STATE OF MISSOURI

DURABLE MEDICAL EQUIPMENT MANUAL

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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

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

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

1.1.A(2) MO HealthNet for Kids

ME CODE	DESCRIPTION
05, 06	Eligible children under the age of 19 in MO HealthNet for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional MO HealthNet.

60	Newborns (infants under age 1 born to a MO HealthNet or managed care participant).
40, 62	Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.
07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70	Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.
36, 56	Children who receive a federal adoption subsidy payment.
71, 72	Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)
73	Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
74	Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.

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

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

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

1.1.A(4) Voluntary Placement Agreement for Children

ME CODE	DESCRIPTION
88	Children seventeen (17) years of age or younger in need of mental health treatment whose parent, legal guardian or custodian has signed an out-of-home care Voluntary

Placement Agreement (VPA) with the Department of Social Services (DSS) Children's Division.

1.1.A(5) State Funded MO HealthNet

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

1.1.A(6) MO Rx

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

1.1.A(7) Women's Health Services

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

1.1.A(8) ME Codes Not in Use

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

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

The Department of Social Services issues a MO HealthNet ID card for each MO HealthNet or managed care eligible participant. For example, the eligible caretaker and each eligible child

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

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

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

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

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

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

1.2.A FORMAT OF MO HEALTHNET ID CARD

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

An ID card does not guarantee benefits. It is important that the provider always check eligibility and the MO HealthNet/Managed Care Eligibility (ME) code on file for the date of

service. The ME code helps the provider know program benefits and limitations including copay requirements.

1.2.B ACCESS TO ELIGIBILITY INFORMATION

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

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

A pregnant woman who has *not* applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits

during pregnancy. The following ME codes identify people who have TEMP eligibility:

58, 59

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

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

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

1.2.C(5) Presumptive Eligibility for Children

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

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

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

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

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

Children determined eligible for out-of-home care, per a signed Voluntary Placement Agreement (VPA), require medical planning and are eligible for a variety of children's treatment services, medical and psychiatric services. The Children's Division (CD) worker makes appropriate referrals to CD approved

contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates.

ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

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

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

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

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

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

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

If a patient who has *not* applied for MO HealthNet, state funded Medical Assistance or MO HealthNet Managed Care benefits is unable to pay for services rendered and appears to meet

eligibility requirements, the provider should encourage the patient or the patient's representative (related or unrelated) to apply for benefits through the Family Support Division in the patient's county of residence. Information can also be obtained by calling the FSD Call Center at (855) 373-4636. Applications for MO HealthNet Managed Care may be requested by phone by calling (888) 275-5908. The county office accepts and processes the application and notifies the patient of the resulting determination.

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

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

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

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

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

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

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

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

1.4.A NEWBORN INELIGIBILITY

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

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

1.4.B NEWBORN ADOPTION

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

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

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

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

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

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

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

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

Senate Bill 539 was passed by the 93rd General Assembly and became effective August 28, 2005. Changes in MO HealthNet Program benefits were effective for dates of service on or after September 1, 2005. The bill eliminated certain optional MO HealthNet services for

individuals age 21 and over that are eligible for MO HealthNet under one of the following categories of assistance:

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

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

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

NOTE: MO HealthNet participants residing in nursing homes are able to use their surplus to pay for federally mandated medically necessary services. This may be done by adjudicating claims through the MO HealthNet claims processing system to ensure best price, quality, and program integrity. MO HealthNet participants receiving home health services receive all federally mandated medically necessary services. MO HealthNet children and those in the assistance categories for pregnant women or blind participants are *not* affected by these changes.

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

care health plan *must* have their basic benefit services provided by or prior authorized by the managed care health plan.

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

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

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

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

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

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

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

- Group 5 consists of uninsured children.

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

* Participants who are identified as eligible for inclusion in the managed care program are *not* enrolled with a managed care health plan until 15 days after they actually select or are assigned to a managed care health plan. When the selection or assignment is in effect, the name of the managed care health plan appears on the IVR/Internet

information. If a managed care health plan name does *not* appear for a particular date of service, the participant is in a fee-for-service status for each date of service that a managed care health plan is *not* listed for the participant.

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

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

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

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

1.5.D HOSPICE BENEFICIARIES

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

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

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

When a participant elects the hospice benefit, the hospice assumes the responsibility for managing the participant's medical care related to the terminal illness. The hospice provides

or arranges for services reasonable and necessary for the palliation or management of the terminal illness and related conditions. This includes all care, supplies, equipment and medicines.

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

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

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

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

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

eligible for MO HealthNet services and *not* restricted to the QMB-only providers and services.

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

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

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

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

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

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

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

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

1.5.G TEMP PARTICIPANTS

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

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

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

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

1.5.G(1) TEMP ID Card

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

A white paper TEMP card can be issued by qualified providers to *pregnant* women whom they presume to be eligible for MO HealthNet based on income guidelines. A TEMP card is issued for a limited period but presumptive eligibility may be extended if the pregnant woman applies for public assistance at the county Family

Support Division office. The TEMP card may only be used for ambulatory prenatal services. Because TEMP services are limited, providers should verify that the service to be provided is covered by the TEMP card.

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

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

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

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

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

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

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

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

Most women who are eligible for Show Me Healthy Women, receive a Show Me Healthy Women-paid screening and/or diagnostic service and are found to need treatment for either breast and/or cervical cancer, are eligible for MO HealthNet coverage. For more information,

providers may reference the Show Me Healthy Women Provider Manual at http://www.dhss.mo.gov/BreastCervCancer/providerlist.pdf .

1.5.I(1) Eligibility Criteria

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

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

The BCCT MO HealthNet Application *must* be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be

approved, if the woman was eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.

1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

An individual and/or spouse must have earnings from employment or self-employment. There is no minimum level of employment or earnings required. The maximum is gross income allowed is 250% of the federal poverty level, excluding any earned income of the worker with a disability between 250 and 300% of the federal poverty level. "Gross income" includes all income of the person and the

person's spouse. Individuals with gross incomes in excess of 100% of the federal poverty level shall pay a premium for participation.

1.5.J(3) Premium Payment and Collection Process

An individual whose computed gross income exceeds 100%, but is not more than 300%, of the FPL must pay a monthly premium to participate in TWHAP. TWHAP premium amounts are based on a formula specified by State statute. On new approvals, individuals in the premium group must select the beginning date of coverage, which may be as early as the first month of the prior quarter (if otherwise applicable) but no later than the month following approval. If an individual is not in the premium group, coverage begins on the first day of the first month the client is eligible.

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

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

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

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

1.5.J(4) Termination of Coverage

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

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

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

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

1.5.K(1) Eligibility Determination

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

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

1.5.K(2) MO HealthNet for Kids Coverage

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

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

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

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

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

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

Children determined eligible for out-of-home care, (ME88), per a signed VPA, are eligible for a variety of children's treatment services, medical and psychiatric

services. The CD worker makes the appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates. Providers should contact the local CD staff for payment information.

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

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

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

Certain MO HealthNet participants are subject to the provisions of Day Specific Eligibility. This means that some MO HealthNet participants lose eligibility at the time of case closure, which may occur anytime in the month. Prior to implementation of Day Specific Eligibility, participants in all categories of assistance retained eligibility through the last date of the

month if they were eligible on the first of the month. As of January 1, 1997, this varies for certain MO HealthNet participants.

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

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

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

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

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

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

1.6.B SPENDDOWN

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

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

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

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

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

1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

On spenddown cases, MO HealthNet only reimburses providers for covered medical expenses that exceed a participant's spenddown amount. MO HealthNet does *not* pay the portion of a bill used to meet the spenddown. To prevent MO HealthNet from paying for an expense used to meet spenddown, MHD withholds the participant liability amount of spenddown met on the first day of coverage for a month. The MHD system tracks the bills received for the first day of coverage until the bills equal the participant's remaining spenddown liability. For the first day of coverage, MHD denies or splits (partially pays) the claims until the participant's liability for that first day is reduced to zero. After MHD has reduced the liability to

zero for the first day of coverage, other claims submitted for that day of spenddown coverage are paid up to the MO HealthNet rate. Claims for all other days of spenddown coverage process in the same manner as those of non-spenddown participants. MHD notifies both the provider and the participant of any claim amount *not* paid due to the bill having been used to meet spenddown.

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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

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

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

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

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

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

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

1.7.A NEW APPROVAL LETTER

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

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

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

Reinstated Temporary MO HealthNet for Needy Families (TMNF) individuals have received a letter from the Family Support Division that serves as notification

of temporary medical eligibility. They may use this letter to contact providers to access services.

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

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

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

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

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

participant of individuals being added to a case and authorizes MO HealthNet coverage for individuals being added.

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

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

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

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

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

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

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

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

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

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

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

1.8 TRANSPLANT PROGRAM

The MO HealthNet Program provides limited coverage and reimbursement for the transplantation of human organs or bone marrow/stem cell and related medical services. Current policy and procedure is administered by the MO HealthNet Division with the assistance of its Transplant Advisory Committee.

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

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

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

1.8.B PATIENT SELECTION CRITERIA

The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the

type of transplant to be performed. The patient *must* have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

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

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

1.8.C CORNEAL TRANSPLANTS

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

1.8.D ELIGIBILITY REQUIREMENTS

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

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

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

1.8.E MANAGED CARE PARTICIPANTS

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

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

Claims for the pre-transplant assessment and care are the responsibility of the managed care health plan and *must* be authorized by the MO HealthNet managed care health plan.

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

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

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

1.8.F MEDICARE COVERED TRANSPLANTS

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

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

END OF SECTION

TOP OF SECTION

SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

2.1.C PROVIDER ENROLLMENT ADDRESS

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

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit
P. O. Box 6500
Jefferson City, Missouri 65102
mmac.providerenrollment@dss.mo.gov

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

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

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

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

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

2.2 NOTIFICATION OF CHANGES

A provider *must* notify the Provider Enrollment Unit within five (5) days by certified mail of:

- Change of provider address. This is necessary to ensure that all checks and correspondence are received promptly. Indication of change of address on a claim form is *not* sufficient.
- Change of ownership of business. A new participation agreement is required.
- Change of Licensure.

- Change of direct deposit information.

2.3 RETENTION OF RECORDS

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

2.3.A ADEQUATE DOCUMENTATION

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

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

2.4 NONDISCRIMINATION POLICY STATEMENT

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

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

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

2.6 FRAUD AND ABUSE

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

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

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

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

The penalties for such acts range from misdemeanors to felonies with fines *not* to exceed $25,000 and imprisonment up to 5 years, or both.

Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are *not* limited to, the following:

- Review of participant profiles of use of services and payment made for such.

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

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

2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

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

2.7 OVERPAYMENTS

The Missouri Medicaid Audit and Compliance Unit routinely conduct postpayment reviews of MO HealthNet claims. If during a review an overpayment is identified, the Missouri Medicaid Audit and Compliance Unit is charged with recovering the overpayment pursuant to 13 CSR 70-3.030. The Missouri Medicaid Audit and Compliance Unit maintains the position that all providers are held responsible for overpayments identified to their participation agreement regardless of any extrinsic relationship they may have with a corporation or other employing entity. The provider is responsible for the repayment of the identified overpayments. Missouri State Statute, Section 208.156, RSMo (1986) may provide for appeal of any overpayment notification for amounts of $500 or more. An appeal *must* be filed with the Administrative Hearing Commission within 30 days from the date of

mailing or delivery of the decision, whichever is earlier; except that claims of less than $500 may be accumulated until such claims total that sum and, at which time, the provider has 90 days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the Commission.

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

2.8 POSTPAYMENT REVIEW

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

2.9 PREPAYMENT REVIEW

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

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

2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

MO HealthNet providers *must* complete a Direct Deposit for Individual Provider form to receive reimbursement for services through direct deposit into a checking or savings account. The

application should be downloaded, printed, completed and mailed along with a voided check or letter from the provider's financial institution to:

Missouri Medicaid Audit and Compliance (MMAC)

Provider Enrollment Unit

P.O. Box 6500

Jefferson City, MO 65102

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

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

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

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

All payments are direct deposited.

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

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

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

Please be aware that any updates or changes made to the emomed file will *not* update the provider master file. Therefore updates or changes should be requested in writing. Requests can be emailed to the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section (www.mmac.providerenrollment@dss.mo.gov).

END OF SECTION

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SECTION 3 - PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES

The MO HealthNet Division and Missouri Medicaid Audit and Compliance Unit has staff to assist providers and potential providers with questions regarding enrollment, claims filing, payment problems, participant eligibility verification, prior authorization status, etc. Assistance can be obtained by contacting the appropriate unit.

3.1.A WIPRO INFOCROSSING HELP DESK

Wipro Infocrossing provides a help desk for use by fee-for-service providers, electronic billers and managed health care 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 MO HealthNet Division.
- front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- front-line assistance to managed health care 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 PROVIDER ENROLLMENT UNIT

The Missouri Medicaid Audit and Compliance Unit Provider Enrollment Section sends provider enrollment packets and processes enrollment applications and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained at mmac.providerenrollment@dss.mo.gov.

3.3 PROVIDER RELATIONS COMMUNICATION UNIT

This unit responds to specific provider inquiries concerning MO HealthNet eligibility, claim filing instructions, billing errors, etc. Routine questions, in most cases, can be handled by telephone and e-mail. Providers should submit complex inquiries in writing.

A copy of a lost Remittance Advice older than three years can be obtained by contacting the Provider Relations Communication Unit's number (573) 751-2896. A minimal copy fee is required

prior to release of the replacement. An old or lost RA within three years can be requested at the billing web site at www.emomed.com. In the section "File Management" you can request and print a current RA by clicking on "Printable Remittance Advice". To retrieve an older RA click on "Request Aged RA's" fill out the required information and submit. The RA will be under "Printable Aged RA's" the next day. The requested RA will remain in the system for 5 days.

Providers can access information through various methods, including the interactive voice response (IVR) system, Internet (www.emomed.com), Family Support Call Center, and written inquiries, which are described in this section.

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 inquiry options:

1. Participant eligibility
2. Last two check amounts
3. Claim status
5. MO HealthNet informational message
0. Speak to MO Health Net Specialist

This system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service during their period of enrollment as an active MO HealthNet provider. The 10-digit NPI number *must* be entered each time any of the IVR options are accessed. ***The provider should listen to all eligibility information, particularly the suboptions.***

Option 1. Participant Eligibility

The caller is prompted to supply the following information:

- Provider's NPI number
- MO HealthNet participant's ID, Social Security Number or casehead ID
- Date of birth (if inquiry by Social Security Number)
- Dependant date of birth (if inquiry by casehead ID)
- First date of service (mm/dd/yy)
- Last date of service (mm/dd/yy)

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 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 QMB or the Presumptive Eligibility (TEMP) Program. Please reference the provider manual for a description of these services. Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Refer to Section 1 for more 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-menu. The sub-menu options include:

1 Managed care enrollment and health plan name and telephone number

2 Eye exam and eyeglass information

3 Third party liability information

4 Medicare Part A, Part B, Part C, Part D and/or QMB coverage

5 MO HealthNet ID, participant name, spelling of participant name and repeat of eligibility information

6 Repeat of confirmation number

7 Inquiry on another participant

8 Return to the main menu

9 End the call

0 Transfer to a MO HealthNet hotline specialist

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

Option 2. Last Two Check Amounts

The caller is prompted to supply their NPI number.

The caller is given the last two remittance advice (RA) dates, RA numbers and electronic payment check amounts. Check amount inquiries are limited to ten provider numbers per call. The caller is told if the provider for which the inquiry being made is eligible to bill their claims electronically.

Option 3. Claim Status

The caller is prompted to supply the following:

- Provider’s NPI number

- Participant ID
- First date of service (mm/dd/yy)
- Claim type (optional), valid values are:

  zero (0) - any claim type

  One (1) - medical

  Two (2) - inpatient

  Three (3) - outpatient

  Four (4) - dental

  Five (5) - home health

  Six (6) - drug

  Seven (7) - nursing home

  Eight (8) - Medicare crossover

The caller is provided the status of the most current claim that matches the date of service and claim type entered. The caller is told whether the claim is paid, denied, approved to pay or being processed. The caller is given the amount paid, RA date and the internal control number (ICN). In cases where a claim has been denied, the IVR reads an explanation of the EOB assigned to the denied claim. Claim status inquiries are limited to ten inquiries per call.

Option 5. MO HealthNet Informational Message

The caller is prompted to supply their MO HealthNet provider number.

The caller is given the option to select from a list of informational messages. The IVR tells the caller to which MO HealthNet Program or topic each informational message pertains. When a particular message option is selected, a detailed message is read to the caller by the IVR. The informational messages available through this option may include, but are *not* limited to, changes or additions to the MO HealthNet Program, areas of interest for specific provider types, changes to the managed care program, and special instructions for receiving additional information. The messages are similar to the types of informational messages occasionally appearing on the cover page of provider remittance advices. If no informational messages are currently available on the message area, callers are *not* able to select option 5 from the main menu.

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.

If needed information is *not* available through the above options, the IVR allows the caller to request to speak to a MO HealthNet hotline specialist. Please allow for a 15 to 20 second waiting period for the IVR to complete the call transfer process. If all specialists are busy, the call is put into a queue and will be answered in the order it was received.

3.3.B MO HEALTHNET SPECIALIST

Specialists are on duty between the hours of 8:00AM and 5:00PM, Monday through Friday (except holidays) to provide information *not* available through the interactive voice response (IVR) system. The IVR number is (573) 751-2896. Providers are urged to:

- Review the provider manual and bulletins before calling the IVR.
- Have all material related to the problem (such as Remittance Advice, claim forms, and participant information) available for discussion.
- Have the provider's NPI number available.
- Limit the call, if possible, to three questions or three to four minutes. 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.

3.3.C INTERNET

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://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.

The internet inquiry options include the same inquiry options available through the interactive voice response (IVR) system. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security Number and date of birth, claim status and check inquiry. 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 Remittance Advice from the Internet. Access to this information is restricted to users with authorization. In addition to the Remittance Advice, 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 web site include: claim submission; claim attachment submission; inquiries on claim status, attachment status, and check amounts; and credit adjustment(s).

Refer to Section 1 for more detailed information on participant eligibility.

3.3.D WRITTEN INQUIRIES

Letters directed to the Provider Relations Communication Unit are answered by trained MO HealthNet specialists. 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 lodge 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 provider's name, NPI number, address, and telephone number. Written inquiries should also include the MO HealthNet participant's full name, MO HealthNet identification number, and birthdate. A copy of all pertinent information, such as Remittance Advice forms, invoices, participant information, form letters, and timely filing documentation *must* be included with the written inquiry.

3.4 PROVIDER EDUCATION UNIT

This unit serves as a major link of communication and assistance between The MO HealthNet Division and the provider community. Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MO HealthNet Program. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to furnish assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, computer-to-computer trainings and both individual and associational meetings to provide instructions on procedures, policy changes, benefit changes, etc., which affect the provider community.

Representatives are available, when in the state office, to talk with providers in person or by telephone. The Provider Education Unit is located at 615 Howerton Court, Jefferson City, Missouri. Providers may call (573) 751-6683 to arrange an appointment.

3.5 PARTICIPANT SERVICES

Providers may direct participants to the MO HealthNet Participant Services Unit for questions regarding such things as MO HealthNet-covered services, the denial or payment of claims filed with the MO HealthNet Program, and the location of participating providers in their areas of the state. This unit can be helpful, 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.

Participants who have problems or questions concerning MO HealthNet should be directed to call (800) 392-2161 or to write:

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

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

3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is *not* received within 60 days, providers may resubmit a new claim to the fiscal agent. However, providers should not resubmit a claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of the claim. Refer to 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 MO HealthNet web site at www.dss.mo.gov/mhd/providers/index.htm. Choose the "MO HealthNet forms" link in the right column.

3.7.A RISK APPRAISAL FORM

See Section 13.66 of the Physician's Manual for information on the Risk Appraisal for Pregnant Women.

3.8 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MO HealthNet 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 Section 15.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include: (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of Restricted Participant (PI-118) and 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.

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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 MO HealthNet Division, (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 MO HealthNet 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 MO HealthNet Division 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 MO HealthNet 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 MO HealthNet Division. Under this set of circumstances, the provider may file a claim with the MO HealthNet Division 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 MO HealthNet Division 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 MO HealthNet Division (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, 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 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 REQUEST FORM

Adjustments to MO HealthNet payments are only accepted if filed within 24 months from the date of the Remittance Advice on which payment was made. If the processing of an adjustment necessitates filing a new claim, the timely limits for resubmitting the new, corrected claim is limited to 90 days from the date of the remittance advice indicating recoupment, or 12 months from the date of service, whichever is longer. Only adjustments that are the result of lawsuits or settlements are accepted beyond 24 months.

When overpayments are discovered, it is always the provider's responsibility to notify the state agency. When Individual Adjustment Request forms for overpayments are submitted 24 months after the date of the Remittance Advice on which payment was made, the provider is notified by letter that a recoupment will be made by deducting the amount of the overpayment from the next provider's electronic payment or check written to him or her.

Occasionally the claims-processing system is *not* able to process an Individual Adjustment Request form in the usual manner. In that situation, the provider is informed by letter that a recoupment of the paid claim will be made and that a new, corrected claim *must* be resubmitted. The timely filing limit for resubmitting the new, corrected claim is *no* more than 90 days from the date of the Remittance Advice indicating the recoupment or 12 months from the date of service, whichever is longer. A copy of the Remittance Advice indicating the recoupment *must* be attached to the new claim.

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 internet/emomed claim, “12” is the year 2012, 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 2012, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2012.

Date of Payment/Denials: The date on the Remittance Advice at the top center of each page under the words “Remittance Advice.”

Twelve-Month Time Limit Unit: 366 days.

Six-Month Time Limit: 181 days.

Twenty-four-Month Time Limit: 731 days.

END OF SECTION

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SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

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

> "Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan."

The following is a list of common TPRs; however, the list should *not* be considered to be all inclusive.

Assault—Court Ordered Restitution
Automobile—Medical Insurance
CHAMPUS/CHAMPVA
Health Insurance (Group or Private)
Homeowner's Insurance
Liability & Casualty Insurance
Malpractice Insurance
Medical Support Obligations
Medicare
Owner, Landlord & Tenant Insurance
Probate
Product Liability Insurance
Trust Accounts for Medical Services Covered by MO HealthNet
Veterans' Benefits
Worker's Compensation.

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

MO HealthNet funds are used after all other potential resources available to pay for the medical service have been exhausted. There are exceptions to this rule discussed later in this section. The intent of requiring MO HealthNet to be payer of last resort is to ensure that tax dollars are *not* expended when another liable party is responsible for all or a portion of the medical service charge. It is to the provider's benefit to bill the liable TPR before billing MO HealthNet because many resources pay in excess of the maximum MO HealthNet allowable.

Federal and state regulations require that insurance benefits or amounts resulting from litigation are to be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. See 42 CFR 433 subpart D and RSMo 208.215 for further

reference. In essence, MO HealthNet does *not* and should *not* pay a claim for medical expenses until the provider submits documentation that all available third party resources have considered the claim for payment. Exceptions to this rule are discussed later in this section of the provider manual.

All TPR benefits for MO HealthNet covered services *must* be applied against the provider's charges. These benefits *must* be indicated on the claim submitted to MO HealthNet. Subsequently, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable and the TPR benefit amount, capping the payment at the MO HealthNet allowable. For example, a provider submits a charge for $100 to the MO HealthNet Program for which the MO HealthNet allowable is $80. The provider received $75 from the TPR. The amount MO HealthNet pays is the difference between the MO HealthNet allowable ($80) and the TPR payment ($75) or $5.

5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES

Managed care health plans in the MO HealthNet Managed Care program *must* ensure that the health plan and its subcontractors conform to the TPL requirements specified in the managed care contract. The following outlines the agreement for the managed health care plans.

The managed care health plan is responsible for performing third party liability (TPL) activities for individuals with private health insurance coverage enrolled in their managed care health plan.

By law, MO HealthNet is the payer of last resort. This means that the managed care health plan contracted with the State of Missouri shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., pay and chase). The managed care health plan shall act as an agent of the state agency for the purpose of coordination of benefits.

The managed care health plan shall cost avoid all claims or services that are subject to payment from a third party health insurance carrier. If a third party health insurance carrier (other than Medicare) requires the managed care health plan member to pay any cost-sharing amount (such as copayment, coinsurance or deductible), the managed care health plan is responsible for paying the cost-sharing (even to an out-of-network provider). The managed care health plan's liability for such cost-sharing amounts shall *not* exceed the amount the managed care health plan would have paid under the managed care health plan's payment schedule.

If a claim is cost-avoided, the establishment of liability takes place when the managed care health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.

If the probable existence of a Third Party Resource (TPR) *cannot* be established or third party benefits are *not* available at the time the claim is filed, the managed care health plan *must* pay the full amount allowed under the managed care health plan's payment schedule.

The requirement to cost avoid applies to all covered services except claims for labor and delivery and postpartum care; prenatal care for pregnant women; preventative pediatric services; or if the claim is for a service provided to a managed care health plan member on whose behalf a child support enforcement order is in effect. The managed care health plan is required to provide such services and then recover payment from the third party health insurance carrier (pay and chase).

In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances:

- Worker's Compensation
- Tort-feasors
- Motorist Insurance
- Liability/Casualty Insurance

The managed care health plan shall immediately report to the MO HealthNet Division any cases involving a potential TPR resulting from any of the above circumstances. The managed care health plan shall cooperate fully with the MO HealthNet Division in all collection efforts. If the managed care health plan or any of its subcontractors receive reimbursement as a result of a listed TPR, that payment *must* be forwarded to the MO HealthNet Division immediately upon receipt.

IMPORTANT: Contact the MO HealthNet Division, Third Party Liability Unit, at (573) 751-2005 for questions about Third Party Liability.

5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR

The provider may *not* bill the participant for any unpaid balance of the total MO HealthNet covered charge when the other resource represents all or a portion of the MO HealthNet maximum allowable amount. The provider is *not* entitled to any recovery from the participant except for services/items which are *not* covered by the MO HealthNet Program or services/items established by a written agreement between the MO HealthNet participant and provider indicating MO HealthNet is *not* the intended payer for the specific service/item but rather the participant accepts the status and liability of a private pay patient.

Missouri regulation does allow the provider to bill participants for MO HealthNet covered services if, due to the participant's action or inaction, the provider is *not* reimbursed by the MO HealthNet Program. It is the provider's responsibility to document the facts of the case. Otherwise, the MO HealthNet agency rules in favor of the participant.

5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 contained a number of changes affecting the administration of a state's Medicaid TPL Program. A provision of this law implemented by Federal Regulations effective February 15, 1990, is described below:

> Under law and federal regulation, a provider may *not* refuse to furnish services covered under a state's Medicaid plan to an individual eligible for benefits because of a third party's potential liability for the service(s). See 42 CFR 447.20(b).

This provision prohibits providers from discriminating against a MO HealthNet participant based on the possible existence of a third party payer. A participant may *not* be denied services based solely on this criterion. Federal regulation does provide the state with authority to sanction providers who discriminate on this basis.

A common misconception is that incorrect information regarding third party liability affects participant eligibility. Providers have refused services to participants until the third party information available to the state is either deleted or changed. Third party information reflects the participant's records at the time the MO HealthNet eligibility is verified and is used to notify providers there is probability of a third party resource. Current MO HealthNet third party information is used when processing provider claims. Therefore, incorrect third party information does *not* invalidate the participant's eligibility for services. The federal regulation cited in the paragraph above prohibits providers from refusing services because of incorrect third party information in the participant's records.

5.2 HEALTH INSURANCE IDENTIFICATION

Many MO HealthNet participants are dually eligible for health insurance coverage through a variety of sources. The provider should always question the participant or caretaker about other possible insurance coverage. While verifying participant eligibility, the provider is provided information about possible insurance coverage. The insurance information on file at the MO HealthNet Division (MHD) does *not* guarantee that the insurance(s) listed is the only resource(s) available nor does it guarantee that the coverage(s) remains available.

5.2.A TPL INFORMATION

MO HealthNet participants may contact Participant Services, (800) 392-2161, if they have any questions concerning their MO HealthNet coverage. Providers may reference a point of service (POS) terminal, the Internet or they may call the interactive voice response (IVR) system at (573) 635-8908 for TPL information. Refer to Sections 1 and 3 for further information.

In addition to the insurance company name, city, state and zip code, the Internet, IVR or POS terminal also gives a code indicating the type of insurance coverage available (see Section 5.3). For example, if "03" appears in this space, then the participant has hospital, professional and pharmacy coverage. If the participant does *not* have any additional health insurance coverage either known or unknown to the MO HealthNet agency, a provider *not* affected by the specified coverage, such as a dental provider, does *not* need to complete any fields relating to TPL on the claim form for services provided to that participant.

5.2.B SOLICITATION OF TPR INFORMATION

There may be coverage available to the participant that is *not* known to MHD. It is the provider's responsibility and in his/her best interest to solicit TPR information from the participant or caretaker at the time service is provided whether or not MHD is aware of the availability of a TPR. The fact that the TPR information is unknown to MHD at the time service is provided does *not* release the liability of the TPR or the underlying responsibility of the provider to utilize those TPR benefits.

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse's employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.
- CHAMPUS/CHAMPVA or veteran's benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the "Improved Pension Program," effective in 1979.
- If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency requirement for aliens or refugees) and the Part B premium be paid. Individuals who

have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)

- If the participant is disabled, coverage may exist under Medicare, Worker's Compensation, or other disability insurance carriers.
- If the participant is an over age disabled dependent (in or out of school), coverage may exist as an over age dependent on most group plans.
- If the participant is in school, coverage may exist through group plans.
- A relative may be paying for health insurance premiums on behalf of the participant.

5.3 INSURANCE COVERAGE CODES

Listed below are the codes that identify the type of insurance coverage the participant has:

AC Accident

AM Ambulance

CA Cancer

CC Nursing Home Custodial Care

DE Dental

DM Durable Medical Equipment

HH Home Health

HI Inpatient Hospital

HO Outpatient Hospital—includes outpatient and other diagnostic services

HP Hospice

IN Hospital Indemnity—refers to those policies where benefits *cannot* be assigned and it is *not* an income replacement policy

MA Medicare Supplement Part A

MB Medicare Supplement Part B

MD Physician—coverage includes services provided and billed by a health care professional

MH Medicare Replacement HMO

PS Psychiatric—physician coverage includes services provided and billed by a health care

professional

RX Pharmacy

SC Nursing Home Skilled Care

SU Surgical

VI Vision

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

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

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

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

5.5 MEDICAL SUPPORT

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

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

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

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

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

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

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

5.6.A EXCEPTION TO TIMELY FILING LIMIT

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

5.6.B TPR CLAIM PAYMENT DENIAL

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

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

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

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

5.7 THIRD PARTY LIABILITY BYPASS

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

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

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

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

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

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

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

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

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

5.9 LIABILITY AND CASUALTY INSURANCE

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

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

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

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

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

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

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

5.9.A TPL RECOVERY ACTION

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

5.9.B LIENS

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

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

5.9.C TIMELY FILING LIMITS

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

5.9.D ACCIDENTS WITHOUT TPL

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

Examples are:

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

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

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

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

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

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

If the provider receives payment from a third party resource after receiving MO HealthNet reimbursement for the covered service, the provider *must* promptly submit an Individual Adjustment

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

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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

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

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

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

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

COPAYMENT: Copayments are fixed dollar amounts identified by the insurance policy that are the responsibility of the patient; e.g., $3 that a beneficiary must pay when they use a particular service or services. MO HealthNet cannot reimburse copayment amounts. An insurance plan's copayment requirements should not be confused with the MO HealthNet cost sharing (copayment, coinsurance, shared dispensing fee) requirements established for specific MO HealthNet services.

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

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

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

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

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

The second type of managed care plan is known as an individual (or independent) practice association (IPA) or a preferred provider organization (PPO), each of which is a network of doctors who work individually out of their own offices. This arrangement gives the patient some degree of choice within the group. If a patient goes outside the network, however, the plan reimburses at a lower percentage. Generally an IPA may be prepaid, while a PPO is similar to a

traditional plan, in that claims may be filed and reimbursed at a predetermined rate if the services of a participating doctor are utilized. Some IPAs function as HMOs.

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

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

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

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

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SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

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

6.2.B(2)(ii) Copy Claim – Original

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

6.2.B(2)(iii) Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

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

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

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

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

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

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

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

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

    • An ICN that credits (recoups) the original paid amount and

    • An ICN that repays the claim with the corrected payment amount.

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

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

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

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

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

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

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Initiate the start of services that require prior authorization.

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

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

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

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

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

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

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

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

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

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

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

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

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

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

The written request *must* include:

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

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

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

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

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

END OF SECTION

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

9.3 DIAGNOSIS CODE

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

9.4 INTERPERIODIC SCREENS

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

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

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

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
99381 - 99385	Preventative Screen; new patient	$23.00
99391 - 99395	Preventative Screen; established patient	$15.00

9.5 FULL HCY/EPSDT SCREEN

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
99381EP-99385EP	Full Medical Screening	$60.00
99391EP-99395EP		

99381EPUC-99385EPUC 99391EPUC-99395EPUC	Full Medical Screening with Referral	$60.00

A full HCY/EPSDT screen includes the following:

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

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

It is mandatory that the Healthy Children and Youth Screening guide be retained in the patient's medical record as documentation of the service that was provided. The Healthy Children and Youth Screening guide is *not* all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener *must* sign and date the guide and retain it in the patient's medical record.**

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

Youth Screening guide may be photocopied or obtained at no charge from the MO HealthNet Division. Providers *must* have this form in the medical record if billing the screening.

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

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

9.6.A DEVELOPMENTAL ASSESSMENT

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
9942959	Developmental/Mental Health partial screen	$15.00
9942959UC	Developmental/Mental Health partial screen with Referral	$15.00

This screen includes the following:

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

9.6.A(1) Qualified Providers

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

- Physician, nurse practitioner or nurse midwife*;
- Speech/language therapist;
- Physical therapist;
- Occupational therapist; or
- Professional Counselors, Social Workers, and Psychologists.

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

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

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT

9938152EP-9938552EP 9939152EP-9939552EP	HCY Unclothed Physical and History	$20.00
9938152EPUC-9938552EPUC 9939152EPUC-9939552EPUC	HCY Unclothed Physical and History with Referral	$20.00

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 or nurse midwife*.

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

9.6.C VISION SCREENING

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
9942952	Vision Screening	$5.00
9942952UC	Vision Screening with Referral	$5.00

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 or nurse midwife*;
- Optometrist.

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

9.6.D HEARING SCREEN

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
99429EP	HCY Hearing Screen	$5.00
99429EPUC	HCY Hearing Screen with Referral	$5.00

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 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	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
99429	HCY Dental Screen	$20.00
99429UC	HCY Dental Screen with Referral	$20.00

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

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

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)

EXPOSURE PATHWAYS

OCCUPATIONAL
Plumbers, pipe fitters
Lead miners
Lead smelters and refiners
Auto repairers
Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers

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

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

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

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

9.7.B LEAD RISK ASSESSMENT

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

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

risk *must* receive a blood lead level test, unless the child has already received a blood lead test within the last six months of the periodic visit.

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

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

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

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

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

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

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

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

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

(Capillary specimen or venous blood samples.)

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT
83655	Lead, quantitative blood	$15.00

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

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

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

Recommended Interventions:

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

9.7.E(2) Blood Lead Level 10-19 µg/dL

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

Recommended Interventions:

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

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

9.7.E(3) Blood Lead Level 20-44 µg/dL

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

Recommended Interventions:

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

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

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

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

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

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.
- A child with a confirmed blood lead level greater than 44 µg/dL should be treated promptly with appropriate chelating agents and *not* returned to an environment where lead hazard exposure may continue until it is controlled.

- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

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

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

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

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

Recommended Interventions:

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

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

9.7.F COORDINATION WITH OTHER AGENCIES

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

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

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

9.7.G(1) Environmental Lead Investigation

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

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

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

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

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

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

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

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

9.7.H ABATEMENT

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

9.7.I LEAD CASE MANAGEMENT

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

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

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

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

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

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

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

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

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

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

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

Quest Diagnostics
11636 Administration
St. Louis, MO 63146

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

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

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

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

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

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

Arup Laboratories

500 Chipeta Way

Salt Lake City, UT 84108

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Hygenic Lab

Wallace State Office Building

Des Moines, IA 50307

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

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

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

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Tamarac Medical

7800 Broadway Ste. 2C

Centennial, Co 80122

Specialty Laboratories
2211 Michigan Ave.
Santa Monica, CA 90404

9.8 HCY CASE MANAGEMENT

CODE	DESCRIPTION	MAXIMUM ALLOWABLE AMOUNT
T1016EP	HCY Case Management	$12.50
T1016TSEP	HCY Case Management; Follow-up	$10.00

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

9.9 IMMUNIZATIONS

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

9.9.A VACCINE FOR CHILDREN (VFC)

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

9.10 ASSIGNMENT OF SCREENING TIMES

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

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

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

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:

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

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

9.11.A DENTAL SCREENING SCHEDULE

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

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

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

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

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

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

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

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.15 STATE-ONLY FUNDED PARTICIPANTS

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

9.16 MO HEALTHNET MANAGED CARE

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

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or mental illness, or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid state plan. Services *must* be

sufficient in amount, duration and scope to reasonably achieve their purpose and may only be limited by medical necessity. According to the MO HealthNet Managed Care contracts, the MO HealthNet Managed Care health plans are responsible for providing all EPSDT/HCY services for their enrollees.

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

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

a) A comprehensive unclothed physical examination

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

c) Health education (including anticipatory guidance)

d) Appropriate immunizations according to age

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

f) Lead screen according to established guidelines

g) Hearing screen

h) Vision screen

i) Dental screen

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

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

Full Screen	99381EP through 99385EP and 99391EP through 99395EP
Unclothed Physical and History	99381 through 99385 and 99391 through 99395
Developmental/Mental Health	9942959 9942959UC

Hearing Screen	99429EP 99429EPUC
Vision Screen	9942952 9942952UC
Dental Screen	99429 99429UC

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

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

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

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

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

END OF SECTION

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SECTION 10 - FAMILY PLANNING

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

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

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

END OF SECTION

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SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

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

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

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

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

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

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

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

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

Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052), Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

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

a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health plan is *not* listed for the participant.

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

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

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

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

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

Managed Care Health Plan members fall into four groups:

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

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

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

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

- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;
- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
- AIDS Waiver participants (individuals twenty-one (21) years of age and over);
- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level;
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
- Individuals with ME code 81 (Temporary Assignment Category);
- Individuals eligible under ME code 82 (MoRx);
- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and

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

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

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

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

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

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

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

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

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

- Inpatient hospital services
- Outpatient hospital services
- Emergency medical, behavioral health, and post-stabilization care services
- Ambulatory surgical center, birthing center
- Asthma education and in-home environmental assessments

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

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

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

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

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

    - Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.
- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are *not* limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing

- Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME Codes listed for Group 4, Section 1.5.C
- Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
- Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs

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

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

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

to receive these extra benefits.

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

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

- Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure.
- The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.

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

11.8 QUALITY OF CARE

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

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

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

provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

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

11.9.A NON-BILLING MO HEALTHNET PROVIDER

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

11.10 EMERGENCY SERVICES

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

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

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

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

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

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

11.11.A ELIGIBILITY FOR PACE

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

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

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

11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the

Intellectually Disabled (ICF/ID);

- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

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

11.11.D PACE COVERED SERVICES

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

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

- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;
- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

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

END OF SECTION

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SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

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

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

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

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

12.2 DURABLE MEDICAL EQUIPMENT SERVICES

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

12.3 DETERMINING A FEE

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

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

- Recommendations from the State Medical Consultant and/or advisory committees;

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

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

12.3.A ON-LINE FEE SCHEDULE

MO HealthNet fee schedules through the MO HealthNet Division are available at http://dss.mo.gov/mhd/providers/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 the Durable Medical Equipment Provider Manual for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

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

12.5 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay. The copay amount is paid by the participant at the time services are rendered. Services of the Durable Medical Equipment Program described in this manual are *not* subject to a copay amount.

12.6 A MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

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

12.6.A MANAGED HEALTH CARE

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

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

The MO HealthNet Program utilizes the managed care delivery system for certain included MO HealthNet eligibles. Refer to Section 1 and Section 11 of the Durable Medical Equipment Provider Manual for a detailed description.

END OF SECTION

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SECTION 13-BENEFITS AND LIMITATIONS

13.1 CONDITIONS OF PARTICIPATION

13.1.A PROVIDER PARTICIPATION

To participate in the MO HealthNet Durable Medical Equipment (DME) Program, only the following types of providers are reimbursed by MO HealthNet for items covered under the DME Program. Each of the following provider types *must* be enrolled as a DME provider:

- Rental and Sales Providers;
- Prosthetic Fabricators;
- Rehabilitation Centers;
- Orthotic Fabricators;
- Physicians (M.D., D.O., Podiatrists) (may dispense orthotic devices and artificial larynx);
- Pharmacies; and
- Hospitals.

The following providers may write a prescription for items covered under the DME Program, with the exception of diabetic shoes and inserts:

- Physicians (M.D., D.O., Podiatrists); and
- Advanced Practice Nurses who have a collaborative practice agreement with a physician that allows for prescription of such items.

