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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01, 04, 11, 12, 13, 14, 15, 16</td>
<td>Elderly, blind and disabled individuals who meet the MO HealthNet eligibility criteria in the community or a vendor facility; or receive a Missouri State Supplemental Conversion or Supplemental Nursing Care check.</td>
</tr>
<tr>
<td>03</td>
<td>Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.</td>
</tr>
<tr>
<td>55</td>
<td>Individuals who qualify to have their Medicare Part B Premiums paid by the state. These individuals are eligible for reimbursement of their Medicare deductible coinsurance and copay amounts only for Medicare covered services.</td>
</tr>
<tr>
<td>18, 43, 44, 45, 61</td>
<td>Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.</td>
</tr>
<tr>
<td>10, 19, 21, 24, 26</td>
<td>Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.</td>
</tr>
</tbody>
</table>
23, 41  Children in a Nursing Facility/ICF/MR.

28, 49, 67  Children placed in foster homes or residential care by DMH.

33, 34  Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.

81  Temporary medical eligibility code. Used for individuals reinstated to MHF for 3 months (January-March, 2001), due to loss of MO HealthNet coverage when their TANF cases closed between December 1, 1996 and February 29, 2000. Used for White v. Martin participants and used for BCCT.

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

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

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

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

1.1.A(2)  MO HealthNet for Kids

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

PRODUCTION : 02/04/2023
Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.

Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.

Children who receive a federal adoption subsidy payment.

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

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

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

Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families must pay a monthly premium. There is a premium.
Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.

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

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

### 1.1.A(4) Voluntary Placement Agreement for Children

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

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

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

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

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

57. Children who receive a state only adoption subsidy payment.

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

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

1.1.A(6) MO Rx

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

1.1.A(7) Women’s Health Services

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

Women’s Health Services Program provides family planning and limited testing and treatment of Sexually Transmitted Diseases to women, ages 18 through 55, who have family income at or below 201% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children’s Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.

1.1.A(8) ME Codes Not in Use

The following ME codes are not currently in use:

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

The Department of Social Services issues a MO HealthNet ID card for each MO HealthNet or managed care eligible participant. For example, the eligible caretaker and each eligible child receives his/her own ID card. Providers must use the card that corresponds to each individual/child to verify eligibility and determine any other pertinent information applicable to the participant. Participants enrolled in a MO HealthNet managed health care plan also receive an ID card from the
managed health care plan. (Refer to Section 1.2.C for a listing of MO HealthNet/MO HealthNet Managed Care Eligibility (ME) codes identifying which individuals are to receive services on a fee-for-service basis and which individuals are eligible to enroll in a managed health care plan.

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

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

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

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

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

### 1.2.A  FORMAT OF MO HEALTHNET ID CARD

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

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

Providers must verify eligibility via the Internet or by using the interactive voice response (IVR) system by calling (573) 751-2896 and keying in the participant ID number shown on the face of the card. Refer to Section 3 for information regarding the Internet and the IVR inquiry process.

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

A pregnant woman who has not applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits during pregnancy. The following ME codes identify people who have TEMP eligibility:
1.2.C(4)  **Temporary Medical Eligibility for Reinstated TANF Individuals**

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

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

1.2.C(5)  **Presumptive Eligibility for Children**

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

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

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

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

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7)  **Voluntary Placement Agreement**

Children determined eligible for out-of-home care, per a signed Voluntary Placement Agreement (VPA), require medical planning and are eligible for a variety of children's treatment services, medical and psychiatric services. The Children's Division (CD) worker makes appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates.
ME code 88 identifies children receiving coverage under a VPA.

1.2.D  THIRD PARTY INSURANCE COVERAGE

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

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

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

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

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

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

If a patient who has not applied for MO HealthNet, state funded Medical Assistance or MO HealthNet Managed Care benefits is unable to pay for services rendered and appears to meet eligibility requirements, the provider should encourage the patient or the patient’s representative (related or unrelated) to apply for benefits through the Family Support Division in the patient’s
county of residence. Information can also be obtained by calling the FSD Call Center at (855) 373-4636. Applications for MO HealthNet Managed Care may be requested by phone by calling (888) 275-5908. The county office accepts and processes the application and notifies the patient of the resulting determination.

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

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

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

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

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

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

The Family Support Division office assigns a MO HealthNet ID number to the child as quickly as possible and gives the ID number to the hospital, physician, or nurse-midwife. Family Support Division staff works out notification and verification procedures with local hospitals.
The Family Support Division office explores the child’s eligibility for other types of assistance beyond the newborn policy. However, the eligibility determination for another type of assistance does not delay or prevent the newborn from being added to the mother’s case when the Family Support Division staff is notified of the birth.

1.4.A NEWBORN INELIGIBILITY

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

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

1.4.B NEWBORN ADOPTION

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

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

The managed care health plan must have written policies and procedures for enrolling the newborn children of program members effective to the time of birth. Newborns of program eligible mothers who were enrolled at the time of the child’s birth are automatically enrolled with the mother’s managed care health plan. The managed care health plan should have a
procedure in place to refer newborns to an enrollment counselor or Family Support Division to initiate eligibility determinations or enrollment procedures as appropriate. A mother of a newborn may choose a different managed care health plan for her child; unless a different managed care health plan is requested, the child remains with the mother’s managed care health plan.

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

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

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

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

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

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

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

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

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

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

MO HealthNet Managed Care health plans may also issue their own individual health plan ID cards. The individual must be eligible for MO HealthNet and enrolled with the managed
care health plan on the date of service for the managed care health plan to be responsible for services. MO HealthNet eligibility dates are different from managed care health plan enrollment dates. Managed care enrollment can be effective on any date in a month. Sometimes a participant may change managed care health plans and be in one managed care health plan for part of the month and another managed care health plan for the remainder of the month. Managed care health plan enrollment can be verified by the IVR/Internet.

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

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

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

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

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

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

- Group 5 consists of uninsured children.

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

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

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

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

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

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

1.5.D HOSPICE BENEFICIARIES

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

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

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

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

Any provider, other than the attending physician, who provides care related to the terminal illness to a hospice participant, must contact the hospice to arrange for payment. MO
HealthNet reimburses the hospice provider for covered services and the hospice reimburses the provider of the service(s).

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual must:

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

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

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

QMB coverage includes the services of providers who by choice do not participate in the MO HealthNet Program and providers whose services are not currently covered by MO HealthNet but who are covered by Medicare, such as chiropractors and independent therapists. Providers who do not wish to enroll in the MO HealthNet Program for MO HealthNet participants and providers of Medicare-only covered services may enroll as QMB-
only providers to be reimbursed for deductible, coinsurance, and copay amounts only for QMB eligibles. Providers who wish to be identified as QMB-only providers may contact the Provider Enrollment Unit via their e-mail address: mmac.providerenrollment@dss.mo.gov.

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

1.5.F WOMEN’S HEALTH SERVICES PROGRAM (ME CODES 80 and 89)
The Women’s Health Services Program provides family planning and family planning-related services to low income women, ages 18 through 55, who are not otherwise eligible for Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, or health insurance that provides family planning services.

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

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

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

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

1.5.G TEMP PARTICIPANTS
The purpose of the Temporary MO HealthNet During Pregnancy (TEMP) Program is to provide pregnant women with access to ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility. Certain qualified providers, as determined by the Family Support Division, may issue TEMP cards. These providers have the responsibility for making limited eligibility determinations for their patients based on preliminary information that the patient’s family income does not exceed the applicable MO HealthNet for Pregnant Women income standard for a family of the same size.
If the qualified provider makes an assessment that a pregnant woman is eligible for TEMP, the qualified provider issues her a white paper temporary ID card. The participant may then obtain ambulatory prenatal services from any MO HealthNet-enrolled provider. If the woman makes a formal application for MO HealthNet with the Family Support Division during the period of TEMP eligibility, her TEMP eligibility is extended while the application is pending. If application is not made, the TEMP eligibility ends in accordance with the date shown on the TEMP card.

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

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

1.5.G(1) TEMP ID Card

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

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

The start date (FROM) is the date the qualified provider issues the TEMP card, and coverage expires at midnight on the expiration date (THROUGH) shown. A TEMP replacement letter (IM-29 TEMP) may also be issued when the TEMP individual has formally applied for MO HealthNet and is awaiting eligibility determination.
Third party insurance information does not appear on a TEMP card.

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

Missouri and the Centers for Medicare & Medicaid (CMS) have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St. Louis. PACE is an integrated service system that includes primary care, restorative therapy, transportation, home health care, inpatient acute care, and even long-term care in a nursing facility when home and community-based services are no longer appropriate. Services are provided in the PACE center, the home, or the hospital, depending upon the needs of the individual. Refer to Section 11.11.E.
The target population for this program includes individuals age 55 and older, who are identified by the Missouri Department of Health and Senior Services, Division of Senior Services and Regulation through a health status assessment with specific types of eligibility categories and at least 21 points on the nursing home level of care assessment. These targeted individuals must reside in the St. Louis area within specific zip codes. Refer to Section 11.11.A.

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

1.5.1 MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT

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

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

1.5.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 payment.
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 \textit{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.

\textbf{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 \textit{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.

\textbf{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 \textit{not} enrolled in managed care. While the children \textit{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;

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

**1.6.A DAY SPECIFIC ELIGIBILITY**

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

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

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

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

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

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

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

### 1.6.B SPENDDOWN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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

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

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

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

### 1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

It is common for MO HealthNet participants to be issued an eligibility letter from the Family Support Division or other authorizing entity that may be used in place of an ID card. Participants who are new approvals or who need a replacement card are given an authorization letter. These letters are valid proof of eligibility in lieu of an ID Card. Dates of eligibility and most restrictions are contained in these letters. Participants who are enrolled or who will be enrolled in a managed care health plan may **not** have this designation identified on the letter. It is important that the provider verify the managed care enrollment status for participants who reside in a managed care service area. If the participant does **not** have an ID Card or authorization letter, the provider may also verify...
eligibility by contacting the IVR or the Internet if the participant’s MO HealthNet number is known. Refer to Section 3.3.A

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

**1.7.A **NEW APPROVAL LETTER

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

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

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

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

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

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

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

Eligibility determinations for Presumptive Eligibility for Children are limited to qualified entities approved by the state. Currently only children's hospitals are approved. Upon determination of eligibility, the family is provided with a
Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers should be checking eligibility as for any client.

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

The PEOMB sent to the participant clearly indicates that it is not a bill and that it does not change the participant’s MO HealthNet benefits.
The PEOMB does not report the capitation payment made to the managed care health plan in the participant’s behalf.

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

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

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

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

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

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

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

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

1.8 TRANSPLANT PROGRAM

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

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.
SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

2.1.C PROVIDER ENROLLMENT ADDRESS

Specific information about MO HealthNet participation requirements and enrollment can be obtained from:

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit

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2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

A provider wishing to submit claims or attachments electronically or access the Internet web site, www.emomed.com, must be enrolled as an electronic billing provider. Providers wishing to enroll as an electronic billing provider may contact the Wipro Infocrossing Help Desk at (573) 635-3559.

Providers wishing to access the Internet web site, www.emomed.com, must complete the online Application for MO HealthNet Internet Access Account. Please reference http://manuals.momed.com/Application.html and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

In accordance with the Affordable Care Act of 2010 (the Act), MO HealthNet must comply with the Medicaid payment provision located in Section 6505 of the Act, entitled “Prohibition on Payment to Institutions or Entities Located Outside of the United States.” The provision prohibits MO HealthNet from making any payments for items or services provided under the State Plan or under a waiver to any financial institutions, telemedicine providers, pharmacies, or other entities located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If it is discovered that payments have been made to financial institutions or entities outside of the previously stated approved regions, MO HealthNet must recover these payments. This provision became effective January 1, 2011.

2.2 NOTIFICATION OF CHANGES

A provider must notify the Provider Enrollment Unit of any changes affecting the provider’s enrollment records within ninety (90) days of the change, in writing, using the appropriate enrollment forms specified by the Provider Enrollment Unit, with the exception of a change in ownership or control of any provider. Change in ownership or control of any provider must be reported within thirty (30) days. The Provider Enrollment Unit is responsible for determining whether a current MO HealthNet provider record should be updated or a new MO HealthNet provider record should be created. A new MO HealthNet provider record is not created for any changes including, but not limited to, a change in ownership, a change of operator, tax identification
change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations.

2.3 RETENTION OF RECORDS

MO HealthNet providers must retain for 5 years (7 years for the Nursing Home, CSTAR and Community Psychiatric Rehabilitation Programs), from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and must furnish or make the records available for inspection or audit by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to MO HealthNet may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider’s participation in the MO HealthNet Program. This policy continues to apply in the event of the provider’s discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance.

2.3.A ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. 13 CSR 70-3.030, Section(2)(A) defines “adequate documentation” and “adequate medical records” as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.

2.4 NONDISCRIMINATION POLICY STATEMENT

Providers must comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.
Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

### 2.5 STATE’S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

Providers of services and supplies to MO HealthNet participants must comply with all laws, policies, and regulations of Missouri and the MO HealthNet Division, as well as policies, regulations, and laws of the federal government. A provider must also comply with the standards and ethics of his or her business or profession to qualify as a participant in the program. The Missouri Medicaid Audit and Compliance Unit may terminate or suspend providers or otherwise apply sanctions of administrative actions against providers who are in violation of MO HealthNet Program requirements. Authority to take such action is contained in 13 CSR 70-3.030.

### 2.6 FRAUD AND ABUSE

The Department of Social Services, Missouri Medicaid Audit and Compliance Unit is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Title XIX Medicaid Program by either providers or participants. Section 1909 of the Social Security Act contains federal penalty provisions for fraudulent acts and false reporting on the part of providers and participants enrolled in MO HealthNet.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal and State laws, regulations and policies.

Abuse is defined as provider, supplier, and entity practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary costs to the Medicaid program.

Frequently cited fraudulent or abusive practices include, but are not limited to, overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

The penalties for such acts range from misdemeanors to felonies with fines not to exceed $25,000 and imprisonment up to 5 years, or both.
Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are not limited to, the following:

- Review of participant profiles of use of services and payment made for such.
- Review of provider claims and payment history for patterns indicating need for closer scrutiny.
- Computer-generated listing of duplication of payments.
- Computer-generated listing of conflicting dates of services.
- Computer-generated overutilization listing.
- Internal checks on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, participant eligibility, etc.
- Medical staff review and application of established medical services parameters.
- Field auditing activities conducted by the Missouri Medicaid Audit and Compliance Unit or its representatives, which include provider and participant contacts.

