, 42 CFR 433.139 (B)(3)(i)(ii) requires the state Medicaid agency to pay and chase these claims when the provider elects *not* to pursue the third party resource for payment.

If the claim falls into one of the above categories and the provider elects *not* to bill the third party resource, the Third Party Liability Unit pursues reimbursement of the MHD payment for this service directly from the TPR. The provider *must* indicate on the claim form whether or not the TPR has been billed.

When this option is exercised, the provider's payment is limited to the MHD payment amount. If a TPR payment is received after MHD has been billed for the service, the payment *must* be forwarded to the MHD agency to be distributed as specified by federal regulation.

13.26.B TPL LIABILITY INSURANCE REPORTING FORM

Many providers have requested the capability to report changes in insurance coverage directly to MHD when they learn of them from the patient or the insurance company. In the past, changes were to be reported to the patient's caseworker. A form has been developed for the provider to report changes or additions to a patient's insurance records.

Please refer to Section 5 of this manual for additional information regarding submission of this form.

13.27 MANAGED CARE BEHAVIORAL HEALTH SERVICES

MHD managed care health plans provide behavioral health services for adults, children, and youth, except for those children and youth in state care and custody (Group 4). Children in Group 4 receive behavioral health services on a fee-for-service basis outside of the health plan. ABA services for children and youth (under age 21) with ASD are also provided to managed care members on a fee-for-service basis outside of the health plan. Refer to Section 1 and Section 11 for further information.

13.28 REPORTING CHILD ABUSE CASES

State Statute at 210.115 RSMo (Cum. Supp. 1992) requires hospitals and other specified personnel to report possible child abuse cases to the Family Support Division Child Abuse Hotline. Children's Division Child Abuse and Neglect Hotline Unit (CA/NHU) accepts

confidential reports of suspected child abuse, neglect, or exploitation. Reports are received through a toll-free telephone line which is answered 7 days a week, 24 hours a day. Members of certain occupational groups, such as teachers, social workers, and physicians, are mandated by law to make reports to the hotline. Any person may report, and anonymous reports are accepted from individuals who are *not* mandated by occupation to report. Effective August 28, 2004, Missouri law requires Mandated Reporters to identify themselves when making a report.

The toll-free number is (800) 392-3738.

Persons calling from outside Missouri should dial (573) 751- 3448.

Text telephone number: (800) 669-8689.

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SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS

See Section 13 for special documentation requirements. 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.

END OF SECTION

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SECTION 15—BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. 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 5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12 Version 5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference www.dss.mo.gov/mhd/ for further information. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, Version 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

15.3 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for all behavioral health services, unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit electronically or on a CMS-1500 claim form. An example of a correctable error is the use of an invalid procedure code.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, if the claim shows an incorrect number of units for a procedure and the claim pays, that claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS

When a patient has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payer. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, an electronic claim *must* be submitted to MO HealthNet along with the Medicare Remittance Advice attached indicating the denial. Reference Section 16.5 of this manual for instructions for submission of claims to MO HealthNet.

If a claim was submitted to Medicare indicating that the patient also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), an electronic crossover claim *must* be submitted to MO HealthNet. Reference Section 16 for billing instructions.

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 the field number 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 the 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, e.g., 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 participant has both Medicare and MO HealthNet, check both boxes.
*1a.	Insured's I.D.	Enter the patient's 8-digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the participant'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	Enter month, day and year of birth.
Sex		Mark appropriate box.
**4.	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of 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. If no private insurance is involved, leave blank.
**7.	Insured's Address	Enter the primary policy holder's address; enter policy holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.

**9.	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
**9a.	Other Insured's 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. If no private insurance is involved, leave blank. (See Note)(1)
**9b.	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. If no private insurance is involved, leave blank. (See Note)(1)
**9c.	Employer's Name	Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
**9d.	Insurance Plan Name or Program Name	Enter the secondary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. If no private insurance is involved, leave blank. (See Note)(1)
**10a-10c.	Is Patient's Condition Related to:	If services on the claim are related to participant's employment, auto accident or other accident, mark the appropriate box. If the services are *not* related to an accident, leave blank. (See Note)(1)
10d.	Reserved for local use.	May be used for comments/descriptions. (See Note)(1)
**11.	Insured's Policy or FECA Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group such as, an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
**11a.	Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policy holder.