Providers *must* be Medicare approved prior to enrollment with the MO HealthNet Division (MHD). Providers *must* enroll with the same name and address for which their Medicare number is issued. Each Medicare DME supplier *must* have a separate Medicare number and National Provider Identifier (NPI) for each location and *must* enroll each location where MHD services are provided. MHD will *not* backdate enrollment prior to the Medicare effective date. Representatives of a DME company or warehouse are *NOT* considered providers and are *not* eligible to enroll.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.

13.1.B OUT-OF-STATE SERVICES

Out-of-state (nonbordering) providers who render services to MO HealthNet participants located in Missouri are ONLY permitted to receive reimbursement if:

- Medicare coinsurance and/or deductible amounts on covered services provided to participants who have *BOTH* MO HealthNet and Medicare.

- Durable Medical Equipment (DME) or supplies is *NOT* available in Missouri or a bordering state of Missouri.

If prior authorization is approved or reimbursement made for a DME item(s) on behalf of a MO HealthNet participant who is *not* Medicare eligible, or for equipment and/or supplies that are available in Missouri or a bordering state, the reimbursement that was paid may be recouped.

13.1.C NONDISCRIMINATION

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 or religious beliefs.

13.1.D RETENTION OF RECORDS

MO HealthNet providers *must* retain for five (5) 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 Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an active MO HealthNet provider through change of ownership or any other circumstance.

13.2 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) defines "adequate documentation" and "adequate medical records" as follows:

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

13.3 PARTICIPANT NONLIABILITY

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

13.4 EMERGENCY SERVICES

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.

13.5 OUT-OF-STATE, NONEMERGENCY SERVICES

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

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

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

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

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. An explanation why services can't be provided in Missouri.

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

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

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

1. All Medicare/MO HealthNet crossover claims;
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require a PA continue to require a PA 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.

13.6 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Durable Medical Equipment Program described in this manual are *not* subject to a copay amount.

13.7 GENERAL INFORMATION

The MO HealthNet Program reimburses qualified participating Durable Medical Equipment (DME) providers for certain DME items, such as: prosthetics; orthotics; respiratory care equipment; parenteral nutrition; ostomy supplies; wheelchairs and hospital beds, etc. These items *must* be for use in the participant's home when ordered in writing by the participant's physician or advanced practice nurse.

Although an item is classified as DME, it may *not* be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part, the equipment meets the definition of DME or prosthesis, and the equipment is used in the participant's home.

Even though a DME item may serve some useful medical purpose, consideration *must* be given by the physician and the DME supplier to what extent, if any, it is reasonable for MO HealthNet to pay for the item as opposed to another realistically feasible alternative pattern of care.

Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the participant.

If two (2) different items each meet the need of the participant, the less expensive item *must* be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are *not* medically necessary, are *not* reimbursable.

13.8 DEFINITIONS

MO HealthNet is designed to assist participants in obtaining medical care. Reimbursement may be made for expenses incurred for durable medical equipment provided the conditions in the following subsections are met.

13.8.A DURABLE MEDICAL EQUIPMENT (DME)

DME is equipment that:

- can withstand repeated use;

- is primarily and customarily used to serve a medical purpose;
- is *not* useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

All requirements of the definition *must* be met in order for the equipment to be covered under MO HealthNet.

13.8.B PARTICIPANT'S HOME

A participant's home *may* be:

- his/her own dwelling;
- an apartment;
- a relative's home; or
- a boarding home.

An institution may *not* be considered a participant's home if the institution:

- meets at least the basic requirements of a hospital; or
- meets the basic requirements of a nursing home.

13.9 PURCHASE OF DURABLE MEDICAL EQUIPMENT (DME)

The participant *must* be eligible for MO HealthNet at the time the equipment or device is delivered or obtained. Items purchased become the property of the participant.

Some items are covered by MO HealthNet as purchase items only, while others are rental items only. Refer to Section 19 to determine if the item to be dispensed can be purchased or rented.

13.9.A PURCHASE OF USED DURABLE MEDICAL EQUIPMENT (DME)

Used equipment is covered only if the item has been solely used by the participant; i.e. the participant previously rented the equipment.

13.9.B DELIVERY OF ITEMS COVERED UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

Items that are covered under the DME Program *must* be dispensed to the participant before the provider bills MO HealthNet for the item. Holding equipment until MO HealthNet payment is received constitutes a payment for a service *not* provided and is in violation of State Regulation 13 CSR 70-3.030 (23).

All charges for delivery, pickup, shipping, freight, C.O.D. and handling are included in the MO HealthNet allowed reimbursement amount and are *not* paid for separately or billable to the participant.

13.9.C REPLACEMENT OF PURCHASED ITEMS

Replacement of purchased items covered under the DME Program that are medically necessary and are lost, stolen, destroyed or required because of a change in the participant's condition are covered. Items with restriction of pre-certification *must* contact the MHD call center. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays. Items requiring a Prior Authorization (PA) Request form or Certificate of Medical Necessity *must* contain the following information:

- Explanation for continuing need of the item;
- How the item was lost or destroyed;
- Copy of the police report if the item was stolen or destroyed in an automobile accident, fire, etc.;
- Nature of the change in the participant's condition.

Replacement of items resulting from participant abuse or neglect is *not* covered and may be billed to the participant.

13.10 RENTAL OF DURABLE MEDICAL EQUIPMENT (DME)

The Certificate of Medical Necessity attachment or Prior Authorization (PA) Request form for equipment are reviewed in order to determine initially if the item should be purchased or rented based on the diagnosis and prognosis of the participant and the anticipated period of need prescribed by the participant's physician. Items requiring pre-certification utilizes a management tool to determine the same. If the period of need indicates that it is less expensive to purchase the equipment, MHD may elect to purchase the equipment. Likewise, if it is less expensive to rent the equipment, MHD may elect to rent the equipment. If necessary, the routing modifier or service modifier on the PA Request form is changed by the consultant. An explanatory message appears on the disposition letter. Providers *must* request the purchase or rental of equipment based on the anticipated period of need.

13.10.A ELIGIBILITY DURING DURABLE MEDICAL EQUIPMENT (DME) RENTAL

If a participant is not eligible for MO HealthNet services during a portion of the rental month, rental is paid only for the days each month the participant is eligible. A message appears on the Remittance Advice that reflects the reason for the reduced payment. The participant is responsible for the non-eligible rental period.

13.10.B REACHING THE PURCHASE PRICE OF A DURABLE MEDICAL EQUIPMENT (DME) ITEM

When the rental payments reach the MO HealthNet allowed purchase price, the item becomes the property of the participant. A message appears on the Remittance Advice stating that the equipment has been purchased by MO HealthNet and is the property of the participant.

13.10.C REPLACEMENT OF RENTED DURABLE MEDICAL EQUIPMENT (DME) ITEMS

MO HealthNet does *not* reimburse the provider or the participant for the replacement of a rented DME item that is stolen, lost or destroyed.

13.10.D BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) RENTAL

When billing for the rental of a DME item, the from and to dates of the claim *must* always be completed. The units of service should always be "1," unless otherwise specified in Section 19 of the DME Provider Manual.

Once the Certificate of Medical Necessity has been submitted and approved, any claim submitted matching the information on the approved Certificate of Medical Necessity can be processed for payment. This includes all monthly claims for rental.

13.11 REPAIR OF DURABLE MEDICAL EQUIPMENT (DME)

Repair of participant-owned DME or prosthetic or orthotic device (whether purchased by MO HealthNet outright, purchased through rental payments or paid for by the participant) is covered if:

- The item to be repaired is a covered item under the DME Program.
- The repairs do *not* exceed 60% of the cost of a new piece of equipment, or orthotic or prosthetic device.
- The item is *not* under the provider's or manufacturer's warranty.
- The repairs are *not* required as a result of participant abuse.
- The participant is *not* in an institution unless the repair is for a custom or power wheelchair or augmentative communication, orthotic or prosthetic device.
- The equipment is *not* being rented.
- There is a continuing medical need for the equipment.

- The repairs are *not* a result of a defect in materials or workmanship.

Reimbursement for a repair is based on the reasonable charge for parts and the allowable reimbursement amount for labor.

13.11.A BILLING GUIDELINES FOR DURABLE MEDICAL EQUIPMENT (DME) REPAIR

The HCPCS code for the specific item along with the routing modifier, RB, *must* be used to bill when submitting a claim for repair of an item. If there is *not* a specific HCPCS code to use to bill the repair, the following repair codes may be used to bill for pieces and parts:

Z0160	Repair of equipment, replace or repair minor parts
L4210	Orthotic repair or replace minor parts
L7510	Prosthetic repair or replace minor parts

The amount of time required for the repair or modification may be billed under the following labor codes:

K0739	Repair or non-routine service for DME, other than oxygen equipment, requiring the skill of a technician, labor component, per 15 minutes
L4205	Repair of orthotic device, labor component, per 15 minutes
L7520	Repair of prosthetic device, labor component, per 15 minutes

List the actual time in the units field of the claim form in 15-minute increments.

A Certificate of Medical Necessity is required for most repair claims (refer to Section 19 for specific requirements). The Certificate of Medical Necessity may be submitted through the MO HealthNet Web Portal at www.emomed.com. Repairs under $500.00 do *not* require a physician's signature.

Medical necessity for replacement, a detailed description and the age of the item being repaired must be documented on the Certificate of Medical Necessity. If there is labor to be billed, a detailed explanation of the time involved must also be listed on the Certificate of Medical Necessity.

When billing for a repair, copies of the invoices showing the MSRP, or the invoice of cost, *must* be submitted with the claim form through the MO HealthNet Web Portal at www.emomed.com. Claims are manually priced at this time; *not* at the time of the approval of the Certificate of Medical Necessity.

If a repair requires Prior Authorization (PA), a detailed description and the age of the item being repaired must be documented on the PA. If the item(s) requested are manually priced, the invoice or MSRP must be submitted with the PA to establish an allowed amount for reimbursement.

13.12 WARRANTIES

When an orthotic device, prosthetic device or other equipment has been purchased, the following warranties *must* be provided by the provider, unless the manufacturer's warranty is for a greater length of time. If the manufacturer's warranty is less than the following, a statement from the manufacturer or copy of their printed policy *must* be submitted.

- 1 year for prosthetic devices
- 90 days for custom orthotics
- 30 days for standard braces
- 1 year for equipment such as walkers, wheelchairs, hospital beds, etc.

13.13 TRADE-IN OF DURABLE MEDICAL EQUIPMENT (DME)

When a DME item is traded in on a new item, the trade-in amount *must* be deducted from the purchase price and the reduced amount billed. An explanation *must* be noted on the Certificate of Medical Necessity or Prior Authorization (PA) Request form.

13.14 REIMBURSEMENT GUIDELINES

- MO HealthNet payment is the lower of the provider's usual and customary charge to the general public or the MO HealthNet maximum allowed amount, less any third party resource.

- Sales tax is *not* covered by MO HealthNet, nor can it be billed to the participant. Providers should contact the Tax Administration Bureau on a regular basis to ensure that items covered under the DME Program are *not* subject to Missouri sales tax.

- Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or portion of payment for services from a participant will only be allowed as outlined in State Regulation 13 CSR 70-4.040 and 13 CSR 70-4.050.

- Providers *must* accept the MO HealthNet payment as the full and complete payment and may *not* accept additional payment from the participant. Accepting a portion of payment for services from the participant is in violation of State Regulation 13 CSR 70-3.030.
- Quantities in excess of the limit may be covered if medically necessary. Pre-certification of excess quantities must be obtained for items that require pre-certification. For items that do not require pre-certification, medical necessity justification in letter form from the prescriber must be submitted along with a paper claim for review by a MHD State consultant.
- Charges for shipping, freight, C.O.D., handling, delivery and pickup are included in the reimbursement for items covered under the DME Program and are *not* billable to the MO HealthNet participant.

13.15 DELIVERY REQUIREMENTS

13.15.A PROOF OF DELIVERY

Proof of delivery is required for verification that equipment or supplies were received by the participant. DME providers must maintain proof of delivery documentation in their files for 5 years for every item provided.

For the purpose of the proof of delivery information provided below, ”designee” is defined as “any person who can sign and accept the delivery of durable medical equipment on behalf of the participant.” DME providers, their employees or anyone who may have a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

DME providers shallnot bill for an item prior to receipt of documentation of proof of delivery. In addition, for items of durable medical equipment that require fitting, set-up and/or instruction, the DME provider shall not bill prior to providing the participant with proper set-up, fitting and instruction. Documentation of any set-up fitting and/or instructions provided must be maintained in the DME provider’s participant record.

13.15.B DIRECT DELIVERY

DME providers may deliver an item or supply directly to the participant or their designee. An example of proof of delivery made directly to a participant is a signed and dated delivery slip. It is recommended the delivery slip include the following:

- Participant’s name
- Quantity delivered
- Detailed description of the item being delivered
- Brand name of the item
- Serial number (if applicable)

The date of signature on the delivery slip must be the date that the item/supply was received by the participant or designee. In instances where the item/supply is delivered directly by the

DME provider, the actual date the participant received the item/supply shall be the date of service on the claim.

13.15.C MAIL ORDER/SHIPPING SERVICE DELIVERY

If a DME provider uses a shipping or mail order service, an example of proof of delivery should include the services tracking slip and the DME provider's own shipping invoice. If possible, the DME provider's record should also include the delivery service's package identification number for the package sent to the participant. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and, if possible the date delivered. DME providers should use the shipping date as the date of service on the claim.

13.15.D SUPPLY REFILLS-NO AUTO REFILLS

For DME items supplied as refills to the original order (e.g. nebulizers supplies, CPAP supplies, diapers, etc), the DME provider MUST contact the participant or caregiver prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the participant. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modification to the order. Contact with the participant or designee regarding refills must take place no sooner than 14 days prior to the delivery/shipping date.

For all items that are provided on a recurring basis, DME providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. DME providers must not deliver refills without a specific refill request from a participant. Items delivered without a valid, documented refill request are not covered and may not be billed to the participant. For items that the participant obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of request for refill.

DME providers must not dispense a quantity of supplies exceeding a participant's expected utilization. DME providers must be attentive to changed or atypical utilization patterns on the part of their clients. DME providers must verify with the ordering physicians that any changed or atypical utilization is warranted.

The date of service for items supplied as refills to the original order may be the actual delivery date or ship date depending on the method of deliver, or within three calendar days after the delivery date or ship date. For example, if an item is delivered by the supplier on June 1st, the date of service billed on the claim may be June 1, June 2, June 3 or June 4. This flexibility is allowed to ensure a participant is able to receive the refill of supplies without a gap in service and the provider is able to bill for the supplies provided.

13.15.E EXCEPTIONS TO THE DATE OF SERVICE

A DME provider may deliver a DME item to a participant in a hospital or nursing facility for the purpose of fitting or training the participant in the proper use of them. This may be done up to 2 days prior to the participant's anticipated discharge to their home. The DME provider shall bill the date of discharge as the date of service on the claim and use the place of service (POS) 12 (home). The item must be for subsequent use in the participant's home. No billing may be made for the item for those days the participant was receiving training or fitting in the hospital or nursing facility. The DME provider must ensure the participant's equipment is properly set-up and the patient is instructed on in-home use of the equipment prior to billing. Services cannot be billed prior to the date the patient is discharged.

13.16 PAYMENT FOR CUSTOM-MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO PARTICIPANT'S LOSS OF ELIGIBILITY OR DEATH

MO HealthNet payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom HCY equipment when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is *not* covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

13.16.A PREREQUISITE FOR PAYMENT OF CUSTOM-MADE ITEMS

The following prerequisites apply to all such payments:

- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization (PA) Request, if required) and at the time of any subsequent service, preparatory and prior to the actual ordering of fabrication of the device or item; and
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for medical purpose by any other individual; and
- The custom-made device or item *must* have been delivered or placed if the participant is living; and
- The provider *must* have entered "see attachment" in Field #19 of the claim form and *must* have attached a provider-signed statement to the claim. The statement *must* explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is *not* possible due to this reason. The statement *must* also include the total

amount of salvage value, which the provider estimate is represented in case where delivery or placement is *not* possible.

13.16.B PAYMENT OF CUSTOM-MADE ITEMS AND DEVICES

a. If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or copayment.

b. If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable amount for the total service, less any applicable cost sharing or coinsurance. The "net billed charge" shall be the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

- Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent salvage value. The salvage value must be clearly documented in the medical records.

- Any provider-determined retail salvage value of the unplaced or undelivered item must be subtracted by the provider from the charge for the item, and only the net reduced charge entered on the claim form line for the item. These items are subject to review as to salvage value adjustment represented in the billed charge.

c. The date of service that is shown on the claim form for the item (custom wheelchair, braces, etc.) when situation a. or b. applies must be the last date on which service is provided to the eligible participant (and following receipt of an approved PA, if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time service is provided. Use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) must be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitute the allowable MO HealthNet payment for the service, no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant *must* be immediately advised that completion of the work and delivery or placement of the item is *not* covered by MO HealthNet. It is then the participant's choice to request completion of the

work on a private-payment basis. If participant death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does *not* reimburse the provider.

13.17 MO HEALTHNET MANAGED CARE HEALTH PLAN

Certain items and/or services that have been initiated or prior authorized by the MHD before the enrollment effective date in a MO HealthNet Managed Care health plan are reimbursed on a fee-for-service basis by the state agency when placement occurs after the MO HealthNet Managed Care health plan enrollment is effective. The MHD is financially responsible for these items or services in accordance with the following:

- Augmentative communication devices and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the MO HealthNet Managed Care health plan, but placement occurs after the effective date of the MO HealthNet Managed Care health plan enrollment.
- Custom and power wheelchairs and custom HCY equipment that have been prior authorized by MHD prior to the enrollment effective date in the MO HealthNet Managed Care health plan, but placement occurs after the effective date of MO HealthNet Managed Care health plan enrollment.

Providers *must* contact the Provider Communications Unit at (573) 751-2896 for instructions on how to bill for these items/services.

Certain items and/or services that have been initiated or prior authorized by the MO HealthNet Managed Care health plan before the effective date enrolled in the MO HealthNet Fee-For-Service Program are reimbursed by the Managed Care health plan when placement occurs after MO HealthNet Fee-For-Service enrollment is effective. The Managed Care health plan is financially responsible for these items or services in accordance with the following:

- Augmentative communication devices and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the MO HealthNet Fee-For-Service Program, but placement occurs after the effective date of the MO HealthNet Fee-For-Service Program enrollment.
- Custom and power wheelchairs and custom HCY equipment that have been prior authorized by the Managed Care health plan prior to the enrollment effective date in the MO HealthNet Fee-For-Service Program, but placement occurs after the effective date of MO HealthNet Fee-For-Service Program enrollment.

13.18 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A NURSING HOME

DME is *not* covered for those participants residing in a nursing home (place of service 12, 31 or 99 with level of care 1 or 2). DME is included in the nursing home per diem rate and *not* paid for separately with the exception of the following items:

- Augmentative Communication Devices and Accessories;
- Custom Wheelchairs;
- Power Wheelchairs;
- Orthotic and Prosthetic Devices;
- Total Parenteral Nutrition; and
- Volume Ventilators.

MO HealthNet requires all providers of custom and power wheelchairs provide equipment that meets the participant's needs for mobility and positioning in a cost-effective manner for participants in a nursing home. The Prior Authorization (PA) Request is denied if the chair is considered *not* medically necessary, if it is *not* a custom wheelchair or if a less expensive alternative wheelchair is available.

Supporting documentation for custom and power wheelchairs *must* be included with the PA Request. Section 1, Field #9 of the PA Request form *must* clearly list the name and address of the nursing home in which the participant resides.

13.18.A PRIOR AUTHORIZATION (PA) REQUESTS/LETTERS OF MEDICAL NECESSITY FOR CUSTOM OR POWER WHEELCHAIRS

When submitting a PA request for a custom or power wheelchair, there *must* be comprehensive written documentation submitted with the PA request. Letters of medical necessity and supporting documentation *must* be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers). In addition, letters of medical necessity generated by the supplier *must* be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers).

Letters of medical necessity *must* clearly and specifically explain the following:

- The diagnosis/comorbidites and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Description of existing equipment, age and specifically why it is *not* meeting the participant's needs;
- Explanation as to why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, manual wheelchair);
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components;
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment; and
- Documentation/explanation as requested by the State consultant.

13.18.B ASSISTIVE TECHNOLOGY PROFESSIONAL

Custom or power wheelchairs for participants residing in a nursing home *must* be supplied by a provider that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP *must* have direct, in-person, face-to-face interaction and involvement in the wheelchair selection for the participant. The provider record should document how the ATP was involved and directed the wheelchair selection process.

13.18.C PHYSICIAN FACE-TO-FACE EVALUATION

For a custom or power wheelchair to be covered for a participant residing in a nursing home, a treating physician *must* conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. Physicians shall document the face-to-face examination in a detailed narrative note in the participant's chart in the format they use for other entries. Supplier or facility created forms that the physician completes are *not* a substitute for the comprehensive medical record/chart note indicated above. The physician face-to-face examination *must* provide information about the following elements but may include other details:

History of the present condition(s) and past medical history that is relevant to mobility needs:

- Symptoms that limit ambulation;
- Diagnoses that is responsible for symptoms;
- Progression of ambulation difficulty over time;
- Other diagnoses that may relate to ambulatory problems;
- Cardiopulmonary examination; and
- Weight and height.

Physical examination that is relevant to mobility needs:

- Existing ambulatory assistance (cane, walker, wheelchair, caregiver) that is currently being utilized;
- Ability to stand up from a seated position without assistance;
- Description of the ability to perform activities of daily living;
- Distance the participant can walk without stopping;
- Pace of ambulation;
- Musculoskeletal examination to include arm and leg strength and range of motion; and
- Neurological examination to include documentation of functional ambulation and balance and coordination.

The physician examination *must* be tailored to the individual participant's condition. The history *must* clearly illustrate the participant's functional abilities and limitations on a typical day. It *must* contain as much objective data as possible. The physical examination *must* be focused on the body systems responsible for the participant's ambulatory difficulty or impact the participant's ambulatory ability.

After the face-to-face visit with the physician, the physician may choose to refer the participant to a licensed physical or occupational therapist for completion of the physical portion of the exam. (The physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers.) There is no separate reimbursement outside the nursing home per diem for a physical or occupational therapy evaluation). A prior evaluation completed by a licensed physical or occupational therapist within the past 90 days may also be utilized for the physical portion of the exam. All areas noted above for the physical exam *must* be

addressed. If utilized, the physical or occupational therapy exam *must* be reviewed by the physician after completion, agreed on or amended, and signed before issuing the physician order.

The face-to-face examination *must* be completed prior to any examination performed by the DME provider. The DME provider *must* receive the written report of this examination within 90 days after completion of the face-to-face physician examination.

A date stamp or equivalent *must* be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination *must* be submitted with the PA request.

13.18.D PHYSICIAN ORDER

When requesting a custom or power wheelchair for a nursing home participant, a physician order *must* be received by the DME provider within 90 days after completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician order *must* contain all of the following:

- Participant's name;
- Description of the item that is ordered (may be general such as power wheelchair, manual wheelchair);
- Date of the face-to-face examination;
- Pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair;
- Length of need; and
- Physician's signature;

Date of the physician signature. A date stamp or equivalent *must* be used to document receipt date.

13.18.E POWER WHEELCHAIRS AND ACCESSORIES FOR NURSING HOME PARTICIPANTS

In addition to the requirements above, requests for Group 2 power wheelchairs for nursing home participants *must*:

A. Document one of the following diagnoses:

1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1);

2. Other spinal cord diseases (336.0-336.3);
3. Multiple Sclerosis (340);
4. Other demyelinating disease (341.0-341.9);
5. Cerebral Palsy (343.0-343.9);
6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335.23-335.9);
7. Post-polio paralysis (138);
8. Traumatic brain injury resulting in quadriplegia (344.09);
9. Spina Bifida (741.00-741.93);
10. Childhood cerebral degeneration (330.0-330.9);
11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized); or
12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be documented by the physician in the face-to-face visit); and

B. Explain why a less costly mobility device is unable to meet the participant's needs including a description of equipment trials and their effectiveness.

Requests for Group 3 power wheelchairs will only be considered when the following criteria are met:

A. All criteria for a Group 2 power wheelchair are met;

B. Medical justification provides extensive documentation of why a Group 2 power wheelchair and other less costly devices will *not* meet the participant's needs;

C. Documentation includes the length of time the participant has resided in the nursing home; and

D. One of the following:

Documentation includes a copy of the discharge plan from the nursing home's participant record that clearly states the participant's discharge date is in the next 90 days to an independent or less restrictive living

environment and that the participant will be involved in activities that require the client to utilize a wheelchair in the community on a frequent basis (e.g. work, shopping, self-transport to appointments). Supporting documentation from a physician, social worker or occupational therapist/physical therapist explaining the participant's discharge plans and mobility needs *must* accompany the discharge plan; or

The medical necessity justification provides clear documentation that the participant requires specialty controls other than a joy stick to independently operate the wheelchair.

The following equipment is *not* considered medically necessary for participants residing in a nursing home:

- Group 1 power wheelchairs;
- Group 4 power wheelchairs;
- Multiple power seat function (i.e., power tilt and recline); and
- Power elevating leg rests/lower extremity power articulating platform.

13.18.F COVERAGE OF CUSTOM WHEELCHAIRS FOR NURSING HOME PARTICIPANTS

MHD will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one participant and cannot be used by anyone else. Prior authorization is required. All PA requests *must* indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B, and C below describes the criteria utilized for a wheelchair to be considered custom. Criteria for individual HCPCS codes are listed following criteria A, B and C below.

A. Any wheelchair with a custom seating system. A custom seating system is a wheelchair seating system which is individually made for a patient using a plaster model of a patient, a computer generated model of the patient (i.e. CAD-CAM technology), or the detailed measurements of the patient to create either: (a) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or (b) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could *not* be easily re-adapted for use by another individual.

   To qualify for a custom seating system, an individual *must* meet all the requirements of a custom fabricated seat cushion or a custom fabricated back cushion as described in

Section 13.30.G of the Durable Medical Equipment provider manual. The PA request *must* document the following:

1. Why a pre-fabricated system is *not* sufficient to meet the participant's seating and positioning needs;
2. What orthopedic deformity is present and its fixed or flexible presentation;
3. What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning; and
4. Why any existing system is *not* meeting the participant's seating and positioning needs.

B. A specially-sized or constructed wheelchair that is provided to a participant whose anatomical measurements require the following:

1. Wheelchair seat width of 25 inches or more;
2. Wheelchair with a weight capacity for 351 or more pounds; or
3. Wheelchair with a seat to floor height of less than 15 1/2 inches.

C. A wheelchair for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses or conditions:

1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00 344.1);
2. Other spinal cord diseases (336.0-336.3);
3. Multiple sclerosis (340);
4. Other demyelinating disease (341.0-341.9);
5. Cerebral palsy (343.0-343.9);
6. Anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9);
7. Post-polio paralysis (138);
8. Traumatic brain injury resulting in quadriplegia (344.09);
9. Spina bifida (741.00-741.93);
10. Childhood cerebral degeneration (330.0-330.9);
11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis). Current stage II or

greater pressure ulcer *must* be noted and described by the physician in the face-to-face visit; justification *must* document what other types of skin protection measures have been utilized; or

12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning. Any or all of these abnormalities *must* be noted and described by the physician in the documentation of the face-to-face visit.

HCPCS code specific requirements are as follows:

- Wheelchairs described by HCPCS codes K0001, K0002, and K0003 will *not* be considered custom wheelchairs.
- Wheelchairs described by HCPCS code K0004 may be considered custom if criterion A, B or C above is met. Documentation for K0004 *must* justify why a less costly device cannot be used.
- Wheelchairs described by HCPCS code K0005 may be considered custom if criterion A or B above is met along with one of the following diagnosis codes:

    1. Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1);
    2. Other spinal cord diseases (336.0-336.3);
    3. Multiple Sclerosis (340);
    4. Other demyelinating disease (341.0-341.9);
    5. Cerebral Palsy (343.0-343.9);
    6. Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (335.0-335.21, 335-23-335.9);
    7. Post-polio paralysis (138);
    8. Traumatic brain injury resulting in quadriplegia (344.09);
    9. Spina Bifida (741.00-741.93);
    10. Childhood cerebral degeneration (330.0-330.9);
    11. Current stage II or greater pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface (trunk, spine or pelvis) (*must* be noted and described by the physician in the face-to-face visit documentation; justification *must* document what other types of skin protection measures have been utilized); or

12. Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (*must* be noted and described by the physician in the face-to-face visit documentation).

- Documentation for a K0005 *must* justify why a K0004 and other less costly device cannot be used.
- Wheelchairs described by HCPCS code E1161 may be considered custom if criterion C above is met.
- Wheelchairs described by HCPCS codes K0006 and K0007 may be considered custom if two (2) of the requirements stated in criterion B above are met.
- Wheelchairs described by HCPCS code K0009 will generally be considered noncovered for participants residing in a nursing home. Requests for K0009 wheelchairs will only be considered in extenuating circumstances and when the following exists:

A. Extensive documentation explaining why no other manual wheelchair (K0001-K0007) will meet the participant's needs; and

B. The participant's anatomical measurements are provided and document the participant requires one of the following:

- A wheelchair seat width of 25 inches or more; or
- A wheelchair with a weight capacity of 351 or more pounds.

13.18.G WHEELCHAIRS AND OPTIONS/ACCESSORIES FOR NURSING HOME PARTICIPANTS

Mo HealthNet requires use of the item-specific HCPCS code for all wheelchairs and wheelchair option/accessories for nursing home participants. The modifier SC *must* be added to the HCPCS code along with the appropriate NU (purchase) or RR (rental) modifier.

All wheelchair bases, initial options/accessories, and upgrade options/accessories for participants residing in a nursing home require prior authorization.

PLEASE NOTE: MO HealthNet reimbursement for wheelchairs and wheelchair options/accessories for participants residing in a nursing home is limited to participant-owned custom or power wheelchairs. Custom wheelchairs *must* meet the definition of a custom wheelchair as defined in Section 13.18.F in the MO HealthNet Durable Medical Equipment provider manual. Reimbursement for all other manual wheelchairs and options/accessories is included in the nursing home per diem.

13.19 COVERAGE OF DURABLE MEDICAL EQUIPMENT (DME) FOR PARTICIPANTS IN A HOSPITAL

DME items dispensed to a participant while receiving inpatient or outpatient care is included in the hospital payment and *not* paid for separately under the DME Program.

A hospital, which is enrolled as a DME provider, cannot be paid through the DME Program for any item covered under the DME Program that is used for inpatient/outpatient care.

13.20 AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

13.20.A AUGMENTATIVE COMMUNICATION DEVICE (ACD) DEFINITION

Augmentative Communication Devices (ACDs) are speech prostheses and are regarded as Durable Medical Equipment (DME). ACDs are alternative and supplemental communication equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition that precludes or significantly interferes with the participant's participation in activities of daily living. Examples of ACDs are communication picture boards/books, speech amplifiers, speech enhancers and electronic devices that produce speech or written output. Related accessories such as overlays, batteries, wheelchair mounts, switches, cables, pointing devices, etc. are also considered. A portable or desktop computer is only considered when the primary use of the computer is the participant's communication device. Examples of noncovered items include, but are *not* limited to: printers, office/business software, software intended for academic purposes, Internet access and computer tables.

13.20.B ELIGIBILITY FOR AUGMENTATIVE COMMUNICATION EQUIPMENT

MHD reimburses for electronic or manual ACDs, regardless of the participant's age, when the device is deemed medically necessary through pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

The Manufacturer Suggested Retail Price (MSRP) is required for manually-priced procedure codes. Refer to Section 19 for specific procedure code restrictions. The MSRP should be submitted electronically with the claim. The attachment and completion of the MSRP instructions are available at www.emomed.com.

13.20.C AUGMENTATIVE COMMUNICATION DEVICE (ACD) EVALUATION TEAM/SITE

For ACD team/sites currently enrolled as a speech-language pathologist, rehabilitation center or outpatient hospital but *not* previously approved by the Bureau of Special Health Care

Needs (BSHCN) that wish to be considered as a MO HealthNet ACD evaluation team/site, contact the Provider Enrollment Unit via e-mail at: providerenrollment@dss.mo.gov. Providers should state if they are currently enrolled as a MO HealthNet provider. Approval is given to speech-language pathologists, rehabilitation centers or outpatient hospitals that meet the following criteria:

- The ACD team/site leader *must* be a Missouri licensed speech-language pathologist who has a certificate of clinical competency from the American Speech-Language-Hearing Association.
- The speech-language pathologist *must* possess at a minimum two (2) years experience in the evaluation and selection of ACDs and *must* have expertise in the determination of which speech and specific ACD and strategies to use to maximize functional communication.
- In addition to the speech-language pathologist, team membership may include but is *not* limited to the following: Missouri licensed audiologist, educator, occupational therapist, physical therapist, physician, manufacturer's representative, social worker, case manager or a second speech pathologist. At least two (2) of these professionals *must* participate in the ACD evaluation. ACD team/site membership may change with each evaluation performed.
- The speech pathologist or any of the ACD team members may *not* be a vendor of ACDs or have a financial relationship with a vendor/manufacturer. This excludes the manufacturer's representative.

A description of the ACD team/site evaluation protocol as well as equipment available for an ACD evaluation *must* be submitted to MHD, Provider Enrollment Unit.

Approval is granted based on an ACD team evaluation concept and compliance with the requirements. The provider is notified in writing of any deficiencies. Approval may be granted upon correction of these deficiencies.

13.20.D AUGMENTATIVE COMMUNICATION EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

The ACD evaluation *must* be performed by a MO HealthNet approved ACD evaluation site. The ACD evaluation *must* be documented in the participant file and *must* include the following information:

- Medical diagnosis related to communication dysfunction leading to the need for an ACD;
- Current communication status and limitations;

- Speech and language skills, which *must* include prognosis for speech and/or written communication;
- Cognitive readiness for use of an ACD;
- Interactional/behavioral and social abilities both verbal and nonverbal;
- Cognitive, postural, mobility, sensory (visual and auditory), capabilities and medical status;
- Limitations of participant's current communication abilities without an ACD (if a device is currently in use, a description of the limitation of this device);
- Motivation to communication via use of an ACD;
- Residential, vocational, educational and other situations requiring communication;
- Participant's name, address, date of birth and MO HealthNet/MO HealthNet Managed Health Care plan ID number;
- ACD's ability to meet projected communication needs (e.g., ACD growth potential, how long it meets needs);
- Anticipated changes, modification or upgrades for up to two (2) years;
- Training plans;
- Plans for parental/caregiver training and support;
- Statement as to why prescribed ACD is the most appropriate and cost effective device. Comparison of the advantages, limitations and cost of alternative systems evaluated with the participant *must* be included; and
- Complete description of ACD prescribed including all medically necessary accessories or modification.

13.20.E MODIFICATION/REPLACEMENT/REPAIR OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

The initial prescription of an ACD should attempt to take into account all projected changes in a participant's communication abilities for at least two (2) years. However, if changes occur in participant needs, capabilities or potential for communication, necessary modifications/replacements may be considered.

Supporting documentation for the modification or replacement *must* include:

- Reevaluation of the participant by a MO HealthNet approved ACD evaluation team/site; and
- Changes in the participant's communication abilities that support the medical necessity/appropriateness of the requested changes.

If requesting a different ACD from the one currently being used by the participant, a new ACD evaluation by a MO HealthNet approved site *must* be performed. Pre-certification is required.

Replacement of an ACD is considered due to loss, non-repairable damage, or if the ACD is no longer functional. Pre-certification is required.

Routine repairs of an ACD *not* covered by warranty are covered. A Certificate of Medical Necessity *must* be submitted and *must* document the reason for the repair. The participant's physician *must* sign the Certificate of Medical Necessity if the repair is $500.00 and over. Battery replacement is considered a repair.

13.20.F RENTAL OF AN AUGMENTATIVE COMMUNICATION DEVICE (ACD)

Rental of an ACD is approved only if the participant's ACD is being repaired, modified or if the participant is undergoing a limited trial period (3 months) to determine appropriateness and ability to use the ACD. If a trial period (3 months) is recommended, the trial period and the subsequent purchase of an ACD require separate pre-certification. The treating speech-language pathologist *must* confirm the participant is utilizing the selected device daily and accurately in a variety of communication situations and demonstrates the cognitive and physical ability to effectively use the device during the trial period.

In addition to the modifier NU, new equipment, modifier NR, new when rented, will be assigned with the approved pre-certification for the purchase following the required trial period of an ACD. The DME provider *must* submit the appropriate procedure code with both NU and NR modifiers when billing the purchase of the device.

All rental payments are deducted from the MO HealthNet purchase price should the trial period indicate the need for purchase of the device. The combined reimbursement for each month of the trial period (3 months) and subsequent purchase is complete payment for the device.

13.21 EQUIPMENT

Canes, crutches, walkers, commodes, decubitus care equipment, hospital beds, bed side rails, bed pans, trapeze equipment, etc. are covered equipment. For specific equipment codes and billing requirements, refer to Section 19.

13.21.A MANUAL HOSPITAL BEDS

Manual hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.21.B SEMI-ELECTRIC HOSPITAL BED

Semi-electric hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.21.C TRAPEZE BAR

A trapeze bar is covered when the participant is bed confined and the device is needed to change body positioning or to get in and out of bed due to respiratory conditions or other medical reasons.

13.21.D MATTRESS AND SIDE RAILS

A mattress and/or side rails cannot be billed in addition to a hospital bed. Mattress and side rails may only be billed when the bed is owned by the participant or if needed for replacement.

Side rails may be covered if the participant is bed confined, disoriented, experiences vertigo, has a neurological disorder, or is paraplegic or quadriplegic.

13.21.E CANES AND CRUTCHES

Canes and crutches require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.21.F COMMODES

Commodes require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32for pre-certification guidelines.

13.21.G PATIENT LIFT (HYDRAULIC)

Hydraulic patient lifts are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

Electric lifts are *not* covered.

13.21.H PRESSURE REDUCING SUPPORT SURFACES

Pressure reducing support surfaces, other than those listed below, require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

Pressure reducing support surfaces such as a powered air flotation bed (low air loss therapy—E0193), powered pressure reducing mattresses, or air fluidized beds (E0194) are *not* covered under the HCY or DME Programs. These types of pressure reducing support surfaces may be requested through the Exceptions Process Program. Refer to Section 20, Exception Process, for requirements for consideration of coverage.

13.21.I COVERAGE CRITERIA FOR OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE (E0760NU)

Osteogenesis stimulators are covered for those participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

Initial pre-certification is limited to the physician specified length of need up to a 3-month pre-certification. If the device continues to be medically necessary, subsequent pre-certification *must* be requested by the treating physician through the submission of a help ticket through CyberAccess[sm] or by contacting the MHD helpdesk at 800-392-8030.

The provider of the osteogenesis stimulator *must* assure that the participant utilizing the device is properly instructed in use of the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the osteogenesis stimulator device. The provider *must* maintain written documentation in the participant's medical record regarding the instruction of use for the osteogenesis stimulator.

The device *must* be capable of producing a treatment log indicating the participant's use. This information *must* be available to MHD upon request.

The device is available as a rent-to-purchase item only and may only be supplied once in a lifetime.

13.22 HEALTHY CHILDREN AND YOUTH (HCY) EPSDT PROGRAM (FOR PARTICIPANTS 20 AND UNDER)

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, or other health care professional visit or exam (interperiodic screen) may be covered for participants age 20 and under.

It is important to note that every MO HealthNet eligible child should have a complete HCY (EPSDT) screen. If the child has *not* had a full screen, the provider should refer the child for a full screen to be done at a later date. Refer to Section 9 for information about screening providers.

Refer to Section 19.1 for reimbursement guidelines, quantity limitations and specific restrictions for each HCY procedure code.

13.22.A UNDER PADS, DIAPERS, BRIEFS AND PROTECTIVE UNDERWEAR/PULL-ONS

Underpads, diapers, briefs and protective underwear/pull-ons require pre-certification. Any combination of incontinence products is limited to 186 per month and will be pre-certified without the EP modifier. Claims submitted for quantities of 186 per month or less should exclude the EP modifier. For quantities exceeding 186 per month, justification of medical necessity *must* be submitted through a CyberAccess[sm] help ticket or a phone call to the help desk. If approved, pre-certification will include an EP modifier. Claims for quantities of greater than 186 per month should include the EP modifier. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for complete pre-certification guidelines.

Providers *must not* dispense any incontinence products unless the participant agrees replacement of the item is desired and necessary; no automatic shipping is allowed.

13.22.B RENT-TO-PURCHASE FOR CHEST WALL OSCILLATION DEVICES (E0483EPRR)

High frequency chest wall oscillation devices (E0483EPRR) are only covered for participants age 20 and under and are reimbursed on a rent-to-purchase basis only. If the device continues to be utilized and is medically necessary, it will be considered purchased after the total of all rental payments equals the purchase price. If the use of device is discontinued at any time, the provider *must* stop billing for the device.

Chest wall oscillation device rental (E0483EPRR) requires pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.22.C PULSE OXIMETER

13.22.C(1) Pulse Oximeter Reimbursement

Pulse oximeters are reimbursed on a rent-to-purchase basis. Pre-certification is required. DME pre-certification criteria documents may be found at

http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.22.C(2) Pulse Oximeter Supplies

All oximeters that are rented include probes, cables, repair, education, maintenance and periodic downloading of recorded data, as requested by the participant's physician.