In cases referred to law enforcement officials for prosecution, the Missouri Medicaid Audit and Compliance Unit has the obligation, where applicable, to seek restitution and recovery of monies wrongfully paid even though prosecution may be declined by the enforcement officials.

### 2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

It is the responsibility of each provider to ensure the accuracy of all data transmitted on claims submitted to MO HealthNet, regardless of the media utilized. As provided in 13 CSR 70.3.030, sanctions may be imposed by MO HealthNet against a provider for failure to take reasonable measures to review claims for accuracy. Billing errors, including but not limited to, incorrect ingredient indicators, quantities, days supply, prescriber identification, dates of service, and usual and customary charges, caused or committed by the provider or their employees are subject to adjustment or recoupment. This includes, but is not limited to, failure to review remittance advices provided for claims resulting in payments that do not correspond to the actual services rendered. Ongoing, overt or intentionally misleading claims may be grounds for allegations of fraud and will be appropriately pursued by the agency.

### 2.7 OVERPAYMENTS

The Missouri Medicaid Audit and Compliance Unit routinely conduct postpayment reviews of MO HealthNet claims. If during a review an overpayment is identified, the Missouri Medicaid Audit and Compliance Unit is charged with recovering the overpayment pursuant to 13 CSR 70-3.030. The Missouri Medicaid Audit and Compliance Unit maintains the position that all providers are held responsible for overpayments identified to their participation agreement regardless of any extrinsic relationship they may have with a corporation or other employing entity. The provider is responsible
for the repayment of the identified overpayments. Missouri State Statute, Section 208.156, RSMo (1986) may provide for appeal of any overpayment notification for amounts of $500 or more. An appeal must be filed with the Administrative Hearing Commission within 30 days from the date of mailing or delivery of the decision, whichever is earlier; except that claims of less than $500 may be accumulated until such claims total that sum and, at which time, the provider has 90 days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the Commission.

Compliance with this decision does not absolve the provider, or any other person or entity, from any criminal penalty or civil liability that may arise from any action that may be brought by any federal agency, other state agency, or prosecutor. The Missouri Department of Social Services, Missouri Medicaid Audit and Compliance Unit, has no authority to bind or restrict in any way the actions of other state agencies or offices, federal agencies or offices, or prosecutors.

2.8 POSTPAYMENT REVIEW

Services reimbursed through the MO HealthNet Program are subject to postpayment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in monetary recoupments according to 13 CSR 70-3.030 (5) and the provider may be subjected to prepayment review on all MO HealthNet claims.

2.9 PREPAYMENT REVIEW

MMAC may conduct prepayment reviews for all providers in a program, or for certain services or selected providers. When a provider has been notified that services are subject to prepayment review, the provider must follow any specific instructions provided by MMAC in addition to the policy outlined in the provider manual. In the event of prepayment review, the provider must submit all claims on paper. Claims subject to prepayment review are sent to the fiscal agent who forwards the claims and attachments to the MMAC consultants.

MMAC consultants conduct the prepayment review following the MO HealthNet Division’s guidelines and either recommend approval or denial of payment. The claim and the recommendation for approval or denial is forwarded to the MO HealthNet fiscal agent for final processing. Please note, although MMAC consultants recommend payment for a claim, this does not guarantee the claim is paid. The claim must pass all required MO HealthNet claim processing edits before actual payment is determined. The final payment disposition on the claim is reported to the provider on a MO HealthNet Remittance Advice.
2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

MO HealthNet providers must complete a Direct Deposit for Individual Provider form to receive reimbursement for services through direct deposit into a checking or savings account. The application should be downloaded, printed, completed and mailed along with a voided check or letter from the provider’s financial institution to:

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

This form must be used for initial enrollment, re-enrollment, revalidation, or any update or change needed. All providers are required to complete the Application for Provider Direct Deposit form regardless if the reimbursement for their services will be going to another provider.

In addition to completion of the Application for Provider Direct Deposit form, all clinics/groups must complete the Direct Deposit for Clinics & Groups form.

Direct deposit begins following a submission of a properly completed application form to the Missouri Medicaid Audit and Compliance Unit, the successful processing of a test transaction through the banking system and the authorization to make payment using direct deposit. The state conducts direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply, as limited or modified by law.

The Missouri Medicaid Audit and Compliance Unit will terminate or suspend the direct deposit for administrative or legal actions, including but not limited to: ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

All payments are direct deposited.

For questions regarding direct deposit or provider enrollment issues, please send an email to mmac.providerenrollment@dss.mo.gov

The MO HealthNet Remittance Advice is available on line. The provider must apply online via the Application for MO HealthNet Internet Access Account link.

Once a user ID and password is obtained, the www.emomed.com website can be accessed to retrieve current and aged remittance advices.

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

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

2.11 NATIONAL CORRECT CODING INITIATIVE

MO HealthNet incorporates the Medicaid National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits in its claims processing system. Effective August 23, 2022, for dates of service on or after July 1, 2022, the MO HealthNet Division (MHD) will require providers to follow Centers for Medicare & Medicaid Services (CMS) MUE edits. An MUE for a Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code is the maximum units of service that a provider would report under most circumstances for a single participant on a single date of service. Not all HCPCS/CPT codes have an MUE assigned by CMS. If there is no MUE for a code, providers should use the MO HealthNet maximum quantity on the online fee schedule located on the MHD website at: https://dss.mo.gov/mhd/providers/pages/cptagree.htm.

Providers can find the current NCCI edits online at: https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits.

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](http://www.emomed.com).

**Sub-Option 2. Eye Glass and Eye Exam Information**

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

- If no eyeglass information exists, the IVR reads that the participant has not received an eye exam and has not received eye glass frames or lenses to date under the MO HealthNet program.
• If frames, lens, and/or exam information exist, then the IVR will read different types of responses based on the data. A couple of examples include:
  o If frames, lens, and exam information exists and all occur on the same date.
  o Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
  o If frames, lens exist for different dates and no exam date.
  o Eye glass frames were last issued on (Frames Date).
  o Eye glass lenses were last issued on (Lens Date).
  o This participate has not had an eye examination to date under the MO HealthNet program.

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

**Sub-Option 3. Third Party Liability (TPL) Information**

The participant’s TPL information on file will be provided through sub-option 3.

• If no TPL exists for the participant or TPL Name is blank, the IVR reads that information.
• If Medicare Part C exists, the IVR reads that information.
• If TPL Part C information is not available, the IVR reads to contact the participant for the information.
• If Medicare Part C does not exist, the IVR reads that this participant does not have Third party coverage on the dates of service requested.
• If TPL exists, then IVR will read up to five records to the caller.
  o Third party insurance is provided by (TPL NAME).
  o If Court Ordered, the IVR will read that this coverage is court ordered.
  o If Policy Number = ‘unknown, the IVR will read that the Policy number is unknown.
  o If Policy Number is known, the IVR will read the policy number is (Policy Number).
  o If Group Number = ‘unknown, the IVR will read that the group number is unknown.
  o If the Group Number is known, the IVR will read that the group number is (Group Number).

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

**Sub-Option 4 Medicare and QMB Information**

If no Part A, B, or QMB information exists on file for the participant, then nothing is read.
If Part A, B, and/or QMB information exists then the IVR will read different types of responses based on the data on file. A couple of examples include:

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

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

**Main Option 2. Provider IVR Check Inquiry**

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

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

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

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

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

The provider can access claim status information, including processing status, denial, and approved status.
• Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID.
• Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.
• Once 6 digit number is entered, the IVR prompts for the type of claim.
  o If Drug claim is selected, then IVR prompts for prescription number entry.

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

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

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

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

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

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

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

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

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

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

Main Option 5. Participant Annual Review Date

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

The caller is prompted to enter the following information.

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

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

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

  After valid or error response IVR then reads menu options.

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

Transfer Routine

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

Number of Inquiries

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

3.3.A(1) Using the Telephone Key Pad

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

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

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

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

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

• Have the provider’s NPI number available.

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

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

Please note that there are no limits on how many inquiries you can access through the MHD web-based www.emomed.com system. Limitations associated with the number of inquiries are only applicable to the IVR, speaking with a specialist, and email communications.

3.3.C INTERNET

Providers may submit claims on the internet via the MHD web based electronic claims filing system. The website address is www.emomed.com. 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 emailing MHD.ClinicalServices@dss.mo.gov, or visit the MHD webpage at http://dss.mo.gov/mhd/cs/.

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

### 3.11 Pharmacy and Medical Pre-certification Help Desk

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

To become a CyberAccess user, contact the help desk at 888-581-9797 or 573-632-9797, or email cyberaccesshelpdesk@xerox.com. For non-emergency service or equipment exception requests only, please use Fax #: (573) 522-3061; Drug PA Fax #: (573) 636-6470.

### 3.12 Third Party Liability (TPL)

Providers should contact the TPL Unit to report any MO HealthNet participant who has sustained injuries due to an accident or when they have problems obtaining a response from an insurance carrier. Any unusual situations concerning third party insurance coverage for a MO HealthNet participant should also be reported to the TPL Unit. The TPL Unit’s number is 573-751-2005.
SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

Claims from participating providers who request MO HealthNet reimbursement must be filed by the provider and must be received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. Refer to Section 4.5, Definitions, for a detailed explanation of terms.

4.1.B MEDICARE/MO HEALTHNET CLAIMS

Claims that initially have been filed with Medicare within the Medicare timely filing requirement and that require separate filing of a claim with the MHD meet the timely filing requirement by being submitted by the provider and received by the state agency within 12 months from the date of service or 6 months from the date on Medicare’s provider notice of the allowed claim, whichever is later. Claims denied by Medicare must be filed by the provider and received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. The counting of the 6-month period begins with the date of adjudication of Medicare payment and ends with the date of receipt.

Refer to Section 16 for billing instructions of Medicare/MO HealthNet (crossover) claims.

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

Claims for participants who have other insurance must first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim must still meet the MHD timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does not serve to extend the filing requirement.) If the provider has not had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait no longer than 6 months after the date of service before contacting the TPL Unit. If the MHD waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the MHD timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.
The 12 month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the 12 months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the MHD. Under this set of circumstances, the provider may file a claim with the MHD later than 12 months from the date of service. The provider must submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MHD may accept and pay this specific type of claim without regard to the 12 month timely filing rule; however, all claims must be filed for MO HealthNet reimbursement within 24 months from the date of service in order to be paid.

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

Claims that were originally submitted and received within 12 months from the date of service and were denied or returned to the provider must be resubmitted and received within 24 months of the date of service.

4.2.A CLAIMS FILED AND DENIED

Claims that are denied may be resubmitted. A resubmission filed beyond the 12-month filing limit must either include an attachment, a Remittance Advice or Return to Provider letter, or the claim must have the original ICN entered in the appropriate field for electronic or paper claims (reference Section 15 of the applicable provider manual). Either the attachment or the ICN must indicate the claim had originally been filed within 12 months of the date of service. The same Remittance Advice, letter or ICN can be used for each resubmission of that claim.

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

Some paper claims received by the fiscal agent cannot be processed because the wrong claim form is submitted or additional data is required. These claims are not processed through the system but are returned to the provider with a Return to Provider letter. When these claims are resubmitted more than 12 months after the date of service (and had been filed timely), a copy of the Return to Provider letter should be attached instead of the required Remittance Advice to document timely filing as explained in the previous paragraph. The date on the letter determines timely filing.
4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

In accordance with 13 CSR 70-3.100, claims that are not submitted in a timely manner as described in this section are denied. However, at any time in accordance with a court order, the MHD may make payments to carry out a hearing decision, corrective action or court order to others in the same situation as those directly affected by it. As determined by the state agency, the MHD may make payment if a claim was denied due to state agency error or delay. In order for payment to be made, the MHD must be informed of any claims denied due to the MHD error or delay within 6 months from the date of the remittance advice on which the error occurred; or within 6 months of the date of completion or determination in the case of a delay; or 12 months from the date of service, whichever is longer.

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT

Providers can adjust or void paid or denied claims on eMOMED up to 24 months from the date of service if the claim was submitted originally within 12 months of the date of service.

Providers should submit the Provider Initiated Self Disclosure Report Form for overpaid claims that are older than 24 months from the DOS. Be sure to complete all of the fields listed on the form.

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

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

Providers should not adjust claims if the incorrect claim was identified as a result of a Missouri Medicaid Audit and Compliance (MMAC) audit or investigation. Providers should contact MMAC to address repayment of the overpayment amount.

Voiding a claim and submitting a Provider Initiated Self Discloser Form on the same claim can result in a double recoupment.

Providers can direct questions regarding Self Disclosures to the MMAC Financial Section at mmac.financial@dss.mo.gov or by calling (573) 751-3399. More information is also available on the MMAC webpage.
4.5 DEFINITIONS

**Claim:** Each individual line item of service on a claim form for which a charge is billed by a provider for all claim form types except inpatient hospital. An inpatient hospital service claim includes all the billed charges contained on one inpatient claim document.

**Date of Service:** The date that serves as the beginning point for determining the timely filing limit. For such items as dentures, hearing aids, eyeglasses, and items of durable medical equipment such as an artificial larynx, braces, hospital beds, or wheelchairs, the date of service is the date of delivery or placement of the device or item. It applies to the various claim types as follows:

- **Nursing Homes:** The last date of service for the billing period indicated on the participant's detail record. Nursing Homes must bill electronically, unless attachments are required.
- **Pharmacy:** The date dispensed.
- **Outpatient Hospital:** The ending date of service for each individual line item on the claim form.
- **Professional Services:** The ending date of service for each individual line item on the claim form.
- **Dental:** The date service was performed for each individual line item on the claim form.
- **Inpatient Hospital:** The through date of service in the area indicating the period of service.

**Date of Receipt:** The date the claim is received by the fiscal agent. For a claim that is processed, this date appears as the Julian date in the internal control number (ICN). For a claim that is returned to the provider, this date appears on the Return to Provider letter.

**Date of Adjudication:** The date that appears on the Remittance Advice indicating the determination of the claim.

**Internal Control Number (ICN):** The 13-digit number printed by the fiscal agent on each document that processes through the claims processing system. The first two digits indicate the type of claim. The year of receipt is indicated by the 3rd and 4th digits, and the Julian date appears as the 5th, 6th, and 7th digits. For example, in the number 4912193510194, “49” is an eMOMED claim, “17” is the year 2017, and “193” is the Julian date for July 11.