		If no private insurance is involved, leave blank. (See Note)(1)
**11b.	Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
**11c.	Insurance Plan Name	Enter the primary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
**11d.	Other Health Plan	Indicate whether the participant has another health insurance plan; if so, complete Fields #9-#9d with the secondary insurance information. If no private insurance is involved, leave blank. (See Note)(1)
12.	Patient's Signature	Leave blank.
13.	Insured's Signature	This field should only be completed when the participant 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 or MO HealthNet. Otherwise payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.	Date of Current Illness, Injury or Pregnancy	Leave blank.
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
*17.	Name of Referring Physician or Other Source	Enter the name of the referring MO HealthNet enrolled primary care provider.
*17a.	Other ID	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in 17b is required to

		report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in 17b.
*17b.	NPI	Enter the NPI number of the referring or ordering provider.
**18.	Hospitalization Dates	Leave Blank.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.	Lab Work Performed Outside Office	Leave blank.
*21.	Diagnosis	Enter the complete ICD, current edition, diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22.	Medicaid Resubmission	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 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. Multiple dates of service *cannot* be billed on a single line of the claim form. Each date of service *must* be shown on a separate line of the claim form with no more than six (6) lines per claim form.
*24b.	Place of Service	Enter the appropriate place of service code in the unshaded area of the claim. See Section 15.8 for the list of appropriate place of service codes. Reference Section 13.30 for Program Specific Place of Service Codes.
24c.	EMG - Emergency	Leave blank.
*24d.	Procedure Code	Enter the appropriate procedure code and applicable modifiers, if any, corresponding to the service rendered in the unshaded area of this field.

*24e.	Diagnosis Code or Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21 in the unshaded area of this field.
*24f.	Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of this field. This should be the total charge when there are multiple units entered for a line item.
*24g.	Days or Units	Enter the number of units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1," if the field is left blank.
24h.	EPSDT/HCY/Family Planning	If this service is an EPSDT/HCY screening or referral, enter an "E" in the unshaded area of this field.
**24i.	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded are if the rendering/performing provider is required to report a Provider Taxonomy Code to MO HealthNet.
**24j.	Rendering Provider ID #	If the provider Taxonomy qualifier was reported in 24i, enter the 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering/performing the service in the unshaded area. This field is only required if the billing provider is a clinic, FQHC, teaching institution, or a group practice.
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be listed here.
27.	Assignment	Not required on MO HealthNet only claims.
*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.	Balance Due	Enter the difference between the total charge (Field #28) and the amount paid (Field #29).
31.	Provider Signature	Not required.
**32.	Name and Address of Service Facility	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 if other than home or*

		office.
**32a	NPI Number	Enter the 10-digit NPI number of the service facility location in field 32.
**32b	Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. A Provider Taxonomy Code must be reported if the provider has a one to many provider NPI.
*33.	Billing Provider Info & Phone #	Enter the provider's name, address, and phone number.
*33a	NPI Number	Enter the NPI number of the Billing Provider listed in field 33.
**33b	Other ID#	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. A provider taxonomy code must be reported if the provider has a one to many provider NPI.

* These fields are mandatory on *all* CMS-1500 claim forms.
** These fields are mandatory only in specific situations, as described.
(1) NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

15.8 PLACE OF SERVICE CODES AND DEFINITIONS

CODE		DEFINITION
03	School	A facility whose primary purpose is education (e.g., public school).
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency

		shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do *not* require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians or Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. Services performed in a Head Start facility may use this place of service.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	Congregate residential facility care setting for children and

		adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
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, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room-Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing 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, which provides a setting for labor, delivery, and immediate post-partum 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 Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32	Nursing Facility	A facility which 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 which provides room, board and other personal assistance services, generally on a long-term basis, and which 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 are provided.
46	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 Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
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 and 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 to a hospital-0 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 which 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 SNF.
55	Residential Substance Abuse Treatment Facility	A facility which 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 which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
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 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, which 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 a State or local health department that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which 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 (e.g., private school).

15.9 INSURANCE TPL CODES

Type of insurance TPL 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 Divisions' participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 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 ELIGIBILITY DATES. Reference Section 5 of this manual, Third Party Liability.