One (1) non-disposable probe per 12-month period or one (1) disposable probe per 60-day period is allowed per participant for pulse oximeters that have been purchased. A Certificate of Medical Necessity justifying the need for the replacement probe *must* be maintained in the file. The Certificate of Medical Necessity *must* also justify the use of disposable probes as opposed to non-disposable probes when disposable probes are utilized.

Providers *must not* just dispense supplies simply because the quantity limitations allow it. The participant *must* agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed. Billing for pulse oximeter probes above the quantity allowed as the usual maximum quantity, in the absence of documentation clearly explaining the medical necessity of the excess quantity, is denied as *not* medically necessary. A letter of justification from the participant's physician *must* be submitted with the claim form for probes in excess of those allowed.

13.22.D COUGH STIMULATING DEVICE

Cough stimulating devices are covered for participants age 20 and under and are reimbursed on a rent-to-purchases basis only. Pre-certification is required. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.22.E CRANIAL REMOLDING ORTHOSIS

Cranial remolding orthosis, pediatric, rigid with soft interface material (S1040EPNU) is reimbursed as a purchase item only. A neurosurgeon and/or cranial facial team *must* prescribe use of the cranial remolding orthosis as an appropriate form of treatment for participants from birth through 12 months of age.

The orthotist providing the cranial orthosis *must* be trained and certified to evaluate, modify and dispense the cranial orthosis for proper fit. The fabricated cranial orthosis *must* have FDA 510(K) clearance.

Cranial remolding orthosis require pre-certification. Any replacement of the cranial orthosis due to growth during the post-operative period for the diagnosis of craniosynostosis will require a new pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.23 TOTAL PARENTERAL NUTRITION (TPN)

Total Parenteral Nutrition (TPN) is covered for participants with severe permanent disease of the gastrointestinal tract that prevents absorption of sufficient nutrients to maintain weight and strength.

The participant *must* have a condition involving the gastrointestinal tract that results in significant malabsorption. TPN is noncovered for conscious participants whose need for parenteral nutrition is due to lack of appetite or a cognitive problem. The participant *must* require TPN to sustain life. Adequate nutrition *must not* be possible by dietary adjustment, oral supplements, or tube enteral nutrition.

TPN is covered under the Durable Medical Equipment (DME) Program for participants in a nursing home.

One (1) supply kit (B4220 or B4222) and one (1) administration kit (B4224) is covered for each day that parenteral nutrition is administered, when such kits are used and medically necessary.

When homemix TPN solutions are used the component carbohydrates amino acids, additives, and lipids are separately billable.

When premix TPN solutions are used there is no separate authorization for the carbohydrates, amino acids, or additives (vitamins, trace elements, heparin, electrolytes). However, lipids may be separately authorized with premix solutions. An invoice of cost is required when billing for B5200.

TPN procedure codes that are defined as one (1) unit equals one (1) day may be billed by date of service or by consecutive dates of service. Participant's receiving TPN on Monday, Wednesday and Friday *must* be billed by date of service while participants with daily infusions should be billed with from and through dates of service. The number of units billed *must* equal the number of days when billing consecutive from and through dates of service.

TPN procedure codes that are defined as one (1) unit equals 500 ml *must* be billed as such. These procedure codes should be billed on the date the item is initially dispensed regardless of the number of days it covers. Refer to Section 19 for TPN procedure codes and restrictions.

Parenteral nutrition infusion pump, portable or stationary, are reimbursed on a rent-to-purchase basis only. It will be considered purchased after the total of rental payments equals the purchase price. Refer to Section 19 for reimbursement guidelines. If use of the device is discontinued at any time, the provider *must* discontinue billing of the device.

TPN formula, supplies and infusion pump require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.24 ENTERAL NUTRITION

MO HealthNet Division (MHD) covers medically necessary enteral nutrition products for children under the age of 21. Effective for dates of service on and after December 01, 2013, MHD will implement the following policy regarding enteral nutrition formula and supplies.

13.24.A ENTERAL NUTRITION FORMULA

Enteral nutrition is covered for a patient under the age of 21 when criteria A or B are met, and both C and D are met.

A. WIC (Special Supplemental Nutrition program for Women, Infants and Children) eligibility has been ruled out; OR
B. The WIC benefit is exhausted (as determined by the Department of Health and Senior Services); AND
C. The WIC eligibility information from A or B above is documented in the DME Provider Record; AND
D. The child also meets one of the following medical criteria:
    1. Has a nasogastric tube, gastrostomy tube or jejunostomy tube for feeding purposes; OR
    2. Is under 6 years of age and has a diagnosis of failure to thrive (defined as: oral intake less than bodily requirements; an imbalance possibly related to the inability to ingest/digest/absorb nutrients); OR
    3. Meets the criteria below in a and also meets either criterion b or c:
        a. Has one of the following diagnoses: ALS, cystic fibrosis, esophageal/stomach cancer, pulmonary insufficiency, non-healing/chronic wounds, dysphagia, renal failure (on dialysis), advanced AIDS with gastrointestinal co-morbidity, severe trauma or burns, traumatic brain injury; AND
        b. During the past 6 weeks has a documented serum protein level below 6 and/or serum albumin level below 3.5 performed by an accredited lab; OR
        c. Recent dietician evaluation determines sufficient caloric intake is not obtainable through regular food preparation alternatives (i.e. liquified/pureed foods); or a speech pathologist evaluation documents a failed swallow study; OR
    4. Has an unplanned weight loss of 10% or more over the past 3 months plus at least one of the following conditions:

a. On-going cancer treatment; OR
b. Advanced AIDS; OR
c. Pulmonary insufficiency; OR
d. Status post severe trauma/burn/brain injury; OR
e. One of the following malabsorption diagnoses: Short bowel syndrome, celiac sprue, tropical sprue, gastrointestinal fistula, nutritional marasmus, Whipple's disease, intestinal lymphangiestasia, chronic carbohydrate intolerance; OR

5. The participant has one of the conditions listed in 4 a-e above and a history of body weight maintained by supplementation within the past 6-12 months (documentation must be in the DME provider record and may be requested for State review); OR
6. The participant meets criterion 3b or 3c above and has a medical condition for which the DME provider record contains detailed documentation from the prescribing physician's progress notes justifying the medical necessity of enteral formula.

A list of covered enteral formula HCPCS (Healthcare Common Procedure Coding System) codes can be found in Section 19 of the MO HealthNet DME Provider Manual. Section 19 also lists reimbursement requirements (i.e. medical necessity form, invoice of cost) and maximum allowable amounts for each HCPCS code.

13.24.B. SPECIAL ENTERAL FORMULA

Special nutrient formulas (HCPCS codes B4149, B4153-B4157, B4161, and B4162) are produced to meet unique nutrient needs for specific disease conditions. The DME provider's record for the participant must adequately document the specific condition and the need for the special nutrient. This information shall be made available to the State upon request.

13.24.C ENTERAL NUTRITION SUPPLIES

Enteral nutrition may be administered by oral intake or by feeding tube via gravity, syringe or pump. Pump administration is covered only when one of the following criteria is met:

1. The patient has a jejunostomy tube; OR
2. The patient has a gastrostomy tube or NG tube and the medical record documents one of the following:
   a. A trial and failure of administration by both gravity and syringe or documentation that those methods of administration are medically contraindicated; OR

b. A pump is medically necessary due to reflux and/or aspiration; severe diarrhea; dumping syndrome; administration rate less than 100 ml/hr; blood glucose fluctuations; or circulatory overload.

The appropriate feeding supply kit must correspond to the prescribed and documented method of administration based on medical need.

13.25 ORTHOTIC DEVICES

Orthotic devices are covered by MO HealthNet when prescribed by a physician (M.D. or D.O.) or a podiatrist (except for diabetic shoes and inserts). The orthotic device *must* be necessary and reasonable for the treatment of the participant's illness or injury. It *must* be used to support a weak or deformed body member, or restrict or eliminate motion in a diseased or injured part of the body. The orthotic device *must* be covered by MO HealthNet.

13.25.A ORTHOPEDIC SHOES

Orthopedic shoes, and modifications or additions to shoes, are covered only if they are an integral part of a brace, or the participant is diabetic or 20 years of age or under. "Integral" means that the shoes are necessary for completeness of the brace. A pair of shoes may be reimbursed even if only one (1) shoe is an integral part of a unilateral brace.

13.25.B SHOES FOR DIABETIC PARTICIPANTS

Shoes, inserts and and/or modifications for diabetic participants require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

A modification of a custom molded or depth shoe may be covered as a substitute for an insert. Although *not* intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges (A5504), metatarsal bars (A5505) or offset heels (A5506). Other modifications of diabetic shoes (A5507) include, but are *not* limited to flared heels.

Quantities of shoes, inserts, and/or modifications greater than those allowed will be denied.

Inserts used in noncovered shoes are not covered.

Deluxe features of diabetic shoes (A5508) are not covered.

There is no separate reimbursement for certification of need or prescription of footwear, or for fitting of shoes, inserts, or modifications.

The particular type of footwear (shoes, inserts, modifications) which is necessary *must* be prescribed by a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. The footwear *must* be fitted and furnished by a podiatrist or other qualified individual, such as a pedorthist, orthotist or prosthetist.

The certifying physician provides the medical care for and manages the beneficiary's systemic diabetic condition. The certifying physician *must* be an M.D. or D.O. and may *not* be a podiatrist, physician assistant, nurse practitioner or clinical nurse specialist.

13.25.C SERVICES INCLUDED IN REIMBURSEMENT OF ORTHOTIC DEVICES

The following items are included in the MO HealthNet maximum allowable reimbursement for orthotic devices and are *not* reimbursed separately and may *not* be billed to the participant:

- Cost of the orthosis;
- Design of the orthosis;
- Required visits or fittings with the provider prior to receiving the orthosis; and
- Proper fitting of the orthosis.

13.25.D BILLING REQUIREMENTS FOR ORTHOTIC DEVICES

Refer to Section 19 for a list of covered orthotic procedure codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

13.26 OSTOMY SUPPLIES

Non-sterile ostomy supplies are covered for ostomates if prescribed by the participant's attending physician. Ostomy supplies are *not* covered for participants in a hospital or nursing home. Refer to Section 19 for a list of covered ostomy procedure codes, the MO HealthNet maximum allowed amount and the quantity limitations for each procedure code.

13.26.A NONCOVERED OSTOMY SUPPLIES

The following ostomy supplies are *not* reimbursable under the Durable Medical Equipment (DME) Program:

Absorption Flakes, Absorption Pad, Aerszoin Spray, Allucotton Dressing, Benzoin Tincture, Carrying Case, Catheter Shields, Cellucotton, Chux, Cleansers, Covers, Cutting Tools, Deodorizers, Dilating Glove, Disposable Liners, Drain Eez, Drying Hanger, Drying Rack, Dusting Powder, Enema Bags, Fiberall, Filters, Finger Cots,

Flanellets, Foxy Covers, Fresh Tales, Gauze Pads, Gauze Sponges, Germicide, Gloves, Hexon, Incontinent Pads, Lemon Hexon, Nitrazine Paper, Ostomy Skin Bond or Cement Remover, Oxy-Chinol Tablets, Ozium, Spray, Perma-Type, Post-Op Bags, Post-Op Pouches, Post-Op Sets, Skin Barrier Dispensers, Skin Conditioners, Soaking Tray, Spreader, Staphine Spray, Stericol Tablets, Sterile Gloves, Stoma Centering Collars, Stoma Centering Guide, Surgical Sponges, Surge Pads, Syringes, Tape Dispensers, Toppers, Torbot Sanitizer, Travel Bag, Wash Bottle, and Waterproof Sheeting.

13.26.B BILLING AND REIMBURSEMENT OF OSTOMY SUPPLIES

An invoice of the provider's cost for manually-priced ostomy supplies *must* accompany each CMS-1500 claim for payment. The invoice *must* be legible, include the price that was paid for the ostomy supply, and document the quantity in a box or case. Manually-priced ostomy supplies are reimbursed at the provider's cost plus 20%.

13.27 OXYGEN AND RESPIRATORY EQUIPMENT

Oxygen and respiratory equipment is covered for home use when it is determined to be medically necessary and appropriate and prescribed by the participant's attending physician.

13.27.A OXYGEN

Home oxygen therapy is covered for participants who meet the Durable Medical Equipment (DME) pre-certified medical criteria. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

If a participant travels out of their provider's usual service area, it is the participant's responsibility to arrange for oxygen during that time period. MO HealthNet will only pay one (1) provider for oxygen during any one (1) rental month.

13.27.A(1) Certification Requirements

Certification of the need for oxygen therapy will be completed when the authorized prescriber requests pre-certification as indicated below.

- The blood gas study reported for initial certification requests *must* be the most recent study obtained prior to the pre-certification request. This

blood gas study *must* be obtained within 30 days prior to the date of the pre-certification request.

- For participants age 21 and older initially meeting criteria in Group I of the medical criteria document and for children meeting criterion 3A of the medical criteria document, the most recent qualifying blood gas study prior to the thirteenth month of therapy *must* be reported on the recertification request. Recertification of Group I participants is required 12 months after the initial certification. If the participant is *not* seen and reevaluated within 90 days prior to recertification, but is subsequently seen, payment may be made for dates of service between the scheduled recertification date and the physician visit date. No additional certification will be required after the 12-month recertification.
- For participants age 21 and older initially meeting criteria in Group II of the medical criteria document, the most recent blood gas study which was performed between the 61st and 90th day following the initial certification *must* be reported on the recertification request.
- Recertification of Group II participants is required every three (3) months. Any Group II participant who meets Group I criteria on recertification will be subject to Group I recertification requirements. If a qualifying test is *not* obtained between the 61st and 90th day of home oxygen therapy, but the participant continues to use oxygen and a test is obtained later, and if that test meets Group I or II criteria, coverage resumes with the date of that test.
- The participant *must* be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification request. The participant *must* be seen and reevaluated by the treating physician within 90 days prior to any recertification.
- For any revised certification, the blood gas study reported on the revised certification request *must* be the most recent test performed prior to the revised date.
- A revised certification is required when there is a change in the type of oxygen delivery system or there is the addition of a portable system to a stationary system.

A revised oxygen therapy certification *must* be filed when the prescribed maximum flow rate changes from one of the following categories to another: (a) less than one (1) Liter Per Minute (LPM); (b) one (1) to four (4) LPM; (c) greater

than four (4) LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the participant on four (4) LPM *must* be performed within 30 days prior to the start of the greater than four (4) LPM flow rate.

13.27.A(2) Testing Specifications

The qualifying blood gas study *must* be performed by a physician or a qualified provider of laboratory services. Blood gas studies performed by a provider of oxygen equipment are *not* acceptable. In addition, the qualifying blood gas study may *not* be paid for by any provider of oxygen equipment.

For sleep oximetry studies, the oximeter provided to the participant *must* be tamper-proof and *must* have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.

When oxygen therapy meets criteria based on an oxygen study obtained during exercise, there *must* be documentation of three (3) oxygen studies in the participant's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

The qualifying blood gas study may be performed while the participant is on oxygen as long as the gas values meet the Group I or Group II criteria.

13.27.A(3) Modifier

The monthly payment amount for stationary oxygen is subject to adjustment depending on the gen prescribed (liters per minute or LPM) and whether or *not* portable oxygen is also prescribed.

If a participant qualifies for additional payment for greater than four (4) LPM of oxygen and also meets the requirement for portable oxygen, payment will *not* be made for the portable oxygen. The provider *must* use the QF modifier on the stationary code.

The following modifiers *must* be used when billing oxygen for a participant who requires more than four (4) LPM:

- QF – greater than four (4) LPM and portable oxygen is prescribed
- QG – greater than four (4) LPM

13.27.A(4) Oxygen Contents

Oxygen contents (stationary and portable) are *not* billable with any type of oxygen system rental (i.e., if participant owns stationary but rents portable all contents are included in the rental of the portable; if the participant owns the portable and rents the stationary all contents are included in the stationary rental).

13.27.A(5) Oxygen Therapy *Not* Covered

1. Angina pectoris in the absence of hypoxemia.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 will improve the oxygenaton of tissues with impaired circulation.
4. Terminal illnesses that do *not* affect the respiratory system.

13.27.B OXYGEN SUPPLIES, MAINTENANCE AND REPAIR

Cannulas, masks, or any supply used with an oxygen concentrator, portable or stationary oxygen system is included in the monthly rental of that device and is *not* paid for separately.

Delivery, set-up, maintenance and repair fees are also included in the monthly rental reimbursement and are *not* paid for separately.

13.27.C PORTABLE OXYGEN SYSTEMS

Portable oxygen systems are only covered for participants when:

- The qualifying ABG/oximetry testing is performed at rest or exercise; and
- There is a physician prescription for portable oxygen.
- The provider record *must* include a description of the activities or exercise routine (e.g., amount and frequency of ambulation) that the participant undertakes on a regular basis, and that requires the portable system in the home (i.e., the documentation *must* describe the medical therapeutic purpose to be served by the portable system that cannot be met by a stationary system).

13.27.D VENTILATOR

A volume ventilator or pressure support ventilator may be covered by MO HealthNet if prescribed and pre-certified by the participant's attending physician. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

The monthly reimbursement includes **but is *not* limited to the following:**

- All Circuits, Brackets and Filters
- Ambu Bag
- Batteries and Battery Charger
- Cleaning Solution and Supplies
- Initial Set-Up and Participant Training
- Maintenance of the Ventilator
- Professional Support
- Sterile Water
- All Trach Care Supplies
- Tubing
- Ventilator Unit

Non-invasive ventilators such as BiPap ST may *not* be billed under the ventilator code.

Equipment that may be billed in addition to a ventilator when medically appropriate and necessary are:

- Humidifiers;
- Oxygen, Oxygen Concentrators and Oxygen Delivery Systems; or
- Suction Pumps.

Ventilators are covered for participants residing in a nursing home.

13.27.E BACK-UP VENTILATOR

A back-up ventilator may be covered if a volume or pressure support ventilator has been previously pre-certified and the participant requires ventilation 24 hours per day. The monthly rental reimbursement shall include all items, supplies and services as listed for the ventilator.

For participants residing in a nursing home, a back-up ventilator is included in the nursing home per diem rate and is *not* paid separately.

A back-up ventilator requires pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.27.F NEBULIZER, COMPRESSOR, SUCTION PUMP AND IPPB

Delivery, set-up, maintenance, pick-up and repair are included in the monthly rental reimbursement and are *not* reimbursed separately. All supplies, with the exception of disposable breathing circuits (A4618) for an IPPB, are also included in the monthly rental reimbursement and are *not* reimbursed separately.

Two (2) nebulizer kits per month are allowed for participant-owned equipment. Additional supplies for participant-owned equipment are *not* covered under the DME Program.

For respiratory equipment that has been purchased through monthly rental payments or has been purchased outright, supplies for this equipment, with the exception of a nebulizer kit, may be requested through the Exceptions Process. Refer to Section 20 for Exception Process instructions.

Nebulizers, compressors and suction pumps require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.27.G APNEA MONITOR

Apnea monitors are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of heart rate and respiratory rate an *must* meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors *must* have alarming mechanisms to alert care givers of cardiorespiratory distress or other events which require immediate intervention and *must* be capable of

recording and storing events and of providing event recording downloads or printouts of such data.

Apnea monitors may be authorized for infants. An infant is described as a child whose age ranges from birth to 12 months of age. Infant Cardiopulmonary Resuscitations (CPR) training of caregivers by certified trainers is recommended.

The following diagnosis or conditions alone are *not* indications for monitoring, and are ***not*** covered:

1) Seizure disorders (without life threatening events);
2) Hydrocephalus, uncomplicated;
3) Mental Retardation;
4) Irreversible terminal conditions;
5) Congenital heart defects, with or without associated arrhythmias;
6) Distant family history of apnea or SIDS (other than an immediate sibling);
7) History of apnea monitor use with other siblings;
8) History of apnea with other sibling(s);
9) Parental anxiety or family member request of a monitor; and
10) Monitoring of blood oxygen saturation.

Apnea monitors require pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.27.H(1) Apnea Monitor Reimbursement

Apnea monitors are reimbursed on a rental basis. The maximum months of rental which may be reimbursed for an apnea monitor is limited to a total of 12 months. Pre-certification is required for months one (1) through four (4). Additional pre-certification is required for months five (5) through 12. For the appropriate procedure code, reference Section 19.

All supplies such as electrodes, wires and belts are included in the monthly rental reimbursement and are *not* reimbursed separately. Repair, maintenance, initial set-up, event recording, pnuemogram and professional support are also included in the monthly rental reimbursement.

13.28 RESPIRATORY ASSIST DEVICES (RAD) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Any RAD or CPAP device that has been rented by MO HealthNet for 12 or more months is considered purchased. No further rental payments are made and providers may only bill for supplies and repairs needed for continued use after the initial 12-month rental period. If utilization of the RAD or CPAP device is discontinued at any time, the provider *must* stop billing for the equipment, related accessories and supplies.

RAD and CPAP devices require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

13.28.A COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE (E0601RR)

A single-level CPAP device (E0601RR) may be covered if the participant has a diagnosis of Obstructive Sleep Apnea (OSA) documented by an attended, facility-based polysomnogram and is pre-certified.

Polysomnographic studies *must* be performed in a facility-based sleep study laboratory and *not* in the home and may *not* be performed by a DME provider. Portable multi-channel home sleep testing devices are also *not* acceptable.

13.28.B CONTINUED COVERAGE FOR A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE BEYOND THE FIRST THREE (3) MONTHS (E0601KJRR)

Continued coverage for a CPAP device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertain from either the participant or the treating physician that the participant is continuing to use the CPAP device. This information *must* be documented in the DME provider's record. If this criterion is met, pre-certification *must* be obtained and services should be billed utilizing the KJ modifier.

If the above criterion is *not* met, continued rental coverage of the device is *not* approved.

13.28.C COVERAGE FOR A RESPRIATORY ASSIST DEVICE (RAD) (E0470 AND E0471) FOR THE FIRST THREE (3) MONTHS OF THERAPY

The treating physician *must* be qualified by virtue of experience and training in non-invasive respiratory assistance to order and monitor use of a RAD. Physicians who treat participants for other medical conditions may or may *not* be so qualified, and if *not*, though they may be the treating physician of the participant for other conditions, they are *not* considered the

treating physician for the prescribing of Non-invasive Positive Pressure Respiratory Assistance (NPPRA) therapy.

In order for a RAD (E0470 or E0471) to be covered, the treating physician *must* fully document in the participant's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc, in addition to a copy of the polysomnogram.

A RAD (E0470or E0471) used to administer NPPRA therapy is covered for participants with clinical disorder groups characterized as restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea (CSA) or OSA (E0470 only), and participants that meet criteria in the DME pre-certification criteria document.

Polysomnographic studies *must* be performed in a facility-based sleep study laboratory and *not* in the home and may *not* be performed by a DME provider. Portable multi-channel home sleep testing devices are also *not* acceptable.

13.28.D CONTINUED COVERAGE CRITERIA FOR A RESPIRATORY ASSIST DEVICE (RAD) BEYOND THE FIRST THREE (3) MONTHS OF THERAPY

Participants covered for the first three (3) months of a RAD without a backup rate feature (E0470) or a RAD with a backup rate feature (E0471) *must* be reevaluated to establish the medical necessity of continued coverage by MO HealthNet. While the participant may certainly need to be evaluated at earlier intervals after therapy is initiated, the reevaluation upon which MO HealthNet will base a decision to continue coverage beyond this time *must* occur no sooner than 61 days after initiating therapy by the treating physician. MO HealthNet will *not* continue coverage for the 4th and succeeding months of NPPRA therapy until this reevaluation has been completed.

Continued coverage for RAD beyond the first three (3) months of therapy requires additional pre-certification. If the medical criteria is met, services should be billed utilizing the KJ modifier for months four (4) through 12.

13.28.E SUPPLIES FOR RESPIRATORY ASSIST DEVICES (RADs) AND CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICES

Supplies used with RAD and CPAP devices are covered when the coverage criteria for the device is met. If the coverage criteria are *not* met, the supplies are *not* covered. Supplies, repairs and maintenance are included in the first 12 months of rental reimbursement and are *not* reimbursed separately. Providers *must not* dispense supplies simply because the quantity

limitations allow. The participant *must* agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed.

The supplies provided *must* be based on the type of delivery system the participant utilizes. Supplies billed that are inconsistent with the delivery system utilized by the participant are subject to denial or recoupment.

Procedure codes A7044 (oral interface used with positive airway pressure device, each) and A7045 (exhalation port with or without swivel used with accessories for positive airway devices, replacement only) are covered up to one every 180 days; however, these items are rarely needed.

A non-heated (E0561) or heated humidifier (E0562) is covered separately when ordered by the treating physician and pre-certified for use with a covered BIPAP device. A replacement water chamber for a humidifier used with a positive airway pressure device (A7046) may also be covered (a maximum of one per 180 days) when this replacement item is medically necessary.

13.29 PROSTHETIC DEVICES

Prosthetic devices (excluding dentures, hearing aids and artificial eyes) are covered by MO HealthNet when prescribed by a physician (M.D./D.O) and when the device replaces all or a portion of the function of a permanently inoperative or malfunctioning body member.

13.29.A PROSTHETIC SOCKS AND SHEATHS

Prosthetic socks and sheaths are limited to six (6) socks and sheaths per limb per participant per 12-month period.

13.29.B MASTECTOMY BRAS AND BREAST PROSTHESIS

Mastectomy bras are limited to three (3) per year, per participant.

Silicone breast prostheses are limited to one (1) per side, every 24 months. Form prostheses are limited to one (1) per side every six (6) months.

Mastectomy bras and breast prosthesis require pre-certification. Durable Medical Equipment (DME) pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.32 for pre-certification guidelines.

The modifier LT (left) or RT (right) along with the appropriate procedure code *must* be used when submitting a claim for a breast prosthesis. If filing for a bilateral prosthesis, bill on two (2) separate lines of the claim form.

13.29.C SERVICES INCLUDED IN REIMBURSEMENT

The following items/services are included in the MO HealthNet maximum allowable reimbursement for a prosthetic device:

- Cost of the prosthesis;
- Design of the prosthesis;
- Required visits or fittings with the provider prior to receiving the prosthesis;
- Proper fitting of the prosthesis;
- All necessary post-fitting and adjustment visits for one (1) year after receiving the prosthesis;
- Necessary modifications for one (1) year after receiving the prosthesis, unless the required because of physical growth or excessive stump shrinkage; and
- One-year warranty to cover defects in materials and workmanship.

Refer to Section 19 for a complete list of covered prosthetic codes, the MO HealthNet maximum allowed amount and the billing guidelines for each procedure code.

13.30 WHEELCHAIRS

Standard, power and custom wheelchairs are covered by MO HealthNet when determined to be medically appropriate and necessary and is prescribed by the participant's attending physician.

13.30.A STANDARD WHEELCHAIRS

Standard wheelchairs are covered when the participant's condition is such that the alternative is chair or bed confinement. A Certificate of Medical Necessity is required for the purchase or rental of a manual wheelchair. Refer to Section 19 for a complete list of covered codes and the MO HealthNet maximum allowed amount.

13.30.A(1) Manual Wheelchair Basic Equipment Package

Manual wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a list of items included in the basic equipment package for manual wheelchairs.

- Seat width: 15"-19"
- Seat depth: 15"-19"
- Calf rests
- Wheel lock assembly
- Hand rims
- Upholstery
- Bearings
- Complete set of tires and casters (with the exception of the items listed below that can be billed separately)
    - Insert for pneumatic propulsion tire (removable), any type
    - Foam-filled propulsion tire, any size
    - Foam-filled caster tire, any size
    - Foam propulsion tire, any size
    - Foam caster tire, any size

- Front caster assembly with solid tire

- Armrests: fixed, swingaway or detachable; fixed height
- Footrests: fixed, swingaway or detachable

13.30.B POWER WHEELCHAIRS

Power mobility devices are covered by MO HealthNet if prescribed by the participant's attending physician and prior authorized. The participant's condition is such that a power mobility device is medically appropriate and necessary and the participant is unable to propel a manual wheelchair.

13.30.B(1) Power Wheelchair Basic Equipment Package

Power wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement at the time of initial issue for these items unless otherwise noted.

To keep in alignment with Medicare guidelines, below is a list of the items included in the basic equipment package for power wheelchairs.

- Lap belt or safety belt (shoulder harness/straps or chest straps/vest may be billed separately)
- Battery charger
- Complete set of tires and casters, any type
- Leg rests (no separate reimbursement if fixed, swingaway, or detachable non-elevating leg rests with or without calf pad are provided, elevating leg rests may be billed separately)
- Footrests/foot platform (no separate reimbursement if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided)
- Angle adjustable footplates (no separate reimbursement for Group 1 or 2 power wheelchairs, angle adjustable footplates may be billed separately for Group 3, 4 and 5 power wheelchairs)
- Armrests (no separate reimbursement if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided, adjustable height armrests may be billed separately)
- Weight specific components (braces, bars, upholstery, brackets, motors, gears, etc. as required by participant weight capacity)

- Any seat width and depth (with the exception of the list of items below that may be billed separately for Group 3 and 4 power wheelchairs with a sling/solid seat/back)
    - For Standard Duty, seat width and/or depth greater than 20 inches
    - For Heavy Duty, seat width and/or depth greater than 22 inches
    - For Very Heavy Duty, seat width and/or depth greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Any back width (with the exception of the items listed below for Group 3 and 4 power wheelchairs with a sling/solid seat/back that may be billed separately)
    - For Standard Duty, back width greater than 20 inches
    - For Heavy Duty, back width greater than 22 inches
    - For Very Heavy Duty, back width greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Controller and Input device. There is no separate billing/reimbursement if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Non-standard seat dimensions and non-standard back dimensions should be billed with code K0108. No separate billing at the time of initial issue is to be submitted for these items unless otherwise noted.

13.30.C POWER WHEELCHAIR ACCESSORIES

Wheelchair accessories for power chairs *must* be billed under the specific code(s). If there is no specific code(s), K0108 may be used. K0108 may only be listed one (1) time on the Prior Authorization (PA) Request form.

13.30.C(1) Power-Operated Vehicle (Scooters) Basic Equipment Package

Power-operated vehicles (scooters) are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a listing of the items included in the basic equipment package for power-operated vehicles.

- Battery or batteries required for operation
- Battery charger
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation
- All options and accessories are included in the initial issue.

13.30.D WHEELCHAIR BATTERIES

Providers may bill up to a half-hour of labor under K0739 when billing for the replacement of batteries.

13.30.E CUSTOM WHEELCHAIRS

A custom wheelchair is defined as a chair that is tailor made for one (1) participant and cannot be used by anyone else. Custom wheelchairs and accessories are covered if prescribed by the participant's attending physician and prior authorized.

Custom wheelchairs are covered for participants in a nursing home when certain criteria are met. Refer to Section 13.18 for additional nursing home guidelines.

13.30.F WHEELCHAIR ACCESSORIES *NOT* OTHERWISE LISTED

Procedure code K0108 may only be used in the following circumstances and always requires prior authorization.

- When there is no specific accessory code(s) for the wheelchair accessory to be dispensed for custom or standard wheelchairs.

13.30.F(1) Wheelchair Option/Accessory Replacement And Repair

The following are claim filing requirements for replacement of wheelchair options/accessories.

- The appropriate HCPCS code for the specific option/accessory *must* be billed. The routing modifier, RB, *must* always be used when the accessory is a replacement for the same part. The RB modifier and the SC modifier *must* be used for participants residing in a nursing home.
- The procedure code Z0160RB or Z0160RBSC may be used for replacement items that do *not* have a HCPCS code and have an MSRP of $500 or less. Items with an MSRP greater than $500 *must* be prior authorized utilizing procedure code K0108RB and K0108RBSC.
- Items that are new additions or upgrades to a wheelchair *must not* be billed with the RB modifier. The RB modifier is only utilized for replacement of existing options/accessories.
- Labor required for replacement of an option or accessory, or repair of a wheelchair maybe billed under the procedure code K0739RB or K0739RBSC (Repair or non-routine service for DME, other than oxygen, requiring the skill of a technician, labor component, per 15 minutes). One unit of labor is equal to 15 minutes of time.
- A Certificate of Medical Necessity is required for most option/accessory replacement codes and labor code. The labor code and option/accessory codes should be included on the same Certificate of Medical Necessity. The Certificate of Medical Necessity *must* document the following:
    - Make and model name of the wheelchair;
    - The initial date of service for purchase of the wheelchair;

- Medical necessity for replacement for each option/accessory code; and
- An explanation of the time involved.

13.30.G WHEEL CHAIR SEAT AND BACK CUSHIONS

MO HealthNet utilizes the following coverage criteria when reviewing PA requests for wheelchair seat and back cushions.

A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) may be covered for a participant who has a manual wheelchair or who has a power wheelchair with a sling/solid seat/back which meets MO HealthNet coverage guidelines. If the participant has a power-operated vehicle or a power wheelchair with a captain's chair seat, a general use seat and back cushion is *not* covered.

A skin protection seat cushion (E2603, E2604, K0734, K0735) is covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and meets MO HealthNet coverage guidelines for it; and
2. The participant has either of the following:
    - Current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; or
    - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post-polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), or Parkinson's disease (332.0).

A positioning seat cushion (E2605, E2606) and positioning back cushion (E2613-E2616, E2620, E2621) are covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the meets MO HealthNet guidelines for it; and

2. The participant has any significant postural asymmetries that are due to a diagnosis listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42), hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), or spinocerebellar disease (334.0-334.9).

A combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737) is covered for a participant who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met.

A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met.

1. Participant meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion.
2. Participant meets all of the criteria for a prefabricated positioning back cushion.
3. There is comprehensive written documentation submitted with the PA request that clearly and specifically explains the following:
    - Why a prefabricated system is *not* sufficient to meet participant's seating and positioning needs;
    - What orthopedic deformity is present; and it's fixed or flexible presentation;
    - What altered muscle tone is present; and it's increased or decreased presentation that affects seating and positioning; and
    - Why any existing system is *not* meeting participant seating and positioning needs.

If the above information is *not* included with the documentation submitted or if additional documentation is needed, the PA request is denied and additional information requested.

13.30.H CUSTOM MOLDED SEAT AND BACK CUSHION REIMBURSEMENT

Custom molded wheelchair seat (E2609) and back (E2617) cushions are reimbursed at 80% of the Manufacturer's Suggested Retail Price (MSRP) for manual wheelchairs and 85% of MSRP for power wheelchairs. The maximum reimbursement for each code is $1,300. Charges for all modifications and mounting hardware is added together to determine the total MSRP. Charges for molding fees and other labor charges are *not* to be included in the MSRP rate. These charges are *not* reimbursed separately for cushions for new wheelchairs. Labor is allowed for repairs and replacement cushions.

13.30.I DOCUMENTATION FOR WHEELCHAIR PRIOR AUTHORIZATION (PA) REQUESTS

Justification *must* accompany the PA Request form when requesting prior authorization for a custom or power wheelchair. Justification *must* include comprehensive written documentation that clearly and specifically explains all of the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair;
- Description and history of limitations/functional deficits;
- Description of physical and cognitive abilities to utilize equipment;
- History of previous interventions/past use of mobility devices;
- Descriptions of existing equipment, age and specifically why it is *not* meeting participant needs;
- Why a less costly mobility device is unable to meet participant needs (i.e., cane, walker, standard wheelchair);
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components; and
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment.

If the participant has been evaluated by a physical therapist, occupational therapist or in a wheelchair clinic, the information obtained in the evaluation *must* also be included. The DME provider *must* ensure that the wheelchair being requested is adequate to meet the participant's physical needs as well as environmental needs (e.g., the wheelchair fits through the doors of the participant's home).

13.31 PRIOR AUTHORIZATION

Prior authorization approves the medical necessity of the requested service only. It does *not* guarantee payment, nor does it guarantee that the amount billed is the amount reimbursed. The participant *must* be MO HealthNet eligible and eligible for the service on the date of the service or the date the equipment or prosthesis is received by the participant.

13.31.A SUBMISSION OF DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION (PA) REQUEST

DME PA Requests and supporting documentation *mus*t be submitted to MO HealthNet's claim processing agent, Wipro Infocrossing by facsimile (fax) to (573) 659-0207 or by mail at P.O. Box 5700, Jefferson City, MO 65102. Disposition letters for PA Requests received by fax will be returned via the fax number through which the request was sent. Providers are encouraged to ensure requests are sent only from fax numbers *not* blocked. Disposition letters that cannot be successfully returned via fax will be mailed to the provider.

A PA request for an HCY item *must* clearly be marked as an HCY request.

The following documentation *must* be included on, or submitted with, the PA Request form:

- A detailed explanation from the prescribing physician and/or therapist that includes the nature of the item to be provided, the duration of time the item is needed, and the projected outcome the item should provide. Listing only a diagnosis code and description does *not* provide sufficient information to determine the medical necessity of the item being requested; and
- An invoice showing the provider's cost of the item(s) being requested, unless Section 19.1 indicates that a prior authorized code has a maximum allowed amount established. The invoice *must* indicate the number of items in a box or case if applicable.

DME items that require prior authorization can be identified by the abbreviation "PA" (prior authorization) under the "Reimbursement Guidelines" column in Section 19 of the DME Provider Manual.

13.31.B CLARIFICATION OF PRIOR AUTHORIZATION (PA) CHANGES

Providers should only submit a change to an approved PA Request when there is something on the disposition letter that needs to be corrected, changed or discontinued. Only the disposition letter should be submitted with the changes made directly on the disposition letter. Invoices *must* be included if a price has changed. A PA change request should be submitted when:

- A correction needs to be made to the modifier;
- A procedure code needs to be corrected or changed;
- A new item needs to be added to an existing PA Request;
- A correction or change to the from and/or through date;
- An increase or decrease in requested units or dollars; or
- Services have been discontinued to a participant.

DO *NOT* submit a PA change request when:

- Services continue to be medically necessary beyond the current approved period of time (recertification or renewal);
- The participant's MO HealthNet number is incorrect. (The existing PA Request *must* be closed and a new PA Request submitted under the correct number); or
- An initial PA Request or renewal request is denied then resubmitted with corrections.

In the above situations, a new PA Request *must* be submitted. (text new 6/06)

13.32 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT (DME)

Pre-certification serves as a utilization management tool allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two-step process. Requests for pre-certification *must* be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a collaborative practice agreement with a physician that allows for prescription of such items. Speech pathologists are an authorized prescriber for augmentative communication devices only. The

enrolled DME provider will access the pre-certification process. All requests *must* be approved by the MHD. Providers are encouraged to sign up for the MO HealthNet Web tool - CyberAccess[SM]- which automates the pre-certification process. To become a CyberAccess[SM] user, contact the ACS-Heritage help desk at 1-888-581-9797 or 573-632-9797 or send an e-mail to MOHealthNetCyberaccess@heritage-info.com. The CyberAccess[SM] tool allows each pre-certification to automatically reference the participant's claim history including applicable ICD diagnosis codes and CPT procedure codes. Requests for pre-certification are also received by the MO HealthNet call center at 800-392-8030. Requests for pre-certification *must* meet medical criteria established by the MHD in order to be approved. Medical criteria is published in provider bulletins and posted on the MHD web site at www.dss.mo.gov/mhd prior to implementation. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. If a pre-certification request submitted through CyberAccess[SM] is denied, providers may click on the help ticket box to have a MO HealthNet call center representative contact them. The call center is available Monday through Friday from 8:00 am to 5:00 pm, excluding state holidays.

Items of DME that require pre-certification can be identified by the abbreviation "PC" (pre-certification) under the "Reimbursement Guidelines" column in Section 19 of the DME Provider Manual.

PLEASE NOTE: An approved pre-certification request does *not* guarantee payment. The provider *must* verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 751-2896 or by logging in to the MO HealthNet Web portal.

13.33 DURABLE MEDICAL EQUIPMENT (DME) PROGRAM BILLING REMINDERS

Prior authorization approves the medical necessity of the item. It does *not* guarantee payment for the item as the participant *must* be MO HealthNet eligible on the date the equipment is dispensed. It is the responsibility of the MO HealthNet provider to ascertain the participant’s MO HealthNet status.

Charges for delivery, pick-up, shipping, freight, handling and COD are included in the MO HealthNet reimbursement of all purchased or rented equipment, medical supplies, oxygen, orthotics and prosthetics, TPN, IV therapy and enteral therapy and cannot be billed to the participant.

DME provided to participants in a nursing home is not covered under the DME Program with the exception of: volume ventilators, TPN, custom and power wheelchairs, orthotics, prosthetics, and augmentative communication devices.

Reimbursement for items through the DME Program is the lower of the provider’s usual and customary charge or the MO HealthNet allowable amount.

For participants with both Medicare and MO HealthNet coverage, a Medicare denial is *not* required for submitting a MO HealthNet claim for volume ventilators for participants in a nursing home.

A Certificate of Medical Necessity is valid for six (6) months. A new Certificate of Medical Necessity *must* be completed every six (6) months.

For specific equipment codes and billing requirements refer to Section 19.

Medical criteria documents for items requiring pre-certification may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm.

13.34 NONCOVERED SERVICES UNDER THE DURABLE MEDICAL EQUIPMENT (DME) PROGRAM

13.34.A NONCOVERED ITEMS

MO HealthNet does *not* cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, new equipment of unproven value and equipment of questionable current usefulness or therapeutic value.