**Julian Date:** The number of a day of the year when the days of the year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 2016, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2016.

**Date of Payment/Denials:** The date on the Remittance Advice at the top center of each page under the words “Remittance Advice.”
Twelve-Month Time Limit Unit: 366 days.

Six-Month Time Limit: 181 days.

Twenty-four-Month Time Limit: 731 days.
SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

The purpose of this section of the provider manual is to provide a good understanding of Third Party Liability (TPL) and MO HealthNet. The federal government defines a third party resource (TPR) as:

“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
- Tricare
- 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 services.
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 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 managed care health plan must provide labor, delivery, and postpartum care; prenatal care for pregnant women; preventive pediatric services; and services that are provided to a Managed Care member on whose behalf a child support enforcement order is in effect. If a third party liability payer exists for these services, the provider may bill the third party liability payer.

The managed care health plan shall apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum services. The health plan shall make payments without regard to potential TPL for pediatric preventive services, unless they have made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days. The health plan shall make payments to providers if payment has not been made from a third party liability derived from a child support enforcement order within 100 days after the provider has initially submitted a claim to such third party for payment of Medicaid services.

If the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division 42 CFR 433.139 (b)(3) requires the state Medicaid agency to pay and chase these claims when the provider has billed the TPR and been unable to obtain payment and 100 days have passed since the date of service. The provider must submit an attestation that all conditions have been met in order to receive payment.

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.
• Tricare 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—including 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 HEALTH CARE PLANS

Employers frequently offer commercial 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 health care plan unless a referral was made by the commercial 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 health care policies pay an out-of-plan provider at a reduced rate.

MO HealthNet only reimburses providers who are not affiliated with the commercial health care plan if the commercial health care plan has paid primary or there is a legitimate denial from the commercial health plan, and MO HealthNet is paying secondary. See section 5.6.B for additional information on legitimate denials.

Frequently, commercial 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.

If the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division 42 CFR 433.139 (b)(3) requires the state Medicaid agency to pay and chase these claims when the provider has billed the TPR and been unable to obtain payment and 100 days have passed since the date of service. The provider must submit an attestation that all conditions have been met in order to receive payment.

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. Post payment 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.

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 legitimate denial of payment by the insurance company, the claim is denied for MO HealthNet payment.

A legitimate 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 legitimate 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 legitimate 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 legitimate 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 intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is related to preventative pediatric care.

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 post-payment 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 motorist 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.
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. 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 wraparounds 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.

COMMERCIAL HEALTH CARE PLANS: Commercial health 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.

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

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

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

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

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

END OF SECTION

TOP OF SECTION
SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

6.2.B(1)(i) Void

To void a claim from the claim status screen on emomed, choose the void tab. This will bring up the paid claim in the system; scroll to the bottom of the claim and 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 should submit the Provider Initiated Self Disclosure Report Form for overpaid claims that are older than 24 months from the DOS. Be sure to complete all of the fields listed on the form.
MMAC encourages providers and entities to establish and implement a compliance integrity plan. MMAC also encourages providers and entities to self-disclose or report findings, along with funds to compensate for the errors or a suggested repayment plan, which requires MMAC approval, to the address below:

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

Providers should not adjust claims if the incorrect claim was identified as a result of a Missouri Medicaid Audit and Compliance (MMAC) audit or investigation. Providers should contact MMAC to address repayment of the overpayment amount.

Voiding a claim and submitting a Provider Initiated Self Discloser Form on the same claim can result in a double recoupment.

Providers can direct questions regarding Self-Disclosures to the MMAC Financial Section at mmac.financial@dss.mo.gov or by calling (573) 751-3399. More information is also available on the MMAC webpage.

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

1. An adjustment that credits the original payment and then repays the claim based on the adjusted information appears on the Remittance Advice as a two-step transaction consisting of two ICN’s.

   • An ICN that credits (recoups) the original paid amount and
   • An ICN that repays the claim with the corrected payment amount.

2. An adjustment that credits or recoups the original payment but does not repay the claim (resulting in zero payment) appears on the Remittance Advice with one ICN that credits (recoups) the original paid amount.
SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

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

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

8. Prescriber's MO HealthNet Provider Identifier Enter the NPI number if the prescriber participates in the MO HealthNet Program.

9. Date Prescribed Enter the date the service or item was prescribed or identified by the prescriber as medically necessary in month/date/year numeric format, if required by program. This date must be prior to or equal to the date of service.

10. Diagnosis Enter the appropriate ICD code(s) that prompted the request for this service or item, if required by program.

11. Prognosis Enter the participant's prognosis and the anticipated results of the requested service or item.

12. Provider Name and Address Enter provider's name, address, and telephone number.

13. MO HealthNet Provider Identifier Enter provider's NPI number.

14. Provider Signature The provider must sign here with an original signature. This certifies that the information given on the form is true, accurate and complete.

END OF SECTION

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

- The provider performing the service must submit the PA Request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.

- The service must be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.

- Do not request prior authorization for services to be provided to an ineligible person (see Sections 1 and 13 of the applicable provider manual).

- Expanded HCY (EPSDT) services are limited to participants 20 years of age and under and are not reimbursed for participants 21 and over even if prior authorized.

- See Section 20 for specific criteria and guidelines regarding prior authorization of non-covered services through the Exceptions Process for participants 21 and over.

- Prior authorization does not guarantee payment if the participant is or becomes enrolled in managed care and the service is a covered benefit.

- Payment is not made for services initiated before the approval date on the PA Request form or after the authorization deadline.

- For services to continue after the expiration date of an existing PA Request, a new PA Request must be completed and submitted prior to the end of the current PA.

### 8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

- Section II, HCY Service Request, is applicable for participants 20 years of age and under and should be completed when the information is known.

- In Section III, Service Information, the gray area is for state use only.

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

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

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

• Complete each field in Section IV. See Sections 13 and 14 of the applicable provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.

• Section V, Prescribing/Performing Practitioner, must be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which are prescribed by a physician/practitioner that require prior authorization. Reference the applicable provider manual for additional instructions.

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

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

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

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

• Initiate the start of services that require prior authorization.

• Request continued services when services continue to be medically necessary beyond the current approved period of time.
1. The dates for the services requested cannot overlap dates that are already approved and must be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.

- Correct a participant MO HealthNet number if the original PA Request had a number on it and services were approved.

1. When submitting a PA Request due to an error in the participant MO HealthNet number on the original PA Request, attach a copy of the MO HealthNet Authorization Determination giving original approval to the new request.

2. Fields #17 through #23 in Section III must be identical to the original approval.

3. The PA Request form should be clearly marked as a “correction of the participant MO HealthNet number” and the error must be explained in detail in Field #24 of Section III.

4. Mark the PA Request “Special Handle” at the top of the form.

- Change providers within a group during an approved authorization period.

1. When submitting a PA Request due to a change of provider within a group, attach a copy of the MO HealthNet Authorization Determination showing the approval to the new PA Request form.

2. Section III, Field #19 “FROM” must be the date the new provider begins services and Field 20 “THROUGH” cannot exceed the through date of the previously approved PA Request.

3. The PA Request form should be clearly marked at the top “change of provider,” and the change must be explained in Field #24 of Section III.

4. Mark the PA Request “Special Handle” at the top of the form. Use Field #24 to provide a detailed explanation.

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

- Correct a procedure code.
- Correct a modifier.
- Add a new service to an existing plan of care.
- Correct or change the “from” or “through” dates.
1. The “from” date may not precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.

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

- Increase or decrease requested units or dollars.

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

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

- Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

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

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

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

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

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

The written request must include:

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

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

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

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

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.
SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

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

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

9.4 INTERPERIODIC SCREENS

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

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

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

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

9.5 FULL HCY/EPSDT SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381EP-99385EP</td>
<td>Full Medical Screening</td>
</tr>
</tbody>
</table>
A full HCY/EPSDT screen includes the following:

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

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

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

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they
make them available to appropriate state and federal officials on request. Providers must document the screening in the medical record if billing a screening.

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

Office visits and screenings that occur on the same day by the same provider are not covered unless the medical necessity is clearly documented in the participant’s record.
9.6.A DEVELOPMENTAL ASSESSMENT

PROEDURE
CODE         DESCRIPTION

99429 59   Developmental/Mental/Behavioral Health
           partial screen

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

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

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

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

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

9.6.A(1) Qualified Providers

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

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

PRODUCTION : 02/04/2023
• Professional counselors, social workers, marital and family therapists, and psychologists.
*only infants age 0-2 months; and females age 15-20 years

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

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9938152EP-9938552EP</td>
<td>HCY Unclothed Physical and History</td>
</tr>
<tr>
<td>9939152EP-9939552EP</td>
<td>History</td>
</tr>
<tr>
<td>9938152EPUC-9938552EPUC</td>
<td>HCY Unclothed Physical and History with Referral</td>
</tr>
<tr>
<td>9939152EPUC-9939552EPUC</td>
<td>History with Referral</td>
</tr>
</tbody>
</table>

The HCY unclothed physical and history includes the following:

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

9.6.B(1) Qualified Providers

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

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

9.6.C VISION SCREENING

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9942952</td>
<td>Vision Screening</td>
</tr>
<tr>
<td>9942952UC</td>
<td>Vision Screening with Referral</td>
</tr>
</tbody>
</table>
This screen can include observations for blinking, tracking, corneal light reflex, pupillary response, ocular movements. To test for visual acuity, use the Cover test for children under 3 years of age. For children over 3 years of age utilize the Snellen Vision Chart.

9.6.C(1) Qualified Providers

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

• Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
• Optometrist.
* only infants age 0-2 months; and females age 15-20 years

9.6.D HEARING SCREEN

PROCEDURE
CODE DESCRIPTION
99429EP HCY Hearing Screen

99429EPUC HCY Hearing Screen with Referral

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

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

9.6.D(1) Qualified Providers

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

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

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

PROCEDURE CODE DESCRIPTION
99429 HCY Dental Screen

99429UC HCY Dental Screen with Referral

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

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

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

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

9.6.E(1)   Qualified Providers

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

9.6. F   ALL PARTIAL SCREENERS

The provider of a partial medical screen must have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.
9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)

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

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

CMS has also determined that there are no guidelines or policies for states or local health departments to reference in determining that an area is a lead free zone. Until there is specific information or guidance from the Centers for Disease Control (CDC) on how lead free zones are determined, CMS will not recognize them in the context of screening Medicaid eligible children for lead poisoning.

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

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

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

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

SIGNS AND SYMPTOMS

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

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

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

EXPOSURE PATHWAYS

**OCCUPATIONAL**
- Plumbers, pipe fitters
- Lead miners
- Lead smelters and refiners
- Auto repairers
- Glass manufacturers
- Shipbuilders
- Printers
- Plastic manufacturers
- Police Officers
- Steel welders and cutters
- Construction workers
- Bridge reconstruction workers
- Rubber products manufacturers
- Gas station attendants
- Battery manufacturers
- Chemical and chemical preparation manufacturers
- Industrial machinery and equipment operators
- Firing Range Instructors

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

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

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

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

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

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

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

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

9.7.C(4) MO HealthNet Managed Care Health Plans
The MO HealthNet Managed Care health plans are responsible for mandatory risk assessment for children between the ages of 6 months and 72 months. MO HealthNet Managed Care health plans are also responsible for mandatory blood testing if a child is at risk or if the child is 12 or 24 months of age. MO HealthNet Managed Care health plans must follow the HCY Lead Risk Assessment Guide when assessing a child for risk of lead poisoning or when treating a child found to be poisoned.

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

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

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

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

(Capillary specimen or venous blood samples.)

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

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

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

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

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

9.7.E(2) Blood Lead Level 10-19 µg/dL

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

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

*Retesting must always be completed using venous blood.

9.7.E(3) Blood Lead Level 20-44 µg/dL

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

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

*Retesting must always be completed using venous blood.

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.
If the blood lead results are in the 45-69 µg/dL range, a confirmatory venous blood lead level must be obtained within 48 hours.

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

Recommended Interventions:

• Provide family education and follow-up testing.

• Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.

• Contact local public health agency to provide environmental investigation and to assure lead-hazard control.

• Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.

• A child with a confirmed blood lead level greater than 44 µg/dL should be treated promptly with appropriate chelating agents and not returned to an environment where lead hazard exposure may continue until it is controlled.

• Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.

• When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

  * Retesting must always be completed using venous blood.

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

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

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

Recommended Interventions:

• Hospitalize child and begin medical treatment immediately.

• Begin coordination of care (case management), medical management, environmental investigation, and lead hazard control immediately.
• Blood lead levels greater than 69 µg/dL must have an urgent repeat venous test, but chelation therapy should begin immediately (not delayed until test results are available.)

• *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, the lead hazards have been removed, and there are no new exposures.

• When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

  * Retesting must always be completed using venous blood.

9.7.F  COORDINATION WITH OTHER AGENCIES

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

9.7.G  ENVIRONMENTAL LEAD INVESTIGATION

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

9.7.G(1)  Environmental Lead Investigation

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

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

PRODUCTION: 02/04/2023
All licensed lead risk assessors *must* be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children *must* also be enrolled as a MO HealthNet provider. Lead risk assessors *must* use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

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

- **T1029UATG** Initial Environmental Lead Investigation
- **T1029UA** First Environmental Lead Reinvestigation
- **T1029UATF** Second Environmental Lead Reinvestigation
- **T1029UATS** Subsequent Environmental Lead Reinvestigation

Certificate of Medical Necessity *must* be attached to claim for this procedure

Federal Medicaid regulations prohibit Medicaid coverage of environmental lead investigations of locations other than the principle residence. The Missouri Department of Health and Senior Services recommend that all sites where the child may be exposed be assessed, e.g., day care, grandparents' home, etc.

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

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

### 9.7.H ABATEMENT

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

### 9.7.I LEAD CASE MANAGEMENT

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

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

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

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

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

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

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

PRODUCTION : 02/04/2023
9.8 HCY CASE MANAGEMENT

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

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

9.9 IMMUNIZATIONS

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

9.9.A VACCINE FOR CHILDREN (VFC)

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

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9.10 ASSIGNMENT OF SCREENING TIMES

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

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

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

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

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

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

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

<table>
<thead>
<tr>
<th>Newborn</th>
<th>3 Years</th>
</tr>
</thead>
</table>
### 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.