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SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS

16.1 GENERAL INFORMATION

This section includes general information about the Medicare and MO HealthNet Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and MO HealthNet are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

  Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.
- MO HealthNet is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. MO HealthNet is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Mo HealthNet benefits by completing an application form at a Family Support Division (FSD) office.

  In Missouri, MO HealthNet claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the MO HealthNet Division within the Department of Social Services, which is the single state agency for the administration of the MO HealthNet Program.
- For participants having both Medicare and MO HealthNet eligibility, the MO HealthNet Program pays the cost-sharing amounts indicated by Medicare due on the Medicare allowed amount. These payments are referred to as “Crossovers."
- “Cost-sharing” amounts include the participant’s co-insurance, deductible, and any co-pays that are due for any Medicare-covered service.

16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS)

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first. After making payment, the Medicare contractor forwards the claim information to MO HealthNet for payment of cost-sharing amounts. (Reference Section 16.3 for instructions to bill MO HealthNet when Medicare denies a service.)

The MO HealthNet payment of the cost-sharing appears on the provider's MO HealthNet Remittance Advice (RA).

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The Medicare contractor does *not* send crossovers to MO HealthNet
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for MO HealthNet.
- The MO HealthNet participant information on the crossover claim does *not* match the fiscal agent's participant file.
- The provider's National Provider Identifier (NPI) number is *not* on file in the MO HealthNet Division's provider files.

MO HealthNet no longer accepts paper crossover claims. Medicare/MO HealthNet (crossover) claims that do not cross automatically from Medicare to MO HealthNet must be filed through the MO HealthNet billing web portal at www.emomed.com or through the 837 electronic claims transaction. Before filing an electronic crossover claim, providers should wait 30 days from the date of Medicare payment to avoid duplication. The following tips are provided to make filing a claim at the MO HealthNet billing web portal successful:

1) Through the MO HealthNet billing web portal at www.emomed.com, choose the claim form that corresponds with the claim form used to bill Medicare. Enter all appropriate information from that form.

2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.

3) There must be an "Other Payer" header form completed for every crossover claim type. This provides information that pertains to the whole claim.

4) Part A crossover claims need only the "Other Payer" header form completed and not the "Other Payer" detail form.

5) Part B and B of A crossover claims need the "Other Payer" header form completed. An "Other Payer" detail form is required for each claim line detail with the group code, reason code and adjustment amount information.

6) Choose the appropriate codes that can be entered in the "Group Code" field on the "Other Payer" header and detail forms from the dropdown box. For example, the "PR" code (Patient Responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare EOMB.

7) The codes to enter in the "Reason Code" field on the "Other Payer" header and detail forms are also found on the Medicare EOMB. If not listed there, choose the most appropriate code from the list of "Claim Adjustment Reason Codes". These HIPAA mandated codes can be found at www.wpc-edi.com/codes. For example, on the "Claim Adjustment Reason Codes" list the code for "deductible amount" is 1 and for "coinsurance amount" it is 2. Therefore, choose a "Reason Code" of "1" for deductible amounts due and a "Reason Code" of "2" for coinsurance amounts due.

8) The "Adjust Amount" should reflect any amount not paid by Medicare including any cost-sharing amounts and any non-allowed amounts.

9) If there is a commercial insurance payment or denial to report on the crossover claim, complete an additional "Other Payer" header form. Complete an additional "Other Payer" detail form(s) as appropriate.

Note: For further assistance on how to bill crossover claims, please contact Provider Education at (573) 751-6683.

16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE

Not all services covered under the MO HealthNet Program are covered by Medicare. (Examples are: eyeglasses, most dental services, hearing aids, adult day health care, personal care or most eye exams performed by an optometrist.) In addition, some benefits that are provided under Medicare coverage may be subject to certain limitations. The provider will receive a Medicare Remittance Advice that indicates if a service has been denied by Medicare. The provider may submit a Medicare denied claim to MO HealthNet electronically using the proper claim form for consideration of reimbursement through the 837 electronic claims transaction or through the MO HealthNet web portal at www.emomed.com. If the 837 electronic claims transaction is used, providers should refer to the implementation guide for assistance. The following are tips to assist in successfully filing Medicare denied claims through the MO HealthNet web portal at www.emomed.com:

1) To bill through the MO HealthNet web portal, providers should select the appropriate claim type (CMS 1500, UB-04, Nursing Home, etc.) Do *not* select the Medicare crossover claim form. Complete all pertinent data for the MO HealthNet claim.