- Air conditioners
- Bathtub rails
- Canopy beds
- Car Seats
- Computers (unless determined to be used for an augmentative communication device)
- Dialysis equipment
- Electric bathtub lifts
- Elevators
- Environmental control systems
- Equipment used in non-medical context
- External power or electronic prosthetic devices
- Furniture
- Home modifications
- Labor for the assembling of wheelchairs or equipment
- Massage equipment
- Medical alert system
- Medical necessity bags
- Motivation-type devices

- Pacemaker monitor
- Refrigerators
- Repair, replacement or continued rental of equipment for which a continuing need *cannot* be established
- Sales tax
- Seat lift chairs
- Stair lifts or glides
- Standers
- Sunshade/canopies
- Treadmill
- Water softening systems
- Wheelchair lifts
- Wheelchair ramps
- Whirlpool tubs or pumps

This list is *not* all-inclusive. If there is *not* a specific code listed in Section 19, the item is *not* covered.

13.34.B DUAL ELIGIBLES IN MEDICARE COMPETITVE BIDDING AREA (CBA)

Medicare implemented a competitive bidding program in January 2011, for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). For Medicare beneficiaries whose permanent residence is in a statistical area affected by the CBA program, only contract suppliers will be eligible to provide competitive bid items and receive payment from Medicare. Complete information on the competitive bidding process can be found on the Center for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/.

MO HealthNet will align policy with Medicare for dual-eligible participants who reside in a CBA. If Medicare denies reimbursement for a DME competitively bid service that was provided to a participant by a non-contract or non-demonstration supplier, the service is not covered by MO HealthNet and *must* not be billed to MO HealthNet for reimbursement. The participant is not liable for payment unless the non-contract supplier in a CBA has informed the participant in writing prior to receiving the item that there would be no Medicare or MO HealthNet coverage due to the supplier's contract status, and the participant understands that

he/she will be liable for all costs that the non-contract supplier may charge the participant for the item.

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SECTION 14—SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require a Prior Authorization Request form, Certificate of Medical Necessity attachment or a Pre-Certification. Refer to Section 14.2 for durable medical equipment (DME) instructions for requesting prior authorization.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Section 19, Procedure Codes, for specific documentation requirements. Refer to Sections 1-11 and Section 20 for general program documentation requirements.

Please be aware that when a specific procedure requires an attachment, the attachment remains a positive requirement and *must* accompany the claim form or Prior Authorization Request form.

14.1 CERTIFICATE OF MEDICAL NECESSITY

A Certificate of Medical Necessity attachment is required for many DME services. Refer to Section 19 for a complete list of procedure codes covered under the DME Program and their specific documentation requirements.

The determination of medical necessity is based on the information contained on the Certificate of Medical Necessity attachment. Therefore, it is important that every field on the form be completed. It is also important to include on the Certificate of Medical Necessity attachment the procedure code, a complete description of the item; brand name; model number, if applicable; accessories or components, if applicable; diagnosis; prognosis; the reason why the equipment/item is needed and the anticipated length of need.

When the medical consultant *cannot* determine medical necessity based on the information provided, the claim may be denied.

The Certificate of Medical Necessity attachment should be submitted electronically. The attachment and completion instructions are available at www.emomed.com.

14.2 PRIOR AUTHORIZATION

Many items covered under the DME Program require prior approval by the MO HealthNet Division. Refer to Section 8 for complete instructions on completing the Prior Authorization Request form.

Procedure codes that require prior authorization are listed in Section 19.

14.2.A REQUESTING PRIOR AUTHORIZATION

When requesting prior authorization for approval to dispense certain DME items, providers should submit as much information as possible as to why the specific item is being requested. The information *must* include the description of the item to be provided, the anticipated length of need, the projected outcome the item should provide, and the diagnosis and prognosis of the recipient. If there is *not* enough room on the Prior Authorization Request form, include the information on an additional sheet of paper. The participant's attending physician *must* sign the Prior Authorization Request form. If in Section 19 it is indicated that a procedure code requires an evaluation or an invoice of cost, those documentation requirements *must* accompany the Prior Authorization Request form.

14.2.B RETURN OF PRIOR AUTHORIZATION REQUEST FORMS

The fiscal agent returns processed Prior Authorization Request forms to the provider. The Prior Authorization Request form is marked approved, denied, or additional information required. The MO HealthNet allowable reimbursement amount is entered on approved Prior Authorization Request forms. Authorization expires three months (unless otherwise indicated) following the date of approval, which is located at the very bottom of the Prior Authorization Request form.

14.2.C RETURNED/DENIED PRIOR AUTHORIZATION REQUEST FORMS

If the Prior Authorization Request is returned for additional information or for further clarification, the provider is urged to explain in detail or attach as much documentation as possible to support the medical necessity of the item being requested.

14.3 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION (OREMJ) FORM

The Oxygen and Respiratory Equipment Medical Justification (OREMJ) attachment is no longer required for claims submitted for oxygen and oxygen delivery systems. The OREMJ should be maintained in the participant's file. A Pre-Certification must be submitted to request oxygen systems and equipment. Refer to Section 19 for specific oxygen codes.

14.4 PRE-CERTIFICATION PROCESS FOR DURABLE MEDICAL EQUIPMENT

Pre-certification serves as a utilization management tool, allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two-step process. Requests for pre-certification must be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a collaborative practice agreement with a physician that allows for prescription of such items. The enrolled DME provider will access the pre-certification initiated by the prescriber to complete the second step of the pre-certification process. All requests must be approved by the MHD. Providers are encouraged to sign up for the MO HealthNet Web tool – CyberAccessSM- which automates the pre-certification process. To become a CyberAccess[SM] user, contact the ACS-Heritage help desk at 1-888-581-9797 or 573-632-9797 or send an e-mail to MOHealthNetCyberaccess@heritage-info.com. The CyberAccess[SM] tool allows each pre-certification to automatically reference the individual participant's claim history, including applicable ICD diagnosis codes and CPT procedure codes. Requests for pre-certification will also be taken by the MO HealthNet call center at 800-392-8030. Requests for pre-certification must meet medical criteria established by the MHD in order to be approved. Medical criteria is published in provider bulletins and posted on the MHD Web site prior to implementation. If a pre-certification request submitted through CyberAccess[SM] is denied, providers may click on the box to have a MO HealthNet call center representative contact them. The call center is available Monday through Friday, from 8:00 am to 5:00 pm, excluding state holidays.

Items of DME that require pre-certification can be identified by the abbreviation "PC" (pre-certification) under the "Reimbursement Guidelines" column in Section 19 of the DME Provider Manual.

PLEASE NOTE: An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 635-8908 or by logging the MO HealthNet Web portal.

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SECTION 15-BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC 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 website address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference www.dss.mo/gov/mhd/providers 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.

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 durable medical equipment (DME) services. Instructions on how to complete the CMS-1500 claim form are in Section 15.5.

15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit on a CMS-1500 claim form. An example of a correctable error is the use of an invalid procedure code or an incorrect type of service code.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, a provider bills for a partial month rental and should have billed for the entire month. If everything else on the claim is correct, the claim will pay. That claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.6 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first as primary payor. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, a paper claim *must* be submitted to MO HealthNet with the Medicare Remittance Advice attached indicating the denial. Reference Section 16.5 of this manual for instructions for submission of claims to MO HealthNet.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is *not* received from MO HealthNet within 60 days of the Medicare remittance advice date (a reasonable period for transmission for Medicare and MO HealthNet processing), a paper crossover claim *must* be submitted to MO HealthNet. Reference Section 16 for billing instructions.

15.7 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed, check the Medicaid box and if the participant has both Medicare and MO HealthNet, check both boxes.
*1a. Insured's I.D.	Enter the patient's eight-digit MO HealthNet or MO HealthNet Managed Care ID number as shown on the patient's ID card.
*2. Patient's Name	Enter last name, first name, middle initial *in that order* as it appears on the ID card.
3. Patient's Birth Date	Enter month, day, and year of birth.
Sex	Mark appropriate box.
**4. Insured's Name	If there is other insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13.
5. Patient's Address	Enter address and telephone number if available.
**6. Patient's Relationship to Insured	Mark appropriate box if there is other insurance.
**7. Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if

		available.
8.	Patient Status	Not Required.
**9.	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. (See Note)(1)
**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. (See Note)(1)
**9b.	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. (See Note)(1)
**9c.	Employer's Name	Enter the secondary policyholder's employer name. (See Note)(1)
**9d.	Insurance Plan	Enter the secondary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan.* (See Note)(1)
**10a-10c.	Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are *not* related to an accident, leave blank. (See Note)(1)
10d.	Reserved for Local Use	May be used for comments/descriptions. (See Note)(1)
**11.	Insured's Policy or Group 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. (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. (See Note)(1)
**11b.	Employer's Name	Enter the primary policyholder's employer

		name. (See Note)(1)
**11c.	Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the item provided, attach valid denial from the insurance plan.* (See Note)(1)
**11d.	Other Health Plan	Indicate whether the recipient has another health insurance plan; if so, complete Fields #9-#9d with the secondary insurance information. (See Note)(1)
12.	Patient's Signature	Leave blank.
13.	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider or MO HealthNet. Otherwise payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.	Date of Current Illness, Injury or Pregnancy	Leave blank.
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
**17.	Name of referring provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order 1. Referring provider 2. Ordering Provider 3. Supervising Provider
**17a	Other ID	Enter ID, and the MO HealthNet legacy number of the provider.
**17b	NPI	Enter the NPI number of referring, ordering, or supervising provider.

18. Hospitalization Dates	Leave blank.
19. Reserved for Local Use	This field may be used for additional remarks or descriptions.
20. Lab Work Performed Outside Office	Leave blank.
*21. Diagnosis	Enter the complete applicable ICD CM diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22. Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim.
23. Prior Authorization Number	Leave blank.
*24a. Date of Service	Enter the date of service under "from" in month/day/year format, using six-digit format. All line *items must* have a from date. *A "to" date is required when billing for DME rental,* (TOS "T").
*24b. Place of Service	Enter the appropriate place of service code. 11 Office, Community Health Centers 12 Home 22 Outpatient Hospital 24 Ambulatory Surgical Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 71 State or Local Public Health Clinic 97 Non-Public School

	98 Public School 99 Other Unlisted Facility
*24c. EMG-Emergency	Enter the appropriate type of service code for the procedure code billed. The valid TOS codes for DME are: A DME Purchase T DME Rental 0 (zero) DME Repair, Replacement or Modification
*24d. Procedure Code	Enter the appropriate HCPCS code corresponding to the item dispensed. Description of the service is required for DME providers**.** Enter the description in the modifier field and/or use the next line.
*24e. Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21.
*24f. Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge for multiple days or units. When an item has been prior authorized, the amount approved *must* be billed instead of the usual and customary charge**.**
*24g. Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. DME—for DME rental of equipment under the *regular* DME Program (TOS T), the "from" and "to" dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity *must* always be a "1." When billing ostomy supplies under procedure code A4421, the quantity is always a "1." Please refer to the specific procedure code instructions in Section 19.
**24h. EPSDT/Family Planning	**If the service is HCY/EPSDT**, enter "E."

24i.	ID Qualifier	Enter in the shaded area of 24I, ID. The other ID# of the rendering provider is reported in 24J in the shaded area.
24j.	Rendering Provider ID	Leave blank.
24k.		
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Not required on MO HealthNet claims.
*28.	Total Charge	Enter the sum of the line item charges for each claim form.
29.	Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments and copay amounts are *not* to be entered in this field**.**
30.	Balance Due	Enter the difference between the total charge (Field #28) and the insurance amount paid (Field #29).
31.	Provider Signature	Not Required.
**32.	Name and Address of Facility	If equipment was delivered to a facility other than the home or office, enter the name and location of the facility.
**32a	NPI#	Enter the 10-digit NPI number of the service facility location in 32.
**32b	Other ID#	Enter the MO HealthNet legacy number.
*33.	Provider Name/ Number/Address	Affix the provider label or write or type the information *exactly* as it appears on the label.

* These fields are mandatory on *all* CMS-1500 claim forms.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

15.6 PLACE OF SERVICE CODES

CODE	DEFINITION
11 Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12 Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
22 Outpatient Hospital	The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do *not* require hospitalization or institutionalization.
24 Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
26 Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF).
31 Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services that does *not* provide the level of care or treatment available in a hospital.
32 Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis health-related care services above the level of custodial care to other than

		mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and that does *not* include a medical component.
34	Hospice	A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families is provided. NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service should be used.
53	Community Mental Health Center	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	Intermediate Care Facility/ Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does *not* provide the level of care or treatment available in a hospital or SNF.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
71	State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a

	physician.
97 Non-Public School	A parochial or private school supported by private funds and governed by a private body.
98 Public School	A school open to any child in the community, supported by tax dollars and governed by a local school district.
99 Other Unlisted Facility	Other service facilities *not* identified above.

15.7 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on the interactive voice response (IVR) system, a point of service (POS) terminal, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability.

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Divisions' participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 635-8908, which allows the provider to inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet at www.emomed.com to verify eligibility and inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR, POS terminal or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PARTICIPANT 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.

END OF SECTION

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SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS

16.1 GENERAL INFORMATION

This section includes general information about the Medicare and MO HealthNet Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and MO HealthNet are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

  Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.
- MO HealthNet is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. MO HealthNet is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Mo HealthNet benefits by completing an application form at a Family Support Division (FSD) office.

  In Missouri, MO HealthNet claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the MO HealthNet Division within the Department of Social Services, which is the single state agency for the administration of the MO HealthNet Program.
- For participants having both Medicare and MO HealthNet eligibility, the MO HealthNet Program pays the cost-sharing amounts indicated by Medicare due on the Medicare allowed amount. These payments are referred to as “Crossovers."
- “Cost-sharing” amounts include the participant’s co-insurance, deductible, and any co-pays that are due for any Medicare-covered service.

16.2 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET CLAIMS (CROSSOVERS)

When a participant has both Medicare and MO HealthNet coverage, a claim *must* be filed with Medicare first. After making payment, the Medicare contractor forwards the claim information to MO HealthNet for payment of cost-sharing amounts. (Reference Section 16.3 for instructions to bill MO HealthNet when Medicare denies a service.)

The MO HealthNet payment of the cost-sharing appears on the provider's MO HealthNet Remittance Advice (RA).

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The Medicare contractor does *not* send crossovers to MO HealthNet
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for MO HealthNet.
- The MO HealthNet participant information on the crossover claim does *not* match the fiscal agent's participant file.
- The provider's National Provider Identifier (NPI) number is *not* on file in the MO HealthNet Division's provider files.

MO HealthNet no longer accepts paper crossover claims. Medicare/MO HealthNet (crossover) claims that do not cross automatically from Medicare to MO HealthNet must be filed through the MO HealthNet billing web portal at www.emomed.com or through the 837 electronic claims transaction. Before filing an electronic crossover claim, providers should wait 30 days from the date of Medicare payment to avoid duplication. The following tips are provided to make filing a claim at the MO HealthNet billing web portal successful:

1) Through the MO HealthNet billing web portal at www.emomed.com, choose the claim form that corresponds with the claim form used to bill Medicare. Enter all appropriate information from that form.

2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.

3) There must be an "Other Payer" header form completed for every crossover claim type. This provides information that pertains to the whole claim.

4) Part A crossover claims need only the "Other Payer" header form completed and not the "Other Payer" detail form.

5) Part B and B of A crossover claims need the "Other Payer" header form completed. An "Other Payer" detail form is required for each claim line detail with the group code, reason code and adjustment amount information.

6) Choose the appropriate codes that can be entered in the "Group Code" field on the "Other Payer" header and detail forms from the dropdown box. For example, the "PR" code (Patient Responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare EOMB.

7) The codes to enter in the "Reason Code" field on the "Other Payer" header and detail forms are also found on the Medicare EOMB. If not listed there, choose the most appropriate code from the list of "Claim Adjustment Reason Codes". These HIPAA mandated codes can be found at www.wpc-edi.com/codes. For example, on the "Claim Adjustment Reason Codes" list the code for "deductible amount" is 1 and for "coinsurance amount" it is 2. Therefore, choose a "Reason Code" of "1" for deductible amounts due and a "Reason Code" of "2" for coinsurance amounts due.

8) The "Adjust Amount" should reflect any amount not paid by Medicare including any cost-sharing amounts and any non-allowed amounts.

9) If there is a commercial insurance payment or denial to report on the crossover claim, complete an additional "Other Payer" header form. Complete an additional "Other Payer" detail form(s) as appropriate.

Note: For further assistance on how to bill crossover claims, please contact Provider Education at (573) 751-6683.

16.3 BILLING OF SERVICES NOT COVERED BY MEDICARE

Not all services covered under the MO HealthNet Program are covered by Medicare. (Examples are: eyeglasses, most dental services, hearing aids, adult day health care, personal care or most eye exams performed by an optometrist.) In addition, some benefits that are provided under Medicare coverage may be subject to certain limitations. The provider will receive a Medicare Remittance Advice that indicates if a service has been denied by Medicare. The provider may submit a Medicare denied claim to MO HealthNet electronically using the proper claim form for consideration of reimbursement through the 837 electronic claims transaction or through the MO HealthNet web portal at www.emomed.com. If the 837 electronic claims transaction is used, providers should refer to the implementation guide for assistance. The following are tips to assist in successfully filing Medicare denied claims through the MO HealthNet web portal at www.emomed.com:

1) To bill through the MO HealthNet web portal, providers should select the appropriate claim type (CMS 1500, UB-04, Nursing Home, etc.) Do *not* select the Medicare crossover claim form. Complete all pertinent data for the MO HealthNet claim.

2) Some fields are required for Medicare and not for Third Party Liability (TPL). The code entered in the "Filing Indicator" field will determine if the attachment is linked to TPL or Medicare coverage.

16.4 MEDICARE PART C CROSSOVER CLAIMS FOR QMB PARTICIPANTS

Medicare Advantage/Part C plans do not forward electronic crossover claims to MHD. Therefore, providers must submit Medicare Advantage/Part C crossover claims through the MHD Web portal at www.emomed.com. The following are tips to assist in successfully filing Medicare Advantage/Part C crossover claim through the MO HealthNet web portal at www.emomed.com:

1) Access the MHD web portal at www.emomed.com. Choose the appropriate Part C crossover claim format. Enter all appropriate information from the Medicare Advantage/Part C plan claim. Do not use the Medicare Part A or Part B crossover claim format.

2) HELP screens are accessible to provide instructions in completing the crossover claim forms, the "Other Payer" header and "Other Payer" detail screens. The HELP screens are identified by a "?" and is located in the upper right-hand corner.

3) The filing indicator for Medicare Advantage/Part C crossover claims is 16 followed by the appropriate claim type.

4) There must be an "Other Payer" header detail screen completed for every crossover claim format. This provides information that pertains to the whole claim.

5) Medicare Advantage/Part C institutional claims need only the "Other Payer" header detail screen completed and not the "Other Payer" line detail screen.

6) Medicare Advantage/Part C outpatient and professional crossover claims need the "Other Payer" header detail screen completed. An "Other Payer" line detail screen is required to be completed for each claim detail line with group code, reason code and adjustment amount information.

7) The appropriate code from the codes available in the "Group Code" drop down box on the "Other Payer" header and detail screens *must* be selected. For example, the "PR" code (patient responsibility) is understood to be the code assigned for the cost-sharing amounts shown on the Medicare Advantage/Part C explanation of benefits.

8) The codes to enter in the "Reason Code" field on the "Other Payer" header and detail screens are found on the Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" that can be accessed at http://www.wpc-edi.com/codes/Codes.asp. For example, enter "Reason Code" of "1" for deductible amounts, "2" for coinsurance amounts and "3" for co-payment amounts.

16.4.A MEDICARE PART C COORDINATION OF BENEFITS FOR NON-QMB PARTICIPANTS

For non-QMB MO HealthNet participants enrolled with a Medicare Advantage/Part C Plan, MO HealthNet will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet provider manual at http://manuals/momed.com. In accordance with this policy, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e., CMS-1500, UB-04). ***Do not use a crossover claim***.

16.5 TIMELY FILING

Claims that have been initially filed with Medicare within the Medicare timely filing requirements, and which are submitted as a crossover through an 837 electronic claim transaction or through the MO HealthNet Web portal at www.emomed.com meet the timely filing requirement by being submitted by the provider and received by the MO HealthNet Division within six months of the date of the allowed Medicare RA/EOMB or one (1) year from the date of service. Refer to Section 4 for further instructions on timely filing.

16.6 REIMBURSEMENT

The MO HealthNet Division reimburses the cost-sharing amount as determined by the Medicare contractor and reflected on the Medicare RA/EOMB. MHD prorates the reimbursement amount allowing a prorated amount for each date the individual was MO HealthNet eligible. Days on which the participant was not MO HealthNet eligible are not reimbursed.

16.6.A REIMBURSEMENT OF MEDICARE PART A AND MEDICARE ADVANTAGE/PART C INPATIENT HOSPITAL CROSSOVER CLAIMS

MO HealthNet is responsible for deductible and coinsurance amounts for Medicare Part A and deductible, coinsurance and copayment amounts for Medicare Advantage/Part C crossover claims only when the MO HealthNet applicable payment schedule exceeds the amount paid by Medicare plus calculated pass-through costs. In those situations where MO

HealthNet has an obligation to pay a crossover claim, the amount of MO HealthNet's payment is limited to the lower of the actual crossover amount or the amount the MO HealthNet fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participant to be considered a Medicare/Medicaid crossover claim. For further information, please see 12.4 of the Hospital Program Manual.

16.6.B REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS

MO HealthNet reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services is seventy-five percent (75%) of the allowable cost sharing amount. The cost sharing amount includes the coinsurance, deductible and/or copayment amounts reflected on the Medicare RA/EOMB from the Medicare carrier or fiscal intermediary. The crossover claims for Medicare Advantage/Part C outpatient hospital services must have been provided to QMB or QMB Plus participant to be reimbursed at seventy-five percent (75%) of the allowable cost sharing amount. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

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SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

Crossovers
Inpatient
Outpatient (Includes Rural Health Clinic and Hospice)
Medical
Nursing Home
Home Health
Dental
Drug
Capitation
Credits

Claims in each category are listed alphabetically by participant's last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider's address.
PARTICIPANT NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are *not* on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant's current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11— Paper Drug 13— Inpatient 14— Dental 15— Paper Medical 16— Outpatient 17— Part A Crossover 18— Paper Medicare/MO HealthNet Part B Crossover Claim 21— Nursing Home 40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries. 41— Direct Electronic MO HealthNet Information (DEMI) 43— MTB/DEMI 44— Direct Electronic File Transfer (DEFT) 45— Accelerated Submission and Processing (ASAP) 46— Adjudicated Point of Service (POS) 47— Captured Point of Service (POS)

	49— Internet 50— Individual Adjustment Request 55— Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is *not* present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions PR—Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is *not* printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

CHECK AMOUNT	The total check amount for the provider.
EARNINGS REPORT	
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
EARNINGS DATA	
NO. OF CLAIMS PROCESSED	The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED	The total dollar amount processed for the provider.
CHECK AMOUNT	The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

Claim Payment Reduction/Cutback	Claim Group Code	Description	Claim Adjustment Reason Code	Description
Payment reimbursed at the maximum allowed	CO	Contractual Obligation	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment reduced by	OA	Other	23	Payment adjusted because

other insurance amount		Adjustment		charges have been paid by another payer
Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has *not* met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.

17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.

17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

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SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

The diagnosis code *must* be entered on the claim form exactly as it appears in the applicable ICD-CM. Note that the appropriate code(s) may be three, four or five digits, depending upon the patient's diagnosis. The fourth and fifth digits give greater detail or specificity, and *must* be used as applicable to the patient's diagnosis(es) when available.

Diagnosis codes are *not* included in this section. Claims may be denied if a three digit code is used. The applicable ICD-CM may require a fourth or fifth digit. The applicable ICD-CM (Volume I) should be used as a guide in the selection of the appropriate three, four or five digit diagnosis code. The applicable ICD-CM may be purchased in softbound or binder. The binder contains all three volumes, which are:

Volume 1: Diseases: Tabular List
Volume 2: Diseases: Alphabetic Index
Volume 3: Procedures: Tabular List and Alphabetic Index

Additional information regarding the applicable ICD-CM may be found at www.cdc.gov/nchs/icd.htm.

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SECTION 19 - PROCEDURE CODES

19.1 HEALTHY CHILDREN & YOUTH (HCY) COVERED ONLY FOR PARTICIPANTS AGE 0-20

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
BEDS					
E0300	RB EP	Pediatric Crib Hosp Grade Fully Enclosed	MN, IOC	MP	
E0300	NU EP	Pediatric Crib Hosp Grade Fully Enclosed	PA, IOC	MP	
E0300	RR EP	Pediatric Crib Hosp Grade Fully Enclosed	PA, IOC	MP	
E0316	NU EP	Safety Enclosure Frame/Canopy For Use W Hospital Bed Any Type	PA, IOC	MP	
E0316	RR EP	Safety Enclosure Frame/Canopy For Use W Hospital Bed Any Type	PA, IOC	MP	
E0328	NU EP	Pediatric Hospital Bed, Manual	PA, IOC	MP	
E0328	RR EP	Pediatric Hospital Bed, Manual	PA, IOC	MP	
E0328	RB EP	Pediatric Hospital Bed, Manual	PA, IOC	MP	
E0329	NU EP	Pediatric Hospital Bed, Semi/Elect	PA, IOC	MP	
E0329	RR EP	Pediatric Hospital Bed, Semi/Elect	PA, IOC	MP	
E0329	RB EP	Pediatric Hospital Bed, Semi/Elect	PA, IOC	MP	
INCONTINENCE SUPPLIES					
A4520	NU	Incont Garment Any Type Each	PC	$0.50	186/30, non-covered for children 3 years and under
A4520	NU EP	Incont Garment Any Type Each	PC	$0.50	+186/30, non-covered for children 3 years and under

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4554	NU	Disposable Underpads All Sizes	PA, IOC	MP	186/30, non-covered for children 3 years and under
A4554	NU EP	Disposable Underpads All Sizes	PA, IOC	MP	+186/30, non-covered for children 3 years and under
T4521	NU	Adult Size Brief/Diaper Size Small Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4521	NU EP	Adult Size Brief/Diaper Size Small Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4522	NU	Adult Size Brief/Diaper Size Medium Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4522	NU EP	Adult Size Brief/Diaper Size Medium Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4523	NU	Adult Size Brief/Diaper Size Large Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4523	NU EP	Adult Size Brief/Diaper Size Large Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4524	NU	Adult Size Brief/Diaper Size X-Large Each	PC	$0.50	186/30, non-covered for children 3 years and under

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
T4524	NU EP	Adult Size Brief/Diaper Size X-Large Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4525	NU	Adult Size Protective Underwear Pull-On Small	PC	$0.70	186/30, non-covered for children 3 years and under
T4525	NU EP	Adult Size Protective Underwear Pull-On Small	PC	$0.70	+186/30, non-covered for children 3 years and under
T4526	NU	Adult Size Protective Underwear Pull-On Medium	PC	$0.70	186/30, non-covered for children 3 years and under
T4526	NU EP	Adult Size Protective Underwear Pull-On Medium	PC	$0.70	+186/30, non-covered for children 3 years and under
T4527	NU	Adult Size Protective Underwear Pull-On Large	PC	$0.70	186/30, non-covered for children 3 years and under
T4527	NU EP	Adult Size Protective Underwear Pull-On Large	PC	$0.70	+186/30, non-covered for children 3 years and under
T4528	NU	Adult Size Protective Underwear Pull-On Extra Large Each	PC	$0.70	186/30, non-covered for children 3 years and under

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
T4528	NU EP	Adult Size Protective Underwear Pull-On Extra Large Each	PC	$0.70	+186/30, non-covered for children 3 years and under
T4529	NU	Pediatric Size Brief Diaper Small/Medium Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4529	NU EP	Pediatric Size Brief Diaper Small/Medium Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4530	NU	Pediatric Size Brief Diaper Large Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4530	NU EP	Pediatric Size Brief Diaper Large Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4531	NU	Pediatric Size Disposable Protective Underwear/Pull-On Sm/Med	PC	$0.50	186/30, non-covered for children 3 years and under
T4531	NU EP	Pediatric Size Disposable Protective Underwear/Pull-On Sm/Med	PC	$0.50	+186/30, non-covered for children 3 years and under
T4532	NU	Pediatric Size Disposable Protective Underwear/ Pull-On Large Each	PC	$0.50	186/30, non-covered for children 3 years and under

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
T4532	NU EP	Pediatric Size Disposable Protective Underwear/ Pull-On Large Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4533	NU	Youth Size Disposable Incontinence Product, Brief/Diaper Each	PC	$0.50	186/30, non-covered for children 3 years and under
T4533	NU EP	Youth Size Disposable Incontinence Product, Brief/Diaper Each	PC	$0.50	+186/30, non-covered for children 3 years and under
T4534	NU	Youth Size Disposable Incontinence Product, Protective Underwear/Pull-On Each	PC	$0.70	186/30, non-covered for children 3 years and under
T4534	NU EP	Youth Size Disposable Incontinence Product, Protective Underwear/Pull-On Each	PC	$0.70	+186/30, non-covered for children 3 years and under
T4537	NU	Bed Size Protective Underpad Reusable	PA, IOC	MP	186/30, non-covered for children 3 years and under
T4537	NU EP	Bed Size Protective Underpad Reusable	PA, IOC	MP	+186/30, non covered for children 3 years and under
T4541	NU	Disposable Underpad Large Each	PA, IOC	MP	186/30, non covered for children 3 years and under
T4541	NU EP	Disposable Underpad Large Each	PA, IOC	MP	+186/30, non covered for children 3 years and under

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
T4542	NU	Disposable Underpad Small Each	PA, IOC	MP	186/30, non covered for children 3 years and under
T4542	NU EP	Disposable Underpad Small Each	PA, IOC	MP	+186/30, non covered for children 3 years and under
T4543	NU	Disposable Incontinence Product; Brief/Diaper, Bariatric Each	PC	$0.50	186/30, non covered for children 3 years and under
T4543	NU EP	Disposable Incontinence Product; Brief/Diaper, Bariatric Each	PC	$0.50	+186/30, non covered for children 3 years and under
IV DRUG THERAPY					
A4221	NU EP	Supplies For Maintenance Of Drug Infusion Catheter Per Week (List Drug Separately)		$22.26	I unit = 1 week
A4222	NU EP	Supplies For External Drug Infusion Pump Per Cassette Or Bag (List Drug Separately)		$44.17	
A4223	NU EP	Infusion Supplies Not Used W Infusion Pump Per Cassette/Bag	MN, IOC	MP	
E0781	NU EP	Amb Infusion Pump Single Or Multi Channels Elec/Battery Operated W Admin Equip Worn By Patient		$8.82	Rental
K0552	NU EP	Supplies For External Drug Infusion Pump Syringe Type Cartridge Sterile Each		$2.65	
S1015	NU EP	IV Tubing Extension Set	MNF	$4.34	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
MEDICAL SUPPLIES					
A4206	NU EP	Syringe W Needle Sterile 1cc Each	MNF	$0.35	100/30
A4207	NU EP	Syringe W Needle Sterile 2 cc Each	MNF	$0.35	30/30
A4208	NU EP	Syringe W Needle Sterile 3 cc Each	MNF	$0.35	100/30
A4209	NU EP	Syringe W Needle Sterile 5 cc Or Greater Each	MNF	$0.36	100/30
A4211	NU EP	Supplies For Self-Admin Inject	PA, IOC	MP	
A4212	NU EP	Non-Coring Needle Or Stylet W/Wo Catheter	MNF	$5.69	15/30
A4213	NU EP	Syringe Sterile 20cc Or Great Each	MNF	$0.80	100/30
A4215	NU EP	Needles Only Sterile Any Size Each	MNF	$0.08	100/30
A4216	NU EP	Sterile Water/Saline 10 Ml	MNF	$0.45	100/30
A4217	NU EP	Sterile Water/Saline 500 Ml	MNF	$2.66	30/30
A4244	NU EP	Alcohol Or Peroxide Per Pint		$2.84	1/30
A4245	NU EP	Alcohol Wipes Per Box		$1.00	1/30
A4246	NU EP	Betadine Or Phisohex Solution Per Pint	MNF	$3.31	2/30
A4247	NU EP	Betadine Or Iodine Swabs/Wipes Per Box		$22.00	2/30
A4248	NU EP	Chlorhexidine Containing Antiseptic 1 Ml	MNF	$1.73	2/30
A4310	NU EP	Insertion Tray Wo Drain Bag & Wo Cath	PC	$7.72	1/30
A4311	NU EP	Insert Tray Wo Drainbag W Indwell Cath Foley Type	PC	$12.61	1/30
A4312	NU EP	W Indwell Cath Foley Type 2-Way All Silicone	PC	$18.04	1/30
A4313	NU EP	W Indwell Cath Foley Type 3-Way	PC	$18.52	1/30
A4314	NU EP	Insert Tray W Drain Bag W Indwell Cath Foley Type	PC	$25.29	1/30
A4315	NU EP	W Indwell Cath Foley Type 2-Way All Silicone	PC	$26.39	1/30
A4316	NU EP	W Indwell Cath Roley Type 3-Way For	PC	$28.40	1/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Continuous			
A4320	NU EP	Irrig Tray W Bulb Or Piston Syringe Any Purpose	PC	$5.00	1/30
A4322	NU EP	Irrig Syringe Bulb Or Piston Each	PC	$3.04	4/30
A4326	NU EP	Male External Cath Special Type Each	PC	$9.17	30/30
A4327	NU EP	Female External Urinary Coll Device Metal Cup Each	PC	$44.49	1/7
A4328	NU EP	Female External Urinary Coll Device Pouch Each	PC	$10.45	1/1
A4330	NU EP	Perianal Fecal Collection Pouch W Adhesive Each	PC	$7.15	30/30
A4331	NU EP	Ext Drng Tubing Any Type/Length W Connector/Adaptor; Use W Urinary Legbag Or Urostomy Pouch Each	PC	$3.18	1/30
A4331	NU EP AU	Ext Drng Tubing Any Type/Length W Connector/Adaptor; Use W Urinary Legbag Or Urostomy Pouch Each	PC	$3.18	+1/30
A4332	NU EP	Lub Individ Ster Packet For Uri Cath Insert Each	PC	$0.12	30/30
A4333	NU EP	Urinary Cath Anchor Device Adhesive Skin Attch	PC	$2.20	3/7
A4334	NU EP	Urinary Cath Anchoring Device Leg Strap Each	PC	$4.93	1/30
A4335	NU EP	Incontinence Supply Misc	PC, IOC	MP	
A4338	NU EP	Indwell Cath Foley Type 2-Way Latex W Coating	PC	$12.26	1/30
A4340	NU EP	Indwell Cath Special Type Each	PC	$29.08	1/30
A4344	NU EP	Indwell Cath Foley Type 2-Way All Silicone	PC	$14.50	1/30
A4346	NU EP	Indwell Cath 3-Way Contin Irrig Each	PC	$16.65	1/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4349	NU EP	Male External Cath W/Wo Adhesive Disposable Each	PC	$2.02	30/30
A4351	NU EP	Intermitt Urinary Cath Straight Tip W/Wo Coating Each	PC	$1.81	120/30
A4352	NU EP	Intermitt Urinary Cath Coude W/Wo Coating Each	PC	$6.42	4/30
A4353	NU EP	Intermittent Urinary Catheter W Insertion Supplies	PC	$7.00	120/30
A4354	NU EP	Insert Tray W Drain Bag	PC	$11.80	1/30
A4355	NU EP	Irrigat Tube Set For Continuous Bladder Irrigat Each	PC	$8.82	30/30
A4356	NU EP	External Urethral Clamp Each	PC	$45.63	1/90
A4357	NU EP	Bedside Drain Bag Each	PC	$9.70	1/60
A4357	NU EP AU	Bedside Drain Bag Each	PC	$9.70	+1/60
A4358	NU EP	Urinary Drain Bag, Leg or Abdomen, W Straps, Each	PC	$5.71	1/60
A4402	NU EP	Lubricant Per Ounce	PC	$1.53	8/30
A4402	NU EP AU	Lubricant Per Ounce	PC	$1.53	+8/30
A4450	NU EP	Tape Non-Waterproof Per 18 Square Inches		$0.09	10/30
A4452	NU EP	Tape Waterproof Per 18 Square Inches		$0.36	10/30
A4550	NU EP	Surgical Trays	MNF	$7.18	12/30
A4649	NU EP	Surgical Supply Miscellaneous	PA, IOC	MP	
A4657	NU EP	Syringe W Or Wo Needle Each	MNF	$0.61	4/30
A4927	NU EP	Non-Sterile Gloves	MNF	$11.00	2/30
A4930	NU EP	Gloves Sterile Per Pair	MNF	$0.50	30/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A5102	NU EP	Bedside Drainage Bottle W Or Wo Tubing Rigid Or Expandable Each	PC	$22.58	1/90
A5102	NU EP AU	Bedside Drainage Bottle W Or Wo Tubing Rigid Or Expandable Each	PC	$22.58	+1/90
A5105	NU EP	Urinary Suspensory W Leg Bag W Or Wo Tube	PC	$38.73	1/30
A5112	NU EP	Urinary Leg Bag; Latex	PC	$31.72	
A5120	NU EP	Skin Barrier Wipes or Swabs; Each	MNF	$0.25	31/30
A5121	NU EP	Skin Barrier; Solid 6x6 Or Equivalent Each		$7.46	20/30
A5122	NU EP	Skin Barrier; Solid 8x8 Or Equivalent Each		$12.85	20/30
A5126	NU EP	Adhesive Or Non-Adhesive; Disk Or Foam Pad		$1.32	20/30
A5200	NU EP BA	Percutaneous Catheter/Tube Anchoring Device Adhesive Skin Attachment	PC	$11.30	
MISCELLANEOUS					
A4461	NU EP	Surgical Dressing Holder, Non-Reusable, Each	MNF	$3.29	8/30
A4463	NU EP	Surgical Dressing Holder, Reusable, Each	MNF, IOC	MP	1/30
A4465	NU EP	Non-Elastic Binder For Extremity	MNF	$0.89	2/30
A4660	NU EP	Sphygmomanometer/Blood Pressure Apparatus W Cuff And Stethoscope	MNF	$19.32	1/365
A4663	NU EP	Blood Pressure Cuff Only	MNF	$15.88	1/365
A4670	NU EP	Automatic Blood Pressure Monitor	MNF	$48.02	1/365
A7020	RB EP	Interface,Cough Stim Device	MN, IOC	MP	
A8000	NU EP	Helmet, Protective, Soft, Prefabricated, Includes All Components and Accessories	MNF	$153.35	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A8001	NU EP	Helmet, Protective, Hard, Prefabricated, Includes All Components and Accessories	MNF	$153.35	
A9270	RB EP	Non-Covered Item Or Service	MN, IOC	MP	
A9270	NU EP	Non-Covered Item Or Service	MN, IOC	MP	
A9270	RR EP	Non-Covered Item Or Service	MN, IOC	MP	
A9900	NU EP	Miscellaneous DME Supply Accessory And/Or Service Component Of Another HCPCS Code	PA, IOC	MP	
A9999	RB EP	Misc DME Supply Or Accessory Not Otherwise Specified	MN, IOC	MP	
A9999	NU EP	Misc DME Supply Or Accessory Not Otherwise Specified	PA, IOC	MP	
A9999	RR EP	Misc DME Supply Or Accessory Not Otherwise Specified	PA, IOC	MP	
E0171	NU EP	Commode Chair W Integrated Seat Lift Mechanism, Non-Electric, Any Type	PA, IOC	MP	
E0171	RR EP	Commode Chair W Integrated Seat Lift Mechanism, Non-Electric, Any Type	PA, IOC	MP	
E0172	NU EP	Seat Lift Mechanism Placed Over Or On Top Of Toilet, Any Type	PA, IOC	MP	
E0202	RR EP	Phototherapy (Bilirubin) Light W Photometer		$62.30 Daily Rate	Maximum of 6 days
E0240	RB EP	Bath/Shower Chair W/Wo Wheels Any Size	MN, IOC	MP	
E0240	NU EP	Bath/Shower Chair W/Wo Wheels Any Size	PA, IOC	MP	
E0240	RR EP	Bath/Shower Chair W/Wo Wheels Any Size	PA, IOC	MP	
E0350	NU EP	Control Unit For Electronic Bowel Irrigation/ Evacuation System	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0350	RR EP	Control Unit For Electronic Bowel Irrigation/ Evacuation System	PA, IOC	MP	
E0352	NU EP	Disposable Pack-Water Reservoir Bag Speculum Valving Mechanism & Collect Bag/Box-Use W E0350	PA, IOC	MP	
E0602	RR EP	Breast Pump Manual Any Type	MNF	$2.96	
E0603	RR EP	Breast Pump Electric Ac/Dc Any Type	PA, IOC	MP	
E0617	NU EP	External Defibrillator W Integrated Electrocardiogram Analysis	PA, IOC	MP	
E0638	RB EP	Standing Frame System Any Size W/Wo Wheels	MN, IOC	MP	
E0638	NU EP	Standing Frame System Any Size W/Wo Wheels	PA, IOC	MP	
E0641	NU EP	Standing Frame System, Multi-Positioning (E.G. Three-Way Stander), Any Size	PA, IOC	MP	
E0642	NU EP	Standing Frame System, Mobile (Dynamic Stander), Any Size, Including Pediatric	PA, IOC	MP	
E0705	NU EP	Transfer Board Or Device, Any Type, Each	MN	$43.34	
E0720	NU EP	Tens Two Lead Localized Stimulation	PA	$367.58	
E0730	NU EP	Tens; Four Or More Leads For Multiple Nerve Stimulation	PA	$362.79	
E0731	NU EP	Form Fitting Conductive Garment For Delivery Of Tens/Nmes-W/Layers Of Fabric Separating From Skin	PA	$303.19	
E0744	NU EP	Neuromuscular Stimulator For Scoliosis	PA, IOC	MP	
E0744	RR EP	Neuromuscular Stimulator For Scoliosis	PA, IOC	MP	
E0745	NU EP	Neuromuscular Stimulator Electronic Shock Unit	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0745	RR EP	Neuromuscular Stimulator Electronic Shock Unit	PA, IOC	MP	
E0747	NU EP	Osteogenesis Stimulator; Electrical Non-Invasive Other Than Spinal Applications	PA	$3,527.21	
E0747	RR EP	Osteogenesis Stimulator; Electrical Non-Invasive Other Than Spinal Applications	PA	$350.51	
E0748	NU EP	Osteogenesis Stimulator; Electrical Non-Invasive Spinal Applications	PA	$3,504.35	
E0748	RR EP	Osteogenesis Stimulator; Electrical Non-Invasive Spinal Applications	PA	$350.43	
E0764	NU EP	Functional Neuromuscular Stimulator, Transcutaneous Stimulation Of Muscles	PA	$10,775.87	
E0764	RR EP	Functional Neuromuscular Stimulator, Transcutaneous Stimulation Of Muscles	PA	$934.46	
E0762	NU EP	Transcutaneous Electrical Joint Stimulation Device System, Includes All Accessories	PA, IOC	MP	
E0776	NU EP	IV Pole		$94.33	Purchase
E0776	NU EP BA	IV Pole		$94.33	Purchase
E0776	RR EP	IV Pole		$15.85	Rental
E0776	RR EP BA	IV Pole		$15.85	Rental
E0849	RR EP	Traction Equipment Cervical Free Standing	MNF	$43.51	
E0870	NU EP	Traction Frame Attached To Footboard Extremity Traction (E.G. Buck's)	PA, IOC	MP	
E0870	RR EP	Traction Frame Attached To Footboard Extremity Traction (E.G. Buck's)	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0911	NU EP	Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 LBS Attached To Bed	PA, IOC	MP	
E0911	RR EP	Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 LBS Attached To Bed	PA, IOC	MP	
E0912	NU EP	Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 LBS Free Standing	PA, IOC	MP	
E0912	RR EP	Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 LBS Free Standing	PA, IOC	MP	
E1037	RB EP	Transport Chair Pediatric Size	MN, IOC	MP	
E1037	NU EP	Transport Chair Pediatric Size	PA, IOC	MP	
E1037	RR EP	Transport Chair Pediatric Size	PA, IOC	MP	
E1038	RB EP	Transport Chair Adult Size Patient Weight Capacity Less Than 250 Lbs	MN, IOC	MP	
E1038	NU EP	Transport Chair Adult Size Patient Weight Capacity Less Than 250 Lbs	PA, IOC	MP	
E1038	RR EP	Transport Chair Adult Size Patient Weight Capacity Less Than 250 Lbs	PA, IOC	MP	
E1399	RB EP	DME Misc	PA, IOC	MP	
E1399	NU EP	DME Misc	PA, IOC	MP	
E1399	RR EP	DME Misc	PA, IOC	MP	
E2000	NU EP	Gastric Suction Pump	PA, IOC	MP	
E2000	RR EP	Gastric Suction Pump	PA, IOC	MP	
E8000	NU EP	Gait Trainer Ped Sz Posterior Support Includes All Access	PA, IOC	MP	
E8000	RR EP	Gait Trainer Ped Sz Posterior Support Includes All Access	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E8001	NU EP	Gait Trainer Ped Sz Upright Support Includes All Access	PA, IOC	MP	
E8001	RR EP	Gait Trainer Ped Sz Upright Support Includes All Access	PA, IOC	MP	
E8002	NU EP	Gait Trainer Ped Sz Anterior Support Includes All Access	PA, IOC	MP	
E8002	RR EP	Gait Trainer Ped Sz Anterior Support Includes All Access	PA, IOC	MP	
K0606	NU EP	Automatic Defib Garment W Analysis	PA, IOC	MP	
K0606	RR EP	Automatic Defib Garment W Analysis	PA, IOC	MP	
K0607	NU EP	Replacement Battery For AED	MNF	$194.23	
K0608	NU EP	Replacement Garment For AED	PA, IOC	MP	
K0609	NU EP	Replacement Electrode For AED	PA, IOC	MP	
L0112	NU EP	Cranial Cervical Orthosis	PA	$1,201.01	
L0113	NU EP	Cranial Cervical Orthosis	PA, IOC	MP	
L0113	RB EP	Cranial Cervical Orthosis	PA, IOC	MP	
L6711	NU EP	Term Dev, Hook, Vol Open	MN	$578.07	
L6711	RB EP	Term Dev, Hook, Vol Open	MN	$578.07	
L6712	NU EP	Term Dev, Hook, Vol Close	MN	$1,064.32	
L6712	RB EP	Term Dev, Hook, Vol Close	MN	$1,064.32	
L7611	NU EP	Ped Term Dev, Hook, Vol Open	MN	$578.07	
L7612	NU EP	Ped Term Dev, Hook, Vol Close	MN	$1,064.32	
S1002	NU EP	Customized Item-List In Addition To Code For Basic Item	PA, IOC	MP	
S1040	NU EP	Cranial Remolding Orthosis Includes Fitting And Adjustment	PC	$1,650	
S8265	NU EP	Haberman Feeder	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
S9001	RR EP	Home Uterine Monitor	MN	MP	Includes all supplies usual and customary up to $50/day *not* to exceed $1700/pregnancy.
T1999	NU EP	Misc Therapeutic Items And Supplies Retail Purchase NOC	PA, IOC	MP	
T5001	NU EP	Positioning Seat for Persons with special orthopedic needs	PA, IOC	MP	
T5999	NU EP	Supply Not Otherwise Specified	PA, IOC	MP	
V5266	NU EP	Battery For Use In Hearing Aid Device		$5.00	Per pkg of 4
NUTRITION AND SUPPLIES					
B4034	NU EP BA	Enteral Feeding Supply Kit; Syringe Per Day		5.66 Daily Rate	date span # of days = # of units
B4035	NU EP BA	Pump Fed Per Day		10.79 Daily Rate	date span # of days = # of units
B4036	NU EP BA	Enteral Feeding Pump Gravity Fed Per Day		7.39 Daily Rate	date span # of days = # of units
B4081	NU EP BA	Nasogastric Tubing: W Stylet		$20.00	1/30
B4082	NU EP BA	Nasogastric Tubing Wo Stylet		$14.89	1/30
B4083	NU EP BA	Stomach Tube Levine Type		$2.27	1/30
B4087	NU EP BA	Gastrostomy/Jejunostomy Tube, Any Material, Any Type (Standard)		$33.38	1/90