*only infants age 0-2 months; and females age 15-20 years*
9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

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

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

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

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

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

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.15 STATE-ONLY FUNDED PARTICIPANTS

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

9.16 MO HEALTHNET MANAGED CARE

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

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

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

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

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

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

Plans *must* use the following procedure codes, along with a primary diagnosis code of Z00.00, Z00.01, Z00.10, Z00.11, Z00.121, or Z00.129 when reporting encounter data to the MO HealthNet Division on Full and Partial EPSDT/HCY Screens:

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

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

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

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

### 9.17 ORDERING HCY LEAD SCREENING GUIDE

The HCY Lead Screening Guide may be ordered from Wipro Infocrossing Healthcare Services, P.O. Box 5600, Jefferson City, Missouri 65102 by checking the appropriate item on the Forms Request. If a provider needs additional screening forms they can also make copies.
SECTION 10 - FAMILY PLANNING

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

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

- Adult Day Care Waiver
- Adult Day Health Care (NOTE: The Adult Day Health Care Program ends June 30, 2013)
- Aged and Disabled Waiver
- AIDS Waiver
- Ambulance
- Comprehensive Day Rehabilitation
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- Hospice
- Independent Living Waiver
- Medically Fragile Adult Waiver
- Nursing Home
- Optical
- Personal Care
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy
SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

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

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

11.1 MO HEALTHNET’S MANAGED CARE PROGRAM

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

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

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

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

The central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033), Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052),
Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are not enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does not appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health plan.
"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); or
- Described in Section 1902(e)(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a)).

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);
Aged and Disabled Waiver

- 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.

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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

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

- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are not limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing
  - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME Codes listed for Group 4, Section 1.5.C
  - Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
  - Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs

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

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

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

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

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

The following services are available to MO HealthNet Managed Care members outside the MO HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a Fee-For-Service basis by the MO HealthNet Division:

• 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/adhcpapprovalpackets.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

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• 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 MOHealthNet.

**11.11.A ELIGIBILITY FOR PACE**

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

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

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.
11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals not eligible for PACE enrollment include:
- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

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

11.11.D PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:
- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;
- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
• In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
• Pharmaceutical services, prescribed drugs, and over the counter medications;
• Medical and surgical specialty and consultation services;
• Home health services;
• Inpatient and outpatient hospital services;
• Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
• Emergency room care and treatment room services;
• Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
• Interdisciplinary assessment and treatment planning;
• Nutritional counseling;
• Recreational therapy;
• Meals;
• Case management, care coordination;
• Rehabilitation services;
• Hospice services;
• Ambulatory surgical center services; and
• Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services must be arranged for or provided by the PACE provider and are not reimbursed through Fee-For-Service.
SECTION 12 - REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

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

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

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

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 AGED AND DISABLED WAIVER SERVICES

Reimbursement for aged and disabled waiver services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Division 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 schedule 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 considers the following information when applicable:

- 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 determines a maximum allowable fee for each service based upon the current appropriated funds.

12.3.A ON-LINE FEE SCHEDULE

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

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

Refer to Section 13 of this manual for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

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

Certain MO HealthNet services are subject to participant cost sharing or copay. The cost sharing amount is paid by the participant at the time services are rendered. Services of the Aged and Disabled Waiver Program described in this manual are not subject to a cost sharing or copay amount.

12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

Aged and disabled waiver services are not included as a plan benefit in MO HealthNet's Managed Care program.
SECTION 13 - BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

Aged and Disabled Waiver (ADW) services are included in the Missouri Medicaid Program under the authority of a Home and Community-Based Waiver granted by the Centers for Medicare & Medicaid Services (CMS). Under a waiver, certain services that could not otherwise be reimbursed under Title XIX may be provided to a select group of participants, in order to provide an alternative to institutional care. CMS approval of a waiver is subject to strict conditions of eligibility, accountability, and cost containment. Services provided through the ADW include homemaker services, chore services, basic and advanced respite care, adult day care service, and home delivered meals.

13.1.A SERVICE DEFINITIONS

13.1.A(1) Homemaker Services

Homemaker services (S5130) consist of general household activities provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others in the home. Homemaker services under this program may not be provided by an employee who is a member of the participant’s household or immediate family (parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild). Homemaker services are primarily directed toward home management and assistance with activities of daily living on a regular basis for a person who has a multiplicity of needs and requires this assistance in order to remain in the home. Homemaker services include one (1) or any combination of the following activities:

- Planning and preparing meals, including special diet menus, and cleaning-up meals;
- Tidying and dusting the home;
- Cleaning kitchen counters, cupboards, and appliances, including oven, surface burners, and inside refrigerator;
- Cleaning bathroom fixtures;
- Laundering clothes and linens;
- Making beds and changing sheets;
- Ironing and mending clothes;
- Washing dishes, pots, pans and utensils;
- Washing inside windows and cleaning blinds, which are within reach without climbing;
• Sweeping and/or vacuuming, and mopping floors;
• Bagging trash inside the home and putting it out for pick-up;
• Shopping for essential items (e.g., groceries, cleaning supplies, etc.);
• Performing essential errands (e.g., picking up medication, posting mail, etc.);
• Reading and writing essential correspondence for blind, illiterate, or physically impaired participants; and
• Instructing the participant in ways to become self-sufficient in performing household tasks.

13.1.A(2) Chore Services

Chore services (S5120) provide assistance with short-term intermittent tasks necessary to the maintenance of a clean, safe, sanitary, and habitable home environment. This service is restricted to non-skilled tasks, and the need for service is determined in relationship to the participant’s functioning capacity. As in the case of homemaker services, chore services under this program may not be provided by an employee who is a member of the participant’s household or immediate family. Available services include, at a minimum one (1) or any combination of the following activities:

• Washing walls and woodwork;
• Cleaning closets, basements, and attics;
• Shampooing rugs;
• Airing mattresses and bedding;
• Spraying for insects within the home using over-the-counter supplies; and
• Providing rodent control within the home (e.g., setting traps and putting out over-the-counter supplies).

13.1.A(3) Respite Care Services

Respite care is the provision of required care to a participant in order to provide temporary relief to the usual caregiver(s). In-home respite care is the delivery of the respite services within the confines of the participant’s normal living situation. Services are oriented toward maintenance and supervision and include meal preparation, minor personal care, and companion sitting. Respite services provided by members of the participant’s household or immediate family are not covered by MO HealthNet.

Basic respite care (S5150) is intended to offer periods of caregiver relief.

• Basic respite is authorized as a 15-minute unit.
• Additional in-home services—other than respite—may be authorized on the same day as basic respite care. However, the additional Home and Community Based Services (HCBS) cannot be provided at the same time as the authorized respite services.

In-home respite care **must** include the provision of the following services as appropriate to the needs of the participant, authorized by the Missouri Division of Senior and Disability Services (DSDS) or their designee, and specified in a person centered care plan developed in cooperation with the participant.

• Supervision—the respite care worker **must** provide supervision of the participant for the duration of the service period, although sleeping is permitted when the participant is asleep. The worker **must** be in close proximity to the participant during sleep periods, although **not** necessarily in the same room.

• Companionship—the worker **must** provide companionship during the participant’s waking hours and attempt to make the participant as comfortable as possible.

• Direct Participant Assistance—the worker **must** provide direct participant assistance as needed to meet the needs usually provided by the regular caregiver.

13.1.A(4) **Advanced Respite Care**

Advanced respite care services are maintenance services provided to a participant with special needs in that individual's residence for the purpose of temporary relief to a caregiver who lives with the participant. Participants appropriate for this service include persons with specific needs approved by DSDS or their designee. This includes, but is **not** limited to, participants who:

• are essentially bedfast, requiring turning and positioning and/or transferring from bed to a chair with or without assistive devices;

• require assistance with elimination (ambulation, urinal, bedpan, catheters, and/or ostomies);

• have behavior disorders or disruptive behavior which requires close monitoring;

• have health problems requiring prompting for self-administered medication or manual assistance with oral medications;

• have special monitoring and assistance needs due to swallowing problems; and
• have care needs similar to participants for whom basic respite is appropriately authorized but with a higher level of oversight required.

Advanced respite care (S5150TF) is authorized as a 15-minute unit.

Advanced respite care includes all personal care and advanced personal care services.

Additional in-home services—other than respite—may be authorized on the same day as advanced respite care. However, the additional HCBS cannot be provided at the same time as the authorized respite services.

13.1.A(5) Home Delivered Meals

Home delivered meals (S5170) is a service to provide an individual with one (1) or two (2) meals per day. Each meal contains at least one-third (1/3) of the recommended daily nutritional requirements.

A reimbursable unit of service is one (1) meal delivered to the home of the participant. Individuals must reside in their home or the home of a caregiver.

The maximum units of service are two (2) meals per day.

13.1.A(6) Adult Day Care Services

Adult Day Care (S5100 HC) is provided as a service to meet the needs and provide supervision to aged and disabled participants in an adult day care setting. Services include, but are not limited to, activities of daily living, planned group activities, food services, participant observation, transportation, and skilled nursing services as specified in the plan of care. Planned group activities include socialization, recreation and cultural activities that provide stimulation and help the participant maintain optimal functioning. Authorization for services should not exceed 40 units or 10 hours per day with a maximum of five (5) days per week. The provider must arrange or provide transportation to the adult day care setting at no cost to the participant. Transportation is limited to eight (8) units or two (2) hours maximum per day, which is included in the 10 hour per day maximum.

NOTE: Providers of Adult Day Care service, see the program requirements in Section 13 of the Adult Day Care manual.

13.1.B SERVICE LIMITATIONS

13.1.B(1) Place of Service

An Aged and Disabled Waiver provider may provide care in the following places of service:

12—Home: homemaker, chore, in-home respite care, and home delivered meals.
99—Other Place of Service: adult day care service.

13.1.C PROVIDER PARTICIPATION

The provider of Aged and Disabled Waiver services must have a valid participation agreement in effect with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC). All Aged and Disabled Waiver providers must immediately notify MMAC of any changes in location, telephone number, administrative, or corporate status.

The provider must notify MMAC at least 30 days prior to the termination of the provider agreement.

13.1.C(1) Homemaker, Chore, and In-Home Respite

To enroll in homemaker, chore, and in-home respite, the applicant must complete the necessary Provider Enrollment forms provided by MMAC.

13.1.C(2) Home Delivered Meals

The home delivered meals provider must be enrolled as an Aged and Disabled Waiver Program provider with a home delivered meals specialty and must maintain qualification as a nutrition service provider with the DSDS, meeting the requirements set forth in State Statute 660.099, RSMo., 19 CSR 15-4, 19 CSR 15-7, and the Older American’s Act, PL 114-144, as amended in 2016.

The provider must have the capability to provide the number of meals prior authorized regardless of the location of a participant within the designated service area. Designated service areas are determined by DSDS.

13.1.C(3) Adult Day Care Services

Providers of adult day care services are required to be licensed by the Department of Health and Senior Services and must meet the requirements of 192 RSMo before applying with the MMAC Unit for enrollment as a MO HealthNet Aged and Disabled Waiver provider.

13.1.D PARTICIPANT ELIGIBILITY

Eligibility for aged and disabled waiver services requires current MO HealthNet eligibility. In addition to being MO HealthNet eligible, the participant must:

- be 63 years of age or older;
- be assessed by the Division of Senior and Disability Services (DSDS) or their designee to have certain impairments and unmet needs, such that the participant requires admission to a nursing facility if aged and disabled waiver services are not provided; and
• be willing to receive comprehensive assessment and authorization of services from the DSDS or their designee.

Participants in State-only medical eligibility categories who meet the above criteria are not eligible to receive Aged and Disabled Waiver services reimbursed through MO HealthNet. Reference Section 1 of this manual.

The participant must be eligible for MO HealthNet services and meet the criteria for aged and disabled waiver services on the day the service is delivered. This is a requirement even when the service has been prior authorized by the DSDS or their designee. It is the responsibility of the provider to verify the participant’s MO HealthNet eligibility on the day the service is provided by contacting the interactive voice response (IVR) system at (573) 751-2896 or at https://www.emomed.com. Reference Section 3.3 of this manual for further information.

### 13.1.E AUTHORIZATION OF SERVICES

All units of Title XIX ADW services must be authorized by the DSDS or their designee before services can be delivered. Following development of a care plan by DSDS or their designee, the information is available in the HCBS Web Tool. It is the provider’s responsibility to access this information and provide services in accordance with the person centered care plan.

Specific information about prior authorization of services is contained in Section 14 of this manual.

### 13.2 ADMINISTRATION AND EMPLOYEE RESPONSIBILITY

For each in-home services (homemaker, chore and respite) worker, the provider must maintain documentation of at least two (2) employment or personal references contacted within 30 calendar days of the date of employment. References must be former employers or other reputable persons, excluding relatives of the worker. The documentation shall include the name of the employer and the individual giving the reference, the date, the response given when the reference was obtained by telephone and the signature of the person receiving the reference.

For in-home services workers, the provider must establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition. The provider must ensure that reporting requirements governing communicable diseases as set by the Missouri Department of Health and Senior Services (19 CSR 20-20), are carried out.

The provider must ensure that no in-home services worker is a member of the household or immediate family of the participant being served by that worker. A family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

The provider shall maintain bonding and personal liability insurance coverage on all employees who are involved in delivering in-home waiver services.

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The provider **must** protect the Departments of Social Services and Health and Senior Services and their employees, agents or representatives from any and all liability, loss, damage, cost and expense which may accrue or be sustained by the Departments of Social Services and Health and Senior Services, its officers, agents or employees as a result of claims, demands, costs, suits or judgments against it arising from the loss, injury, destruction or damage, either to person or property, sustained in connection with the performance of the in-home services.

The provider **must** issue to each in-home services worker, at the time of employment, a permanent identification card that shows the provider’s name and the employee’s name and title. The provider shall require each worker to carry the identification card to present to participants as necessary. The provider shall make every effort to repossess this identification card upon termination of employment. If unable to do so, the provider **must** retain on file a statement describing what efforts were made to recover the ID card.

Providers **must** ensure all subcontractors comply with all standards.

Providers **must** have an established grievance system through which a participant may present grievances concerning the operation of the Aged and Disabled Waiver Program. Providers **must** document the participant’s receipt of information regarding the grievance procedures.

Providers **must** establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to the Departments of Social Services' and Health and Senior Services' employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of participant funds or property, or falsification of documentation which verifies service delivery.

Providers **must** have the capability to provide services outside of regular business hours, on weekends, and on holidays in accordance with the person centered service plan (PCCP) for each participant. Services **must** be provided by qualified persons on the provider’s staff.