2) Some fields are required for Medicare and not for Third Party Liability (TPL). The code entered in the "Filing Indicator" field will determine if the attachment is linked to TPL or Medicare coverage.

16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS

Medicare Advantage/Part C plans do not forward electronic crossover claims to MHD. Therefore, providers must submit Medicare Advantage/Part C crossover claims through the MHD Web portal at www.emomed.com. The following are tips to assist in successfully filing Medicare Advantage/Part C crossover claim through the MO HealthNet web portal at www.emomed.com:

1) Access the MHD web portal at www.emomed.com. Choose the appropriate Part C crossover claim format. Enter all appropriate information from the Medicare Advantage/Part C plan claim. Do not use the Medicare Part A or Part B crossover claim format.

2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.

3) The filing indicator for Medicare Advantage/Part C crossover claims is 16 followed by the appropriate claim type.

4) There must be an "Other Payer" header detail screen completed for every crossover claim format. This provides information that pertains to the whole claim.

5) Medicare Advantage/Part C institutional claims need only the "Other Payer" header detail screen completed and not the "Other Payer" line detail screen.

6) Medicare Advantage/Part C outpatient and professional crossover claims need the "Other Payer" header detail screen completed. An "Other Payer" line detail screen is required to be completed for each claim detail line with group code, reason code and adjustment amount information.

7) The appropriate code from the codes available in the "Group Code" drop down box on the "Other Payer" header and detail screens *must* be selected. For example, the "PR" code (patient responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare Advantage/Part C explanation of benefits.

8) The codes to enter in the "Reason Code" field on the "Other Payer" header and detail screens are found on the Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" that can be accessed at http://www.wpc-edi.com/codes/Codes.asp. For example, enter "Reason Code" of "1" for deductible amounts, "2" for coinsurance amounts and "3" for co-payment amounts.

16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS

For non-QMB MO HealthNet participants enrolled with a Medicare Advantage/Part C Plan, MO HealthNet will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet provider manual at http://manuals/momed.com. In accordance with this policy, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e., CMS-1500, UB-04). ***Do not use a crossover claim***.

16.5 TIMELY FILING

Claims that have been initially filed with Medicare within the Medicare timely filing requirements, and which are submitted as a crossover through an 837 electronic claim transaction or through the MO HealthNet Web portal at www.emomed.com meet the timely filing requirement by being submitted by the provider and received by the MO HealthNet Division within six months of the date of the allowed Medicare RA/EOMB or one (1) year from the date of service. Refer to Section 4 for further instructions on timely filing.

16.6 REIMBURSEMENT

The MO HealthNet Division reimburses the cost-sharing amount as determined by the Medicare contractor and reflected on the Medicare RA/EOMB. MHD prorates the reimbursement amount allowing a prorated amount for each date the individual was MO HealthNet eligible. Days on which the participant was not MO HealthNet eligible are not reimbursed.

16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A and deductible, coinsurance and copayment amounts for Medicare Advantage/Part C crossover claims only when the MO HealthNet applicable payment schedule exceeds the amount paid by Medicare plus calculated pass-through costs. In those situations where MO HealthNet has an obligation to pay a crossover claim, the amount of MO HealthNet's

payment is limited to the lower of the actual crossover amount or the amount the MO HealthNet fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participant to be considered a Medicare/Medicaid crossover claim. For further information, please see 12.4 of the Hospital Program Manual.

16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS

MO HealthNet reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services is seventy-five percent (75%) of the allowable cost sharing amount. The cost sharing amount includes the coinsurance, deductible and/or copayment amounts reflected on the Medicare RA/EOMB from the Medicare carrier or fiscal intermediary. The crossover claims for Medicare Advantage/Part C outpatient hospital services must have been provided to QMB or QMB Plus participant to be reimbursed at seventy-five percent (75%) of the allowable cost sharing amount. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

END OF SECTION

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SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

Crossovers
Inpatient
Outpatient (Includes Rural Health Clinic and Hospice)
Medical
Nursing Home
Home Health
Dental
Drug
Capitation
Credits