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
B4088	NU EP BA	Gastrostomy/Jejunostomy Tube, Any Material, Any Type (Low Profile)		$33.38	1/90
B4100	NU EP BO	Food Thickener Oral	MNF	$0.85	*must* be over WIC allotment
B4103	NU EP BA	Enteral Formula For Peds Used To Replace Fluids And Electrolytes	MNF	$2.45	*must* be over WIC allotment
B4103	NU EP BO	Enteral Formula For Peds Used To Replace Fluids And Electrolytes	MNF	$2.45	*must* be over WIC allotment
B4104	NU EP BA	Fiber Additive For Enteral Formula	MN, IOC	MP	*must* be over WIC allotment
B4104	NU EP BO	Fiber Additive For Enteral Formula	MN, IOC	MP	*must* be over WIC allotment
B4149	NU EP BO	Blenderized Natural Foods W Intact Nutrients	MNF	$1.47	*must* be over WIC allotment
B4149	NU EP BA	Blenderized Natural Foods W Intact Nutrients	MNF	$1.47	*must* be over WIC allotment
B4150	NU EP BA	Category I Semi-Synth Protein Isolates 100 Calories = 1 Unit	MNF	$0.62	*must* be over WIC allotment
B4150	NU EP BO	Category I Semi-Synth Protein Isolates 100 Calories = 1 Unit	MNF	$0.62	*must* be over WIC allotment
B4152	NU EP BA	Category Ii Intact Protein Isolates Calorically Dense 100 Calories = 1 Unit	MNF	$0.52	*must* be over WIC allotment
B4152	NU EP BO	Category Ii Intact Protein Isolates Calorically Dense 100 Calories = 1 Unit	MNF	$0.52	*must* be over WIC allotment
B4153	NU EP BA	Category Iii Hydrolyzed Protein Aa 100 Calories = 1 Unit	MNF	$1.76	*must* be over WIC allotment

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
B4153	NU EP BO	Category Iii Hydrolyzed Protein Aa 100 Calories = 1 Unit	MNF	$1.76	*must* be over WIC allotment
B4154	NU EP BA	Category IV Form For Special Metabolic Need 100 Calories = 1 Unit	MNF	$1.14	*must* be over WIC allotment
B4154	NU EP BO	Category IV Form For Special Metabolic Need 100 Calories = 1 Unit	MNF	$1.14	*must* be over WIC allotment
B4155	NU EP BA	Category V Modular Components 100 Calories = 1 Unit	MNF	$0.88	*must* be over WIC allotment
B4155	NU EP BO	Category V Modular Components 100 Calories = 1 Unit	MNF	$0.88	*must* be over WIC allotment
B4157	NU EP BO	Nutrition Complete For Special Metabolic Needs	MN, IOC	MP	*must* be over WIC allotment
B4157	NU EP BA	Nutrition Complete For Special Metabolic Needs	MN, IOC	MP	*must* be over WIC allotment
B4158	NU EP BA	Enteral Formula For Peds Nutritionally Complete W Intact Nutrients	MN, IOC	MP	*must* be over WIC allotment
B4158	NU EP BO	Enteral Formula For Peds Nutritionally Complete W Intact Nutrients	MN, IOC	MP	*must* be over WIC allotment
B4159	NU EP BA	Enteral Formula For Peds Nutrition Complete Soy Based W Intact	MN, IOC	MP	*must* be over WIC allotment
B4159	NU EP BO	Enteral Formula For Peds Nutrition Complete Soy Based W Intact	MN, IOC	MP	*must* be over WIC allotment
B4160	NU EP BA	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF	$0.57	*must* be over WIC allotment
B4160	NU EP BO	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF	$0.57	*must* be over WIC allotment

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
B4161	NU EP BA	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF	$1.80	*must* be over WIC allotment
B4161	NU EP BO	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF	$1.80	*must* be over WIC allotment
B4162	NU EP BA	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF, IOC	MP	*must* be over WIC allotment
B4162	NU EP BO	Enteral Formula For Peds Nutrition Complete Calorically Dense	MNF, IOC	MP	*must* be over WIC allotment
B9000	NU EP BA	Enteral Nutrition Infusion Pump; Wo Alarm		$3.47	
B9002	NU EP BA	Enteral Nutrition Infusion Pump W Alarm		$3.47	
B9998	NU EP BA	NOC For Enteral Supplies	MN, IOC	MP	
B9998	NU EP BO	NOC For Enteral Supplies	MN, IOC	MP	
S9434	NU EP BA	Modified Solid Food Supplements For Inborn Errors Of Metabol	MN, IOC	MP	*must* be over WIC allotment
S9434	NU EP BO	Modified Solid Food Supplements For Inborn Errors Of Metabol	MN, IOC	MP	*must* be over WIC allotment
S9435	NU EP BA	Metabolic Food For Inborn Errors Of Metabol	MN, IOC	MP	*must* be over WIC allotment
S9435	NU EP BO	Metabolic Food For Inborn Errors Of Metabol	MN, IOC	MP	*must* be over WIC allotment
RESPIRATORY EQUIPMENT					

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4606	NU	Oxygen Probe For Use W Oximeter Device, Replacement	MNF	$200.00	1/365
A4606	NU EP	Oxygen Probe For Use W Oximeter Device, Replacement, Disposable	MNF	$30.00	1/60
A4614	NU EP	Peak Expiratory Flow Rate Meter Hand Held	MNF	$19.00	
E0445	RR EP	Oximeter Non-Invasive (Per Month)	PC	$200.00	Continuous monthly monitoring. Rent to purchase. Reimbursement not to exceed $2,400.00.
E0445	RB EP	Oximeter Non-Invasive	MN	MP	
E0482	RR EP	Cough Stimulating Device Alternating Positive And Negative Airway Pressure Rental	PC	$360.12	Rent to purchase. Reimbursement not to exceed $4,321.76.
E0483	RR EP	High Frequency Chest Wall Oscillation Air-Pulse Generator System-Includes Hoses And Vest-Each	PC	$930.23	Rent to purchase. Reimbursement not to exceed $11,162.76.
E0484	NU EP	Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each	MNF	$36.92	
E0484	RR EP	Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each Rental	MNF	$3.69	
E0485	NU EP	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility	PA, IOC	MP	
E0486	NU EP	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility	PA, IOC	MP	
E1372	NU EP	Immersion External Heater For Nebulizer	PA, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1372	RR EP	Immersion External Heater For Nebulizer	PA, IOC	MP	
TRACHEOSTOMY CARE SUPPLIES					
A4480	NU EP	Vabra Aspirator	MNF	$112.50	
A4481	NU EP	Trach Filter Any Type Any Sz Each	MNF	$0.38	30/30
A4605	NU EP	Tracheal Suction Catheter Closed System Each	MNF	$16.40	13/30
A4623	NU EP	Trach Inner Cannula Replace Only	MNF	$5.92	2/30
A4624	NU EP	Trach Suction Tube	MNF	$2.63	90/30
A4625	NU EP	Trach Care Kt For New Trach	MNF	$5.89	1/1
A4626	NU EP	Trach Cleaning Brush Each	MNF	$2.71	2/30
A4628	NU EP	Oropharyngeal Suct Cath Each	MNF	$3.65	1/30
A4629	NU EP	Trach Care Kit For Est Trach	MNF	$4.61	1/1
A7501	NU EP	Tracheostoma Valve Including Diaphram Each	MNF	$105.03	1/120
A7502	NU EP	Replacement Diaphram/Faceplate For Tracheostoma Valve Each	MNF	$49.91	
A7503	NU EP	Filter Holder Or Filter Cap Reuse Use In Trach	MNF	$11.33	
A7504	NU EP	Fltr For Use In A Trach Heat And Moisture Exchange System	MNF	$0.67	
A7505	NU EP	Housing Reusable Wo Adhesive For Use In A Heat And Moisture Exchange	MNF	$4.68	
A7506	NU EP	Adhesive Disc For Use In A Heat And Moisture Exchange System	MNF	$0.33	30/30
A7507	NU EP	Fltr Hldr And Integrated Fltr Wo Adhesive For Use In A Trach	MNF	$2.49	60/30
A7508	NU EP	Housing And Integrated Adhesive For Use In A Trach	MNF	$2.87	1/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A7509	NU EP	Filter Holder And Integrated Filter Housing And Adhesive	MNF	$1.41	1/30
A7520	NU EP	Trach Laryn Tube Non-Cuffed	MNF	$47.48	2/30
A7521	NU EP	Trach Laryn Tube Cuffed	MNF	$47.05	2/30
A7522	NU EP	Trach Laryn Tube Stainless	MNF	$45.16	2/30
A7523	NU EP	Tracheostomy Shower Protect	MNF	$5.81	1/120
A7524	NU EP	Trach Stent/Stud/Button	MNF	$77.40	1/90
A7525	NU EP	Trach Mask	MNF	$2.07	1/30
A7526	NU EP	Trach Tube Collar/Holder Each	MNF	$3.37	15/30
A7527	NU EP	Trach/Laryngectomy Tube Plug Stop Each	MNF	$3.58	
L8515	NU EP	Gelatin Capsule For Tracheoesophageal Voice	MNF	$50.67	
S8189	NU EP	Tracheostomy Supply Not Otherwise Classified	MN, IOC	MP	
WOUND CARE/DRESSINGS					
A6000	NU EP	Non-Contact Wound Warming Wound Cover For Use W Non-Contact Wound Warming Device And Warming Card	PA, IOC	MP	
A6000	RR EP	Non-Contact Wound Warming Wound Cover For Use W Non-Contact Wound Warming Device And Warming Card	PA, IOC	MP	
A6010	NU EP	Collagen Based Wound Filler Dry Form Per Gram Of Collagen	MNF	$30.96	30/30
A6011	NU EP	Collagen Gel/Paste Wound Filler	MNF	$2.28	30/30
A6021	NU EP	Collagen Dress Pad Sz 16 Sq Inches Each	MNF	$21.02	30/30
A6022	NU EP	Collagen Drs Pad Sz More Than 16 Sq Inches Each	MNF	$21.02	30/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6023	NU EP	Coll Drs Pad Sz More Than 48 Sq Inches Each	MNF	$190.30	30/30
A6024	NU EP	Coll Drs Wound Filler Per 6 Inches	MNF	$6.19	30/30
A6025	NU EP	Silicone Gel Sheet Each	MN, IOC	MP	
A6154	NU EP	Wound Pouch Each	MNF	$14.36	30/30
A6196	NU EP	Alginate Dressing Wound Cover Pad Sz 16 Sq Inches Or Less Each	MNF	$7.35	30/30
A6197	NU EP	Alginate Dressing Wound Cover Pad Sz More Than 16 Sq Inches Each Dress	MNF	$16.44	30/30
A6198	NU EP	Alginate Dress Wound Cover Pad Size More That 48 Sq Inches Each	MNF	$112.50	
A6199	NU EP	Alginate Dress Wound Filler Per 6 Inches	MNF	$5.29	30/30
A6203	NU EP	Comp Dress Pad Sz 16 Sq Inches Or Less	MNF	$3.35	12/30
A6204	NU EP	Comp Dress Pad Sz More Than 16 Sq Inches	MNF	$6.23	12/30
A6205	NU EP	Comp Dress Pad Sz More Than 48 Sq Inches	MNF	$4.57	
A6206	NU EP	Contact Layer 16 Sq Inches Or Less Each	MNF	$1.98	4/30
A6207	NU EP	Contact Layer More That 16 Sq Inches But Less Than Or = To 48 Sq Inches	MNF	$7.34	4/30
A6208	NU EP	Contact Layer More Than 48 Sq Inches Each	MNF	$3.42	
A6209	NU EP	Foam Dressing Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$7.48	12/30
A6210	NU EP	Foam Dressing Wound Cover Pad Size More Than 16 Sq Inches	MNF	$19.92	12/30
A6211	NU EP	Foam Dress Wound Cover Pad Sz More Than 48 Sq Inches	MNF	$29.37	12/30
A6212	NU EP	Foam Dress Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$9.70	12/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6213	NU EP	Foam Dressing Wound Cover Pd Sz More Than 16 Sq Inches	MNF	$7.29	12/30
A6214	NU EP	Foam Dress Wound Cover Pd Sz More Than 48 Sq Inches	MNF	$10.29	12/30
A6215	NU EP	Foam Dressing Wound Filler Per Gram	MNF	$2.32	
A6216	NU EP	Gauze Non-Impregnated/Sterile 16 Sq Inches Or Less Wo Adhesive Border Each Dressing		$0.05	60/30
A6217	NU EP	Gauze Non Impregnated Non/Sterile 16 Sq Inches Or Less	MNF	$0.11	90/30
A6218	NU EP	Gauze Non-Impreg Non-Sterile Pad More Than 48 Sq Inches	MNF	$0.59	
A6219	NU EP	Gauze Non Impreg Pad Sz 16 Sq Inches Or Less	MNF	$0.95	30/30
A6220	NU EP	Gauze Non Impreg Pad Sz More Than 16 Sq Inches	MNF	$2.58	30/30
A6221	NU EP	Gauze Non Impreg Pad Sz More Than 48 Sq Inches	MNF	$1.09	30/30
A6222	NU EP	Gauze Impreg Other Than Water Or Normal Saline Pad Sz 16 Sq Inches	MNF	$2.13	30/30
A6223	NU EP	Gauze Impreg Other Than Ware Or Normal Saline	MNF	$2.42	30/30
A6224	NU EP	Gauze Impreg Other Than Water Or Normal Saline Pad	MNF	$3.61	30/30
A6228	NU EP	Gauze Impreg Water Or Normal Saline Pad Sz 16 Sq Inches	MNF	$0.58	30/30
A6229	NU EP	Gauze Impreg Water Or Normal Saline Pad More Than 16 Sq Inches	MNF	$3.61	30/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6230	NU EP	Gauze Impreg Water Or Normal Saline Pad Sz More Than 48 Sq Inches	MNF	$1.77	30/30
A6231	NU EP	Gauze Impreg Hydrogel For Direct Wound Contact Pad	MNF	$4.68	30/30
A6232	NU EP	Gauze Impreg Hydrogel For Direct Wound Contact	MNF	$6.88	30/30
A6233	NU EP	Gauze Impreg Hydrogel For Direct Wound Contact Pad	MNF	$19.19	
A6234	NU EP	Hydrocolloid Dressing Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$6.54	12/30
A6235	NU EP	Hydrocolloid Dress Wound Cover Pad Sz More Than 16 Sq Inches	MNF	$16.82	12/30
A6236	NU EP	Hydrocolloid Dress Wound Cover Pad Sz More Than 48 Sq Inches	MNF	$27.25	12/30
A6237	NU EP	Hydrocolloid Drsg Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$7.91	12/30
A6238	NU EP	Hydrocolloid Drsg Wound Cover Pad Sz More Than 16 Sq Inches	MNF	$22.79	12/30
A6239	NU EP	Hydroc Drsg Wound Cover Pad Sz More Than 48 Sq Inches	MNF	$18.23	12/30
A6240	NU EP	Hydroc Drsg Wound Filler Paste Per Fluid Ounce	MNF	$12.24	30/30
A6241	NU EP	Hydroc Drsg Wound Filler Dry Form Per Gram	MNF	$2.57	30/30
A6242	NU EP	Hydrogel Dressing Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$6.07	30/30
A6243	NU EP	Hydrogel Dressing Wound Cover Pad Sz More Than 16 Sq Inches	MNF	$12.31	30/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6244	NU EP	Hydrogel Dressing Wound Cover Pad Sz More Than 48 Sq Inches	MNF	$39.28	12/30
A6245	NU EP	Hydrogel Dressing Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$7.27	12/30
A6246	NU EP	Hydrogel Dressing Wound Cover Pad Sz More Than 16 Sq Inches	MNF	$9.92	12/30
A6247	NU EP	Hydrogel Dressing Wound Cover Pad Sz More Than 48 Sq Inches	MNF	$23.78	12/30
A6248	NU EP	Hydrogel Dressing Wound Filler Gel Per Fluid Ounce	MNF	$16.24	30/30
A6251	NU EP	Specialty Absorptive Dressing Wound Cover Pad Sz 16 Sq Inches	MNF	$1.99	30/30
A6252	NU EP	Specialty Absorptive Dressing Wound Cover Pad Sz 16 Sq Inches	MNF	$3.25	30/30
A6253	NU EP	Specialty Absorptive Dressing Wound Cover Pad Sz More Than 48 Sq Inches Wo Adhesive Each Dressing	MNF	$6.34	30/30
A6254	NU EP	Specialty Absorptive Drsg Wound Cover Pad Sz 16 Sq Inches Or Less	MNF	$1.21	15/30
A6255	NU EP	Specialty Absorptive Drsg Would Cover More Than 16 Sq Inches	MNF	$3.03	15/30
A6256	NU EP	Spec Absorptive Drsg Wound Cover More Than 48 Sq Inches	MNF	$2.11	
A6257	NU EP	Transparent Film 16 Sq Inches Or Less Each Dressing	MNF	$1.53	12/30
A6258	NU EP	Transparent Film > 16 Sq Inches < Or = To 48 Sq Inches Each Dressing	MNF	$4.30	12/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6259	NU EP	Transparent Film More Than 48 Sq Inches Each Dressing	MNF	$10.94	12/30
A6260	NU EP	Wound Cleansers Any Type Any Size	MN, IOC	MP	
A6261	NU EP	Wound Filler Gel/Paste Per Fluid Ounce	MNF	$0.19	
A6262	NU EP	Wound Filler Dry Form Per Gram	MNF	$0.19	
A6266	NU EP	Impreg Gauze No H20/Sal/Yard	MNF	$1.92	
A6402	NU EP	Gauze Non-Impreg Sterile Pad Sz 16 Sq Inches Or Less	MNF	$0.12	100/30
A6403	NU EP	Gauze Non Impreg Sterile Pad Size More Than 16 Sq Inches	MNF	$0.43	100/30
A6404	NU EP	Gauze Elastic Sterile All Types Per Linear Yard	MNF	$0.58	
A6407	NU EP	Packing Strips Non-Impreg Up To 2 Inc In Wdth Per Linear Yard	MNF	$1.88	100/30
A6441	NU EP	Padding Bandage W >=3"<5"/Yd	MNF	$0.67	90/30
A6442	NU EP	Conform Band S/S W<3"/Yd	MNF	$0.17	180/30
A6443	NU EP	Conform Band N/S W>=3"<5"/Yd	MNF	$0.29	180/30
A6444	NU EP	Conform Band N/S W>=5"/Yd	MNF	$0.56	180/30
A6445	NU EP	Conform Band S W < 3"/Yd	MNF	$0.32	180/30
A6446	NU EP	Conform Band S W >=3" < 5"/Yd	MNF	$0.41	180/30
A6447	NU EP	Conform Band S W >= 5"/Yd	MNF	$0.67	180/30
A6448	NU EP	Lt Comp Band <3"/Yd	MNF	$1.16	12/30
A6449	NU EP	Lt Comp Band >=3"<5"/Yd	MNF	$1.75	12/30
A6450	NU EP	LT COMP BAND >+ =5"/Yd	MNF	$0.36	12/30
A6451	NU EP	Mod Comp Band W>=3"<5"/Yd	MNF	$0.36	12/30
A6452	NU EP	High Comp Band W >= 3"<5"Yd	MNF	$5.91	12/30
A6453	NU EP	Self-Adher Band W<3"/Yd	MNF	$0.61	12/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6454	NU EP	Self Adher Band W >=3"<5"/Yd	MNF	$0.77	12/30
A6455	NU EP	Self Adher Band >=5"/Yd	MNF	$1.39	12/30
A6456	NU EP	Zinc Paste Band W>=3"<5"/Yd	MNF	$1.28	12/30
A6457	NU EP	Tubular Dressing W/Wo Elastic, Any Width, Per Linear Yard	MNF	$1.14	12/30
A6501	NU EP	Compress Burn Garment Bodysuit	MNF	$1,497.56	
A6502	NU EP	Compress Burn Garment Chinstrap	MN, IOC	MP	
A6503	NU EP	Compress Burn Garment Face Hood	MNF	$1,173.12	
A6504	NU EP	Compress Burn Garment Glove - Wrist	MN, IOC	MP	
A6505	NU EP	Compress Burn Garment Glove - Elbow	MN, IOC	MP	
A6506	NU EP	Compress Burn Garment Glove Maxilla	MN, IOC	MP	
A6507	NU EP	Compress Burn Garment Foot - Knee	MNF	$1,473.92	
A6508	NU EP	Compress Burn Garment Foot - Thigh	MN, IOC	MP	
A6509	NU EP	Compress Burn Garment Jacket	MN, IOC	MP	
A6510	NU EP	Compress Burn Garment Leotard	MN	MP	
A6511	NU EP	Compress Burn Garment Panty	MNF	$1,696.70	
A6512	NU EP	Compress Burn Garment NOC	MN	MP	
A6513	NU EP	Compression Burn Mask, Face And/Or Neck Plastic Or Equal, Custom Fabricated	IOC	MP	
A6530	NU EP	Gradient Compression Stocking, Below Knee, 18-30 MMHG, Each	IOC	MP	
A6531	NU EP	Gradient Compression Stocking, Below Knee, 30-40 MMHG, Each		$43.27	
A6532	NU EP	Gradient Compression Stocking, Below Knee, 40-50 MMHG, Each		$60.96	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A6533	NU EP	Gradient Compression Stocking, Thigh Length, 18-30 MMHG, Each	IOC	MP	
A6534	NU EP	Gradient Compression Stocking, Thigh Length, 30-40 MMHG, Each	IOC	MP	
A6535	NU EP	Gradient Compression Stocking, Thigh Length, 40-50 MMHG, Each	IOC	MP	
A6536	NU EP	Gradient Compression Stocking, Full Length/Chap Style, 18-30 MMHG, Each	IOC	MP	
A6537	NU EP	Gradient Compression Stocking, Full Length/Chap Style, 30-40 MMHG, Each	IOC	MP	
A6538	NU EP	Gradient Compression Stocking, Full Length/Chap Style, 40-50 MMHG, Each	IOC	MP	
A6539	NU EP	Gradient Compression Stocking, Waste Length, 18-30 MMHG, Each	IOC	MP	
A6540	NU EP	Gradient Compression Stocking , Waste Length, 30-40 MMHG, Each	IOC	MP	
A6541	NU EP	Gradient Compression Stocking, Waste Length, 40-50 MMHG, Each	IOC	MP	
A6542	NU EP	Gradient Compression Stocking, Custom Made	PA, IOC	MP	
A6543	NU EP	Gradient Compression Stocking, Lymphedema	IOC	MP	
A6544	NU EP	Gradient Compression Stocking, Garter Belt	IOC	MP	
A6545	NU EP	Gradient Compression Wrap, Non-Elastic, Below Knee	IOC	MP	
A6549	NU EP	Gradient Compression Stocking, Not Otherwise Specified	PA, IOC	MP	
A6550	NU EP	Neg Pres Wound Ther Drsg Set	MNF	$23.95	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0231	NU EP	Non-Contact Wound Warming Device (Temp Cntrl Ac Adapter & Power Cord) Use W Warming Card & Cover	PA, IOC	MP	
E0231	RR EP	Non-Contact Wound Warming Device (Temp Cntrl Ac Adapter Power Cord) Use W Warming Card And Cover	PA, IOC	MP	
E0232	NU EP	Warming Card Use W Non-Contact Wound Warming Device & Non-Contact Wound Warming Wound Cover	PA, IOC	MP	
E0232	RR EP	Warming Card Use W Non-Contact Wound Warming Device & Non-Contact Wound Warming Wound Cover	PA, IOC	MP	
E0769	NU EP	Electrical Stimulation Or Electromagnetic Wound Treatment Device	PA, IOC	MP	
E0769	RR EP	Electrical Stimulation Or Electromagnetic Wound Treatment Device	PA, IOC	MP	
E0770	NU EP	Functional Electrical Stimulator, Transcutaneous Stimulation Of Nerve And/Or Muscle Group	PA	MP	
E0770	RR EP	Functional Electrical Stimulator, Transcutaneous Stimulation Of Nerve And/Or Muscle Group	PA, IOC	MP	
E0770	RB EP	Functional Electrical Stimulator, Transcutaneous Stimulation Of Nerve And/Or Muscle Group	PA, IOC	MP	
E2402	RB EP	Neg Press Wound Therapy Pump	PA	MP	
E2402	NU EP	Neg Press Wound Therapy Pump	PA, IOC	MP	
E2402	RR EP	Neg Press Wound Therapy Pump	PA	$1,499.03	

19.2 DURABLE MEDICAL EQUIPMENT (DME)

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
AUGMENTATIVE COMMUNICATION DEVICE					
E1902	NU	Communication Board Nonelec	PC, IOC Aug Com Eval	MP	
E1902	RB	Communication Board Nonelec	MN, IOC	MP	
E1902	RR	Communication Board Nonelec	PC, IOC Aug Com Eval	MP	
E2500	NU	Spch Gen Device Digitized Spch Prerecord <=8 Min	PC Aug Com Eval	$391.06	
E2500	RB	Spch Gen Device Digitized Spch Prerecord <=8 Min	MN, IOC	MP	
E2500	RR	Spch Gen Device Digitized Spch Prerecord <=8 Min	PC Aug Com Eval	$32.59	
E2502	NU	Spch Gen Device Digitized Spch Prerecorded >8min<=20min	PC Aug Com Eval	$1,195.80	
E2502	RB	Spch Gen Device Digitized Spch Prerecorded >8min<=20min	MN, IOC	MP	
E2502	RR	Spch Gen Device Digitized Spch Prerecorded >8min<=20min	PC Aug Com Eval	$99.65	
E2504	NU	Spch Gen Device Digitized Spch Prerecorded >20min<=40min	PC Aug Com Eval	$1,577.42	
E2504	RB	Spch Gen Device Digitized Spch Prerecorded >20min<=40min	MN, IOC	MP	
E2504	RR	Spch Gen Device Digitized Spch Prerecorded	PC	$131.45	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		>20min<=40min	Aug Com Eval		
E2506	NU	Spch Gen Device Digitized Spch Prerecorded >40min	PC, IOC	MP	
			Aug Com Eval		
E2506	RB	Spch Gen Device Digitized Spch Prerecorded >40min	MN, IOC	MP	
E2506	RR	Spch Gen Device Digitized Spch Prerecorded >40min	PC, IOC	MP	
			Aug Com Eval		
E2508	NU	Spch Gen Device Synthesized Spch Spelling Phys Contact	PC, IOC	MP	
			Aug Com Eval		
E2508	RB	Spch Gen Device Synthesized Spch Spelling Phys Contact	MN, IOC	MP	
E2508	RR	Spch Gen Device Synthesized Spch Spelling Phys Contact	PC, IOC	MP	
			Aug Com Eval		
E2510	NU	Spch Gen Device Synthesized Spch Permit W/Multi Methods Msg/Accs	PC, IOC	MP	
			Aug Com Eval		
E2510	RB	Spch Gen Device Synthesized Spch Permit W/Multi Methods Msg/Accs	MN, IOC	MP	
E2510	RR	Spch Gen Device Synthesized Spch Permit W/Multi Methods Msg/Accs	PC, IOC	MP	
			Aug Com Eval		
E2511	NU	Spch Gen Software Program For Pc/Pda	PC, IOC	MP	
			Aug Com Eval		
E2511	RB	Spch Gen Software Program For Pc/Pda	MN, IOC	MP	
E2511	RR	Spch Gen Software Program For Pc/Pda	PC, IOC	MP	
			Aug Com Eval		
E2512	NU	Accessory For Speech Generating Device Mounting System	PC, IOC	MP	
			Aug Com Eval		
E2512	RB	Accessory For Speech Generating Device Mounting	MN, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		System			
E2512	RR	Accessory For Speech Generating Device Mounting System	PC, IOC Aug Com Eval	MP	
E2599	NU	Accessory For Speech Generating Device Not Otherwise Classified	PC, IOC Aug Com Eval	MP	
E2599	RB	Accessory For Speech Generating Device Not Otherwise Classified	MN, IOC	MP	
E2599	RR	Accessory For Speech Generating Device Not Otherwise Classified	PC, IOC Aug Com Eval	MP	
CANES AND CRUTCHES					
A4635	RB	Underarm Pad Crutch Replacement Each	MNF	$5.12	
A4636	RB	Replacement Handgrip Cane Crutch Or Walker Each	MNF	$3.68	
A4637	RB	Replacement Rip Cane Crutch Walker Each	MNF	$1.86	
E0100	NU	Cane Includes Canes Of All Materials Adjustable Or Fixed W/Tip	PC	$18.00	
E0105	NU	Cane Quad Or Three Prong Includes Canes Of All Materials Adjustable Or Fixed W/Tips	PC	$40.00	
E0110	NU	Crutches Forearm Includes Crutches Of Various Materials Adjustable Or Fixed Pair Complete	PC	$77.21	
E0111	NU	Crutch Forearm Includes Crutches Of Various Materials Adjustable Or Fixed Each W/Tip	PC	$50.00	
E0112	NU	Crutches Underarm Wood Adjustable Or Fixed Pair W/Pads Tips And Handgrips	PC	$16.00	
E0113	NU	Crutch Underarm Wood Adjustable Or Fixed Each W/Pad Tip And Handgrip	PC	$8.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0114	NU	Crutches Underarm Other Than Wood Adjustable Or Fixed Pair W/Pads Tips And Handgrips	PC	$45.00	
E0116	NU	Crutch Underarm Other Than Wood Adjustable Or Fixed Each W/Pad Tip And Handgrip	PC	$22.50	
E0118	NU	Crutch Substitute Lower Leg Platform W/Wo Wheels		$70.51	
E0153	NU	Platform Attachment Forearm Crutch Each		$69.38	
E0153	RR	Platform Attachment Forearm Crutch Each		$7.84	
COMMODES, BED PANS AND URINALS					
E0163	NU	Commode Chair Stationary W/Fixed Arms	PC	$90.00	
E0163	RR	Commode Chair Stationary W/Fixed Arms	PC	$10.00	
E0165	NU	Commode Chair Stationary W/Detachable Arms	PC	$136.00	
E0165	RR	Commode Chair Stationary W/Detachable Arms	PC	$13.60	
E0167	RB	Pail Or Pan For Use W/Commode Chair		$12.00	
E0168	NU	Commode Chair Extra Wide And/Or Heavy Duty Stationary Or Mobile W/Wo Arms Any Type	PC	$150.92	
E0168	RR	Commode Chair Extra Wide And/Or Heavy Duty Stationary Or Mobile W/Wo Arms Any Type	PC	$15.09	
E0175	NU	Foot Rest For Use W/Commode Chair Each		$56.30	
E0175	RR	Foot Rest For Use W/Commode Chair Each		$5.63	
E0275	NU	Bed Pan Standard Metal Or Plastic	PC	$13.01	
E0276	NU	Bed Pan Fracture Metal Or Plastic	PC	$11.31	
E0325	NU	Urinal Male Jug Type Any Material	PC	$4.20	
E0326	NU	Urinal Female Jug Type Any Material	PC	$4.20	
DECUBITUS CARE EQUIPMENT					

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4640	RB	Replacement Pad For Use W/Medically Necessary Alternating Pressure Pad Owned By Patient	MNF	$55.00	
E0181	NU	Pressure Pad Alternating W/Pump	PC	$264.10	
E0181	RB	Pressure Pad Alternating W/Pump	MN	MP	
E0181	RR	Pressure Pad Alternating W/Pump	PC	$26.06	
E0182	NU	Pump For Alternating Pressure Pad	MNF	$194.00	
E0182	RB	Pump For Alternating Pressure Pad	MN	MP	
E0182	RR	Pump For Alternating Pressure Pad	MNF	$22.00	
E0184	NU	Dry Pressure Mattress	PC	$193.74	
E0185	NU	Gel Or Gel-Like Pressure Pad For Mattress Standard Mattress Length And Width	PC	$318.28	
E0185	RR	Decubitus Care Pad Flotation Or Gel Pad W/Foam Leveling Pad (Mattress Size)	PC	$34.00	
E0186	NU	Air Pressure Mattress	PC	$216.02	
E0187	NU	Water Pressure Mattress	PC	$209.85	
E0190	NU	Positioning Cushion/Pillow/Wedge Any Shape Or Size	MN, IOC	MP	
E0196	NU	Gel Pressure Mattress	PC	$300.00	
E0197	NU	Air Pressure Pad For Mattress, Standard Mattress Length and Width	PC	$216.01	
E0197	RR	Air Pressure Pad For Mattress, Standard Mattress Length and Width	PC	$21.60	Rent to Purchase. Reimubursement not to exceed $216.01
E0217	NU	Water Circulating Heat Pad W/Pump	MNF	$51.90	
E0218	NU	Water Circulating Cold Pad W/Pump	MNF	$51.90	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
DIABETIC SHOES AND INSERTS					
A5500	NU	For Diabetics Only Off-The-Shelf Depth-Inlay Shoe Man To Acc Multi-Density Inserts Per Shoe	PC	$46.08	
A5501	NU	Diabetics Only Custom Shoe Molded From Cast Of Patients Foot Custom Molded Shoe Per Shoe	PC	$156.20	
A5503	NU	Diabetics Only Off The Shelf Depth-Inlay W/Roller Or Rigid Rocker Bottom Per Shoe	PC	$26.40	
A5504	NU	Diabetics Only Off The Shelf Depth Inlay Shoe Or Custom Molded W/Wedges Per Shoe	PC	$26.40	
A5505	NU	Diabetics Only Off The Shelf Depth Inlay Shoe Or Custom Molded W/Metatarsal Bar Per Shoe	PC	$26.40	
A5506	NU	Diabetics Only Off The Shelf Depth Inlay Or Custom Molded W/Off-Set Heel Per Shoe	PC	$26.40	
A5507	NU	Diabetics Only Off The Shelf Depth Inlay Shoe Or Custom Molded Shoe Per Shoe	PC	$15.30	
A5512	NU	For Diabetics Only, Multiple Density Insert, Direct Formed, Molded To Foot After External Heat Source Of 230 Degrees Fahrenheit Or Higher, Total Contact W/Patient's Foot, Including Arch, Base Layer Minimum Of 1/4 Inch Material Of Shore A 35 Durometer Or 3/16 Inch Material Of Shore A 40 Durometer (Or Higher), Prefabricated, Each	PC	$24.22	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A5513	NU	For Diabetics Only, Multiple Density Insert, Custom Molded From Model Of Patient's Foot, Total Contact W/Patient's Foot, Including Arch, Base Layer Minimum Of 1/4 Inch Material Of Shore A 35 Durometer Or 3/16 Inch Material Of Shore A 40 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each	PC	$36.14	
HOSPITAL BEDS					
E0250	NU	Hospital Bed W/Side Rails Fixed Height W/Mattress	PC	$896.42	
E0250	RB	Hospital Bed W/Side Rails Fixed Height W/Mattress	MN	MP	
E0250	RR	Hospital Bed W/Side Rails Fixed Height W/Mattress	PC	$74.70	
E0251	NU	Hospital Bed W/Side Rails Fixed Height W/o Mattress	PC	$679.28	
E0251	RB	Hospital Bed W/Side Rails Fixed Height W/o Mattress	MN	MP	
E0251	RR	Hospital Bed W/Side Rails Fixed Height W/o Mattress	PC	$56.61	
E0255	NU	Hospital Bed W/Side Rails Variable Height Hi-Lo W/Mattress	PC	$915.67	
E0255	RB	Hospital Bed W/Side Rails Variable Height Hi-Lo W/Mattress	MN	MP	
E0255	RR	Hospital Bed W/Side Rails Variable Height Hi-Lo W/Mattress	PC	$76.30	
E0256	NU	Hospital Bed Variable Height Hi-Lo W/Any Type Side Rails W/o Mattress	PC	$649.70	
E0256	RR	Hospital Bed Variable Height Hi/Lo W/Any Type Side Rails W/o Mattress	PC	$54.15	
E0260	NU	Hospital Bed W/Side Rails Semi-Electric Head And Foot Adjustment W/Mattress	PC	$1,288.04	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0260	RB	Hospital Bed W/Side Rails Semi-Electric Head And Foot Adjustment W/Mattress	MN	MP	
E0260	RR	Hospital Bed W/Side Rails Semi-Electric Head And Foot Adjustment W/Mattress	PC	$107.34	
E0261	NU	Hospital Bed Semi-Electric (Head And Foot Adjustment) W/Any Type Side Rails W/o Mattress	PC	$1,067.36	
E0261	RR	Hospital Bed Semi-Electric W/Any Type Side Rails W/o Mattress	PC	$88.94	
E0271	NU	Mattress Innerspring	MN	$182.14	
E0271	RR	Mattress Innerspring	MN	$21.87	
E0272	NU	Mattress Foam Rubber	MN	$154.42	
E0272	RR	Mattress Foam Rubber	MN	$28.07	
E0290	NU	Hospital Bed Fixed Height W/o Side Rails W/Mattress	PC	$582.52	
E0290	RB	Hospital Bed Fixed Height W/o Side Rails W/Mattress	MN	MP	
E0290	RR	Hospital Bed Fixed Height W/o Side Rails W/Mattress	PC	$48.54	
E0291	NU	Hospital Bed Fixed Height W/o Side Rails W/o Mattress	PC	$431.24	
E0291	RR	Hospital Bed Fixed Height W/o Side Rails W/o Mattress	PC	$35.94	
E0292	NU	Hospital Bed Variable Height Hi-Lo W/o Side Rails W/Mattress	PC	$698.84	
E0292	RR	Hospital Bed Variable Height Hi-Lo W/o Side Rails W/Mattress	PC	$58.24	
E0293	NU	Hospital Bed Variable Height Hi-Lo W/o Side Rails W/o Mattress	PC	$557.39	
E0293	RR	Hospital Bed Variable Heigh Hi/Lo W/o Side Rails W/o Mattress	PC	$46.45	
E0294	NU	Hospital Bed Semi-Electric (Head And Foot Adjustment) W/o Side Rails W/Mattress	PC	$1,018.32	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0294	RR	Hospital Bed Semi-Electric W/o Side Rails W/Mattress	PC	$84.86	
E0295	NU	Hospital Bed Semi-Electric (Head And Foot Adjustment) W/o Side Rails W/o Mattress	PC	$992.58	
E0295	RR	Hospital Bed Semi-Electric W/o Side Rails W/o Mattress	PC	$82.71	
E0305	NU	Bed Side Rails Half Length	MN	$127.00	
E0305	RR	Bed Side Rails Half Length	MN	$15.00	
E0310	NU	Bed Side Rails Full Length	MN	$140.00	
E0310	RR	Bed Side Rails Full Length	MN	$17.00	
MISCELLANEOUS					
A4230	NU	Infusion Set for External Insulin Pump, non needle, canula type		$10.00	
A4231	NU	Infusion Set for External Insulin Pump, needle type		$12.84	
A4232	NU	Syringe with Needle for External Insulin Pump, sterile 3cc		$2.65	
A6257	NU	Transparent Film, sterile, 16 square inches or less, each dressing		$4.53	
E0760	NU	Osteogenesis Stimulator Low Intensity Ultrasound Non-Invasive	PC	$2,586.45	
E0760	RR	Osteogenesis Stimulator Low Intensity Ultrasound Non-Invasive	PC	$269.42	Rent to purchase. Reimubursement not to exceed $2586.45
E0784	RR	External Ambulatory Infusion Pump, Insulin	PC	$370.21	Rent to purchase. Reimubursement not to exceed $4,442.59.