Providers **must** deliver the Aged and Disabled Waiver service within seven (7) calendar days of authorization of the PCCP or on the beginning date specified by the authorization, whichever is later, and on a regular basis thereafter in accordance with the PCCP. The date of authorization is documented in the HCBS Web Tool. If service is not initiated within the required time period, detailed written justification **must** be maintained in the participant’s file and be available to the Departments of Social Services' and Health and Senior Services' employees or representatives upon request.

**13.2.A PARTICIPANT RIGHTS**

The provider shall have a written statement of the participant’s rights, which is to be given to each participant or caregiver at the time service is initiated and that includes, at a minimum, the right to:

- be treated with respect and dignity;
• have all personal and medical information kept confidential;
• have direction over the services provided, to the degree possible, within the PCCP;
• know the provider’s established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;
• receive services without regard to race, creed, color, age, sex or national origin; and
• receive a copy of the code of ethics under which services are provided.

13.2.B ADULT ABUSE, NEGLECT, EXPLOITATION

• The Aged and Disabled Waiver provider must report all instances of potential abuse, neglect and/or exploitation of a participant to the DHSS’ Adult Abuse and Neglect Hotline, (800) 392-0210, including all instances that may involve an employee of the provider.

• Providers and any of their employees, including volunteers, shall agree to not accept donations, contributions, gifts or payments from any participant receiving aged and disabled waiver services.

• Providers must ensure that each employee is registered, screened, and employable according to the Family Care Safety Registry (FCSR), the Office of Inspector General (OIG) and the Employee Disqualification List (EDL) maintained by DHSS, and applicable state laws and regulations prior to employment.

• Providers must monitor the current Division of Regulation and Licensure Employee Disqualification List to ensure that no current or prospective employee’s name appears on the list and must take the appropriate action once it is discovered by the provider that the employee is on the EDL.

13.2.C PARTICIPANT NONLIABILITY

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

13.2.D DISCHARGE POLICIES AND PROCEDURES

Services for a participant shall be discontinued by a provider under the following circumstances:

• When the participant’s case is closed by the state agency, or its designee;

• When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to: death; entry into a nursing home; or the participant no longer needs services. In these circumstances, the provider shall
notify the state agency or its designee in writing and request that the participant’s services be discontinued;

- When the participant, participant’s family, or other person living in the household threatens or abuses the in-home services worker or other provider staff to the point where the staff’s welfare is in jeopardy and corrective action has failed. The provider shall notify the state agency or its designee of the threatening or abusive acts and may request that the service authorization be discontinued;

- When the participant is noncompliant with the person-centered care plan, or the provider is unable to continue to meet the needs of the participant still in need of assistance, the provider shall provide written notice of discharge to the participant or participant’s family and the state agency or its designee at least 21 days prior to the date of discharge. During this 21 day period, the state agency or its designee shall assist in making appropriate arrangements with the participant for transfer to another provider, institutional placement, or other appropriate care. Regardless of circumstances, the provider must continue to provide care in accordance with the care plan for these 21 days or until alternate arrangements can be made by the state agency or its designee, whichever comes first.

Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences have been conducted with the state agency or its designee, participant and participant’s family.

13.2.E PROVIDER COMPLIANCE

The Department of Social Services Missouri Medicaid Audit and Compliance Unit (MMAC) and Department of Health and Senior Services (DHSS) or their designee conduct both program and fiscal monitoring of the Aged and Disabled Waiver Program. Monitoring visits may be announced or unannounced. Providers must agree to comply with any evaluation conducted by MMAC and DHSS. DHSS may, in accordance with the protective service mandate (Chapter 192.2475 RSMo), take action to protect participants from providers who are found to be out of compliance with the requirements of their regulations and of any other regulations applicable to the Aged and Disabled Waiver Program. When such noncompliance is determined by MMAC and DHSS to create a risk of injury or harm to participants, appropriate action is taken. Evidence of such risk may include: unreliable or inadequate provider documentation of services or training due to falsification or fraud, the provider’s failure to deliver services in a reliable and dependable manner, or use of workers who do not meet the minimum training standards. Immediate action by the DSS and DHSS or their designee, may include, but is not limited to:

- Removing the provider from any list of providers, and

- Informing current clients served by the provider of the provider’s noncompliance and that the MMAC has determined the provider unable to deliver safe care. Such
clients are allowed to choose a different provider from the list maintained by the MMAC, which is then authorized to provide service to them.

13.3 HOME AND COMMUNITY-BASED SERVICES (HCBS) SETTINGS REQUIREMENTS

In accordance with 42 CFR 441.301(c)(4), the setting in which HCBS are provided must be integrated in and supports full access of individuals receiving HCBS to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, choose where they live, and receive services in the community to the same degree as individuals who do not receive Home and Community Based Services.

Setting Requirements

To comply with 42 CFR 441.301(c)(4), providers who enroll with MO HealthNet on or after March 17, 2014 must be in compliance and maintain continued compliance with the following requirements. Providers enrolled with MO HealthNet prior to March 17, 2014 who do not meet the following requirements must be in compliance with the requirements by March 17, 2022.

- Be integrated in and support full access to the greater community;
- Provide opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources;
- Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;
- Be selected by the individual from among setting options, including non-disability specific settings and options for a private unit in a residential setting;
- Ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimize individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitate individual choice regarding services and supports, and who provides them.

13.4 PERSONNEL REQUIREMENTS

13.4.A SUPERVISORY STAFF OF IN-HOME SERVICES

An in-home services care supervisor shall be designated by the provider ownership or administrative management to supervise the day to day delivery for direct waiver services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.
The designated supervisor shall be at least 21 years of age. In addition, the supervisor **must** meet at least one (1) of the following criteria before performing the supervisory duties required by these standards. The supervisor **must**:

- be a registered nurse (RN) licensed in the State of Missouri;
- have a baccalaureate degree;
- be a licensed practical nurse (LPN) who is currently licensed in Missouri with at least one (1) year of experience with the direct care of the aged, disabled or infirm; or
- have three (3) years experience in the care of the aged, disabled or infirm.

All providers enrolled to provide home delivered meals shall comply with all personnel requirements pursuant to 19 CSR 15-7.060.

All Adult Day Care Waiver providers shall comply with all personnel requirements pursuant to 19 CSR 30-90.

**13.4.B IN-HOME SERVICES WORKER REQUIREMENTS**

All in-home services workers providing respite and homemaker services who are employed by the provider **must**:

- be at least 18 years of age;
- be able to read, write and follow directions; and
- have at least six (6) months paid work experience as an agency homemaker, nurse aide, housekeeper or household worker, or at least one (1) year experience, paid or unpaid, in caring for children or for older adults or adults with a disability. Successful completion of formal training in nursing arts or as a nursing aide or home health aide, can substitute for the qualifying experience. This information **must** be verified and documented in the employee’s file through reference checks.

All chore workers employed by the provider **must**:

- be at least 18 years of age; and
- be able to read, write, and follow directions.

All providers enrolled to provide home delivered meals shall comply with all personnel requirements pursuant to 19 CSR 15-7.060.

All Adult Day Care Waiver providers shall comply with all personnel requirements pursuant to 19 CSR 30-90.
13.5 SUPERVISION OF IN-HOME SERVICES

The duties of the designated supervisor of in-home services include the following:

- Monitor the provision of services by the in-home services worker to ensure that services are delivered in accordance with the services authorized by the Division of Senior and Disability Services (DSDS) or its designee. This shall include routine review and comparison of the aide’s record of provided services with the person centered care plan for each participant, the units of service authorized (on the person centered care plan), the tasks specified and the authorized frequency of delivered services. Maintain written documentation in the individual participant file including any discrepancies between authorized and delivered units that fall below 100% of service delivery. A description of corrective action taken must be signed and dated by the supervisor and be readily available for monitoring or inspection.

- Complete a written evaluation of each in-home services worker’s performance at least annually. The evaluation must be based in part on at least one (1) on-site visits. The worker must be present during the visits. The written report of the evaluation must document the visits, contain the participants’ names and addresses, the date and time of the visits, the worker’s name, and the supervisor’s observations and notes from the visits. The on-site visits must also include an evaluation of the adequacy of the person centered care plan, including review of the person centered care plan with the participant.

  In addition to information from the on-site visits, the written evaluation must contain sufficient other data on the worker’s performance to demonstrate that the evaluation was based on qualified observation. The written evaluation must show what support, supervision, and other intervention is planned as a result of the evaluation. The evaluation must be signed and dated by the supervisor who prepared it and by the worker. The written record of the evaluation shall be maintained in the personnel file of the worker. If the required evaluation is not performed or not documented, the in-home services worker’s qualification to provide the service may be presumed inadequate and all payments made for services by that worker may be recouped.

- Designate a trainer(s) to perform on-the-job training sessions required as part of the basic training of the in-home services worker. The designated trainer(s) may be the supervisor or a worker who has been employed by the provider at least half-time for a period of six (6) months. A list of designated trainers and documentation of any exceptions waiving the required length of employment must be available for monitoring.

- Communicate, in writing, with the DSDS or their designee regarding changes in any participant’s condition and recommended changes in scope or frequency of service delivery.

- Be available for regular case conferences with the appropriate state agency.
13.6 TRAINING FOR IN-HOME SERVICES

The following information provides guidelines for the minimum training for in-home services workers (homemaker, chore and respite).

13.6.A ORIENTATION AND BASIC TRAINING

Orientation and basic training for all aged and disabled waiver staff must include at least the following:

- Organization, purpose and philosophy of the aged and disabled waiver provider;
- Relationship of the provider to the Division of Senior and Disability Services and the Missouri Medicaid Audit and Compliance Unit;
- Code of ethics;
- Activities that must and must not be performed under the standards for services;
- Basic first aid and procedures to be followed in an emergency;
- Information about record-keeping and report forms required by the standards; and
- Overview of Alzheimer disease and related dementia pursuant to the requirements of 192.2000.7, RSMo.

Additional topics for the orientation of in-home services workers shall include:

- Techniques in basic aged and disabled waiver activities;
- Techniques in food preparation, nutritional requirements, and basic sanitation practices;
- Household management and home maintenance skills;
- Safety precautions and recognition of job hazards; and
- Information about the availability of other community resources.

13.6.B DOCUMENTATION OF BASIC AND IN-SERVICE TRAINING FOR IN-HOME SERVICES WORKERS

All in-home services workers who provide services reimbursed by MO HealthNet must meet or have met the same training standards as are required under the Title XIX Personal Care Program. Under these standards a worker could be trained once for all programs, as long as specific training is provided in each area. Such program specific training must include both classroom and supervised on-the-job components for each program, and detailed documentation must be maintained.

The provider shall have written plans for basic and in-service training of the in-home services workers. These plans should include content for sessions. The plans should be updated as
needed, to reflect the training needs of the provider staff, as well as to incorporate any changes in the standards for Title XIX services.

The provider must maintain a report of each individual worker’s training in that worker’s personnel record. The report must document the dates, hours and location of classroom, in-service and on-the-job training, the trainer's name, the topics, the date of first participant contact, and the worker's signature. Participant contact may be either supervised on-the-job training or unsupervised service delivery. If a waiver of basic training has been granted, the worker’s individual training report shall contain supportive data for the waiver.

Other required documentation includes a topical outline of each session’s content, the mode of training (classroom or on-the-job), the trainer’s name, the location, the date and hours of the session, and the signature of the attendee(s). Deviations in content from the written plan should be noted and explained.

The provider may choose to maintain the above listed documentation in a master training log or may file the documentation in each worker’s personnel file. The documentation must be readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.

13.6.B(1) Basic Training for In-home Services Workers

When individuals are employed as in-home services workers, they shall receive a minimum of 20 hours of basic training. The following requirements apply to this training.

• All basic training must be completed within 30 days of the first day of employment.
• Eight (8) hours of classroom training must be completed prior to first participant contact.
• New employee orientation must include an overview of Alzheimer’s disease and related dementias and methods of communicating with persons with dementia pursuant to the requirements of Section 192.2000.7 RSMo.
• Two (2) hours of basic training must include orientation to the provider and the provider’s protocols for handling emergencies.
• Four (4) hours of basic training must include supervised on-the-job training under the direction of the designated trainer.
• Reading materials shall constitute no more than two (2) of the total 20 hours.
13.6.B(2) Supervised on the Job Training Review for In-Home Services

The on-the-job training review shall consist of the observation of the aide’s performance of services under the direction of a designated trainer. This review may take place during an on-site visit or in a classroom demonstration and must be performed within 30 days of the first date of employment.

The on-the-job training review shall ensure aides have been trained to competently perform all service tasks ensuring all policies, procedures and proper care of participants are met as specified in 19 CSR 15-7.


As part of basic training, the provider shall distribute to all in-home services workers a code of ethics. The code of ethics shall forbid, at a minimum, the following actions:

- Using the participant’s car;
- Consuming the participant’s food or drink (except water);
- Using the participant’s telephone for personal calls;
- Discussing own or others' personal problems or religious or political beliefs with the participant;
- Accepting gifts or tips;
- Bringing other persons to the participant’s home;
- Consuming alcoholic beverages, or using medicine or drugs for any purpose, other than medical, in the participant’s home or prior to service delivery;
- Smoking in the participant’s home;
- Accepting or soliciting money or goods for personal gain from the participant;
- Breaching the participant’s privacy and confidentiality of information and records;
- Purchasing any item from the participant even at fair market value;
- Assuming control of the financial and/or personal affairs of the participant or the participant’s estate including power of attorney, conservatorship, guardianship;
- Residing with the participant in either the participant’s or worker’s residence;
- Taking anything from the participant’s home; and
- Committing any act of abuse, neglect, or exploitation.
13.6.C WAIVER OF BASIC TRAINING FOR IN-HOME SERVICES WORKERS

13.6.C(1) Experience or Aide Certification

The provider must supply eight (8) hours of classroom training, but may waive the additional 12 hours of the in-home services worker's basic training with adequate documentation in the employee’s records that the employee has received similar training during the current or preceding state fiscal year, or has been employed as an aide in an in-home or home health agency at least half-time for six (6) months or more within the current or preceding state fiscal year. The eight (8) hours of classroom training must include two (2) hours of provider agency orientation.

13.6.C(2) Licensed Nurse/Certified Nurse Assistant (CNA)

All basic training requirements, except a minimum two (2) hour provider orientation may be waived, with documentation in the in-home services worker's personnel record that the worker is a registered nurse, licensed practical nurse or certified nurse assistant.