Claims in each category are listed alphabetically by participant's last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider's address.
PARTICIPANT NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are *not* on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant's current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11— Paper Drug 13— Inpatient 14— Dental 15— Paper Medical 16— Outpatient 17— Part A Crossover 18— Paper Medicare/MO HealthNet Part B Crossover Claim 21— Nursing Home 40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries. 41— Direct Electronic MO HealthNet Information (DEMI) 43— MTB/DEMI 44— Direct Electronic File Transfer (DEFT) 45— Accelerated Submission and Processing (ASAP) 46— Adjudicated Point of Service (POS) 47— Captured Point of Service (POS)

	49— Internet 50— Individual Adjustment Request 55— Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is *not* present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions PR—Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is *not* printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.
CHECK AMOUNT	The total check amount for the provider.

EARNINGS REPORT	
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
EARNINGS DATA	
NO. OF CLAIMS PROCESSED	The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED	The total dollar amount processed for the provider.
CHECK AMOUNT	The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

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

Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has *not* met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.

17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.

17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

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SECTION 18 - DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code(s) is a required field, and the accuracy of the code that describes the participant's condition is important.

NOTE: The MO HealthNet claims processing system uses ICD, current edition, codes *only.* DSM codes *must not* be used and are *not* recognized by the claims processing system.

The current edition ICD diagnosis code *must* be entered on the claim form.

18.2 EPSDT/HCY SCREENING SERVICES

When billing for EPSDT/HCY Screening services, reference Sections 9 and 13. The diagnosis code of Z00110, Z00111, Z00121 or Z00129 *must* appear as the primary diagnosis code on the CMS-1500 claim form or the UB-04 claim form for RHC's.

18.3 BEHAVIORAL HEALTH SERVICES CODES

For precertification, the diagnosis code *must* be a valid ICD, current edition, diagnosis code and *must* be mental health or substance use disorder related (excluding for HBAI services). This does *not* include developmental disabilities. The following table lists valid codes for the Behavioral Health Services Program:

ICD-10 Code	Description
F070	Personality change due to known physiological condition
F1010	Alcohol abuse, uncomplicated
F10120	Alcohol abuse with intoxication, uncomplicated
F10129	Alcohol abuse with intoxication, unspecified
F1020	Alcohol dependence, uncomplicated
F1110	Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified

F1120	Opioid dependence, uncomplicated
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F1210	Cannabis abuse, uncomplicated
F1220	Cannabis dependence, uncomplicated
F12220	Cannabis dependence with intoxication, uncomplicated
F12221	Cannabis dependence with intoxication delirium
F12222	Cannabis dependence with intoxication with perceptual disturbance
F12229	Cannabis dependence with intoxication, unspecified
F12250	Cannabis dependence with psychotic disorder with delusions
F12251	Cannabis dependence with psychotic disorder with hallucinations
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unspecified cannabis-induced disorder
F1290	Cannabis use, unspecified, uncomplicated
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated

F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F1326	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1327	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated

F1410	Cocaine abuse, uncomplicated
F14120	Cocaine abuse with intoxication, uncomplicated
F1420	Cocaine dependence, uncomplicated
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium
F14222	Cocaine dependence with intoxication with perceptual disturbance
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14280	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated
F1510	Other stimulant abuse, uncomplicated
F15120	Other stimulant abuse with intoxication, uncomplicated
F1520	Other stimulant dependence, uncomplicated
F15220	Other stimulant dependence with intoxication, uncomplicated
F15221	Other stimulant dependence with intoxication delirium
F15222	Other stimulant dependence with intoxication with perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Other stimulant dependence with stimulant-induced mood disorder
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions

F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15280	Other stimulant dependence with stimulant-induced anxiety disorder
F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15282	Other stimulant dependence with stimulant-induced sleep disorder
F15288	Other stimulant dependence with other stimulant-induced disorder
F1529	Other stimulant dependence with unspecified stimulant-induced disorder
F1590	Other stimulant use, unspecified, uncomplicated
F1610	Hallucinogen abuse, uncomplicated
F16120	Hallucinogen abuse with intoxication, uncomplicated
F1620	Hallucinogen dependence, uncomplicated
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16221	Hallucinogen dependence with intoxication with delirium
F16229	Hallucinogen dependence with intoxication, unspecified
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16288	Hallucinogen dependence with other hallucinogen-induced disorder
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F1690	Hallucinogen use, unspecified, uncomplicated
F17200	Nicotine dependence, unspecified, uncomplicated
F17201	Nicotine dependence, unspecified, in remission