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0603	NU	Replacement Battery or external infusion pump owned by patient, alkaline, 1.5 volt, each		$57.00	
ORTHOTIC REPAIR					
L4205	RB	Repair Of Orthotic Device Labor Component	MN	$10.50	
L4210	RB	Repair Of Orthotic Device Repair Or Replace Minor Parts	MN	MP	
ORTHOTICS					
A4565	NU	Slings	MN	$65.00	
A4565	RB	Slings		MP	
A8000	NU	Soft Protective Helmet Prefab	MN	$105.00	
A8000	RB	Soft Protective Helmet Prefab	MN, IOC	MP	
A8001	NU	Hard Protective Helmet Prefab	MN	$105.00	
A8001	RB	Hard Protective Helmet Prefab	MN, IOC	MP	
A8002	NU	Helmet, Protective, Soft, Custom Fabricated, Includes All Components And Accessories	MN	$350.00	
A8002	RB	Soft Protective Helmet, Custom	MN, IOC	MP	
A8003	NU	Helmet, Protective, Hard, Custom Fabricated, Includes All Components And Accessories	MN	$350.00	
A8003	RB	Hard Protective Helmet, Custom	MN, IOC	MP	
A8004	RB	Soft Interface for Helmet, Replacement Only	MN, IOC	MP	
E1800	NU	Dynamic Adjustable Elbow Extension/Flexion Device	MN	$1,145.80	
E1800	RB	Dynamic Adjustable Elbow Extension/Flexion Device	MN	MP	
E1801	NU	Bi-Directional Static Progressive Stretch Elbow Device W/Rom Adjustment Includes Cuffs	MN	$589.40	
E1805	NU	Dynamic Adjustable Wrist Extension/Flexion Device	MN	$1,181.70	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1805	RB	Dynamic Adjustable Wrist Extension/Flexion Device	MN	MP	
E1806	NU	Bi-Directional Static Progressive Stretch Wrist Device W/Rom Adjustment Includes Cuffs	MN	$329.60	
E1810	NU	Dynamic Adjustable Knee Extension/Flexion Device	MN	$1,165.20	
E1810	RB	Dynamic Adjustable Knee Extension/Flexion Device	MN	MP	
E1811	NU	Bi-Directional Static Progressive Stretch Knee Device W/Rom Adjustment Includes Cuffs	MN	$598.60	
E1812	NU	Dynamic Knee, Extension/Flexion Device W/Active Resistance Control	MN	MP	
E1815	NU	Dynamic Adjustable Ankle Extension/Flexion Device	MN	$1,181.70	
E1815	RB	Dynamic Adjustable Ankle Extension/Flexion Device	MN	MP	
E1816	NU	Bi-Directional Static Progressive Stretch Ankle Device W/Rom Adjustment Includes Cuffs	MN	$333.90	
E1818	NU	Bi-Directional Static Progressive Stretch Forearm Pronation/Supination Device W/Rom Adjustment	MN	$1,301.00	
E1820	NU	Soft Interface Material Dynamic Adjustable Extension/Flexion Device	MN	$80.19	
E1820	RB	Soft Interface Material Dynamic Adjustable Extension/Flexion Device	MN	MP	
E1821	NU	Replacement Soft Interface Material/Cuffs For Bi-Directional Static Progressive Stretch Device	MN	$105.25	
E1825	NU	Dynamic Adjustable Finger Extension/Flexion Device	MN	$1,181.70	
E1825	RB	Dynamic Adjustable Finger Extension/Flexion Device	MN	MP	
E1830	NU	Dynamic Adjustable Toe Extension/Flexion Device	MN	$1,181.70	
E1830	RB	Dynamic Adjustable Toe Extension/Flexion Device	MN	MP	
E1831	NU	Static Str Toe Ext/Flex	MN, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1840	NU	Dynamic Adjustable Shoulder Flexion/Abduction/Rotation Device Includes Soft Interface Material	MN	$3,579.70	
E1841	NU	Multi-Directional Static Prog Stretch Shoulder Device W/Range Of Motion	PA, IOC	MP	
K0669	NU	Seat Or Back Cushion For Wheelchair Doesn't Meet Specific Code	PA, IOC	MP	
K0672	NU	Addition To Lower Extremity Orthosis, Removable Soft Interface, All Components	MN	$73.73	
L0120	NU	Cervical Flexible Non-Adjustable (Foam Collar)	MN	$26.34	
L0120	RB	Cervical Flexible Non-Adjustable (Foam Collar)	MN	MP	
L0130	NU	Cervical Flexible Thermoplastic Collar Molded To Patient	MN	$75.00	
L0130	RB	Cervical Flexible Thermoplastic Collar Molded To Patient	MN	MP	
L0140	NU	Cervical Semi-Rigid Adjustable (Plastic Collar)	MN	$63.55	
L0140	RB	Cervical Semi-Rigid Adjustable (Plastic Collar)	MN	MP	
L0150	NU	Cervical Semi-Rigid Adjustable Molded Chin Cup (Plastic Collar W/Mandibular/Occipital Piece)	MN	$95.00	
L0150	RB	Cervical Semi-Rigid Adjustable Molded Chin Cup (Plastic Collar W/Mandibular/Occipital Piece)	MN	MP	
L0160	NU	Cervical Semi-Rigid Wire Frame Occipital/Mandibular Support	MN	$80.00	
L0160	RB	Cervical Semi-Rigid Wire Frame Occipital/Mandibular Support	MN	MP	
L0170	NU	Cervical Collar Molded To Patient Model	MN	$480.00	
L0170	RB	Cervical Collar Molded To Patient Model	MN	MP	
L0172	NU	Cervical Collar Semi-Rigid Thermoplastic Foam Two Piece	MN	$75.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L0172	RB	Cervical Collar Semi-Rigid Thermoplastic Foam Two Piece	MN	MP	
L0174	NU	Cervical Collar Semi-Rigid Thermoplastic Foam Two Piece W/Thoracic Extension Multiple Post Collar	MN	$125.00	
L0174	RB	Cervical Collar Semi-Rigid Thermoplastic Foam Two Piece W/Thoracic Extension Multiple Post Collar	MN	MP	
L0180	NU	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable	MN	$210.00	
L0180	RB	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable	MN	MP	
L0190	NU	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable Cervical Bars (Somi, Guilford, Taylor Types)	MN	$320.00	
L0190	RB	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable Cervical Bars (Somi, Guilford, Taylor Types)	MN	MP	
L0200	NU	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable Cervical Bars And Thoracic Extension	MN	$340.00	
L0200	RB	Cervical Multiple Post Collar Occipital/Mandibular Supports Adjustable Cervical Bars And Thoracic Extension	MN	MP	
L0220	NU	Thoracic Rib Belt Custom Fabricated	PA	$96.05	
L0220	RB	Thoracic Rib Belt Custom Fabricated	MN	MP	
L0430	NU	Spinal Orthosis Anterior/Posterior Lateral Control W/Interface	MN	$950.00	
L0430	RB	Spinal Orthosis Anterior/Posterior Lateral Control W/Interface	MN, IOC	MP	
L0450	NU	TLSO Flex Prefab Thoracic	MN	$147.29	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L0452	NU	TLSO Flex Custom Fab Thoracic	MN	$298.64	
L0454	NU	TLSO Flex Prefab Sacrococ-T9	MN	$277.85	
L0456	NU	TLSO Flex Prefab	MN	$309.06	
L0458	NU	TLSO 2mod Symphysis-Xipho Prefab	MN	$632.01	
L0460	NU	TLSO 2mod Symphysis-Stern Prefab	MN	$632.01	
L0462	NU	TLSO 3mod Sacro-Scap Prefab	MN	$632.01	
L0464	NU	TLSO 4mod Sacro-Scap Prefab	MN	$632.01	
L0466	NU	TLSO Rigid Frame Prefab Soft Apron	MN	$293.79	
L0468	NU	TLSO Rigid Frame Prefab Pelvic	MN	$373.13	
L0470	NU	TLSO Rigid Frame Pre Subclavical	MN	$514.60	
L0472	NU	TLSO Rigid Frame Hyperex Prefab	MN	$324.27	
L0480	NU	TLSO Rigid Plastic Custom Fab	MN	$1,388.21	
L0482	NU	TLSO Rigid Lined Custom Fab	MN	$1,299.21	
L0484	NU	TLSO Rigid Plastic Cust Fab	MN	$1,353.12	
L0486	NU	TLSO Rigid Lined Cust Fab Two Piece	MN	$1,419.28	
L0488	NU	TLSO Rigid Lined Pre One Piece	MN	$804.16	
L0490	NU	TLSO Rigid Plastic Pre One Piece	MN	$226.61	
L0491	NU	TLSO 2 Piece Rigid Shell	MN	$615.24	
L0492	NU	TLSO 3 Piece Rigid Shell	MN	$378.25	
L5312	NU	Knee Disarticulation (Or Through Knee), Molded Socket, Single Axis Knee, Pylon	MN	$3,486.60	
L5312	RR	Knee Disarticulation (Or Through Knee), Molded Socket, Single Axis Knee, Pylon	MN, IOC	MP	
L0621	NU	Sacroiliac Orthosis Flexible Provides Pelvic/Sacral Support	MN	$90.57	
L0622	NU	Sacroiliac Orthosis Flexible Provides Pelvic/Sacral Support	MN	$232.39	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L0623	NU	Sacroiliac Orthosis Provides Pelvic/Sacral Support W/Rigid Or Semi Rigid	MN	$57.23	
L0624	NU	Sacroiliac Orthosis Provides Pelvic/Sacral Support W/Rigid Or Semi Rigid	MN, IOC	MP	
L0625	NU	Lumbar Orthosis Flexible Provides Lumbar Support Posterior Extends From L-1 to below L-5 Vertebra	MN	$44.12	
L0626	NU	Lumbar Orthosis Sagittal Control W/Rigid Posterior Panels Posterior	MN	$62.45	
L0627	NU	Lumbar Orthosis Sagittal Control W/Rigid Anterior And Posterior Panels	MN	$329.29	
L0628	NU	Lumbar-Sacral Orthosis Flexible Provides Lumbo-Sacral Support Posterior	MN	$67.21	
L0629	NU	Lumbar-Sacral Orthosis Flexible Provides Lumbo-Sacral Support Posterior	MN	$239.31	
L0630	NU	Lumbar-Sacral Orthosis Sagittal Control W/Rigid Posterior Panels	MN	$129.73	
L0631	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Anterior And Posterior	MN	$822.39	
L0632	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Anterior And Posterior	MN	$987.67	
L0633	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Posterior	MN	$229.72	
L0634	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Posterior	MN	$347.23	
L0635	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control Lumbar Flexion Rigid	MN	$805.71	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L0636	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control Lumbar Flexion Rigid	MN	$1,325.29	
L0637	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Anterior	MN	$954.14	
L0638	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control W/Rigid Anterior And Posterior	MN	$1,056.59	
L0639	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control Rigid Shell Panel	MN	$954.14	
L0640	NU	Lumbar-Sacral Orthosis Sagittal-Coronal Control Rigid Shell Panel	MN	$838.26	
L0700	NU	Cervical-Thoracic-Lumbar-Sacral-Orthoses (CTLSO) Anterior-Posterior-Lateral Control Molded To Patient (Minerva Type)	MN	$1,000.00	
L0700	RB	Cervical-Thoracic-Lumbar-Sacral-Orthoses (CTLSO) Anterior-Posterior-Lateral Control Molded To Patient	MN	MP	
L0710	NU	CTLSO Anterior-Posterior-Lateral-Control Molded To Patient Model W/Interface Material (Minerva Type)	MN	$1,050.00	
L0710	RB	CTLSO Anterior-Posterior-Lateral-Control Molded To Patient Model W/Interface Material (Minerva Type)	MN	MP	
L0810	NU	Halo Procedure Cervical Inc Into Jacket Vest	MN	$2,000.00	
L0810	RB	Halo Procedure Vest	MN	MP	
L0820	NU	Halo Procedure Cervical Halo Inc Into Plaster Body Jacket	MN	$1,548.87	
L0820	RB	Halo Procedure Jacket	MN	MP	
L0830	NU	Halo Procedure Cervical Halo Inc Into Milwaukee Type Orthosis	MN	$2,280.54	
L0830	RB	Halo Procedure Orthosis	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L0859	NU	Addition To Halo Procedures Magnetic Resonance Image Compatible System	MN	$400.00	
L0859	RB	Addition To Halo Procedures Magnetic Resonance Image Compatible System	MN	MP	
L0861	NU	Halo Repl Liner/Interface	PA	$184.93	
L0970	NU	TLSO Corset Front	MN	$25.00	
L0972	NU	LSO Corset Front	MN	$25.00	
L0974	NU	TLSO Full Corset	MN	$95.00	
L0976	NU	LSO Full Corset	MN	$85.00	
L0978	NU	Axillary Crutch Extension	MN	$175.00	
L0984	NU	Protective Body Sock Each	MN	$45.00	
L0999	NU	Addition To Spinal Orthosis Not Otherwise Specified	PA	MP	
L1000	NU	CTLSO (Milwaukee) Inclusive Of Furnishing Initial Orthosis Including Model	MN	$1,165.00	
L1000	RB	CTLSO (Milwaukee) Inclusive Of Furnishing Initial Orthosis Including Model	MN	MP	
L1010	NU	Addition To CTLSO Or Scoliosis Orthosis Axilla Sling	MN	$55.00	
L1020	NU	Addition To CTLSO Or Scoliosis Orthosis Kyphosis Pad	MN	$55.00	
L1025	NU	Addition To CTLSO Or Scoliosis Orthosis Kyphosis Pad Floating	MN	$55.00	
L1030	NU	Addition To CTLSO Or Scoliosis Orthosis Lumbar Bolster Pad	MN	$47.37	
L1040	NU	Addition To CTLSO Or Scoliosis Orthosis Lumbar Or Lumbar Rib Pad	MN	$55.00	
L1050	NU	Addition To CTLSO Or Scoliosis Orthosis Sternal Pad	MN	$55.00	
L1060	NU	Addition To CTLSO Or Scoliosis Orthosis Thoracic Pad	MN	$55.00	
L1070	NU	Addition To CTLSO Or Scoliosis Orthosis Trapeze Sling	MN	$65.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1080	NU	Addition To CTLSO Or Scoliosis Orthosis Outrigger	MN	$21.00	
L1085	NU	Addition To CTLSO Or Scoliosis Orthosis Outrigger Bilateral W/Vertical Extensions	MN	$31.00	
L1090	NU	Addition To CTLSO Or Scoliosis Orthosis Lumbar Sling	MN	$55.00	
L1100	NU	Addition To CTLSO Or Scoliosis Orthosis Ring Flange Plastic Or Leather	MN	$75.00	
L1110	NU	Addition To CTLSO Or Scoliosis Orthosis Ring Flange Plastic Or Leather Molded To Patient Model	MN	$120.00	
L1120	NU	Addition To CTLSO Scoliosis Orthosis Cover For Upright Each	MN	$20.00	
L1200	NU	Thoracic-Lumbar-Sacral-Orthosis (TLSO) Inclusive Of Furnishing Initial Orthosis Only	MN	$1,165.00	
L1210	NU	Addition To TLSO (Low Profile) Lateral Thoracic Extension	MN	$45.00	
L1220	NU	Addition To TLSO (Low Profile) Anterior Thoracic Extension	MN	$45.00	
L1230	NU	Addition To TLSO (Low Profile) Milwaukee Type Superstructure	MN	$210.00	
L1240	NU	Addition To TLSO (Low Profile) Lumbar Derotation Pad	MN	$45.00	
L1250	NU	Addition To TLSO (Low Profile) Anterior Asis Pad	MN	$45.00	
L1260	NU	Addition To TLSO (Low Profile) Anterior Thoracic Derotation Pad	MN	$45.00	
L1270	NU	Addition To TLSO (Low Profile) Abdominal Pad	MN	$45.00	
L1280	NU	Addition To TLSO (Low Profile) Rib Gusset (Elastic) Each	MN	$45.00	
L1290	NU	Addition To TLSO (Low Profile) Lateral Trochanteric Pad	MN	$45.00	
L1300	NU	Other Scoliosis Procedure Body Jacket Molded To Patient	MN	$1,165.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Model			
L1300	RB	Other Scoliosis Procedure Body Jacket Molded To Patient Model	MN	MP	
L1310	NU	Other Scoliosis Procedure Post Operative Body Jacket	MN	$1,165.00	
L1310	RB	Other Scoliosis Procedure	MN	MP	
L1499	NU	Spinal Orthosis Not Otherwise Specified	PA	MP	
L1500	NU	Thoracic-Hip-Knee-Ankle Orthosis (THKAO) Mobility Frame (Newington Parapodium Types)	MN	$840.00	
L1500	RB	Thoracic-Hip-Knee-Ankle Orthosis (THKAO) Mobility Frame (Newington Parapodium Types)	MN	MP	
L1600	NU	Hip Orthosis (HO) Abduction Control Of Hip Joints Flexible Frejka Type W/Cover	MN	$75.00	
L1600	RB	Hip Orthosis (HO) Abduction Control Of Hip Joints Flexible Frejka Type W/Cover	MN	MP	
L1610	NU	HO Abduction Control Of Hip Joints Flexible Frejka Cover Only	MN	$25.00	
L1610	RB	HO Abduction Control Of Hip Joints Flexible Frejka Cover Only	MN	MP	
L1620	NU	HO Abduction Control Of Hip Joints Flexible Pavlik Harness	MN	$75.00	
L1620	RB	HO Abduction Control Of Hip Joints Flexible Pavlik Harness	MN	MP	
L1630	NU	HO Abduction Control Of Hip Joints Semi-Flexible (Von Rosen Type)	MN	$85.00	
L1630	RB	HO Abduction Control Of Hip Joints Semi-Flexible (Von Rosen Type)	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1640	NU	HO Abduction Control Of Hip Joints Static Pelvic Band Or Spreader Bar Thigh Cuffs	MN	$300.00	
L1640	RB	HO Abduction Control Of Hip Joints Static Pelvic Band Or Spreader Bar Thigh Cuffs	MN	MP	
L1650	NU	HO Abduction Control Of Hip Joints Static Adjustable (Ilfled Type)	MN	$135.00	
L1650	RB	HO Abduction Control Of Hip Joints Static Adjustable (Ilfled Type)	MN	MP	
L1652	NU	HO Bi Thigh cuffs W/Sprdr Bar	MN	$285.58	
L1660	NU	HO Abduction Control Of Hip Joints Static Plastic Prefabricated Includes Fitting & Adjustments	MN	$127.42	
L1660	RB	HO Abduction Control Of Hip Joints Static Plastic	MN	MP	
L1680	NU	HO Abduction Control Of Hip Joints Dynamic Pelvic Control Adjustable Hip Motion Control Thigh Cuffs	MN	$800.00	
L1680	RB	HO Abduction Control Of Hip Joints Dynamic Pelvic Control Adjustable Hip Motion Control Thigh Cuffs	MN	MP	
L1685	NU	HO Abduction Control Of Hip Joint Post-Operative Hip Abduction Type Custom Fabricated	MN	$850.00	
L1685	RB	HO Abduction Control Of Hip Joint Post-Operative Hip Abduction Type Custom Fabricated	MN	MP	
L1686	NU	HO Post-Operative Hip Abduction Type Prefabricated Includes Fitting & Adjustments	MN	$642.05	
L1686	RB	HO Abduction Control Of Hip Joint Post-Operative Hip Abduction Type	MN	MP	
L1690	NU	Combination Bilateral Lumbo-Sacral Hip Femur Orthosis Providing Adduction & Internal Rotation Control	MN	$1,270.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1700	NU	Legg Perthes Orthosis Toronto Type	MN	$900.00	
L1700	RB	Legg Perthes Orthosis Toronto Type	MN	MP	
L1710	NU	Legg Perthes Orthosis Newington Type	MN	$950.00	
L1710	RB	Legg Perthes Orthosis Newington Type	MN	MP	
L1720	NU	Legg Perthes Orthosis Trilateral (Tachidijan Type)	MN	$850.00	
L1720	RB	Legg Perthes Orthosis Trilateral (Tachidijan Type)	MN	MP	
L1730	NU	Legg Perthes Orthosis Scottish Rite Type	MN	$850.00	
L1730	RB	Legg Perthes Orthosis Scottish Rite Type	MN	MP	
L1755	NU	Legg Perthes Patten Bottom Type Custom Fabricated	MN	$1,140.28	
L1755	RB	Legg Perthes Orthosis Patten Bottom Type	MN	MP	
L1810	NU	Knee Orthosis (KO) Elastic W/Joints	MN	$65.00	
L1810	RB	KO Elastic W/Joints	MN	MP	
L1820	NU	KO Elastic W/Condylar Pads/Joints W/Wo Patellar	MN	$90.00	
L1820	RB	KO Elastic W/Condylar Pads/Joints W/Wo Patellar	MN	MP	
L1830	NU	KO Immobilizer Canvas Longitudinal	MN	$55.00	
L1830	RB	KO Immobilizer Canvas Longitudinal	MN	MP	
L1831	NU	KO Positional Locking Joint	MN	$235.78	
L1832	NU	KO Adjustable Knee Joints Positional Orthosis Rigid Support	MN	$425.00	
L1832	RB	KO Adjustable Knee Joints Positional Orthosis Rigid Support	MN	MP	
L1834	NU	KO W/o Knee Joint Rigid Molded To Patient Model	MN	$180.00	
L1834	RB	KO W/o Knee Joint Rigid Molded To Patient Model	MN	MP	
L1836	NU	Rigid KO W/o Joints	MN	$106.90	
L1840	NU	KO Derotation Medial-Lateral Anterior Cruciate Ligament Custom Fabricated To Patient Model	MN	$600.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1840	RB	KO Derotation Medial-Lateral Anterior Cruciate Ligament Custom Fabricated To Patient Model	MN	MP	
L1843	NU	KO Single Upright Custom Fit	PA	$404.49	
L1845	NU	KO Double Upright Thigh/Calf W/Adjustable Flexion And Extension Joint Medial-Lateral Rot Cntr Custom	MN	$585.00	
L1845	RB	KO Double Upright Thigh/Calf W/Adjustable Flexion And Extension Joint Medial-Lateral Rot Cntr Custom	MN	MP	
L1846	NU	KO Double Upright Thigh/Calf W/Adjustable Flexion And Extension Joint Medial-Lateral Rot Cntr Molded	MN	$600.00	
L1846	RB	KO Double Upright Thigh/Calf W/Adjustable Flexion And Extension Joint Medial-Lateral Rot Cntr Molded	MN	MP	
L1847	NU	Double Upright W/Adjustable Joint W/Inflatable Air Support Chamber(s)	MN	$378.00	
L1850	NU	KO Swedish Type	MN	$210.00	
L1850	RB	KO Swedish Type	MN	MP	
L1860	NU	KO Modification Of Supracondylar Prosthetic Socket Molded To Patient Model (SK)	MN	$895.00	
L1860	RB	KO Modification Of Supracondylar Prosthetic Socket Molded To Patient Model (SK)	MN	MP	
L1885	RB	KO Single Or Double Upright Thigh And Calf W/Functional Active Resistance Control	MN	MP	
L1900	NU	Ankle-Foot Orthosis (AFO) Spring Wire Dorsiflexion Assist Calf Band	MN	$150.00	
L1900	RB	Ankle-Foot Orthosis (AFO) Spring Wire Dorsiflexion Assist Calf Band	MN	MP	
L1902	NU	AFO Ankle Gauntlet	MN	$45.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1902	RB	AFO Ankle Gauntlet	MN	MP	
L1904	NU	AFO Molded Ankle Gauntlet Molded To Patient Model	MN	$250.00	
L1904	RB	AFO Molded Ankle Gauntlet Molded To Patient Model	MN	MP	
L1906	NU	AFO Multiligamentus Ankle Support (Air)	MN	$70.00	
L1906	RB	AFO Multiligamentus Ankle Support (Air)	MN	MP	
L1907	NU	AFO Supramalleolar Custom	MN	$450.75	
L1910	NU	AFO Posterior Single Bar Clasp Attachment To Shoe Counter	MN	$65.00	
L1910	RB	AFO Posterior Single Bar Clasp Attachment To Shoe Counter	MN	MP	
L1920	NU	AFO Single Upright W/Static Or Adjustable Stop (Phelps Or Perlstein Type) Custom Fabricated	MN	$260.30	
L1920	RB	AFO Single Upright W/Static Or Adjustable Stop (Phelps Or Perlstein Type) Custom Fabricated	MN	MP	
L1930	NU	AFO Plastic	MN	$190.00	
L1930	RB	AFO Plastic	MN	MP	
L1932	NU	AFO Rigid Anterior Tibial Section Total Carbon Fiber Or Equal	MN	$714.87	
L1940	NU	AFO Molded To Patient Model Plastic	MN	$325.00	
L1940	RB	AFO Molded To Patient Model Plastic	MN	MP	
L1945	NU	AFO Molded To Patient Model Plastic Rigid Anterior Tibial Section (Floor Reaction)	MN	$400.00	
L1945	RB	AFO Molded To Patient Model Plastic Rigid Anterior Tibial Section (Floor Reaction)	MN	MP	
L1950	NU	AFO Spiral Molded To Patient Model (IRM Type) Plastic	MN	$310.00	
L1950	RB	AFO Spiral Molded To Patient Model (IRM Type) Plastic	MN	MP	
L1951	NU	AFO Spiral Prefabricated	MN	$672.79	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L1960	NU	AFO Posterior Solid Ankle Molded To Patient Model Plastic	MN	$390.00	
L1960	RB	AFO Posterior Solid Ankle Molded To Patient Model Plastic	MN	MP	
L1970	NU	AFO Plastic Molded To Patient Model W/Ankle Joint	MN	$490.00	
L1970	RB	AFO Plastic Molded To Patient Model W/Ankle Joint	MN	MP	
L1971	NU	AFO W/Ankle Joint Prefab	MN	$375.49	
L1980	NU	AFO Single Upright Free Plantar Dorsiflexion Solid Stirrup Calf Band/Cuff (Single Bar "BK" Orthos	MN	$275.00	
L1980	RB	AFO Single Upright Free Plantar Dorsiflexion Solid Stirrup Calf Band/Cuff (Single Bar "BK" Orthosis)	MN	MP	
L1990	NU	AFO Double Upright Free Plantar Dorsiflexion Solid Stirrup Calf Band/Cuff (Double Bar "BK" Orthosis)	MN	$325.00	
L1990	RB	AFO Double Upright Free Plantar Dorsiflexion Solid Stirrup Calf Band/Cuff (Double Bar "BK" Orthosis)	MN	MP	
L2000	NU	KAFO Single Upright Free Knee Ankle Solid Stirrup Thigh And Calf Bands/Cuff Single Bar AK Orthosis	MN	$625.00	
L2000	RB	KAFO Single Upright Free Knee Ankle Solid Stirrup Thigh And Calf Bands/Cuff Single Bar AK Orthosis	MN	MP	
L2005	NU	KAFO Any Material Single Or Double Upright Stance	MN	$2,883.69	
L2010	NU	KAFO Single Upright Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Single Bar AK Orthosis W/o Knee Joint)	MN	$575.00	
L2010	RB	KAFO Single Upright Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Single Bar AK Orthosis W/o Knee Joint)	MN	MP	
L2020	NU	KAFO Double Upright Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Double Bar "AK" Orthosis)	MN	$869.39	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2020	RB	KAFO Double Upright Free Knee Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Double Bar "AK" Orthosis)	MN	MP	
L2030	NU	KAFO Double Upright Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Double Bar "AK" Orthosis)	MN	$700.00	
L2030	RB	KAFO Double Upright Free Ankle Solid Stirrup Thigh And Calf Bands/Cuffs (Double Bar "AK" Orthosis)	MN	MP	
L2034	NU	KAFO Full Plastic, Single Upright, W/Wo Free Motion Knee, Medical Lateral Rotation Control, W/Wo Free Motion Ankle, Custom Fabricated	MN	$1,779.81	
L2034	RB	KAFO Full Plastic, Single Upright, W/Wo Free Motion Knee, Medical Lateral Rotation Control, W/Wo Free Motion Ankle, Custom Fabricated	MN	MP	
L2035	NU	KAFO Full Plastic Static (Ped Sz) W/o Free Motion Ankle	PA	$129.74	
L2036	NU	KAFO Full Plastic Double Upright Free Knee W/Wo Free Motion Ankle	MN	$1,300.00	
L2036	RB	KAFO Full Plastic Double Upright Free Knee W/Wo Free Motion Ankle	MN	MP	
L2037	NU	KAFO Full Plastic Single Upright Free Knee W/Wo Free Motion Ankle	MN	$1,172.33	
L2037	RB	KAFO Full Plastic Single Upright Free Knee W/Wo Free Motion Ankle	MN	MP	
L2038	NU	KAFO Full Plastic W/Wo Knee Joint Multi-Axis Ankle	MN	$1,006.32	
L2038	RB	KAFO Full Plastic W/Wo Knee Joint Multi-Axis Ankle	MN	MP	
L2040	NU	Hip-Knee-Ankle-Foot Orthosis (HKAFO) Torsion Control Bilateral Rotation Straps Pelvic Band/Belt	MN	$95.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2040	RB	HKAFO Torsion Control Bilateral Rotation Straps Pelvic Band/Belt	MN	MP	
L2050	NU	HKAFO Torsion Control Bilateral Torsion Cables Hip Joint Pelvic Band/Belt	MN	$320.00	
L2050	RB	HKAFO Torsion Control Bilateral Torsion Cables Hip Joint Pelvic Band/Belt	MN	MP	
L2060	NU	HKAFO Torsion Control Bilateral Torsion Cables Ball Bearing Hip Joint Pelvic Band/ Belt	MN	$330.00	
L2060	RB	HKAFO Torsion Control Bilateral Torsion Cables Ball Bearing Hip Joint Pelvic Band/ Belt	MN	MP	
L2070	NU	HKAFO Torsion Control Unilateral Rotation Straps Pelvic Band/Belt	MN	$65.00	
L2070	RB	HKAFO Torsion Control Unilateral Rotation Straps Pelvic Band/Belt	MN	MP	
L2080	NU	HKAFO Torsion Control Unilateral Torsion Cable Hip Joint Pelvic Band/Belt	MN	$270.00	
L2080	RB	HKAFO Torsion Control Unilateral Torsion Cable Hip Joint Pelvic Band/Belt	MN	MP	
L2090	NU	HKAFO Torsion Control Unilateral Torsion Cable Ball Bearing Hip Joint Pelvic Band/ Belt	MN	$275.00	
L2090	RB	HKAFO Torsion Control Unilateral Torsion Cable Ball Bearing Hip Joint Pelvic Band/ Belt	MN	MP	
L2106	NU	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Thermoplastic Type Casting Material	MN	$250.00	
L2106	RB	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Thermoplastic Type Casting Material	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2108	NU	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Molded To Patient Model	MN	$600.00	
L2108	RB	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Molded To Patient Model	MN	MP	
L2112	NU	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Soft Pre-Fabricated Includes Fitting & Adjustment	MN	$347.38	
L2112	RB	AFO Fracture Orthosis Tibial Fracture Cast Orthosis Soft Pre-Fabricated Includes Fitting & Adjustment	MN	MP	
L2114	NU	AFO Fracture Orthosis Tibial Fracture Orthosis Semi-Rigid	MN	$350.00	
L2114	RB	AFO Fracture Orthosis Tibial Fracture Orthosis Semi-Rigid	MN	MP	
L2116	NU	AFO Fracture Orthosis Tibial Fracture Orthosis Rigid	MN	$350.00	
L2116	RB	AFO Fracture Orthosis Tibial Fracture Orthosis Rigid	MN	MP	
L2126	NU	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Thermoplastic Type Casting Material Molded	MN	$800.00	
L2126	RB	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Thermoplastic Type Casting Material Molded	MN	MP	
L2128	NU	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Molded To Patient Model	MN	$1,000.00	
L2128	RB	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Molded To Patient Model	MN	MP	
L2132	NU	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Soft	MN	$450.00	
L2132	RB	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Soft	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2134	NU	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Semi-Rigid	MN	$450.00	
L2134	RB	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Semi-Rigid	MN	MP	
L2136	NU	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Rigid	MN	$450.00	
L2136	RB	KAFO Fracture Orthosis Femoral Fracture Cast Orthosis Rigid	MN	MP	
L2180	NU	Addition To Lower Extremity Fracture Orthosis Plastic Shoe Insert W/Ankle Joints	MN	$45.00	
L2182	NU	Addition To Lower Extremity Fracture Orthosis Drop Lock Knee Joint	MN	$12.00	
L2184	NU	Addition To Lower Extremity Fracture Orthosis Limited Motion Knee Joint	MN	$40.00	
L2186	NU	Addition To Lower Extremity Fracture Orthosis Adjustable Motion Knee Joint Lerman Type	MN	$40.00	
L2188	NU	Addition To Lower Extremity Fracture Orthosis Quadrilateral Brim	MN	$222.99	
L2190	NU	Addition To Lower Extremity Fracture Orthosis Waist Belt	MN	$45.00	
L2192	NU	Addition To Lower Extremity Fracture Orthosis Hip Joint Pelvic Band Thigh Flange And Pelvic Belt	MN	$225.00	
L2200	NU	Addition To Lower Extremity Limited Ankle Motion Each Joint	MN	$20.00	
L2210	NU	Addition To Lower Extremity Dorsiflexion Assist (Plantar Flexion Resist) Each Joint	MN	$35.00	
L2220	NU	Addition To Lower Extremity Dorsiflexion And Plantar Flexion Assist/Resist Each Joint	MN	$45.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2230	NU	Addition To Lower Extremity Split Flat Caliper Stirrups And Plate Attachment	MN	$45.00	
L2232	NU	Addition To Lower Extremity Orthosis Rocker Bottom For Total Contact Ankle	MN	$83.76	
L2240	NU	Addition To Lower Extremity Round Caliper And Plate Attachment	MN	$35.00	
L2250	NU	Addition To Lower Extremity Foot Plate Molded Stirrup Attachment	MN	$210.00	
L2260	NU	Addition To Lower Extremity Reinforced Solid Stirrup Scott-Craig Type	MN	$60.00	
L2265	NU	Addition To Lower Extremity Long Tongue Stirrup	MN	$50.00	
L2270	NU	Addition Lower Extremity Varus/Vulgus Correction T Strap Padded/Lined Or Malleolus Pad	MN	$37.00	
L2275	NU	Addition To Lower Extremity Varus/Vulgus Correction Plastic Modification Padded/Lined	MN	$112.00	
L2280	NU	Addition To Lower Extremity Molded Inner Boot	MN	$315.00	
L2300	NU	Addition Abduction Bar Bilateral Hip Involvement Jointed Adjustable	MN	$175.00	
L2310	NU	Addition Abduction Bar Straight	MN	$85.00	
L2320	NU	Non Molded Lacer For Custom Fabricated Orthosis Lower Extremity	MN	$120.00	
L2330	NU	Lacer Molded To Patient Model For Custom Lower Extremity	MN	$250.00	
L2335	NU	Addition Anterior Swing Band	MN	$50.00	
L2340	NU	Addition Pre Tibial Shell Molded To Patient	MN	$300.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2350	NU	Addition Prosthetic Type BK Socket Molded To Patient (Used For PTB AFO)	MN	$450.00	
L2360	NU	Addition Extended Steel Shank	MN	$30.00	
L2370	NU	Addition To Lower Extremity Patten Bottom	MN	$45.00	
L2375	NU	Addition To Lower Extremity Torsion Control Ankle Joint & Half Solid Stirrup	MN	$85.77	
L2380	NU	Addition To Lower Extremity Torsion Control Straight Knee Joint Each Joint	MN	$104.75	
L2385	NU	Addition Straight Knee Joint Heavy Duty Each Joint	MN	$20.00	
L2387	NU	Addition To Lower Extremity, Polycentric Knee Joint, For Custom Fab KAFO, Each Joint	MN	$133.44	
L2387	RB	Addition To Lower Extremity, Polycentric Knee Joint, For Custom Fab KAFO, Each Joint	MN	MP	
L2390	NU	Addition Offset Knee Joint Each Joint	MN	$35.00	
L2390	RB	Addition Offset Knee Joint Each Joint	MN	MP	
L2395	NU	Addition Offset Knee Joint Heavy Duty Each Joint	MN	$40.00	
L2397	NU	Addition To Lower Extremity Orthosis Suspension Sleeve	MN	$88.00	
L2405	NU	Addition Drop Lock Each Joint	MN	$35.00	
L2415	NU	Addition To Knee Lock W/Integrated Release Mechanism (Bail Cable Or Equal) Any Material Each Joint	MN	$96.25	
L2425	NU	Addition To Knee Joint Disc Or Dial Lock For Adjustable Knee Flexion Each Joint	MN	$100.00	
L2430	NU	Addition To Knee Joint Ratchet Lock For Active And Progressive Knee Extension Each Joint	MN	$73.64	
L2492	NU	Addition To Knee Joint Lift Loop For Drop Lock Ring	MN	$71.77	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2500	NU	Addition To Lower Extremity Thigh/Weight Bearing Gluteal/Ischial Weight Bearing Ring	MN	$185.00	
L2510	NU	Addition To Lower Extremity Thigh/Weight Bearing Quadrilateral Brim Molded To Patient Model	MN	$350.00	
L2520	NU	Addition Quadrilateral Brim Custom Fitted	MN	$225.00	
L2525	NU	Addition To Lower Extremity Thigh/Weight Bearing Ischial Containment/Narrow M-L Brim Molded To Patient	MN	$350.00	
L2526	NU	Addition To Lower Extremity Thigh/Weight Bearing Ischial Containment/Narrow M-L Brim Custom Fittee	MN	$225.00	
L2530	NU	Addition Thigh Weight Bearing Lacer Non Molded	MN	$75.00	
L2540	NU	Addition Thigh Weight Bearing Lacer Molded To Patient	MN	$200.00	
L2550	NU	Addition Thigh Weight Bearing High Roll Cuff	MN	$75.00	
L2570	NU	Addition To Lower Extremity Pelvic Control Hip Joint Clevis Type Two Position Joint Each	MN	$175.00	
L2580	NU	Addition To Lower Extremity Pelvic Control Pelvic Sling	MN	$326.66	
L2600	NU	Addition To Lower Extremity Pelvic Control Hip Joint Clevis Type Or Thrust Bearing Free Each	MN	$75.00	
L2610	NU	Addition To Lower Extremity Pelvic Control Hip Joint Clevis Or Thrust Bearing Lock Each	MN	$90.00	
L2620	NU	Addition To Lower Extremity Pelvic Control Hip Joint Heavy Duty Each	MN	$110.00	
L2622	NU	Addition To Lower Extremity Pelvic Control Hip Joint Adjustable Flexion Each	MN	$125.00	
L2624	NU	Addition To Lower Extremity Pelvic Control Hip Joint Adjustable Flexion Extension Abduction Control	MN	$175.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2627	NU	Addition To Lower Extremity Pelvic Control Plastic Molded To Patient Model Reciprocating Hip Joint	MN	$850.00	
L2628	NU	Addition To Lower Extremity Pelvic Control Metal Frame Reciprocating Hip Joint And Cables	MN	$850.00	
L2630	NU	Addition To Lower Extremity Pelvic Control Band And Belt Unilateral	MN	$110.00	
L2640	NU	Addition To Lower Extremity Pelvic Control Band And Belt Bilateral	MN	$110.00	
L2650	NU	Addition To Lower Extremity Pelvic And Thoracic Control Gluteal Pad Each	MN	$104.27	
L2660	NU	Addition To Lower Extremity Thoracic Control Thoracic Band	MN	$110.00	
L2670	NU	Addition To Lower Extremity Thoracic Control Paraspinal Uprights	MN	$30.00	
L2680	NU	Addition To Lower Extremity Thoracic Control Lateral Support Uprights	MN	$30.00	
L2750	NU	Addition To Lower Extremity Orthosis Plating Chrome Or Nickel Per Bar	MN	$64.97	
L2755	NU	High Strength Lightweight Lower Extremity Orthosis	MN	$97.87	
L2760	NU	Addition To Lower Extremity Orthosis Extension Per Extension Per Bar (For Lineal Adjustment For Growth)	MN	$20.00	
L2780	NU	Addition To Lower Extremity Orthosis Non-Corrosive Finish Per Bar	MN	$45.00	
L2785	NU	Addition To Lower Extremity Orthosis Drop Lock Retainer Each	MN	$15.00	
L2795	NU	Addition To Lower Extremity Orthosis Knee Control Full Kneecap	MN	$35.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L2800	NU	Knee Control Knee Cap Medial Or Lateral Lower Extremity Orthosis	MN	$40.00	
L2810	NU	Addition To Lower Extremity Orthosis Knee Control Condylar Pad	MN	$25.00	
L2820	NU	Addition To Lower Extremity Orthosis Soft Interface For Molded Plastic Below Knee Section	MN	$60.00	
L2830	NU	Addition To Lower Extremity Orthosis Soft Interface For Molded Plastic Above Knee Section	MN	$50.00	
L2840	NU	Addition To Lower Extremity Orthosis Tibial Length Sock Fracture Or Equal Each	MN	$31.82	
L2850	NU	Addition To Lower Extremity Orthosis Femoral Length Sock Fracture Or Equal Each	MN	$58.11	
L2861	NU	Torsion Mechanism, Knee/Ankle	MN, IOC	MP	
L2999	NU	Lower Extremity Orthoses Not Otherwise Specified	PA	MP	
L3000	NU	Foot Insert Removable Molded To Patient Model "UCB" Type Berkeley Shell Each	MN	$90.00	
L3001	NU	Foot Insert Removable Molded To Patient Model Spenco Each	MN	$25.00	
L3002	NU	Foot Insert Removable Molded To Patient Model Plastazote Or Equal Each	MN	$43.00	
L3003	NU	Foot Insert Removable Molded To Patient Model Silicone Gel Each	MN	$75.00	
L3010	NU	Foot Insert Removable Molded To Patient Model Longitudinal Arch Support Each	MN	$85.00	
L3020	NU	Foot Insert Removable Molded To Patient Model Longitudinal/ Metatarsal Support Each	MN	$85.00	
L3030	NU	Foot Insert Removable Formed To Patient Foot Each	MN	$45.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3031	NU	Foot Lamination/Prepreg Composite	MN	$38.76	
L3040	NU	Foot Arch Support Removable Premolded Longitudinal Each	MN	$24.00	
L3050	NU	Foot Arch Support Removable Premolded Metatarsal Each	MN	$24.00	
L3060	NU	Foot Arch Support Removable Premolded Longitudinal/Metatarsal Each	MN	$24.00	
L3070	NU	Foot Arch Support Non-Removable Attached To Shoe Longitudinal Each	MN	$10.00	
L3080	NU	Foot Arch Support Non-Removable Attached To Shoe Metatarsal Each	MN	$10.00	
L3090	NU	Foot Arch Support Non-Removable Attached To Shoe Longitudinal/Metatarsal Each	MN	$12.00	
L3100	NU	Hallus-Valgus Night Dynamic Splint	MN	$25.00	
L3140	NU	Foot Abduction Rotation Bar Including Shoes	MN	$30.00	
L3150	NU	Foot Abduction Rotation Bar W/o Shoes	MN	$30.00	
L3160	NU	Foot Adjustable Shoe-Styled Positioning Device	MN	$13.98	
L3170	NU	Foot Plastic Heel Stabilizer	MN	$6.00	
L3201	NU	Orthopedic Shoe Oxford W/Supinator Or Pronator Infant Each	MN	$36.00	
L3202	NU	Orthopedic Shoe Oxford W/Supinator Or Pronator Child Each	MN	$36.00	
L3203	NU	Orthopedic Shoe Oxford W/Supinator Or Pronator Junior Each	MN	$36.00	
L3204	NU	Orthopedic Shoe Hightop W/Supinator Or Pronator Infant Each	MN	$36.00	
L3206	NU	Orthopedic Shoe Hightop W/Supinator Or Pronator Child Each	MN	$36.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3207	NU	Orthopedic Shoe Hightop W/Supinator Or Pronator Junior Each	MN	$36.00	
L3208	NU	Surgical Boot Each Infant	MN	$25.00	
L3209	NU	Surgical Boot Each Child	MN	$25.00	
L3211	NU	Surgical Boot Each Junior	MN	$25.00	
L3212	NU	Benesch Boot Pair Infant	MN	$55.00	
L3213	NU	Benesch Boot Pair Child	MN	$55.00	
L3214	NU	Benesch Boot Pair Junior	MN	$55.00	
L3215	NU	Orthopedic Footwear Ladies Shoes Oxford, Each	MN	$40.00	
L3216	NU	Orthopedic Footwear Ladies Shoes Depth Inlay, Each	MN	$47.50	
L3217	NU	Orthopedic Footwear Ladies Shoes Hightop Depth Inlay, Each	MN	$90.00	
L3219	NU	Orthopedic Footwear Mens Shoes Oxford, Each	MN	$40.00	
L3221	NU	Orthopedic Footwear Mens Shoes Depth Inlay, Each	MN	$47.50	
L3222	NU	Orthopedic Footwear Mens Shoes Hightop Depth Inlay, Each	MN	$45.00	
L3224	NU	Orthopedic Footwear Woman's Shoe Oxford Used As an Integral Part Of A Brace (Orthosis)	MN	$40.00	
L3225	NU	Orthopedic Footwear Man's Shoe Oxford Used As An Integral Part Of A Brace (Orthosis)	MN	$40.00	
L3230	NU	Orthopedic Footwear Custom Shoes Depth Inlay, Each	MN	$40.00	
L3250	NU	Orthopedic Footwear Custom Molded Shoe Removable Inner Mold Prosthetic Shoe, Each	PA	MP	
L3251	NU	Foot Shoe Molded To Patient Model Silicone Shoe Each	PA	MP	
L3252	NU	Foot Shoe Molded To Patient Model Plastazote (Or Similar) Custom Fabricated Each	PA	MP	
L3253	NU	Foot Molded Shoe Plastazote (Or Similar) Custom Fitted	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Each			
L3254	NU	Non-Standard Size Or Width	PA	MP	
L3255	NU	Non-Standard Size Or Length	PA	MP	
L3260	NU	Ambulatory Surgical Boot Each	MN	$50.00	
L3300	NU	Lift Elevation Heel Tapered To Metatarsals Per Inch	MN	$25.00	
L3310	NU	Lift Elevation Heel And Sole Neoprene Per Inch	MN	$40.00	
L3320	NU	Lift Elevation Heel And Sole Cork Per Inch	MN	$85.00	
L3330	NU	Lift Elevation Metal Extension (Skate)	MN	$485.63	
L3332	NU	Lift Elevation Inside Shoe Tapered Up To One-Half Inch	MN	$25.00	
L3334	NU	Lift Elevation Heel Per Inch	MN	$18.00	
L3340	NU	Heel Wedge Sach	MN	$25.00	
L3350	NU	Heel Wedge	MN	$15.00	
L3360	NU	Sole Wedge Outside Sole	MN	$15.00	
L3370	NU	Sole Wedge Between Sole	MN	$20.00	
L3380	NU	Clubfoot Wedge	MN	$12.00	
L3390	NU	Outflare Wedge	MN	$18.00	
L3400	NU	Metatarsal Bar Wedge Rocker	MN	$8.00	
L3410	NU	Metatarsal Bar Wedge Between Sole	MN	$12.00	
L3420	NU	Full Sole And Heel Wedge Between Sole	MN	$36.00	
L3430	NU	Heel Counter Plastic Reinforced	MN	$24.00	
L3440	NU	Heel Counter Leather Reinforced	MN	$24.00	
L3450	NU	Heel Sach Cushion Type	MN	$25.00	
L3455	NU	Heel New Leather Standard	MN	$18.00	
L3460	NU	Heel New Rubber Standard	MN	$15.00	
L3465	NU	Heel Thomas W/Wedge	MN	$20.00	
L3470	NU	Heel Thomas Extended To Ball	MN	$24.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3480	NU	Heel Pad And Depression For Spur	MN	$8.00	
L3485	NU	Heel Pad Removable For Spur	MN	$15.00	
L3500	NU	Orthopedic Shoe Addition; Insole Leather	MN	$23.42	
L3510	NU	Insole Rubber	MN	$23.42	
L3520	NU	Insole Felt Covered W/Leather	MN	$22.40	
L3530	NU	Sole Half	MN	$18.00	
L3540	NU	Sole Full	MN	$24.00	
L3550	NU	Toe Tap Standard	MN	$7.16	
L3560	NU	Toe Tap Horseshoe	MN	$10.00	
L3570	NU	Special Ext To Instep (Leather W/Eyelets)	MN	$24.00	
L3580	NU	Convert Instep To Velcro Closure	MN	$18.00	
L3590	NU	Convert Firm Shoe Counter To Soft Counter	MN	$38.00	
L3595	NU	March Bar	MN	$29.57	
L3600	NU	Transfer Of Orthosis From One Shoe To Another Caliper Plate Existing	MN	$35.00	
L3610	NU	Transfer Caliper Plate New	MN	$45.00	
L3620	NU	Transfer Solid Stirrup Existing	MN	$35.00	
L3630	NU	Transfer Solid Stirrup New	MN	$45.00	
L3640	NU	Transfer Dennis Browne Splint (Riveton) Both Shoes	MN	$18.00	
L3649	NU	Orthopedic Shoe Modification Addition Or Transfer Not Otherwise Specified	PA	MP	
L3650	NU	Shoulder Orthosis (SO) Figure Of "8" Design Abduction Restrainer	MN	$37.00	
L3650	RB	Shoulder Orthosis (SO) Figure Of "8" Design Abduction Restrainer	MN	MP	
L3660	NU	SO Figure Of "8" Design Abduction Restrainer Canvas & Webbing Prefabricated Includes Fitting & Adjustment	MN	$88.65	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3660	RB	SO Figure Of "8" Design Abduction Restrainer Canvas And Webbing	MN	MP	
L3670	NU	SO Acromio/Clavicular (Canvas & Webbing Type) Prefabricated Includes Fitting & Adjustment	MN	$103.85	
L3670	RB	SO Acromio/Clavicular (Canvas & Webbing Type) Prefabricated Includes Fitting & Adjustment	MN	MP	
L3671	NU	Shoulder Orthosis, Shoulder Cap Design, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$703.67	
L3671	RB	Shoulder Orthosis, Shoulder Cap Design, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3672	NU	Shoulder Orthosis, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$875.10	
L3672	RB	Shoulder Orthosis, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3673	NU	Shoulder Orthosis, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes Nontorsion Joint/Turnbuckle, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$953.76	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3673	RB	Shoulder Orthosis, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes Nontorsion Joint/Turnbuckle, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3674	NU	SO Airplane W/Wo Joint CF	MN	$934.43	
L3675	NU	Vest Type Abduction Restrainer Canvas Webbing Type Or Equal	MN	$105.00	
L3702	NU	Elbow Orthosis (EO) W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$225.52	
L3702	RB	Elbow Orthosis (EO) W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3710	NU	EO Elastic W/Metal Joints	MN	$45.00	
L3710	RB	EO Elastic W/Metal Joints	MN	MP	
L3720	NU	EO Double Upright W/Forearm/Arm Cuffs Free Motion	MN	$325.00	
L3720	RB	EO Double Upright W/Forearm/Arm Cuffs Free Motion	MN	MP	
L3730	NU	EO Double Upright W/Forearm/Arm Cuffs Extension/ Flexion Assist	MN	$325.00	
L3730	RB	EO Double Upright W/Forearm/Arm Cuffs Extension/ Flexion Assist	MN	MP	
L3740	NU	EO Double Upright W/Forearm/Arm Cuffs Adjustable Position Lock W/Active Control Custom Fabricated	MN	$782.04	
L3740	RB	EO Double Upright W/Forearm/Arm Cuffs Adjustable Position Lock W/Active Control	MN	MP	
L3760	NU	EO W/Adjustable Position Locking Joint(s) Prefabricated Includes Fitting And Adjustment	MN	$364.60	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3762	NU	Rigid EO W/o Joints	MN	$78.40	
L3763	NU	Elbow Wrist Hand Orthosis; Rigid, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$554.43	
L3763	RB	Elbow Wrist Hand Orthosis; Rigid, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3764	NU	Elbow Wrist Hand Orthosis; Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$582.94	
L3764	RB	Elbow Wrist Hand Orthosis; Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3765	NU	Elbow Wrist Hand Finger Orthosis, Rigid, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,001.39	
L3765	RB	Elbow Wrist Hand Finger Orthosis, Rigid, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3766	NU	Elbow Wrist Hand Finger Orthosis, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,060.39	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3766	RB	Elbow Wrist Hand Finger Orthosis, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN, IOC	MP	
L3806	NU	Wrist Hand Finger Orthoses (WHFO), Includes One or More Nontorsion Joint(s), Elastic Bands, Turnbuckles	MN, IOC	MP	
L3806	RB	Wrist Hand Finger Orthoses (WHFO), Includes One or More Nontorsion Joint(s), Elastic Bands, Turnbuckles	MN, IOC	MP	
L3808	NU	WHFO, Rigid W/o Joints	MN, IOC	MP	
L3891	NU	Torsion Mechanism, Wrist/Elbow	MN, IOC	MP	
L3900	NU	WHFO Dynamic Flexor Hinge Recip Wrist Exten/Flex Finger Flexion/Exten Wrist Or Finger Driven Custom Fabricated	MN	$845.00	
L3901	NU	WHFO Dynamic Flexor Hinge Recip Wrist Exten/Flex Finger Flex/Exten Cable Driven Custom Fabricated	MN	$1,291.93	
L3905	NU	Wrist Hand Orthosis (WHO), Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$352.09	
L3905	RB	Wrist Hand Orthosis (WHO), Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3906	NU	WHO Wrist Gauntlet Custom Fabricated	MN	$291.24	
L3906	RB	WHO Wrist Gauntlet Molded To Patient Model	MN	MP	
L3908	NU	WHO Wrist Extension Control Cock-Up Nonmolded	MN	$20.00	
L3908	RB	WHO Wrist Extension Control Cock-Up Nonmolded	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3912	NU	Hand Finger Orthosis (HFO) Flexion Glove W/Elastic Finger Control Prefabricated Includes Fitting & Adjustment	MN	$80.80	
L3912	RB	Hand Finger Orthosis (HFO) Flexion Glove W/Elastic Finger Control Prefabricated Includes Fitting & Adjustment	MN	MP	
L3913	NU	HFO, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$211.51	
L3913	RB	HFO, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3915	NU	WHO, Includes One or More Nontorsion Joint(s), Elastic Bands, Turnbuckles	MN	$415.15	
L3915	RB	WHO, Includes One or More Nontorsion Joint(s), Elastic Bands, Turnbuckles	MN, IOC	MP	
L3917	NU	Prefab Metacarpal Fx Orthosis	MN	$77.00	
L3919	NU	Hand Orthosis (HO), W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$211.51	
L3919	RB	Hand Orthosis (HO), W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3921	NU	HFO, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$250.84	
L3921	RB	HFO, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3923	NU	Hand Finger Orthosis W/o Joint(s) Prefabricated Includes Fitting And Adjustment Any Type	MN	$28.07	
L3925	NU	Finger Orthosis (FO) PIP/DIP W/Joint Spring	MN	$50.14	
L3925	RB	Finger Orthosis (FO) PIP/DIP W/Joint Spring	MN,IOC	MP	
L3927	NU	FO PIP/DIP W/o Joint Spring	MN	$27.33	
L3927	RB	FO PIP/DIP W/o Joint Spring	MN, IOC	MP	
L3929	NU	HFO Nontorsion Joint, Prefabricated, Includes Fitting and Adjustment	MN	$79.50	
L3929	RB	HFO, Nontorsion Joint Prefabricated, Includes Fitting and Adjustment	MN, IOC	MP	
L3931	NU	WHFO Nontorsion Joint Prefabricated Includes Fitting And Adjustment	MN	$176.83	
L3931	RB	WHFO Nontorsion Joint, Prefabricated, Includes Fitting And Adjustment	MN, IOC	MP	
L3933	NU	FO, W/o Joints, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment	MN	$166.63	
L3933	RB	FO, W/o Joints, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3935	NU	FO, Nontorsion Joint, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment	MN	$172.54	
L3935	RB	FO, Nontorsion Joint, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3956	NU	Addition Of Joint To Upper Extremity Orthosis Any Material; Per Joint	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3960	NU	Shoulder-Elbow-Wrist-Hand Orthosis (SEWHO) Abduction Positioning Airplane Design Prefabricated Includes Fitting and Adjustment	MN	$554.80	
L3960	RB	Shoulder-Elbow-Wrist-Hand Orthosis (SEWHO) Abduction Positioning Airplane Design Prefabricated Includes Fitting and Adjustment	MN	MP	
L3961	NU	SEWHO, Shoulder Cap Design, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,312.10	
L3961	RB	SEWHO, Shoulder Cap Design, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3967	NU	SEWHO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,549.15	
L3967	RB	SEWHO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3971	NU	SEWHO, Shoulder Cap Design, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,470.48	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3971	RB	SEWHO, Shoulder Cap Design, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3973	NU	SEWHO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,549.15	
L3973	RB	SEWHO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3975	NU	SEWHFO, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,312.10	
L3975	RB	SEWHFO, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3976	NU	SEWHFO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,312.10	
L3976	RB	SEWHFO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, W/o Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L3977	NU	SEWHFO, Shoulder Cap Design, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,470.48	
L3977	RB	SEWHFO, Shoulder Cap Design, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3978	NU	SEWHFO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	$1,549.15	
L3978	RB	SEWHFO, Abduction Positioning (Airplane Design), Thoracic Component And Support Bar, Includes One Or More Nontorsion Joints, Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment	MN	MP	
L3980	NU	Upper Extremity Fracture Orthosis Humeral	MN	$89.50	
L3980	RB	Upper Extremity Fracture Orthosis Humeral	MN	MP	
L3982	NU	Upper Extremity Fracture Orthosis Radius/Ulnar	MN	$89.50	
L3982	RB	Upper Extremity Fracture Orthosis Radius/Ulnar	MN	MP	
L3984	NU	Upper Extremity Fracture Orthosis Wrist	MN	$60.00	
L3984	RB	Upper Extremity Fracture Orthosis Wrist	MN	MP	
L3999	NU	Upper Limb Orthosis Not Otherwise Specified	PA	MP	
L4000	RB	Replace Girdle For Milwaukee Orthosis	MN	$700.00	
L4002	NU	Replacement Strap For An Orthosis Includes All Components And Length Any Type	MN, IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L4010	RB	Replace Trilateral Socket Brim	MN	$350.00	
L4020	RB	Replace Quadrilateral Socket Brim Molded To Patient Model	MN	$400.00	
L4030	RB	Replace Quadrilateral Socket Brim Custom Fitted	MN	$325.00	
L4040	RB	Replace Molded Thigh Lacer	MN	$250.00	
L4045	RB	Replace Non-Molded Thigh Lacer For Custom Fabricated Orthosis	MN	$175.00	
L4050	RB	Replace Molded Calf Lacer For Custom Fabricated Orthosis Only	MN	$250.00	
L4055	RB	Replace Non/Molded Calf Lacer For Custom Fabricated Orthosis Only	MN	$150.00	
L4060	RB	Replace High Roll Cuff	MN	$110.00	
L4070	RB	Replace Proximal And Distal Upright For KAFO	MN	$180.00	
L4080	RB	Replace Metal Bands KAFO Proximal Thigh	MN	$90.00	
L4090	RB	Replace Metal Bands KAFO-AFO Calf Or Distal Thigh	MN	$72.00	
L4100	RB	Replace Leather Cuff KAFO Proximal Thigh	MN	$75.00	
L4110	RB	Replace Leather Cuff KAFO-AFO Calf Or Distal Thigh	MN	$67.82	
L4130	RB	Replace Pretibial Shell	MN	$400.00	
L4386	NU	Non-Pneumatic Walking Splint	MN	$127.02	
L4390	RB	Replace Soft Interface Material Multi-Podus Type Splint	MN	MP	
L4392	RB	Replace Soft Interface Material Static AFO	MN	MP	
L4394	RB	Replace Soft Interface Material Foot Drop Splint	MN	MP	
L4396	NU	Static AFO Including Soft Interface Material For Positioning Pressure Reduction May Be Used For Minimal Ambulation	MN	$121.24	
L4398	NU	Foot Drop Splint Recumbent Positioning Device Prefabricated Includes Fitting And Adjustment	MN	$55.81	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L4631	NU	AFO, Walk Boot Type, Cus Fab	PA	$1,250.07	
OSTOMY SUPPLIES					
A4247	NU	Betadine Or Iodine Swabs/Wipes Per Box		$22.00	
A4331	NU	Extension Drainage Tubing Any Type Any Length W/Connector/Adaptor For Use W/Urinary Leg Bag Or Urostomy Pouch, Each		$3.18	1/30
A4357	NU	Bedside Drainage Bag Day Or Night W/Wo Anti-Reflux Device W/Wo Tube Each		$9.70	2/30
A4361	NU	Ostomy Faceplate Each		$15.61	3/180
A4362	NU	Skin Barrier; Solid 4x4 Or Equivalent; Each		$3.46	20/30
A4363	NU	Ostomy Clamp, Any Type, Replacement Only, Each		$2.36	
A4364	NU	Adhesive Liquid Or Equal Any Type Per Ounce Only Per Ounce		$2.93	4/30
A4366	NU	Ostomy Vent Any Type Each		$1.30	10/30
A4367	NU	Ostomy Belt Each		$7.35	1/30
A4368	NU	Ostomy Filter Any Type Each		$0.26	30/30
A4369	NU	Ostomy Skin Barrier Liquid (Spray Brush Etc) Per Oz		$2.06	2/30
A4371	NU	Ostomy Skin Barrier Powder Per Oz		$3.60	10/180
A4372	NU	Skin Barrier Solid 4x4 Equivalent		$4.18	20/30
A4373	NU	Skin Barrier W/Flange		$6.28	20/30
A4375	NU	Ostomy Pouch Drainable W/Faceplate Attached Plastic Each		$17.18	2/30
A4376	NU	Ostomy Pouch Drainable W/Faceplate Attached Rubber Each		$47.58	1/30
A4377	NU	Ostomy Pouch Drainable For Use On Faceplate Plastic Each		$4.29	10/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4378	NU	Ostomy Pouch Drainable For Use On Faceplate Rubber Each		$30.75	4/30
A4379	NU	Ostomy Pouch Urinary W/Faceplate Attached Plastic Each		$15.02	4/30
A4380	NU	Ostomy Pouch Urinary W/Faceplate Attached Rubber Each		$37.33	4/30
A4381	NU	Ostomy Pouch Urinary For Use On Faceplate Plastic Each		$4.61	10/30
A4382	NU	Ostomy Pouch Urinary For Use On Faceplate Heavy Plastic Each		$24.62	4/30
A4383	NU	Ostomy Pouch Urinary For Use On Faceplate Rubber Each		$28.19	4/30
A4384	NU	Ostomy Faceplate Equivalent Silicone Ring Each		$9.62	4/30
A4385	NU	Ostomy Skin Barrier Solid 4x4 Or Equivalent Extended Wear W/o Built-In Convexity Each		$5.10	4/30
A4387	NU	Ostomy Pouch Closed W/Barrier W/Built-In Convexity 1 Piece Each		$3.97	10/30
A4388	NU	Drainable Pouch W/Extended Wear Barrier		$4.36	10/30
A4389	NU	Drainable Pouch W/Standard Wear Barrier		$6.22	10/30
A4390	NU	Ostomy Pouch Drainable W/Extended Wear Barrier Attached W/Built-In Convexity (1 Piece) Each		$9.61	10/30
A4391	NU	Ostomy Pouch Urinary W/Extended Wear Barrier Attached 1 Piece Each		$6.99	8/30
A4392	NU	Ostomy Pouch Urinary W/Standard Wear Barrier Attached W/Built-In Convexity (1 Piece) Each		$6.57	10/30
A4393	NU	Ostomy Pouch Urinary W/Extended Wear Barrier Attached W/Built-In Convexity (1 Piece) Each		$9.04	10/60
A4396	NU	Ostomy Belt W/Peristomal Hernia Support		$40.48	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4397	NU	Irrigation Supply; Sleeve Each		$4.79	4/30
A4398	NU	Ostomy Irrigation Supply; Bag Each		$13.81	2/180
A4399	NU	Ostomy Irrigation Supply; Cone/Catheter Including Brush		$10.42	1/90
A4400	NU	Ostomy Irrigation Set		$45.32	1/90
A4402	NU	Lubricant Per Ounce		$1.53	4/30
A4404	NU	Ostomy Ring Each		$1.69	10/30
A4405	NU	Non-Pectin Based Ostomy Paste		$3.40	4/30
A4406	NU	Pectin-Based Ostomy Paste		$5.74	4/30
A4407	NU	Ostomy Skin Barrier W/Flange Solid Flexible Accordion Extended Wear W/Built-In Convexity 4x4 Or Smaller Each		$8.76	10/30
A4408	NU	Ostomy Skin Barrier W/Flange Solid Flexible Accordion Extended Wear W/Built-In Convexity Larger Than 4x4 Inches Each		$9.87	10/30
A4409	NU	Ostomy Skin Barrier W/Flange (Solid Flex Or Accordion) Extended Wear W/o Built-In Convexity 4x4 Inches Or Smaller Each		$6.22	10/30
A4410	NU	Ostomy Skin Barrier W/Flange (Solid Flex Or Accordion) Extended Wear W/o Built-In Convexity Larger Than 4x4 Inches Each		$9.04	10/30
A4411	NU	Ostomy Skin Barrier, Solid, 4X4, Or Equivalent, Extended Wear, W/Built-In Convexity, Each	IOC	MP	10/30
A4412	NU	Ostomy Pouch, Drainable, High Output, For Use On A Barrier W/Flange (2 Piece System), W/o Filter, Each	IOC	MP	20/30
A4413	NU	Ostomy Pouch Drainable High Output For Use On A Barrier W/Flange (2 Piece System) W/Filter Each		$5.50	20/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4414	NU	Ostomy Skin Barrier W/Flange Solid Flex Accordion W/o Convexity 4x4 Each		$4.93	20/30
A4415	NU	Ostomy Skin Barrier W/Flange Solid Flex Accordion W/o Convexity Larger Than 4x4 Inches Each		$6.00	20/30
A4416	NU	Ostomy Pouch Closed W/Barrier/Filter		$2.75	60/30
A4417	NU	Ostomy Pouch W/Bar/Built-In Convexity/Filter		$3.72	60/30
A4418	NU	Ostomy Pouch Closed W/o Barrier W/Filter		$1.81	60/30
A4419	NU	Ostomy Pouch Closed For Barrier W/Non-Locking Flange/Filter		$1.74	60/30
A4420	NU	Ostomy Pouch Closed For Barrier W/Locking Flange		$1.26	60/30
A4421	NU	Ostomy Supply Miscellaneous	IOC	MP	
A4422	NU	Ostomy Pouch Absorbent Material Each		$0.12	30/30
A4423	NU	Ostomy Pouch For Barrier W/Locking Flange/Filter		$1.86	60/30
A4424	NU	Ostomy Pouch Drain W/Barrier & Filter		$4.75	20/30
A4425	NU	Ostomy Pouch Drain For Barrier W/Non-Locking Flange/Filter		$3.58	20/30
A4426	NU	Ostomy Pouch Drain 2 Piece System		$2.36	20/30
A4427	NU	Ost Pch Drain/Barrier Locking Flange/Filter		$2.31	20/30
A4428	NU	Urine Ostomy Pouch W/Faucet/Tap		$6.51	20/30
A4429	NU	Urine Ostomy Pouch W/Built-In Convexity		$7.52	20/30
A4430	NU	Ostomy Urine Pouch W/Built-In Convexity		$8.52	20/30
A4431	NU	Ostomy Pouch Urine W/Barrier/Tap		$5.08	20/30
A4432	NU	Ostomy Pouch Urine W/Barrier/Flange/Tap		$3.59	20/30
A4433	NU	Urine Ostomy Pouch Barrier W/Locking Flange		$3.34	20/30
A4434	NU	Ostomy Pouch Urine W/Locking Flange/Faucet		$3.76	20/30
A4435	NU	1 Pc Ost Pch Drain High Output		$6.26	20/30
A4450	NU	Non-Waterproof Tape Per 18 Sq Inches		$0.09	40/30