13.6.C(3) Provider Verification

It is ultimately the provider’s responsibility to judge whether or not the previous training for in-home services workers was sufficient to justify a waiver. If the training is waived, the provider should obtain adequate documentation about the employee’s previous training. The provider may obtain written or phone verification of the previous training which includes at least the following:

1. The name, address, and phone number of the employer from whom the training was received.
2. The date or dates of the training.
3. A summary of the content and number of hours of the training.
4. For phone verification, the date of the phone contact, and the name of the person verifying the training information.

13.6.D ADVANCED RESPITE WORKER TRAINING

In addition to meeting the basic training requirements of the Aged and Disabled Waiver Program, the advanced respite worker must receive additional training. The additional training is determined and provided by the provider RN following assessment of the participant's condition and needs. Advanced respite care services shall not be assigned or performed by an advanced respite worker who is not a licensed nurse until the worker has been fully trained to perform the service, and the RN has personally observed and documented successful execution of the service.
The documentation **must** be signed by the RN, filed in the worker's personnel record, and be available for monitoring or inspection by MMAC or DHSS.

### 13.6.E IN-SERVICE TRAINING FOR IN-HOME SERVICES WORKERS

All in-home services workers shall receive a total of 10 hours of in-service training annually after the first 12 months of employment.

At least six (6) hours of the required 10 hours shall be classroom instruction. The additional four (4) hours may use any appropriate training method. A training hour is 60 minutes.

The provider may waive the required annual in-service training hours, and require only two (2) hours of refresher training annually, when the worker has been employed for three (3) years and has completed 30 hours of in-service training that meets the standards set forth in this section. This waiver shall be adequately documented and noted in the employee’s records.

Training should be conducted by the provider staff as well as by professionals available from other agencies such as the University Extension Service, County Health Departments, Red Cross or other community resources. Training shall reinforce and extend the content of orientation training and should include the following:

- Process and effects of aging;
- Problems identification and procedures for making appropriate referrals;
- Meal preparation for special diets;
- Home management and budgeting;
- Comparison shopping techniques;
- Problems common to older adults and adults with disabilities;
- AIDS education;
- Alzheimer’s and related dementia;
- Death and dying; and
- Recognizing and reporting abuse, neglect and financial exploitation.

In-service training for staff performing only chore service activities is left to the discretion of the provider.

### 13.7 RECORDS

The Aged and Disabled Waiver provider shall document implementation of requirements for the following, as applicable:

- Coordination with other providers;
- Non-discrimination on basis of disability; and
13.7.A PARTICIPANT CASE RECORD

The provider shall maintain a participant case record including records of service provision for each participant. The participant record is confidential and shall be protected from damage, theft, and unauthorized inspection. It shall be maintained in a central location, and shall contain at least the following:

• The person centered care plan authorization from the HCBS Web Tool, which documents authorization for all units of service provided;

• Copies of any written communications transmitted to the Division of Senior and Disability Services or their designee;

• Each provider may design its own services log sheet or Electronic Visit Verification (EVV) records, but all paid units of services must be documented. If these documents are not maintained in the participant’s case record, they must be readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services or any other state or federal agency acting on these departments' behalf. If the services delivered differ from the services specified in the person centered care plan, the discrepancy must be explained in writing by the supervisor;

• For in-home services, the participant’s service log sheets or EVV records must contain the in-home services worker’s name, the participant’s name, dates of service delivery, actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service delivery to a single individual and tasks performed on each date. For paper service log sheets the participant’s signature and worker’s signature for each date of service is also required. If the participant cannot write, the participant’s mark (X) shall be witnessed by at least one (1) person who may be the worker. The worker may only sign on behalf of the participant when the participant is unable to sign or make his/her mark (X) and there is no other responsible person present. Initials are not acceptable in lieu of the entire signature. Another responsible person, present in the home while the service is delivered, may sign the service log for each date of service.

• Documentation of all correspondence and contacts with the participant’s physician or other care providers; and

• Any other pertinent documentation regarding the participant.

13.7.B PERSONNEL RECORD

The provider must maintain an individual record for each aged and disabled waiver worker. A personnel record is a confidential record and shall be protected from damage, theft and/or
unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application with the employee's signature showing the date of birth, education, work experience, and the date employed and terminated by the service provider;
- For RNs and LPNs, a copy of their current Missouri license;
- Documentation of at least two (2) references contacted;
- Documentation of basic and in-service training received (individual training report, reference Section 13.6.A and for in-home services workers, also reference Section 13.6.B);
- Documentation for any waiver of employment or training requirements (reference Section 13.6.C);
- Annual performance evaluation which includes observations from one (1) on-site visit for in-home services workers;
- For supervisory staff, documentation that they have been provided with and have read Section 13 of this provider manual;
- Signed statement(s) verifying that the worker received the code of ethics and that the provider policy regarding confidentiality of participant information was explained prior to service delivery;
- Returned ID card for a terminated in-home services worker, or documentation of why it is not available; and
- Copies of the written explanation that document discrepancies between authorized and delivered services, and describing the corrective action taken. These copies must be maintained in a central location and available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.
- Copy of the Family Care Safety Registry (FCSR) Screening conducted prior to employment in accordance with 192.2495.1, RSMo and documentation of compliance with Good Cause Waiver guidelines found in 19 CSR 30-82.060 if applicable. (NOTE: Adult Day Care Facilities shall conduct FCSR screenings at least every 90 days in accordance with 19 CSR 30-90).
- Providers are encouraged to check each employee monthly against the Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) for current employees and prior to employment for prospective employees. All employee background screenings must be retained by the provider either electronically or in paper form and must be made available upon request by DHSS or Social Service’s staff.
• The provider must also maintain the written plans for basic training and in-service training.

13.7.C 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 Agency, and must furnish or make the records available for inspection or audit by the Departments of Social Services and Health and Senior Services or their 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.

13.7.D ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3, Section (1)(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.

13.7.D(1) Required Documentation

The following are the requirements for the documentation of services rendered:

1. The date of service (DOS);

2. The time spent providing the service; Time spent must be documented by one (1) of the following methods:

• Actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service delivery to a single individual is documented. For example, if an in-home services worker is providing services to one (1) individual in a private home setting and devotes undivided attention to the care required by that individual, the
actual clock time the worker began the services for that visit is the start
time, and the actual clock time the worker finished the care for the visit
is the stop time. (Example—Time spent: 9:30 a.m. to 10:30 a.m.) If
more than one (1) visit per day is required, each separate visit has a start
and a stop clock time noted. This method may also be used in a setting
where the worker is providing care to and dividing his or her attention
among several individuals. The actual clock start and stop time for each
period of uninterrupted service delivery for each individual is clearly
documented.

• Any other method that includes all required elements of documentation
listed in this section.

• Pursuant to 660.023, RSMo, and 19 CSR 15-9 all in-home services
provider agencies were required by July 1, 2015, to have, maintain, and
use an electronic visit verification system (EVV) for the purpose of
reporting and verifying the delivery of home and community-based
services as authorized by the Department of Health and Senior Services.
At a minimum, the EVV shall: record the exact date services are
delivered; record the exact time the services begin and exact time the
services end; verify the telephone number from which the services were
registered; verify the number from which the call is placed is a telephone
number unique to the client; require a personal identification number
unique to each personal care attendant; and be capable of producing
reports of services delivered, tasks performed, client identity, beginning
and ending times of services and date of service in summary fashion that
constitute adequate documentation of service.

3. A description of the service (specific tasks);
4. The name of the worker who provided the in-home services;
5. The participant’s name and MO HealthNet number; and
6. For each date of in-home services: the signature of the participant, or the mark
of the participant witnessed by at least one (1) person, or the signature of
another responsible person present in the participant’s home at the time of
service. A responsible person may include the Aged and Disabled Waiver
worker's supervisor, if the supervisor is present in the home at the time of
service delivery. The worker may only sign on behalf of the participant when
the participant is unable to sign and there is no other responsible person
present. The entire signature of the participant or witness to the mark or the
responsible party must be present in the record for each date of service billed
to MO HealthNet. Initials are not acceptable in lieu of the entire signature.
The provider shall *not* submit claims solely on the basis of the prior authorization, but *must* base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing home during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were *not* necessary or could *not* be delivered. The prior authorization merely establishes the maximum number of hours and types of services which may be delivered to a participant during a time period. All units billed to MO HealthNet *must* be supported by the documentation of delivery as described in this section.

For home delivered meals, providers *must* maintain appropriate documentation at the meals distribution site. Appropriate documentation shall include daily meal delivery route logs. At a minimum, each log shall contain the following information: participant name, delivery address, DCN, DOS and a "delivered" indicator. The delivery driver *must* attest, with his/her signature on the log, that the meal(s) were delivered.

For adult day care services, as set forth in 19 CSR 30-90, appropriate documentation *must* be maintained at the facility. Appropriate documentation *must* include at a minimum: the date of service, actual start clock time of when the participant arrives at the facility and end clock time of when the participant leaves the facility, actual start and stop time of transporting the participant to and from the facility, the address from which the participant was picked up and the address where the participant was returned to after day care services, the name of the worker providing the transportation, the name of the day care facility, the participant’s name and MO HealthNet number.

### 13.7.D(2) Unit of Service

A unit of aged and disabled waiver service is defined as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>ONE UNIT EQUALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Chore</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Basic Respite</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Advanced Respite</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Home Delivered Meal</td>
<td>1 meal</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
A unit of service includes time spent completing documentation and obtaining service participant signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall not be included.

Providers shall not bill MO HealthNet participants for any services reimbursed by MO HealthNet or for any services that would have been reimbursed by MO HealthNet if the provider had followed proper policies and procedures for obtaining payment.

NOTE: A unit of service for home delivered meals is defined as a "delivered unit of service" which is a meal delivered to the participant in the participant’s home or home of their caregiver. The maximum units of service are two (2) meals per day.

13.7.D(3) Accrued Units—Homemaker, Chore and Respite (15-Minute Unit Services)

Aged and disabled waiver providers may bill up to one (1) full calendar month of service on one (1) detail line of a claim when billing for homemaker, chore or respite services (15-minute services). It is permissible to accrue partial units (of homemaker, chore or respite) of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month, as long as care delivery is consistent with the person centered care plan.

The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 to 11:40 on June 1, then provides care from 10:00 to 12:10 on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4.

- When billing multiple dates of service on one (1) detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do not round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of service to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15=41.33 units. Bill for 41 whole units (15 minutes) of service.

- When billing multiple dates of service on one (1) detail line of a claim, dates during which the participant is in a hospital, in a nursing home, visiting relatives or is ineligible should not be included in the range of dates.

- When billing multiple dates of service on one (1) detail line of a claim, do not bill for dates of service falling in two (2) separate calendar months.
13.7.D(4) Billing Services by the Month—Home Delivered Meals

Home delivered meal providers may bill up to one (1) full calendar month of service on one (1) detail line of a claim.

The following instructions apply to billing accrued units on one (1) detail line of a claim:

- The "from" and "to" format must be utilized for dates of service.
- The provider must not bill for dates falling in two (2) separate calendar months on the same detail line.
- The provider must only bill for the total delivered units of service, not the total units authorized for any given month.
- When billing for multiple dates of service on one (1) detail line of a claim, the range of dates should not include dates that a participant is in a hospital, in a nursing home, visiting relatives or ineligible.

13.7.D(5) Billing Service by the Day – Adult Day Care

Aged and disabled waiver providers may bill up to 40 units per day on one detail line of a claim when billing for adult day care services.

When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 – 11:40 on June 1, then provides care from 10:00 -12:10 on June 4. Six (6) units of service are billed for June 1, and nine (9) units of service are billed on June 4.

The provider must only bill for the total bill for the total delivered units of service, not the total units authorized for any given month.

13.7.D(6) Billing Services by the Month—Adult Day Care

Aged and disabled waiver providers may bill up to one full calendar month of service on one detail line of a claim when billing for adult day care services.

The following instructions apply to billing accrued units on one detail line of a claim:

- The "from" and "to" format must be utilized for dates of service.
- The provider must not bill for dates falling in two separate calendar months on the same detail line.
- The provider must only bill for the total delivered units of service, not the total units authorized for any given month.
• When billing for multiple dates of service on one detail line of claim, the range of dates should not include dates that a client is in a hospital, in a nursing home, or ineligible.

13.8 QUALITY ASSURANCE

All providers are subject to survey by the Missouri Department of Social Services (DSS) or any entity that DSS authorizes to conduct such surveys to ensure compliance and quality of care.

13.9 AUTHORIZED SERVICES FOR HOSPICE

When electing the hospice benefit, a MO HealthNet participant does not automatically forfeit his or her right to receive medical services such as home and community-based waiver services. When a MO HealthNet participant is authorized with an agency to receive personal care services or home and community-based waiver services for the aged and disabled and then elects hospice, the Division of Senior and Disability Services (DSDS) or their designee must coordinate the person centered care plan in collaboration with the hospice provider to ensure that services are not duplicative.

The hospice may provide short-term inpatient respite care. Aged and disabled waiver respite services are provided in the home. The waiver respite service cannot be authorized during times when inpatient respite care under the hospice benefit is used. Respite care is appropriate for the hospice participant who has a caregiver (other than the hospice provider) who needs to be away from the home for periods of time (two (2) to 12 hour periods or for up to several days at a time). The DSDS or their designee authorizes respite, when necessary, to augment hospice services.

13.10 MANAGED HEALTH CARE PROGRAM

Aged and disabled waiver services are not included as a plan benefit of the MO HealthNet Managed Care Health Plans.

13.11 PARTICIPANT COST SHARING AND COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Aged and Disabled Waiver Program described in this manual are not subject to a cost sharing or copay amount.

13.12 PROVIDER REASSESSMENTS

Home and Community Based Services (HCBS) providers have the option to partner with the Division of Senior and Disability Services (DSDS) to gather the necessary information in order for DSDS to determine continued eligibility for HCBS. If a provider chooses not to participate in the reassessment and care planning process, DSDS will reassess the participant.
13.12.A PROVIDER REQUIREMENTS

If a provider chooses to assist with the reassessment of participants, the following criteria must be met:

- HCBS providers must complete a reassessment packet with Missouri Medicaid Audit and Compliance (MMAC) and must be approved by MMAC as a reassessment provider in order to complete and bill for the completed reassessments.