F17203	Nicotine dependence unspecified, with withdrawal
F17208	Nicotine dependence, unspecified, with other nicotine-induced disorders
F17209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
F17210	Nicotine dependence, cigarettes, uncomplicated
F17211	Nicotine dependence, cigarettes, in remission
F17213	Nicotine dependence, cigarettes, with withdrawal
F17218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17220	Nicotine dependence, chewing tobacco, uncomplicated
F17221	Nicotine dependence, chewing tobacco, in remission
F17223	Nicotine dependence, chewing tobacco, with withdrawal
F17228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17290	Nicotine dependence, other tobacco product, uncomplicated
F17291	Nicotine dependence, other tobacco product, in remission
F17293	Nicotine dependence, other tobacco product, with withdrawal
F17298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
F1810	Inhalant abuse, uncomplicated
F18120	Inhalant abuse with intoxication, uncomplicated
F1820	Inhalant dependence, uncomplicated
F18220	Inhalant dependence with intoxication, uncomplicated
F18221	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified
F1824	Inhalant dependence with inhalant-induced mood disorder
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F1827	Inhalant dependence with inhalant-induced dementia

F18280	Inhalant dependence with inhalant-induced anxiety disorder
F18288	Inhalant dependence with other inhalant-induced disorder
F1829	Inhalant dependence with unspecified inhalant-induced disorder
F1890	Inhalant use, unspecified, uncomplicated
F1920	Other psychoactive substance dependence, uncomplicated
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication delirium
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F1926	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F1927	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder

F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F309	Manic episode, unspecified

F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
F3111	Bipolar disorder, current episode manic without psychotic features, mild
F3112	Bipolar disorder, current episode manic without psychotic features, moderate
F3113	Bipolar disorder, current episode manic without psychotic features, severe
F312	Bipolar disorder, current episode manic severe with psychotic features
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
F3164	Bipolar disorder, current episode mixed, severe, with psychotic features
F3170	Bipolar disorder, currently in remission, most recent episode unspecified
F3171	Bipolar disorder, in partial remission, most recent episode hypomanic
F3172	Bipolar disorder, in full remission, most recent episode hypomanic
F3173	Bipolar disorder, in partial remission, most recent episode manic
F3174	Bipolar disorder, in full remission, most recent episode manic
F3175	Bipolar disorder, in partial remission, most recent episode depressed
F3176	Bipolar disorder, in full remission, most recent episode depressed
F3177	Bipolar disorder, in partial remission, most recent episode mixed
F3178	Bipolar disorder, in full remission, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild

F321	Major depressive disorder, single episode, moderate
F322	Major depressive disorder, single episode, severe without psychotic features
F323	Major depressive disorder, single episode, severe with psychotic features
F324	Major depressive disorder, single episode, in partial remission
F325	Major depressive disorder, single episode, in full remission
F329	Major depressive disorder, single episode, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F3340	Major depressive disorder, recurrent, in remission, unspecified
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F3481	Disruptive mood dysregulation disorder
F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40210	Arachnophobia
F40218	Other animal type phobia
F40220	Fear of thunderstorms
F40228	Other natural environment type phobia
F40230	Fear of blood
F40231	Fear of injections and transfusions

F40232	Fear of other medical care
F40233	Fear of injury
F40240	Claustrophobia
F40241	Acrophobia
F40242	Fear of bridges
F40243	Fear of flying
F40248	Other situational type phobia
F40290	Androphobia
F40291	Gynephobia
F40298	Other specified phobia
F408	Other phobic anxiety disorders
F410	Panic disorder [episodic paroxysmal anxiety] without agoraphobia
F411	Generalized anxiety disorder
F419	Anxiety disorder, unspecified
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F430	Acute stress reaction
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F4320	Adjustment disorder, unspecified
F4321	Adjustment disorder with depressed mood
F4322	Adjustment disorder with anxiety
F4323	Adjustment disorder with mixed anxiety and depressed mood
F4324	Adjustment disorder with disturbance of conduct
F4325	Adjustment disorder with mixed disturbance of emotions and conduct