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A4452	NU	Waterproof Tape Per 18 Sq Inches		$0.36	40/30
A5051	NU	Pouch Closed W/Barrier Attached 1 Piece Each		$2.07	60/30
A5052	NU	Closed Ostomy Pouch W/o Barrier 1 Piece Each		$1.49	60/30
A5053	NU	Closed Ostomy Pouch Faceplate Each		$1.74	60/30
A5054	NU	Closed Ostomy Pouch W/Flange (2 Piece) Each		$1.67	60/30
A5055	NU	Stoma Cap		$1.44	31/30
A5056	NU	Ostomy Pouch Drainable W/Extended Wear Barrier Attached W/Filter		$4.83	10/30
A5057	NU	Ostomy Pouch Drainable W/Extended Wear Barrier Attached W/Built-In Convexity		$9.96	10/30
A5061	NU	Pouch Drainable W/Barrier Attached Each		$2.63	20/30
A5062	NU	Drainable Ostomy Pouch W/o Barrier Each		$2.20	20/30
A5063	NU	Drainable Ostomy Pouch W/Flange Each		$2.21	20/30
A5071	NU	Ostomy Pouch W/Barrier Each		$4.30	20/30
A5072	NU	Urinary Pouch W/o Barrier Each		$3.52	20/30
A5073	NU	Urinary Pouch On Barrier W/Flange Each		$3.15	20/30
A5081	NU	Continent Device; Plug For Continet Stoma		$3.30	31/30
A5082	NU	Continent Device; Catheter For Continent Stoma		$10.87	1/30
A5083	NU	Continent Device, Stoma Absorptive Cover For Continent Stom	IOC	MP	31/30
A5093	NU	Ostomy Accessory; Convex Insert		$1.95	10/30
A5102	NU	Bedside Drainage Bottle W/Wo Tubing Rigid Or Expandable Each		$22.58	2/180
A5112	NU	Urinary Leg Bag; Latex		$31.72	1/30
A5113	NU	Leg Strap; Latex Replacement Only Per Set		$4.70	1/30
A5114	NU	Leg Strap; Foam Or Fabric Replacement Only Per Set		$8.94	1/30
A5120	NU	Skin Barrier, Wipes Or Swabs, Each		$0.25	150/180

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
A5121	NU	Skin Barrier; Solid 6x6 Or Equivalent Each		$7.46	20/30
A5122	NU	Skin Barrier; Solid 8x8 Or Equivalent Each		$12.85	20/30
A5126	NU	Adhesive Or Non-Adhesive; Disk Or Foam Pad		$1.32	20/30
OXYGEN AND RESPIRATORY EQUIPMENT					
A4618	NU	Breathing Circuits	MNF	$4.75	
A7027	NU	Combination Oral/Nasal Mask, Used W/Continuous Positive Airway Pressure Device, Each		$186.52	1/180
A7028	NU	Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each		$49.54	1/180
A7029	NU	Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair		$20.24	1/60
A7030	NU	Full Face Mask Used W/Positive Airway Pressure Device, Each	MNF	$164.74	1/180
A7031	NU	Face Mask Interface, Replacement For Full Face Mask, Each	MNF	$60.93	1/180
A7032	NU	Replacement Cushion For Nasal Application Device, Each	MNF	$35.40	1/180
A7033	NU	Replacement Pillows For Nasal Application Device, Pair	MNF	$24.81	1/60
A7034	NU	Nasal Interface (Mask Or Cannula Type) Used W/Positive Airway Pressure Device, W/Wo Head Strap	MNF	$102.73	1/180
A7035	NU	Headgear Used W/Positive Airway Pressure Device	MNF	$34.71	1/180
A7036	NU	Chinstrap Used W/Positive Airway Pressure Device	MNF	$15.89	1/180
A7037	NU	Tubing Used W/Positive Airway Pressure Device	MNF	$35.82	1/180
A7038	NU	Filter, Disposable, Used W/Positive Airway Pressure Device	MNF	$4.71	2/30
A7039	NU	Filter, Non-Disposable, Used W/Positive Airway Pressure	MNF	$13.38	1/180

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Device			
A7044	NU	Oral Interface Used W/Positive Airway Pressure Device, Each	MNF	$105.59	1/180
A7045	NU	Exhalation Port W/Wo Swivel Used W/Accessories For Positive Airway Devices, Replacement Only	MNF	$17.00	1/180
A7046	NU	Water Chamber For Humidifier, Used W/Positive Airway Pressure Device, Replacement, Each	MNF	$17.04	
E0424	RR	Stationary Gas Oxygen System Rental	PC	$90.00	
E0424	RR QF	Stationary Gas Oxygen System Rental	PC	$135.00	
E0424	RR QG	Stationary Gas Oxygen System Rental	PC	$135.00	
E0431	RR	Portable Gas Oxygen System Rental	PC	$150.00	
E0434	RR	Portable Liquid Oxygen System Rental	PC	$150.00	
E0439	RR	Stationary Liquid System Rental	PC	$90.00	
E0439	RR QF	Stationary Liquid System Rental, > 4 LPM, W/ Portable Oxygen Prescribed	PC	$135.00	
E0439	RR QG	Stationary Liquid System Rental, > 4 LPM	PC	$135.00	
E0441	NU	Oxygen Contents, Gaseous (For Use W/Owned Gaseous Stationary System Or When Both A Stationary And Portable Gaseous System Are Owned)	PC	$74.74	one month supply = one unit
E0442	NU	Oxygen Contents, Liquid (For Use W/Owned Liquid Stationary System)	PC	$74.74	one month supply = one unit
E0443	NU	Portable Oxygen Contents, Gaseous (For Use W/Portable Gaseous System When No Stationary Gas Or Liquid System Is Used)	PC	$74.74	one month supply = one unit
E0444	NU	Portable Oxygen Contents, Liquid (For Use W/Portable Liquid System When No Stationary Gas Or Liquid System Is Used)	PC	$74.74	one month supply = one unit

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0450	RR TW	Volume Control Ventilator Invasive Interface	PC	$412.50	back up for vol. vent
E0450	RR	Volume Control Ventilator Invasive Interface	PC	$825.00	
E0463	RR TW	Pressure Support Ventilator Invasive Interface	PC	$703.19	
E0463	RR	Pressure Support Ventilator Invasive Interface	PC	$1,406.38	
E0470	RB	Respiratory Assist Device Bipap St For Purchase Of Supplies Or Repair Of Patient Owned Device	PA	MP	
E0470	RR	Respirator Assist Device Bilevel W/o Backup Rate Bipaps	PC Sleep Study	$196.08	Months 1-3 Rent to purchase. Reimubursement not to exceed $2,352.96
E0470	RR KJ	Respiratory Assist Device Bilevel W/o Backup Rate Bipaps	PC Use of Device	$196.08	Months 4-12 Rent to purchase. Reimubursement not to exceed $2,352.96.
E0471	RB	Respiratory Assist Device Bipap St Used For Purchase Of Supplies Or Repair Of Patient Owned Device	MN, IOC	MP	
E0471	RR	Respiratory Assist Device Bilevel W/Backup Bipaps	PC	$490.71	Rent to purchase. Reimubursement not to exceed $5,888.52.