- Each month, a list of participants requiring reassessment is sent by DSDS to each provider through SharePoint. Providers must only complete and bill for reassessments of participants that are included in the lists provided by DSDS. Reassessments completed by qualified providers may only be billed for participants when appearing on the list provided by DSDS. Providers may bill only once for these reassessments.

- A provider must ensure that all reassessments are completed by:
  1. Provider staff that have either attended the DSDS sponsored train-the-trainer classes and passed the test; or
  2. Provider qualified staff that was trained by an individual who attended and passed the train-the-trainer class. A list of all individuals who have passed the train-the-trainer test is maintained on the DHSS website at http://health.mo.gov/seniors/hcbs/.

- Providers must maintain all appropriate documentation to verify that the reassessment was completed. This documentation should indicate on what date the reassessment was completed and what provider staff member completed the reassessment.

- Documentation of the reassessment training must be kept in the personnel file of the individual completing the reassessment if the staff member completing the reassessment is not listed on the DSDS maintained Trainer list. Documentation within the personnel file must include the name of the individual who provided the training and the date that the training occurred.
SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

All services covered by the Title XIX (MO HealthNet) Aged and Disabled Waiver (ADW) Program must be prior authorized by the Missouri Division of Senior and Disability Services (DSDS), or its designee. DSDS utilizes the Home and Community Based Services (HCBS) Web Tool, a component of the Department of Social Services, MO HealthNet Division’s (MHD) MO HealthNet Cyber Access system. HCBS providers can receive Web Tool guidance by reviewing the HCBS Web Tool Instructional Guide at the following link. http://health.mo.gov/seniors/hcbs.

The Participant Case Summary Prior Authorization – Care Plan Services line in the HCBS Web Tool indicates an approved, “posted” prior authorization to include the specific prior authorization number (PA#). The expanded line shows which services are authorized, the specific period of time covered by the authorization and the total units per month. The expanded individual service line displays the associated tasks/frequency for the selected service type. To view and print the posted prior authorization, the HCBS provider selects the print icon for the appropriate care plan.

The effective date for the posted authorization cannot precede the completion date of the assessment. The end date for the posted authorization shall not exceed the last full month within 365 days from the completion date of the assessment.

The provider should be aware that if a participant loses MO HealthNet eligibility during an ADW authorized period of time, services are not reimbursed for the ineligible dates. Providers are referred to Section 1 of the manual for details about participant eligibility.

Providers should make sure that the participant's name and identification number on the Participant Case Summary screen match the participant's MO HealthNet ID card, and that the Prior Authorization – Care Plan Services screen contains the provider's correct name for the service to be provided. If any of these items are incorrect, the provider should immediately contact DSDS or its designee to initiate a correction.

In addition to the Prior Authorization – Care Plan Services the provider has access to scanned documents (e.g., Participant Choice Statement, HCBS General Health Evaluation & LOC recommendation, etc.) and Case Notes within the participant’s HCBS Web Tool record by navigating the Case Activity Screen.

The provider also has access to the following information in the participant’s HCBS Web Tool record.

- Prescreen; and
- Assessment Screen.

Any document used to bill for services rendered (e.g., electronic visit verification records, time sheets) must be retained for six (6) years and be open to inspection as specified in Section 13 of this manual.
14.1 PRIOR CONTENTS NO LONGER APPLICABLE

14.2 HOME AND COMMUNITY BASED SERVICES REFERRAL

Referrals for HCBS can be made to DSDS or its designee by utilizing the HCBS Referral form (HCBS-1). This form is designed to provide DSDS or its designee information about probable service needs and other persons significant to the participant's situation. This document can be utilized by accessing the link below and faxing it to DSDS’ call center at (573) 526-2915.


OR

In an effort to expedite the referral process for HCBS, referrals can be made by calling DSDS’ call center toll free at (866) 835-3505.

14.3 PARTICIPANT CHOICE STATEMENT

The Participant Choice Statement allows documentation of the participant’s involvement in determining the plan of care by including the participant’s acknowledgment of their:

- participation in the development of the person centered care plan;
- right to have anyone involved in the development of the person centered care plan;
- right to choose and receive home and community based services rather than nursing facility care;
- right to choose a qualified home and community based provider;
- rights regarding discriminatory behavior in service delivery;
- expectations and responsibilities;
- need to notify the DHSS’s Central Registry Unit (CRU) to report abuse, neglect, or exploitation;
- right to appeal any reduction or closing of services regarding their person centered care plan;
- need to notify the appropriate DSDS Regional Evaluation Team of any problems concerning service delivery as well as changes in health, informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment.

The Participant Choice Statement is completed by DSDS or its designee upon initial assessment and any subsequent assessment. DSDS or its designee reviews the information covered on the form with the
participant and ensures the participant understands the information. The document is scanned and attached in the participant’s HCBS Web Tool record. A copy is provided to the participant.

14.4 PARTICIPANT CASE SUMMARY PRIOR AUTHORIZATION CARE PLAN SERVICES

The Prior Authorization – Care Plan Services with the Finalized Line Items expanded is designed to provide information to the participant and provider identifying the specific service(s), authorization date(s), provider(s), total monthly units, and associated tasks and frequencies that are to be provided.

The authorization is finalized by DSDS or its designee. This information is a component of the HCBS Web Tool and can be accessed by the provider. DSDS or its designee sends a copy of the initial Care Plan to the participant and their physician.

14.5 HOME AND COMMUNITY SERVICES REGIONAL EVALUATION TEAMS MAP

Providers and/or participants must notify the appropriate DSDS Regional Evaluation Team to request a care plan change. A copy of the DSDS, Regional Evaluation Team map may be found by accessing the following link:

SECTION 15-BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12 Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. For Missouri specific information, including connection methods, the biller’s responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12 Version v5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12 Version v5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://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 aged and disabled waiver 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 COMMUNICATIONS CALL CENTER

PRODUCTION :  02/04/2023
Provider Communications Call Center assists providers with inquiries, concerns, and questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verifications. The 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 MO HealthNet Technical 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. If a line item on a claim paid but the payment was incorrect do not resubmit that line item. For instance, if a provider bills the incorrect amount for a service, the claim cannot be resubmitted. It will deny as a duplicate. Section 6 of this manual explains the adjustment request process.

15.6 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of Health Insurance Coverage</td>
<td>Show the type of health insurance coverage applicable to this claim by checking the appropriate box, For example, if a Medicare claim is being filed, check the Medicare box; if a MO HealthNet claim is being filed, check the Medicaid box and if the participant has both Medicare and MO HealthNet, check both boxes.</td>
</tr>
</tbody>
</table>
**1a. Insured’s I.D. Number**  
Enter the patient’s eight-digit MO HealthNet 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 the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13. If no private insurance is involved, leave blank.

**5. Patient’s Address**  
Enter address and telephone number if available.

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

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

**8. Reserved for NUCC Use**  
Leave blank.

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

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

**9b. Reserved for NUCC Use**  
Leave blank.

**9c. Reserved for NUCC Use**  
Leave blank.
**9d.** Insurance Plan Name or Program Name
Enter the other insured’s insurance plan or program name.

*If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. 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 patient’s employment, auto accident, or other accident, mark the appropriate box. If the services are *not* related to an accident, leave blank.

10d. Claim Codes (Designated by NUCC)
Leave blank.

**11.** Insured’s Group Policy or FECA 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, Sex
Enter primary policyholder’s date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note)\(^{(1)}\)

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

**11c.** Insurance Plan Name or Program Name
Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. If no private insurance is involved, leave blank. (See Note)\(^{(1)}\)

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

12. Patient’s or Authorized Person’s Signature
Leave blank.
*13. Insured’s or Authorized Person’s Signature

This field should be completed only when the patient has another health insurance policy. Obtain the policyholder’s or authorized person’s signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of 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. Other Date
Leave blank.

16. Dates Patient Unable to Work
Leave blank.

**17. Name of Referring Provider or Other Source

Enter the name of the referring MO HealthNet enrolled primary care provider or other source. If multiple providers are involved, enter one provider using the following priority order:

1. Referring provider
2. Ordering Provider

**17a. Other ID #
Leave blank.

**17b. NPI
Enter the NPI number of referring or ordering provider.

18. Hospitalization Dates
Leave blank.

19. Additional Claim Information (Designated by NYCC)
Leave blank. Providers may use this field for additional remarks/descriptions.

20. Outside Lab
Leave blank.
21. Diagnosis

Enter the complete current International Classification of Diseases-Clinical Modification (ICD-CM) diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.

NOTE: A diagnosis code is not required when billing home delivered meals services on paper claims. Fields #21 and #24e of the CMS-1500 claim form should be left blank. However, a diagnosis code is required for billing home delivered meals services electronically. Electronically filed claims must have the current ICD-CM diagnosis code Z72.4 (Inappropriate Diet and Eating Habits) in the appropriate field.

22. Resubmission Code

For timely filing purposes; if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.

23. Prior Authorization Number

Leave blank.

24A. Date(s) of Service

Enter the date(s) of service under “from” in MM/DD/YY format, using six-digit format in the unshaded area of the field. All line items must have a from date. Refer to Section 13.6.D(3). For home delivered meals, refer to Section 13.6.D(4). The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.
**24B. Place of Service**
Enter the appropriate place of service code in the unshaded area of the field. For homemaker/chore, in-home respite, and home delivered meals this is 12, “home”. For adult day care, 99 “other unlisted facility”.

**24C. EMG-Emergency**
Leave blank.

**24D. Procedure Code**
Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. See Section 19 of this manual for applicable procedure codes. (Field #19 may be used for remarks or descriptions.)

**24E. Diagnosis Pointer**
Enter A, B, C, D or the actual diagnosis code(s) from Field #21 in the unshaded area of the field.

NOTE: A diagnosis code is **not** required when billing home delivered meals services on paper claims. Fields #21 and #24E of the CMS-1500 claim form should be left blank. However, a diagnosis code is required for billing home delivered meals services electronically. Electronically filed claims **must** have the current ICD-CM diagnosis code, Z72.4 (Inappropriate Diet and Eating Habits), in the appropriate field.

**24F. Charges**
Enter the provider’s usual and customary charge for each line item in the unshaded area of the field. This should be the total charge for multiple days or units.

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

**24H. EPSDT/Family Planning**
Leave blank.

**24I. ID Qualifier**
Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The other ID number if the rendering provider should be reported in 24J in the shaded area.
**24J. Rendering Provider ID**
The individual rendering service is reported here. Enter the NPI number of the provider in the unshaded area of the field.

25. Federal Tax ID Number
   (SSN#/EIN#)
   Leave blank.

26. Patient’s Account Number
   For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.

27. Accept Assignment
   Leave blank.

*28. Total Charge
   Enter the sum of the line item charges.

29. Amount Paid
   Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are **not** to be entered in this field.

30. Reserved for NUCC
   Leave blank.

31. Provider Signature
   Leave blank.

**32. Service Facility Location Information**
If services were rendered in a facility other than the home or office, enter the name and location of the facility.

This field is required when the place of service is other than home or office.

**32a. NPI#**
Enter the NPI number of the service facility location reported in Field #32.

**32b. Other ID#**
Enter number. A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.

*33. Billing Provider Info & Phone
   Provider Name, Number and Address.

**33a. NPI #**
Enter the NPI number of the billing provider in Field #33.

**33b. Other ID #**
Enter number.

MO HealthNet reimburses the lower of the provider's billed charge or the MO HealthNet maximum allowed amount for the unit of service billed. Providers may **not** bill MO HealthNet at a higher rate than they charge their private service clients. Providers **must** bill MO HealthNet their usual and customary rate. Providers **must** maintain appropriate documentation.
* 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, employer's name or other information appears in this field, the claim will deny. See Section 5 of this manual for further TPL information.

15.7 PLACE OF SERVICE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
</tr>
<tr>
<td>99</td>
<td>Other Unlisted Facility</td>
</tr>
<tr>
<td></td>
<td>Other place of service not identified</td>
</tr>
</tbody>
</table>

15.8 INSURANCE COVERAGE

Type of insurance coverage codes identified on the interactive voice response (IVR) system, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability (TPL).

While providers are verifying the patient’s eligibility, they can obtain the TPL information contained on the MO HealthNet’s Division participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, or by accessing the internet at https://www.emomed.com. Reference Sections 1 and 3 of this manual for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by the IVR, or Internet. IT IS THE PROVIDER’S RESPONSIBILITY TO OBTAIN FROM THE PATIENT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.
SECTION 16 - MEDICARE/MEDICAID CROSSOVER CLAIMS

For participants having both Medicare and Medicaid eligibility, MO HealthNet pays the amounts indicated by Medicare to be deductible and/or coinsurance due on the Medicare allowed amount. These payments are referred to as “Crossovers.”

Section 16, Medicare/Medicaid Crossover Claims, 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
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Environmental Lead Assessment
- Hospice
- Independent Living Waiver
- Medically Fragile Adult Waiver
- MRDD Waiver
- Personal Care
- Private Duty Nursing

The following programs contain a modified Section 16, Medicare/Medicaid Crossover Claims

- Dental
- Durable Medical Equipment
- Home Health
- Hospital
- Nursing Home
- Pharmacy

END OF SECTION  
TOP OF PAGE
SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim cannot pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.
17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:
- Crossovers
- Inpatient
- Outpatient (Includes Rural Health Clinic and Hospice)
- Medical
- Nursing Home
- Home Health
- Dental
- Drug
- Capitation
- Credits
Claims in each category are listed alphabetically by participant’s last name. Each category starts on a separate RA page. If providers do not have claims in a category, they do not receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

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

NOTE: If the participant’s name and identification number are not on file, only the first two letters of the last name and the first letter of the first name appear.