F439	Reaction to severe stress, unspecified
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F489	Nonpsychotic mental disorder, unspecified
F5000	Anorexia nervosa, unspecified
F5001	Anorexia nervosa, restricting type
F5002	Anorexia nervosa, binge eating/purging type
F502	Bulimia nervosa
F5081	Binge eating disorder
F5089	Other specified eating disorder
F509	Eating disorder, unspecified

F515	Nightmare disorder
F520	Hypoactive sexual desire disorder
F521	Sexual aversion disorder
F5221	Male erectile disorder
F5222	Female sexual arousal disorder
F5231	Female orgasmic disorder
F5232	Male orgasmic disorder
F524	Premature ejaculation
F525	Vaginismus not due to a substance or known physiological condition
F526	Dyspareunia not due to a substance or known physiological condition
F528	Other sexual dysfunction not due to a substance or known physiological condition
F529	Unspecified sexual dysfunction not due to a substance or known physiological condition
F550	Abuse of antacids
F551	Abuse of herbal or folk remedies
F552	Abuse of laxatives
F553	Abuse of steroids or hormones
F554	Abuse of vitamins
F558	Abuse of other non-psychoactive substances
F600	Paranoid personality disorder
F601	Schizoid personality disorder
F602	Antisocial personality disorder
F603	Borderline personality disorder
F604	Histrionic personality disorder
F605	Obsessive-compulsive personality disorder
F606	Avoidant personality disorder
F607	Dependent personality disorder
F6081	Narcissistic personality disorder
F609	Personality disorder, unspecified

F630	Pathological gambling
F631	Pyromania
F632	Kleptomania
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F640	Transsexualism
F642	Gender identity disorder of childhood
F648	Other gender identity disorders
F649	Gender identity disorder, unspecified
F650	Fetishism
F651	Transvestic fetishism
F652	Exhibitionism
F653	Voyeurism
F654	Pedophilia
F6550	Sadomasochism, unspecified
F6551	Sexual masochism
F6552	Sexual sadism
F6581	Frotteurism
F6589	Other paraphilias
F659	Paraphilia, unspecified
F66	Other sexual disorders
F6811	Factitious disorder with predominantly psychological signs and symptoms
F6813	Factitious disorder with combined psychological and physical signs and symptoms
F688	Other specified disorders of adult personality and behavior
F69	Unspecified disorder of adult personality and behavior
F840	Autistic disorder
F843	Other childhood disintegrative disorder

F845	Asperger's syndrome
F848	Other pervasive developmental disorders
F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F902	Attention-deficit hyperactivity disorder, combined type
F908	Attention-deficit hyperactivity disorder, other type
F909	Attention-deficit hyperactivity disorder, unspecified type
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F913	Oppositional defiant disorder
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified
F952	Tourette's disorder
F980	Enuresis not due to a substance or known physiological condition
F981	Encopresis not due to a substance or known physiological condition
F9821	Rumination disorder of infancy
F9829	Other feeding disorders of infancy and early childhood
F983	Pica of infancy and childhood
F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
R37	Sexual dysfunction, unspecified
R4183	Borderline intellectual functioning
R451	Restlessness and agitation
R452	Unhappiness
R455	Hostility
R456	Violent behavior
R4581	Low self-esteem
R4582	Worries
R45850	Homicidal ideations
R45851	Suicidal ideations
Z600	Problems of adjustment to life-cycle transitions
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discrimination and persecution
Z608	Other problems related to social environment
Z609	Problem related to social environment, unspecified
Z620	Inadequate parental supervision and control
Z621	Parental overprotection
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of child
Z626	Inappropriate (excessive) parental pressure
Z62810	Personal history of physical and sexual abuse in childhood
Z62811	Personal history of psychological abuse in childhood
Z62812	Personal history of neglect in childhood
Z62819	Personal history of unspecified abuse in childhood

Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62890	Parent-child estrangement NEC
Z6332	Other absence of family member
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and divorce
Z636	Dependent relative needing care at home
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting family and household
Z638	Other specified problems related to primary support group
Z644	Discord with counselors
Z654	Victim of crime and terrorism
Z658	Other specified problems related to psychosocial circumstances
Z69010	Encounter for mental health services for victim of parental child abuse
Z69020	Encounter for mental health services for victim of non-parental child abuse
Z69021	Encounter for mental health services for perpetrator of non-parental child abuse
Z6911	Encounter for mental health services for victim of spousal or partner abuse
Z6982	Encounter for mental health services for perpetrator of other abuse
Z7189	Other specified counseling
Z72810	Child and adolescent antisocial behavior
Z72811	Adult antisocial behavior
Z734	Inadequate social skills, not elsewhere classified
Z735	Social role conflict, not elsewhere classified
Z736	Limitation of activities due to disability
Z8651	Personal history of combat and operational stress reaction
Z91410	Personal history of adult physical and sexual abuse
Z91411	Personal history of adult psychological abuse
Z91412	Personal history of adult neglect

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SECTION 19—PROCEDURE CODES

Procedure codes used by MO HealthNet are identified as HCPCS codes (Centers for Medicare & Medicaid Services [CMS] Common Procedure Coding System). HCPCS codes consist of Level I codes (those found in the *Physician's Current Procedural Terminology—CPT®),* and Level II and Level III codes *not* found in CPT®, but assigned by CMS according to need.

19.1 CPT® CODES

Refer to Section 13.13 for a listing of covered procedure codes for psychotherapy services and Section 13.19 for covered procedure codes for ABA services.

END OF SECTION

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SECTION 20 - EXCEPTION PROCESS

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

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

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

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SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

Adult Day Health Care
Aged and Disabled Waiver
Ambulance
Ambulatory Surgical Centers
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
MRDD Waiver
Nurse Midwife
Optical
Pharmacy
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

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SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant

	cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.
Basic/Urban/ Rural Counties	As defined in 20 CSR, the following counties are categorized as: • Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City; • Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney; • Rural – All other counties.
Broker	Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.
Call Abandonment	Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Call Wait Time	Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Clean Claim	A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.
Complaint	A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.
DCN	Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.
Denial Reason	The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: • Non-covered Service • Lack of Day's Notice

- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

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

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

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

Fraud

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

Free Transportation	Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Grievance (Participant)	A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are *not* limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker's personnel, or failure to respect the participant's rights.
Grievance (Transportation Provider)	A written request for further review of a transportation provider's complaint that remains unresolved after completion of the complaint process.
Inquiry	A request from a transportation provider regarding information that would clarify broker's policies and procedures, or any aspect of broker function that may be in question.
Most Appropriate	The mode of transportation that accommodates the participant's physical, mental, or medical condition.
MO HealthNet Covered Services	Covered services under the MO HealthNet program.
Medically Necessary	Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could *not* have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services *must* be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Medical Service Provider	An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.

NEMT Services	Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does *not* include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.
No Vehicle Available	Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All "no vehicle available" trips shall be reported as denials in the category of no vehicle available.
Participant	A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.
Pick-up Time	The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.
Public Entity	State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.
Transportation Provider	Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.
Urgent	A serious, but *not* life threatening illness/injury. Examples include, but are *not* limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do *not* require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant's medical provider.
Will Call	An unscheduled pick-up time when the participant calls the broker or

transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.

If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
    a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards

are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

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

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

TRAVEL STANDARDS: MAXIMUM MILEAGE

Provider/Service Type	**Urban Access County**	**Basic Access County**	**Rural Access County**
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100
Infectious Disease	25	50	100
Nephrology	25	50	100

Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100
Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45

Residential mental health treatment providers	20	30	50
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
    - Participant eligibility; and
    - MO HealthNet covered service.

22.7 COPAYMENTS

The participant is required to pay a $2.00 copayment for transportation services. The $2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
    - 03 - Aid to the blind;
    - 12 - MO HealthNet-Aid to the blind; and
    - 15 - Supplemental Nursing Care-Aid to the blind;
    - 18 - MO HealthNet for pregnant women;
    - 43 - Pregnant women-60 day assistance;
    - 44 - Pregnant women-60 day assistance-poverty;
    - 45 - Pregnant women-poverty; and
    - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the

NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.

2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.
5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for

reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare

representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

END OF SECTION

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SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

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

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

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

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

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

END OF SECTION

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