<table>
<thead>
<tr>
<th>MO HEALTHNET ID</th>
<th>The participant’s current 8-digit MO HealthNet identification number.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICN</td>
<td>The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:</td>
</tr>
</tbody>
</table>

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)
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.
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QTY</td>
<td>The units of service submitted.</td>
</tr>
<tr>
<td>BILLED AMOUNT</td>
<td>The submitted billed amount for the specific detail line.</td>
</tr>
<tr>
<td>ALLOWED AMOUNT</td>
<td>The MO HealthNet maximum allowed amount for the procedure/service.</td>
</tr>
<tr>
<td>PAID AMOUNT</td>
<td>The amount MO HealthNet paid on the claim.</td>
</tr>
<tr>
<td>PERF PROV</td>
<td>The NPI number for the performing provider submitted at the detail.</td>
</tr>
<tr>
<td>SUBMITTER LN ITM CNTL</td>
<td>The submitted line item control number.</td>
</tr>
<tr>
<td>GROUP CODE</td>
<td>The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CR—Correction and Reversals</td>
</tr>
<tr>
<td></td>
<td>OA—Other Adjustment</td>
</tr>
<tr>
<td></td>
<td>PI—Payer Initiated Reductions</td>
</tr>
<tr>
<td></td>
<td>PR—Patient Responsibility</td>
</tr>
<tr>
<td>RSN</td>
<td>The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at <a href="http://www.wpc-edi.com/codes/claimadjustment">http://www.wpc-edi.com/codes/claimadjustment</a>.</td>
</tr>
<tr>
<td>AMT</td>
<td>The dollar amount adjusted for the corresponding reason code.</td>
</tr>
<tr>
<td>QTY</td>
<td>The adjustment to the submitted units of service. This field is not printed if the value is zero.</td>
</tr>
<tr>
<td>REMARK CODES</td>
<td>The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RX—National Council for Prescription Drug Programs Reject/Payment Codes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at <a href="http://www.wpc-edi.com/codes/remittanceadvice">http://www.wpc-edi.com/codes/remittanceadvice</a>.</td>
</tr>
<tr>
<td>CATEGORY TOTALS</td>
<td>Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.</td>
</tr>
<tr>
<td>CHECK AMOUNT</td>
<td>The total check amount for the provider.</td>
</tr>
</tbody>
</table>
EARNINGS REPORT
PROVIDER IDENTIFIER       The provider’s NPI number.
RA #                     The remittance advice number.

EARNINGS DATA
NO. OF CLAIMS PROCESSED  The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED  The total dollar amount processed for the provider.
CHECK AMOUNT             The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at [http://www.wpc-edi.com/content/view/180/223/](http://www.wpc-edi.com/content/view/180/223/). A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A Repricing</td>
<td>OA</td>
<td>Other Adjustment 45</td>
</tr>
<tr>
<td>Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment cut back to federal percentage (IEP therapy services)</td>
<td>OA</td>
<td>Other Adjustment A2</td>
</tr>
<tr>
<td>Contractual adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment reduced by co-payment amount</td>
<td>PR</td>
<td>Patient Responsibility 3</td>
</tr>
<tr>
<td>Co-Payment amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment reduced by patient spenddown amount</td>
<td>PR</td>
<td>Patient Responsibility 178</td>
</tr>
<tr>
<td>Payment adjusted because patient has not met the required spenddown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment reduced by patient liability amount</td>
<td>PR</td>
<td>Patient Responsibility 142</td>
</tr>
<tr>
<td>Claim adjusted by monthly MO HealthNet patient liability amount</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should not have been made at all, there will not be a corrected payment ICN.
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are not listed on the Remittance Advice (RA). To inquire on the status of a submitted claim not appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.
17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.
SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

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

The diagnosis code must be entered on the claim exactly as it appears in the current International Classification of Diseases-Clinical Modification (ICD-CM). Note that the appropriate code(s) may be three (3) to seven (7) digits, depending upon the patient’s diagnosis.

Additional information regarding the current ICD-CM may be found at www.cdc.gov/nchs/icd.htm.
SECTION 19 - PROCEDURE CODES

Procedure codes used by MO HealthNet are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into three (3) subsystems, referred to as level I, level II and level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes. Level III codes have been developed by Medicaid State agencies for use in specific programs. NOTE: Replacement of level III codes is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should reference bulletins for code replacement information.

19.1 PROCEDURE CODES

All homemaker, chore, respite and home delivered meals are authorized by the Department of Health and Senior Services (DHSS)/Division of Senior and Disability Services (DSDS). Participants must be 63 or older to be authorized for these services.

19.1.A HOMEMAKER

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5130</td>
<td>Homemaker service</td>
<td>15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

19.1.B CHORE

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5120</td>
<td>Chore service</td>
<td>15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.
### 19.1.C BASIC RESPITE

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5150</td>
<td>Basic Respite</td>
<td>15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

### 19.1.D ADVANCED RESPITE

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5150TF</td>
<td>Advanced Respite</td>
<td>15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

### 19.1.E HOME DELIVERED MEALS

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5170</td>
<td>Home Delivered Meal</td>
<td>per delivered meal</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

Maximum of two (2) meals per day.

### 19.1.F ADULT DAY CARE SERVICE

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5100HC</td>
<td>Adult Day Care</td>
<td>15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 99-other unlisted facility

Authorization should not exceed 40 units or 10 hours per day with a maximum of five (5) days per week.
19.1.G PROVIDER REASSESSMENTS

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>SERVICE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1028TS</td>
<td>Participant Reassessments</td>
<td>one per year*</td>
</tr>
</tbody>
</table>

*Reassessments are done by the provider upon notification of a list provided by DSDS.
SECTION 20 - EXCEPTION PROCESS

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

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

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

END OF SECTION
SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is not applicable to the following manuals:

- Adult Day Health Care
- Aged and Disabled Waiver
- Ambulance
- Ambulatory Surgical Centers
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- MRDD Waiver
- Nurse Midwife
- Optical
- Pharmacy
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy

END OF SECTION

TOP OF PAGE
SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation’s (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do not have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

- **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
Aged and Disabled Waiver

- 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.

PRODUCTION : 02/04/2023
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Transportation</td>
<td>Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.</td>
</tr>
<tr>
<td>Grievance (Participant)</td>
<td>A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are <em>not</em> limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker’s personnel, or failure to respect the participant’s rights.</td>
</tr>
<tr>
<td>Grievance (Transportation Provider)</td>
<td>A written request for further review of a transportation provider’s complaint that remains unresolved after completion of the complaint process.</td>
</tr>
<tr>
<td>Inquiry</td>
<td>A request from a transportation provider regarding information that would clarify broker’s policies and procedures, or any aspect of broker function that may be in question.</td>
</tr>
<tr>
<td>Most Appropriate</td>
<td>The mode of transportation that accommodates the participant’s physical, mental, or medical condition.</td>
</tr>
<tr>
<td>MO HealthNet Covered Services</td>
<td>Covered services under the MO HealthNet program.</td>
</tr>
<tr>
<td>Medically Necessary Service(s)</td>
<td>Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could <em>not</em> 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 <em>must</em> be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.</td>
</tr>
<tr>
<td>Medical Service Provider</td>
<td>An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NEMT Services</td>
<td>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 <em>not</em> 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.</td>
</tr>
<tr>
<td>No Vehicle Available</td>
<td>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.</td>
</tr>
<tr>
<td>Participant</td>
<td>A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.</td>
</tr>
<tr>
<td>Pick-up Time</td>
<td>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.</td>
</tr>
<tr>
<td>Public Entity</td>
<td>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.</td>
</tr>
<tr>
<td>Transportation Leg</td>
<td>From pick up point to destination.</td>
</tr>
<tr>
<td>Transportation Provider</td>
<td>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.</td>
</tr>
<tr>
<td>Urgent</td>
<td>A serious, but <em>not</em> life threatening illness/injury. Examples include, but are <em>not</em> limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do <em>not</em> 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.</td>
</tr>
</tbody>
</table>
| Will Call                | An unscheduled pick-up time when the participant calls the broker or
transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker must ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days’ notice if they are of an urgent nature. Urgent calls are defined as a serious, but not life threatening illness/injury. Urgent trips may be requested by the participant or participant’s medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do not include transportation. In addition, the broker must arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker must also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are not available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant’s parent/guardian, AND
2. Hospital is more than 120 miles from the participant’s residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.
If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant must be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are not eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.

2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.

3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.

4. Participants who have access to NEMT through the Medicare program.

5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are not related to the participant’s terminal illness.

6. Participants in a MO HealthNet managed care health plan.
   a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall not be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant must request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards
are based on the participant’s county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

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

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

**TRAVEL STANDARDS: MAXIMUM MILEAGE**

<table>
<thead>
<tr>
<th>Provider/Service Type</th>
<th>Urban Access County</th>
<th>Basic Access County</th>
<th>Rural Access County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicians</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCPs</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Neurology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Dermatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Physical Medicine/Rehab</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Vision Care/Primary Eye Care</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Allergy</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Cardiology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nephrology</td>
<td>25</td>
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</table>
### Aged and Disabled Waiver

<table>
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<th>Specialty</th>
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</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
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</tr>
<tr>
<td>Orthopedics</td>
<td>25</td>
<td>50</td>
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</tr>
<tr>
<td>Otolaryngology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Urology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>General surgery</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Psychiatrist-Adult/General</td>
<td>15</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>Psychiatrist-Child/Adolescent</td>
<td>22</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>Psychologists/Other Therapists</td>
<td>10</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>15</td>
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<td>60</td>
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</tbody>
</table>

### Hospitals

<table>
<thead>
<tr>
<th>Type</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Basic Hospital</td>
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</tr>
<tr>
<td>Secondary Hospital</td>
<td>50</td>
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</tr>
</tbody>
</table>

### Tertiary Services

<table>
<thead>
<tr>
<th>Service</th>
<th>100</th>
<th>100</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I or Level II trauma unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Neonatal intensive care unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Perinatology services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cancer services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cardiac services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric subspecialty care</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

### Mental Health Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>25</th>
<th>40</th>
<th>75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health treatment facility</td>
<td>25</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Ambulatory mental health treatment providers</td>
<td>15</td>
<td>25</td>
<td>45</td>
</tr>
</tbody>
</table>

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Aged and Disabled Waiver

Residential mental health treatment providers 20 30 50

<table>
<thead>
<tr>
<th>Ancillary Services</th>
<th>30</th>
<th>30</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Occupational Therapy</td>
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<td>Speech Therapy</td>
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<td>Audiology</td>
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</table>

The broker must transport the participant when the participant has chosen a qualified, enrolled medical service provider who is not within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is not a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the Family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
   • Participant eligibility; and
   • MO HealthNet covered service.

PRODUCTION : 02/04/2023
22.7 COPAYMENTS

The MO HealthNet Division (MHD) does not require copayments for any services at this time. Providers will be notified when copayments are reinstated.

22.8 MODES OF TRANSPORTATION

The broker must arrange the least expensive and most appropriate mode of transportation based on the participant’s medical needs. The modes of transportation that may be utilized by the broker include, but are not limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi or rideshare service;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker must not utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant’s trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.
The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that ModivCare (formerly LogistiCare) provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist ModivCare (formerly LogistiCare) by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller must provide the following information:

- The patient/participant’s name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.
22.11 NON-COVERED SERVICES

The following services are not eligible for NEMT:

1. The broker shall not provide NEMT services to a pharmacy except when a participant has an appointment to receive a vaccination.

2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall not be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.

3. School districts must supply a ride to services covered in a child’s Individual Education Plan (IEP).

4. The broker shall not arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall not provide delivery of DME products in lieu of transporting the participant.

5. The broker shall not provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.

6. The broker shall not provide NEMT services for discharges from a nursing home.

7. The broker shall not authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children’s Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.

2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child’s Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **KCATA/RideKC Connection** KCATA provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Agency DBA Metro Transit** Metro Transit provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.

5. **City Utilities of Springfield, Transit** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.

6. **City of Jefferson/Jefftran** Jefftran is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Jefftran is provided to all eligible individuals with disability without priority given for trip purpose. Jefftran is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.

7. **Nevada City Hospital** Nevada City Hospital transports individuals who live within a 20 mile radius of Nevada.

8. **Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

### 22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker’s network, for as long as the broker is unable to...
provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers must coordinate with the broker with respect to payment. The broker must ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does not apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers’ non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall not utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a “hit” on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under ‘Definition’, must be filed with the NEMT broker. The broker must resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite210
Maryland Heights, MO  63043
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants must be given the rights listed below:
1. **General rule.** The broker must comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker’s personnel and transportation providers take those rights into account when furnishing services to participants.

2. **Dignity and privacy.** Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

3. **Copy of transportation records.** Each participant is guaranteed the right to request and receive a copy of his or her transportation records.

4. **Free exercise of rights.** Each participant is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the broker and the broker’s transportation providers or the state agency treat the participant.

## 22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice must indicate that the broker has denied the services, the reasons for the denial, the participant’s right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant’s estate.

## 22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

ModivCare (formerly LogistiCare)  
13690 Riverport Drive  
Suite 210  
Maryland Heights, MO 63043
22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a ModivCare (formerly LogistiCare) facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the ModivCare (formerly LogistiCare) facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, ModivCare (formerly LogistiCare) will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to ModivCare (formerly LogistiCare).
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform ModivCare (formerly LogistiCare) of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to ModivCare (formerly LogistiCare) so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an
overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and

2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the ModivCare (formerly LogistiCare) Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.

2. A ModivCare (formerly LogistiCare) Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, ModivCare (formerly LogistiCare) will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by ModivCare (formerly LogistiCare).

3. ModivCare (formerly LogistiCare) will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.

4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice ModivCare (formerly LogistiCare) along with a copy of the ModivCare (formerly LogistiCare) Authorized Ancillary Services Form.
for the meals to ModivCare (formerly LogistiCare) MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.

5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the ModivCare (formerly LogistiCare) Facility Department, 13690 Riverport Drive, Suite 210, Maryland Heights, MO 63043. They must reference the job number and date of service on the receipt for reimbursement. The job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.

7. The confirmation number (job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The ModivCare (formerly LogistiCare) staff determines where the driver is and ensures the participant is transported.

2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.

3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.

4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.
22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. ModivCare's (formerly LogistiCare) QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any ModivCare (formerly LogistiCare) representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call ModivCare (formerly LogistiCare) at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All ModivCare (formerly LogistiCare) approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, ModivCare’s (formerly LogistiCare)'s Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for ModivCare (formerly LogistiCare).

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.
C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a ModivCare (formerly LogistiCare) Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a ModivCare (formerly LogistiCare) window decal is applied to the vehicle. This provides for a quick visual identification of a ModivCare (formerly LogistiCare) approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to ModivCare (formerly LogistiCare) through the WMR line referenced above. For reoccurring issues, the ModivCare (formerly LogistiCare) Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. ModivCare (formerly LogistiCare) will attempt to schedule transport with the preferred provider; however ModivCare (formerly LogistiCare) is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. ModivCare (formerly LogistiCare) will investigate any incident causing such a request.
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

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

These attachments should not be submitted with a claim form. These attachments should be mailed separately to:

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

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

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do not need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is not found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment must be submitted incorporating the new procedure code.
23.2  CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.