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0471	RR KJ	Respiratory Assist Device Bilevel W/Backup Bipaps	PC	$490.71	Rent to purchase. Reimubursement not to exceed $5,888.52.
E0500	NU	IPPB Machine W/Manual Valves External Power Source Includes Cylinder Regulator Built-In Nebulization	MNF	$616.00	
E0500	RB	IPPB Machine W/Manual Valves External Power Source Includes Cylinder Regulator Built-In Nebulization	MN	MP	
E0500	RR	IPPB Machine W/Manual Valves External Power Source Includes Cylinder Regulator Built-In Nebulization	MNF	$68.00	
E0550	NU	Humidifier Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	MN	$240.00	
E0550	RB	Humidifier Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	MN	MP	
E0550	RR	Humidifier Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	MN	$30.00	
E0561	NU	Humidifier, Non-Heated, Used W/Positive Airway Pressure Device	PC	$93.45	
E0562	NU	Humidifier, Heated, Used W/Positive Airway Pressure	PC	$263.06	
E0565	RR	Compressor Air Power Source For Equipment Which Is Not Self-Contained Or Cylinder Driven	PC	$30.00	
E0570	NU	Nebulizer W/Compressor E.G. Devilbiss Pulmo-Aid	PC	$156.00	
E0570	RB	Nebulizer W/Compressor E.G. Devilbiss Pulmo-Aid	MN	MP	
E0570	RR	Nebulizer W/Compressor E.G. Devilbiss Pulmo-Aid	PC	$16.10	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0575	NU	Nebulizer Self-Contained Ultrasonic	MNF	$540.00	
E0575	RB	Nebulizer Self-Contained Ultrasonic	MN	MP	
E0575	RR	Nebulizer Self-Contained Ultrasonic	MNF	$75.00	
E0585	NU	Nebulizer W/Compressor And Heater	PC	$240.00	
E0585	RB	Nebulizer W/Compressor And Heater	MN	MP	
E0585	RR	Nebulizer W/Compressor And Heater	PC	$29.81	
E0600	NU	Suction Pump Home Model Portable	PC	$382.00	
E0600	RB	Suction Pump Home Model Portable	MN	MP	
E0600	RR	Suction Pump Home Model Portable	PC	$42.16	
E0601	RB	CPAP Repair/Supplies To Recipient Owned	MN, IOC	MP	
E0601	RR	Nasal Continuous Airway Pressure (CPAP) Device	PC Sleep Study	$85.36	Months 1-3 Rent to purchase. Reimubursement not to exceed $1,024.32.
E0601	RR KJ	Nasal Continuous Airway Pressure (CPAP) Device	PC Use of Device	$85.36	Months 4-12 Rent to purchase. Reimubursement not to exceed $1,024.32.
E0619	RR	Apnea Monitor W/Recorder	PC	$180.00	Months 1-4
E0619	RR KJ	Apnea Monitor W/Recorder	PC	$180.00	Months 5-12
E1390	RR	Oxygen Concentrator Capable Of Delivering 85 Percent Or Greater Oxygen Concentration At The Prescribed Flow Rate	PC	$90.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1390	RR QF	Oxygen Concentrator Capable Of Delivering 85 Percent Or Greater Oxygen Concentration, > 4 LPM W/Portable Oxygen Prescribed	PC	$135.00	
E1390	RR QG	Oxygen Concentrator Capable Of Delivering 85 Percent Or Greater Oxygen Concentration, > 4 LPM W/Portable Oxygen Prescribed	PC	$135.00	
K0730	NU	Controlled Dose Inhalation Drug Delivery System		$1,724.02	
K0730	RR	Controlled Dose Inhalation Drug Delivery System		$145.57	
K0738	RR	Portable Gaseous Oxygen System, Rental; Home Compressor Used To Fill Portable Oxygen Cylinders; Includes Portable Containers, Regulator, Flowmeter, Humidifier, Cannula Or Mask, And Tubing	PC	$150.00	
Z0020	NU	Nebulizer Kit Which Includes Tubing Medicine Cup And Mouth Piece	MNF	$2.25	2/30
PATIENT LIFT TRAPEZE					
E0621	NU	Sling Or Seat Patient Lift Canvas Or Nylon	MNF	$81.59	
E0630	NU	Patient Lift Hydraulic W/Seat Or Sling	PC	$900.00	
E0630	RB	Patient Lift Hydraulic W/Seat Or Sling	MN	MP	
E0630	RR	Patient Lift Hydraulic W/Seat Or Sling	PC	$90.00	
E0910	NU	Trapeze Bars Aka Patient Helper Attached To Bed W/Grab Bar	MNF	$134.00	
E0910	RB	Trapeze Bars Aka Patient Helper Attached To Bed W/Grab Bar	MN	MP	
E0910	RR	Trapeze Bars Aka Patient Helper Attached To Bed W/Grab Bar	MNF	$19.00	
E0940	NU	Trapeze Bar Free Standing Complete W/Grab Bar	MNF	$287.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0940	RB	Trapeze Bar Free Standing Complete W/Grab Bar	MN	MP	
E0940	RR	Trapeze Bar Free Standing Complete W/Grab Bar	MNF	$34.60	
PROSTHETIC REPAIR					
L7510	RB	Prosthetic Device Repair/Replace Minor Parts	MN	MP	
L7520	RB	Repair of Prosthetic Device, Labor Component, Per 15 Minutes	MN	$10.50 Per Unit	
PROSTHETICS					
L5000	NU	Partial Foot Shoe Insert W/Longitudinal Arch Toe Filler	MN	$350.00	
L5000	RB	Partial Foot Shoe Insert W/Longitudinal Arch Toe Filler	MN	MP	
L5010	NU	Partial Foot Molded Socket Ankle Height W/Toe Filler	MN	$900.00	
L5010	RB	Partial Foot Molded Socket Ankle Height W/Toe Filler	MN	MP	
L5020	NU	Partial Foot Molded Socket Tibial Tubercle Height W/Toe Filler	MN	$1,572.01	
L5020	RB	Partial Foot Molded Socket Tibial Tubercle Height W/Toe Filler	MN	MP	
L5050	NU	Ankle Symes Molded Socket Sach Foot	MN	$1,835.12	
L5050	RB	Ankle Symes Molded Socket Sach Foot	MN	MP	
L5060	NU	Ankle Symes Metal Frame Molded Leather Socket Articulated Ankle/Foot	MN	$1,950.00	
L5060	RB	Ankle Symes Metal Frame Molded Leather Socket Articulated Ankle/Foot	MN	MP	
L5100	NU	Below Knee Molded Socket Shin Sach Foot	MN	$1,950.00	
L5100	RB	Below Knee Molded Socket Shin Sach Foot	MN	MP	
L5105	NU	Below Knee Plastic Socket Joints And Thigh Lacer Sach Foot	MN	$1,950.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5105	RB	Below Knee Plastic Socket Joints And Thigh Lacer Sach Foot	MN	MP	
L5150	NU	Knee Disarticulation (Or Through Knee) Molded Socket External Knee Joints Shin Sach Foot	MN	$2,700.00	
L5150	RB	Knee Disarticulation (Or Through Knee) Molded Socket External Knee Joints Shin Sach Foot	MN	MP	
L5160	NU	Knee Disarticulation (Or Through Knee) Molded Socket Bent Knee Configuration External Knee Joints	MN	$2,800.00	
L5160	RB	Knee Disarticulation (Or Through Knee) Molded Socket Bent Knee Configuration External Knee Joints	MN	MP	
L5200	NU	Above Knee Molded Socket Single Axis Constant Friction Knee Shin Sach Foot	MN	$2,750.00	
L5200	RB	Above Knee Molded Socket Single Axis Constant Friction Knee Shin Sach Foot	MN	MP	
L5210	NU	Above Knee Short Prosthesis No Knee Joint ("Stubbies") W/Foot Blocks No Ankle Joints Each	MN	$1,020.00	
L5210	RB	Above Knee Short Prosthesis No Knee Joint ("Stubbies") W/Foot Blocks No Ankle Joints Each	MN	MP	
L5220	NU	Above Knee Short Prosthesis No Knee Joint ("Stubbies") W/Articulated Ankle/Foot Dynamically A	MN	$1,500.00	
L5220	RB	Above Knee Short Prosthesis No Knee Joint ("Stubbies") W/Articulated Ankle/Foot Dynamically A	MN	MP	
L5230	NU	Above Knee For Proximal Femoral Focal Deficiency Constant Friction Knee Shin Sach Foot	MN	$2,900.00	
L5230	RB	Above Knee For Proximal Femoral Focal Deficiency Constant Friction Knee Shin Sach Foot	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5250	NU	Hip Disarticulation Canadian Type; Molded Socket Hip Joint Single Axis Constant Friction Knee Shin	MN	$4,000.00	
L5250	RB	Hip Disarticulation Canadian Type; Molded Socket Hip Joint Single Axis Constant Friction Knee Shin	MN	MP	
L5270	NU	Hip Disarticulation Tilt Table Type; Molded Socket Locking Hip Joint Single Axis Constant Friction	MN	$4,000.00	
L5270	RB	Hip Disarticulation Tilt Table Type; Molded Socket Locking Hip Joint Single Axis Constant Friction	MN	MP	
L5280	NU	Hemipelvectomy Canadian Type; Molded Socket Hip Joint Single Axis Constant Friction Knee Shin Sach Foot	MN	$4,300.00	
L5280	RB	Hemipelvectomy Canadian Type; Molded Socket Hip Joint Single Axis Constant Friction Knee Shin Sach Foot	MN	MP	
L5301	NU	Below Knee Molded Socket Shin Each Foot Endoskeletal System	MN	$2,063.71	
L5301	RB	Below Knee Molded Socket Shin Each Foot Endoskeletal System	MN	MP	
L5321	NU	Above Knee Molded Socket Open End Sach Foot Endoskeletal System Single Axis Knee	MN	$2,607.16	
L5321	RB	Above Knee Molded Socket Open End Sach Foot Endoskeletal System Single Axis Knee	MN	MP	
L5331	NU	Hip Disarticulation Canadian Type Molded Socket Endoskeletal System Hip Joint Single Axis Knee	MN	$4,407.19	
L5331	RB	Hip Disarticulation Canadian Type Molded Socket Endoskeletal System Hip Joint Single Axis Knee	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5341	NU	Hemipelvectomy Canadian Type Molded Socket Endoskeletal System Hip Joint Single Axis Knee Sach	MN	$4,504.77	
L5341	RB	Hemipelvectomy Canadian Type Molded Socket Endoskeletal System Hip Joint Single Axis Knee Sach	MN	MP	
L5400	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment	MN	$950.00	
L5410	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment	MN	$399.13	
L5420	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment	MN	$1,050.00	
L5430	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment	MN	$473.83	
L5450	NU	Immediate Post Surgical Or Early Fitting Application Of Non-Weight Bearing Rigid Dressing Below Knee	MN	$250.00	
L5460	NU	Immediate Post Surgical Or Early Fitting Application Of Non-Weight Bearing Rigid Dressing Above Knee	MN	$250.00	
L5460	RB	Immediate Post Surgical Or Early Fitting Application Of Non-Weight Bearing Rigid Dressing Above Knee	MN	MP	
L5500	NU	Initial Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Plaster Sock	MN	$750.00	
L5500	RB	Initial Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Plaster Sock	MN	MP	
L5505	NU	Initial Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach	MN	$1,050.00	
L5505	RB	Initial Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5510	NU	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Plaster Socket	MN	$750.00	
L5510	RB	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Plaster Socket	MN	MP	
L5520	NU	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic	MN	$800.00	
L5520	RB	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic	MN	MP	
L5530	NU	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic Or Equal Molded To Model	MN	$1,450.00	
L5530	RB	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic Or Equal Molded To Model	MN	MP	
L5535	NU	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Prefabricated Adjustable Open End	MN	$750.00	
L5535	RB	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Prefabricated Adjustable Open End	MN	MP	
L5540	NU	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Laminated Socket Molded To Model	MN	$1,750.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5540	RB	Preparatory Below Knee "PTB" Type Socket Non-Alignable System Pylon No Cover Sach Foot Laminated Socket Molded To Model	MN	MP	
L5560	NU	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach Foot Plaster	MN	$650.00	
L5560	RB	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach Foot Plaster	MN	MP	
L5570	NU	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable Systme Pylon No Cover Sach Foot Thermoplastic	MN	$650.00	
L5570	RB	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic	MN	MP	
L5580	NU	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic	MN	$1,850.00	
L5580	RB	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Alignable System Pylon No Cover Sach Foot Thermoplastic	MN	MP	
L5585	NU	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Align System Pylon No Cover Sach Foot Prefabricated Adjustable	MN	$1,250.00	
L5585	RB	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Align System Pylon No Cover Sach Foot Prefabricated Adjustable	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5590	NU	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Align System Pylon No Cover Sach Foot Laminated Socket	MN	$1,500.00	
L5590	RB	Preparatory Above Knee-Knee Disarticulation Ischial Level Socket Non-Align System Pylon No Cover Sach Foot Laminated Socket	MN	MP	
L5595	NU	Preparatory Hip Disarticulation-Hemipelvectomy Pylon No Cover Sach Foot Thermoplastic Or Equal Molded To Patient Model	MN	$3,019.34	
L5595	RB	Preparatory Hip Disarticulation-Hemipelvectomy Pylon No Cover Sach Foot Thermoplastic Or Equal	MN	MP	
L5600	NU	Preparatory Hip Disarticulation-Hemipelvectomy Pylon No Cover Sach Foot Laminated Socket Molded to Patient Model	MN	$3,365.02	
L5600	RB	Preparatory Hip Disarticulation-Hemipelvectomy Pylon No Cover Sach Foot Laminated Socket Molded to Patient Model	MN	MP	
L5610	NU	Addition To Lower Extremity Endoskeletal System Above Knee Hydracadence System	MN	$2,070.02	
L5610	RB	Addition To Lower Extremity Endoskeletal System Above Knee Hydracadence System	MN	MP	
L5611	NU	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage W/Friction Swing Phase Control	MN	$1,384.96	
L5611	RB	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage W/Friction Swing Phase Control	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5613	NU	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4-Bar Linkage W/Hydraulic Swing Phase Control	MN	$2,237.36	
L5613	RB	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage W/Hydraulic Swing Phase Control	MN	MP	
L5614	NU	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage W/Pneumatic Swing Phase Control	MN	$1,339.73	
L5616	NU	Addition To Lower Extremity Endoskeletal System Above Knee, Universal Multiplex System Friction Swing Phase Control	MN	$1,192.44	
L5616	RB	Addition To Lower Extremity Endoskeletal System Above Knee, Universal Multiplex System Friction Swing Phase Control	MN	MP	
L5617	NU	Addition To Lower Extremity Quick Change Self-Aligning Unit Above Or Below Knee Each	MN	$419.49	
L5617	RB	Addition To Lower Extremity Quick Change Self-Aligning Unit Above Or Below Knee Each	MN	MP	
L5618	NU	Addition To Lower Extremity Test Socket Symes	MN	$200.00	
L5618	RB	Addition To Lower Extremity Test Socket Symes	MN	MP	
L5620	NU	Addition To Lower Extremity Test Socket Below Knee	MN	$210.00	
L5620	RB	Addition To Lower Extremity Test Socket Below Knee	MN	MP	
L5622	NU	Addition To Lower Extremity Test Socket Knee Disarticulation	MN	$250.00	
L5622	RB	Addition To Lower Extremity Test Socket Knee Disarticulation	MN	MP	
L5624	NU	Addition To Lower Extremity Test Socket Above Knee	MN	$250.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5624	RB	Addition To Lower Extremity Test Socket Above Knee	MN	MP	
L5626	NU	Addition To Lower Extremity Test Socket Hip Disarticulation	MN	$325.00	
L5626	RB	Addition To Lower Extremity Test Socket Hip Disarticulation	MN	MP	
L5628	NU	Addition To Lower Extremity Test Socket Hemipelvectomy	MN	$375.00	
L5628	RB	Addition To Lower Extremity Test Socket Hemipelvectomy	MN	MP	
L5629	NU	Addition To Lower Extremity Below Knee Acrylic Socket	MN	$235.00	
L5629	RB	Addition To Lower Extremity Below Knee Acrylic Socket	MN	MP	
L5630	NU	Addition To Lower Extremity Symes Type Expandable Wall Socket	MN	$450.00	
L5630	RB	Addition To Lower Extremity Symes Type Expandable Wall Socket	MN	MP	
L5631	NU	Addition To Lower Extremity Above Knee Or Knee Disarticulation Acrylic Socket	MN	$200.00	
L5631	RB	Addition To Lower Extremity Above Knee Or Knee Disarticulation Acrylic Socket	MN	MP	
L5632	NU	Addition To Lower Extremity Symes Type PTB Brim Design Socket	MN	$186.00	
L5632	RB	Addition To Lower Extremity Symes Type PTB Brim Design Socket	MN	MP	
L5634	NU	Addition To Lower Extremity Symes Type Posterior Opening (Canadian) Socket	MN	$245.27	
L5634	RB	Addition To Lower Extremity Symes Type Posterior Opening (Canadian) Socket	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5636	NU	Addition To Lower Extremity Symes Type Medial Opening Socket	MN	$193.42	
L5636	RB	Addition Socket	MN	MP	
L5637	NU	Addition To Lower Extremity Below Knee Total Contact	MN	$215.00	
L5637	RB	Addition To Lower Extremity Below Knee Total Contact	MN	MP	
L5638	NU	Addition To Lower Extremity Below Knee Total Contact Leather Socket	MN	$364.94	
L5638	RB	Addition To Lower Extremity Below Knee Total Contact Leather Socket	MN	MP	
L5639	NU	Addition To Lower Extremity Below Knee Total Contact Wood Socket	MN	$840.74	
L5639	RB	Addition To Lower Extremity Below Knee Wood Socket	MN	MP	
L5640	NU	Addition Knee Disarticulation Leather Socket	MN	$500.00	
L5640	RB	Addition Knee Disarticulation Leather Socket	MN	MP	
L5642	NU	Addition Above Knee Leather Socket	MN	$500.00	
L5642	RB	Addition Above Knee Leather Socket	MN	MP	
L5643	NU	Addition To Lower Extremity Hip Disarticulation Flexible Inner Socket External Frame	MN	$1,167.13	
L5643	RB	Addition To Lower Extremity Hip Disarticulation Flexible Inner Socket External Frame	MN	MP	
L5644	NU	Addition To Lower Extremity Above Knee Wood Socket	MN	$484.15	
L5644	RB	Addition To Lower Extremity Above Knee Wood Socket	MN	MP	
L5645	NU	Addition Below Knee Flexible Inner Socket External Frame	MN	$450.00	
L5645	RB	Addition Below Knee Flexible Inner Socket External Frame	MN	MP	
L5646	NU	Addition Below Knee Air Cushion Socket	MN	$300.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5646	RB	Addition Below Knee Air Cushion Socket	MN	MP	
L5647	NU	Addition Below Knee Suction Socket	MN	$750.00	
L5647	RB	Addition Below Knee Suction Socket	MN	MP	
L5648	NU	Addition Above Knee Air Cushion Socket	MN	$300.00	
L5648	RB	Addition Above Knee Air Cushion Socket	MN	MP	
L5649	NU	Addition to Lower Extremity Ischial Containment/Narrow M-L Socket	MN	$800.00	
L5649	RB	Addition to Lower Extremity Ischial Containment/Narrow M-L Socket	MN	MP	
L5650	NU	Addition To Lower Extremity Total Contact Above Knee Or Knee Disarticulation Socket	MN	$75.00	
L5650	RB	Addition To Lower Extremity Total Contact Above Knee Or Knee Disarticulation Socket	MN	MP	
L5651	NU	Addition To Lower Extremity Above Knee Flexible Inner Socket External Frame	MN	$952.62	
L5651	RB	Addition To Lower Extremity Above Knee Flexible Inner Socket External Frame	MN	MP	
L5652	NU	Addition To Lower Extremity Suction Suspension Above Knee Or Knee Disarticulation Socket	MN	$225.00	
L5652	RB	Addition To Lower Extremity Suction Suspension Above Knee Or Knee Disarticulation Socket	MN	MP	
L5653	NU	Addition to Lower Extremity Knee Disarticulation Expandable Wall Socket	MN	$300.00	
L5653	RB	Addition to Lower Extremity Knee Disarticulation Expandable Wall Socket	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5654	NU	Addition to Lower Extremity Symes (Kemble Pelite Aliplast Plastazote Or Equal)	MN	$235.00	
L5654	RB	Addition to Lower Extremity Symes (Kemble Pelite Aliplast Plastazote Or Equal)	MN	MP	
L5655	NU	Addition To Lower Extremity Socket Insert; Below Knee (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	$210.40	
L5655	RB	Addition To Lower Extremity Socket Insert; Below Knee (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	MP	
L5656	NU	Addition To Lower Extremity Knee Disarticulation (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	$235.00	
L5656	RB	Addition To Lower Extremity Knee Disarticulation (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	MP	
L5658	NU	Addition To Lower Extremity Above Knee (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	$225.00	
L5658	RB	Addition To Lower Extremity Above Knee (Kemblo Pelite Aliplast Plastazote Or Equal)	MN	MP	
L5661	NU	Addition To Lower Extremity Multi-Durometer Symes	MN	$300.00	
L5661	RB	Addition To Lower Extremity Multi-Durometer Symes	MN	MP	
L5665	NU	Addition To Lower Extremity Multi-Durometer Below Knee	MN	$300.00	
L5665	RB	Addition To Lower Extremity Multi-Durometer Below Knee	MN	MP	
L5666	NU	Addition To Lower Extremity Below Knee Cuff Suspension	MN	$55.00	
L5666	RB	Addition To Lower Extremity Below Knee Cuff Suspension	MN	MP	
L5668	NU	Addition To Lower Extremity Below Knee Molded Distal Cushion	MN	$55.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5668	RB	Addition To Lower Extremity Below Knee Molded Distal Cushion	MN	MP	
L5670	NU	Addition To Lower Extremity Below Knee Molded Supracondylar Suspension (PTS Or Similar)	MN	$100.00	
L5670	RB	Addition To Lower Extremity Below Knee Molded Supracondylar Suspension (PTS Or Similar)	MN	MP	
L5671	NU	Addition To Lower Extremity Below Knee/Above Knee Suspension Locking Mechanism (Shuttle Lanyard Or Equal)	MN	$500.06	
L5671	RB	Addition To Lower Extremity Below Knee/Above Knee Suspension Locking Mechanism (Shuttle Lanyard Or Equal)	MN	MP	
L5672	NU	Addition To Lower Extremity Below Knee Removable Medial Brim Suspension	MN	$165.00	
L5672	RB	Addition To Lower Extremity Below Knee Removable Medial Brim Suspension	MN	MP	
L5673	NU	Socket Insert W/Locking Mechanism	MN	$600.75	
L5676	NU	Addition To Lower Extremity Below Knee, Knee Joints, Single Axis, Pair	MN	$250.00	
L5676	RB	Addition To Lower Extremity Below Knee, Knee Joints, Single Axis, Pair	MN	MP	
L5677	NU	Addition To Lower Extremity Below Knee, Knee Joints, Polycentric, Pair	MN	$280.00	
L5677	RB	Addition To Lower Extremity Below Knee, Knee Joints, Polycentric, Pair	MN	MP	
L5678	NU	Addition To Lower Extremity Below Knee Joint Covers Pair	MN	$18.00	
L5678	RB	Addition To Lower Extremity Below Knee Joint Covers	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Pair			
L5679	NU	Socket Insert W/o Locking Mechanism	MN	$500.61	
L5680	NU	Addition To Lower Extremity Below Knee Thigh Lacer Non-Molded	MN	$200.00	
L5680	RB	Addition To Lower Extremity Below Knee Thigh Lacer Non-Molded	MN	MP	
L5681	NU	Below Knee/Above Knee Custom Fab Socket	MN	$1,055.81	
L5682	NU	Addition To Lower Extremity Below Knee, Thigh Lacer, gluteal/Ischial Molded	MN	$504.39	
L5682	RB	Addition To Lower Extremity Gluteal/Ischial Molded	MN	MP	
L5683	NU	Initial Socket Insert	MN	$1,055.81	
L5684	NU	Addition To Lower Extremity Below Knee Fork Strap	MN	$25.00	
L5684	RB	Addition To Lower Extremity Below Knee Fork Strap	MN	MP	
L5685	NU	Addition To Lower Extremity Prosthesis Below Knee Prosthesis Suspension/Sealing Sleeve	MN	$110.14	
L5686	NU	Addition To Lower Extremity Prosthesis Below Knee (Extension Control)	MN	$15.00	
L5686	RB	Addition To Lower Extremity Prosthesis Below Knee (Extension Control)	MN	MP	
L5688	NU	Addition To Lower Extremity Prosthesis Below Knee Waist Belt Webbing	MN	$45.00	
L5688	RB	Addition To Lower Extremity Prosthesis Below Knee Waist Belt Webbing	MN	MP	
L5690	NU	Addition To Lower Extremity Prosthesis Below Knee Waist Belt Padded And Lined	MN	$60.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5690	RB	Addition To Lower Extremity Prosthesis Below Knee Waist Belt Padded And Lined	MN	MP	
L5692	NU	Addition To Lower Extremity Above Knee Pelvic Control Belt Light	MN	$65.00	
L5692	RB	Addition To Lower Extremity Above Knee Pelvic Control Belt Light	MN	MP	
L5694	NU	Addition To Lower Extremity Above Knee Pelvic Control Belt Padded And Lined	MN	$75.00	
L5694	RB	Addition To Lower Extremity Above Knee Pelvic Control Belt Padded And Lined	MN	MP	
L5695	NU	Addition To Lower Extremity Above Knee Pelvic Control Sleeve Suspension Neoprene Or Equal Each	MN	$122.29	
L5695	RB	Addition To Lower Extremity Above Knee Pelvic Control Sleeve Suspension Neoprene Or Equal Each	MN	MP	
L5696	NU	Addition To Lower Extremity Above Knee Or Knee Disarticulation Pelvic Joint	MN	$145.00	
L5696	RB	Addition To Lower Extremity Above Knee Or Knee Disarticulation Pelvic Joint	MN	MP	
L5697	NU	Addition To Lower Extremity Above Knee Or Knee Disarticulation Pelvic Band	MN	$20.00	
L5697	RB	Addition To Lower Extremity Above Knee Or Knee Disarticulation Pelvic Band	MN	MP	
L5698	NU	Addition To Lower Extremity Above Knee Or Knee Disarticulation Silesian Bandage	MN	$90.00	
L5698	RB	Addition To Lower Extremity Above Knee Or Knee Disarticulation Silesian Bandage	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5699	NU	All Lower Extremity Prostheses Shoulder Harness	MN	$139.82	
L5699	RB	All Lower Extremity Prostheses Shoulder Harness	MN	MP	
L5700	NU	Replacement Socket Below Knee Molded To Patient Model	MN	$2,040.00	
L5701	NU	Replacement Socket Above Knee/Knee Disarticulation Including Attachment Plate Molded To Patient Model	MN	$2,753.00	
L5702	NU	Replacement Socket Hip Disarticulation Including Hip Joint Molded To Patient Model	MN	$4,008.00	
L5703	NU	Ankle, Symes, Molded To Patient Model, Socket W/o Solid Ankle Cushion Heel (Sach) Foot, Replacement Only	MN	$1,807.20	
L5703	RB	Ankle, Symes, Molded To Patient Model, Socket W/o Solid Ankle Cushion Heel (Sach) Foot, Replacement Only	MN	MP	
L5704	NU	Replacement Custom Shaped Protective Cover Below Knee	MN	$432.00	
L5705	NU	Replacement Custom Shaped Protective Cover Above Knee	MN	$709.00	
L5706	NU	Replacement Custom Shaped Protective Cover Knee Disarticulation	MN	$702.00	
L5707	NU	Replacement Custom Shaped Protective Cover Hip Disarticulation	MN	$998.00	
L5710	NU	Addition, Exoskeletal Knee-Shin System, Single Axis, Manual Lock	MN	$225.00	
L5710	RB	Addition, Exoskeletal Knee-Shin System, Single Axis, Manual Lock	MN	MP	
L5711	NU	Addition Exoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MN	$250.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5711	RB	Addition Exoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MN	MP	
L5712	NU	Addition Exoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MN	$275.00	
L5712	RB	Addition Exoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MN	MP	
L5714	NU	Addition Exoskeletal Knee-Shin System Single Axis Variable Friction Swing Phase Control	MN	$200.00	
L5714	RB	Addition Exoskeletal Knee-Shin System Single Axis Variable Friction Swing Phase Control	MN	MP	
L5716	NU	Addition Exoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MN	$300.00	
L5716	RB	Addition Exoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MN	MP	
L5718	NU	Addition Exoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MN	$300.00	
L5718	RB	Addition Exoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MN	MP	
L5722	NU	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MN	$750.00	
L5722	RB	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MN	MP	
L5724	NU	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MN	$900.00	
L5724	RB	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5726	NU	Addition Exoskeletal Knee-Shin System Single Axis External Joints Fluid Swing Phase Control	MN	$1,200.00	
L5726	RB	Addition Exoskeletal Knee-Shin System Single Axis External Joints Fluid Swing Phase Control	MN	MP	
L5728	NU	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MN	$2,000.00	
L5728	RB	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MN	MP	
L5780	NU	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic/Hydrapneumatic Swing Phase Control	MN	$900.00	
L5780	RB	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic/Hydrapneumatic Swing Phase Control	MN	MP	
L5785	NU	Addition Exoskeletal System Below Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	$300.00	
L5785	RB	Addition Exoskeletal System Below Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5790	NU	Addition Exoskeletal System Above Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	$500.00	
L5790	RB	Addition Exoskeletal System Above Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5795	NU	Addition Exoskeletal System Hip Disarticulation Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	$700.00	
L5795	RB	Addition Exoskeletal System Hip Disarticulation Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5810	NU	Addition Endoskeletal Knee-Shin System Single Axis Manual Lock	MN	$360.00	
L5810	RB	Addition Endoskeletal Knee-Shin System Single Axis	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Manual Lock			
L5811	NU	Addition Endoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MN	$470.00	
L5811	RB	Addition Endoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MN	MP	
L5812	NU	Addition Endoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MN	$450.00	
L5812	RB	Addition Endoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MN	MP	
L5814	NU	Addition Endoskeletal Knee-Shin System Polycentric; Hydraulic Swing Phase Control Mechanical Stance Phase Lock	MN	$2,787.34	
L5816	NU	Addition Endoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MN	$169.00	
L5816	RB	Addition Endoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MN	MP	
L5818	NU	Addition Endoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MN	$841.00	
L5818	RB	Addition Endoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MN	MP	
L5822	NU	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MN	$1,276.95	
L5822	RB	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MN	MP	
L5824	NU	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MN	$1,192.71	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5824	RB	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MN	MP	
L5826	NU	Hydraulic Swing Phase Control W/Miniature High Activity Frame	PA	$2,343.81	
L5828	NU	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MN	$2,351.63	
L5828	RB	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MN	MP	
L5830	NU	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic/ Swing Phase Control	MN	$1,557.19	
L5830	RB	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic/Swing Phase Control	MN	MP	
L5840	NU	Addition Endoskeletal Knee-Shin System 4-Bar Linkage Or Multiaxial Pneumatic Swing Phase Control	MN	$2,103.00	
L5845	NU	Addition Endoskeletal Knee-Shin System Stance Flexion Feature Adjustable	MN	$1,345.21	
L5845	RB	Addition Endoskeletal Knee-Shin System Stance Flexion Feature Adjustable	MN	MP	
L5848	NU	Knee-Shin Sys Hydraul Stance	MN	$863.12	
L5850	NU	Addition Endoskeletal System; Above Knee Or Hip Disarticulation Knee Extension Assist	MN	$101.48	
L5850	RB	Addition Endoskeletal System; Above Knee Or Hip Disarticulation Knee Extension Assist	MN	MP	
L5855	NU	Addition Endoskeletal System Hip Disarticulation, Mechanical Hip Extension Assist	MN	$286.00	
L5856	NU	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System Microprocessor Control Feature Swing	MN	$19,264.21	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		And Stance Phase			
L5857	NU	Addition To Lower Extremity Prosthesis Endoskeletal Knee-Shin System Microprocessor Control Feature Swing Phase Only	MN	$6,832.81	
L5858	NU	Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System, Microprocessor Control Feature, Stance Phase Only, Includes Electronic Sensor(s), Any Type	MN	$14,917.69	
L5858	RB	Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System, Microprocessor Control Feature, Stance Phase Only, Includes Electronic Sensor(s), Any Type	MN	MP	
L5910	NU	Addition Below Knee Alignable System	MN	$250.00	
L5910	RB	Addition Below Knee Alignable System	MN	MP	
L5920	NU	Addition Endoskeletal System Above Knee Or Hip Disarticulation Alignable System	MN	$250.00	
L5920	RB	Addition Endoskeletal System Above Knee Or Hip Disarticulation Alignable System	MN	MP	
L5925	NU	Addition Endoskeletal System Above Knee, Knee Disarticulation Or Hip Disarticulation, Manual	MN	$309.00	
L5930	NU	Addition Endoskeletal System High Activity Knee Control Frame	MN	$2,523.60	
L5930	RB	Addition Endoskeletal System High Activity Knee Control Frame	MN	MP	
L5940	NU	Addition Endoskeletal System Below Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	$300.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5940	RB	Addition Endoskeletal System Below Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5950	NU	Above Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	$500.00	
L5950	RB	Above Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5960	NU	Hip Disarticulation Ultra Light Material (Titanium Carbon Fiber Or Equal)	MN	$500.00	
L5960	RB	Hip Disarticulation Ultra Light Material (Titanium Carbon Fiber Or Equal)	MN	MP	
L5961	NU	Endo Poly Hip, Pneu/Hyd/Rot	MN IOC	MP	
L5962	NU	Addition Endoskeletal System Below Knee Flexible Protective Outer Surface Covering System	MN	$544.00	
L5964	NU	Addition Endoskeletal System Above Knee Flexible Protective Outer Surface Covering System	MN	$799.00	
L5966	NU	Addition Endoskeletal System Hip Disarticulation Flexible Protective Outer Surface Covering System	MN	$1,035.00	
L5968	NU	Addition To Lower Limb Prosthesis Multiaxial Ankle W/Swing Phase Active Dorsiflexion Feature	MN	$2,391.00	
L5970	NU	All Lower Extremity Prostheses Foot External Keel Sach Foot	MN	$75.00	
L5970	RB	All Lower Extremity Prostheses Foot External Keel Sach Foot	MN	MP	
L5971	NU	All Lower Extremity Prosthesis, Solid Ankle Cushion Heel (Sach) Foot, Replacement Only	MN	$180.13	
L5971	RB	All Lower Extremity Prosthesis, Solid Ankle Cushion Heel (Sach) Foot, Replacement Only	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5972	NU	All Lower Extremity Prostheses Flexible Keel Foot (Safe Sten Bock Dynamic Or Equal)	MN	$260.00	
L5972	RB	All Lower Extremity Prostheses Flexible Keel Foot (Safe Sten Bock Dynamic Or Equal)	MN	MP	
L5974	NU	All Lower Extremity Prostheses Foot Single Axis Ankle/Foot	MN	$201.33	
L5974	RB	All Lower Extremity Prostheses Foot Single Axis Ankle/Foot	MN	MP	
L5975	NU	All Lower Extremity Prosthesis; Combination Single Axis Ankle And Flexible Keel Foot	MN	$305.00	
L5976	NU	All Lower Extremity Prostheses Energy Storing Foot (Seattle Carbon Copy Ii Or Equal)	MN	$500.00	
L5976	RB	All Lower Extremity Prostheses Energy Storing Foot (Seattle Carbon Copy Ii Or Equal)	MN	MP	
L5978	NU	All Lower Extremity Prostheses Foot Multiaxial Ankle/Foot	MN	$250.00	
L5978	RB	All Lower Extremity Prostheses Foot Multiaxial Ankle/Foot	MN	MP	
L5979	NU	All Lower Extremity Prostheses Multiaxial Ankle/Foot Dynamic Response	MN	$2,112.00	
L5980	NU	All Lower Extremity Prostheses Flex Foot System	MN	$2,000.00	
L5980	RB	All Lower Extremity Prostheses Flex Foot System	MN	MP	
L5981	NU	All Lower Extremity Prostheses Flex-Walk System Or Equal	MN	$2,318.00	
L5982	NU	All Exoskeletal Lower Extremity Prostheses Axial Rotation Unit	MN	$150.00	
L5982	RB	All Exoskeletal Lower Extremity Prostheses Axial Rotation Unit	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L5984	NU	All Endoskeletal Lower Extremity Prostheses Axial Rotation Unit	MN	$300.00	
L5984	RB	All Endoskeletal Lower Extremity Prostheses Axial Rotation Unit	MN	MP	
L5985	NU	All Endoskeletal Lower Extremity Prostheses Dynamic Prosthetic Pylon	MN	$211.71	
L5985	RB	All Endoskeletal Lower Extremity Prostheses Dynamic Prosthetic Pylon	MN	MP	
L5986	NU	All Lower Extremity Prostheses Multi-Axial Rotation Unit ("MCP" Or Equal)	MN	$530.00	
L5986	RB	All Lower Extremity Prostheses Multi-Axial Rotation Or Unit ("MCP Or Equal)	MN	MP	
L5987	NU	All Lower Extremity Prosthesis Shank Foot System W/Vertical Loading Pylon	MN	$5,399.06	
L5988	NU	Addition To Lower Limb Prosthesis Vertical Shock Reducing Pylon Feature	MN	$1,315.00	
L5990	NU	Addition To Lower Extremity Prosthesis User Adjustable Heel Height	MN	$1,456.19	
L5999	NU	Lower Extremity Prosthesis Not Otherwise Specified	PA	MP	
L6000	NU	Partial Hand Robin-Aids Thumb Remaining (Or Equal)	MN	$1,291.64	
L6000	RB	Partial Hand Robin-Aids Thumb Remaining (Or Equal)	MN	MP	
L6010	NU	Partial Hand Robin-Aids Little And/Or Ring Finger Remaining (Or Equal)	MN	$1,442.40	
L6010	RB	Partial Hand Robin-Aids Little And/Or Ring Finger Remaining (Or Equal)	MN	MP	
L6020	NU	Partial Hand Robin-Aids No Finger Remaining (Or Equal)	MN	$1,378.33	
L6020	RB	Partial Hand Robin-Aids No Finger Remaining (Or Equal)	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6050	NU	Wrist Disarticulation Molded Socket Flexible Elbow Hinges Triceps Pad	MN	$1,600.00	
L6050	RB	Wrist Disarticulation Molded Socket Flexible Elbow Hinges Triceps Pad	MN	MP	
L6055	NU	Wrist Disarticulation Molded Socket W/Expandable Interface Flexible Elbow Hinges Triceps Pad	MN	$1,800.00	
L6055	RB	Wrist Disarticulation Molded Socket W/Expandable Interface Flexible Elbow Hinges Triceps Pad	MN	MP	
L6100	NU	Below Elbow Molded Socket Flexible Elbow Hinge Triceps Pad	MN	$1,600.00	
L6100	RB	Below Elbow Molded Socket Flexible Elbow Hinge Triceps Pad	MN	MP	
L6110	NU	Below Elbow Molded Socket (Muenster Or Northwestern Suspension Types)	MN	$1,700.00	
L6110	RB	Below Elbow Molded Socket (Muenster Or Northwestern Suspension Types)	MN	MP	
L6120	NU	Below Elbow Molded Double Wall Split Socket Step-Up Hinges Half Cuff	MN	$2,200.00	
L6120	RB	Below Elbow Molded Double Wall Split Socket Step-Up Hinges Half Cuff	MN	MP	
L6130	NU	Below Elbow Molded Double Wall Split Socket Stump Activated Locking Hinge Half Cuff	MN	$2,200.00	
L6130	RB	Below Elbow Molded Double Wall Split Socket Stump Activated Locking Hinge Half Cuff	MN	MP	
L6200	NU	Elbow Disarticulation Molded Socket Outside Locking Hinge Forearm	MN	$2,300.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6200	RB	Elbow Disarticulation Molded Socket Outside Locking Hinge Forearm	MN	MP	
L6205	NU	Elbow Disarticulation Molded Socket W/Expandable Interface Outside Locking Hinges Forearm	MN	$2,500.00	
L6205	RB	Elbow Disarticulation Molded Socket W/Expandable Interface Outside Locking Hinges Forearm	MN	MP	
L6250	NU	Above Elbow Molded Double Wall Socket Internal Locking Elbow Forearm	MN	$2,200.00	
L6250	RB	Above Elbow Molded Double Wall Socket Internal Locking Elbow Forearm	MN	MP	
L6300	NU	Shoulder Disarticulation Molded Socket Shoulder Bulkhead Humeral Section Internal Locking Elbow	MN	$3,000.00	
L6300	RB	Shoulder Disarticulation Molded Socket Shoulder Bulkhead Humeral Section Internal Locking Elbow	MN	MP	
L6310	NU	Shoulder Disarticulation Passive Restoration (Complete Prosthesis)	MN	$2,775.29	
L6310	RB	Shoulder Disarticulation Passive Restoration (Complete Prosthesis)	MN	MP	
L6320	NU	Shoulder Disarticulation Passive Restoration (Shoulder Cap Only)	MN	$1,708.64	
L6320	RB	Shoulder Disarticulation Passive Restoration (Shoulder Cap Only)	MN	MP	
L6350	NU	Interscapular Thoracic Molded Socket Shoulder Bulkhead Humeral Section Internal Locking Elbow Forearm	MN	$3,300.00	
L6350	RB	Interscapular Thoracic Molded Socket Shoulder Bulkhead Humeral Section Internal Locking Elbow Forearm	MN	MP	
L6360	NU	Interscapular Thoracic Passive Restoration (Complete Prosthesis)	MN	$2,409.28	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6360	RB	Interscapular Thoracic Passive Restoration (Complete Prosthesis)	MN	MP	
L6370	NU	Interscapular Thoracic Passive Restoration (Shoulder Cap Only)	MN	$1,690.22	
L6370	RB	Interscapular Thoracic Passive Restoration (Shoulder Cap Only)	MN	MP	
L6380	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment And Suspension Of Components And One Cast Change Wrist Disarticulation Or Below Elbow	MN	$959.97	
L6382	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment And Suspension Of Components And One Cast Change Elbow Disarticulation Or Above Elbow	MN	$1,128.06	
L6384	NU	Immediate Post Surgical Or Early Fitting Application Of Initial Rigid Dressing Including Fitting Alignment And Suspension Of Components And One Cast Change Shoulder Disarticulation Or Interscapular Thoracic	MN	$1,429.70	
L6386	NU	Immediate Post Surgical Or Early Fitting Each Additional Cast Change And Realignment	MN	$342.38	
L6388	NU	Immediate Post Surgical Or Early Fitting Application Of Rigid Dressing Only	MN	$354.76	
L6400	NU	Below Elbow Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	PA	$1,886.31	
L6400	RB	Below Elbow Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6450	NU	Elbow Disarticulation Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	PA	$2,611.46	
L6450	RB	Elbow Disarticulation Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	MN	MP	
L6500	NU	Above Elbow Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	PA	$2,819.43	
L6500	RB	Above Elbow Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	MN	MP	
L6550	NU	Shoulder Disarticulation Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	PA	$3,074.99	
L6550	RB	Shoulder Disarticulation Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	MN	MP	
L6570	NU	Interscapular Thoracic Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	PA	$3,348.16	
L6570	RB	Interscapular Thoracic Molded Socket Endoskeletal System Including Soft Prosthetic Tissue Shaping	MN	MP	
L6580	NU	Preparatory Wrist Disarticulation Or Below Elbow Single Wall Plastic Socket Friction Wrist Flexible Elbow Hinges	MN	$1,261.31	
L6580	RB	Preparatory Wrist Disarticulation Or Below Elbow Single Wall Plastic Socket Friction Wrist Flexible Elbow Hinges	MN	MP	
L6582	NU	Preparatory Wrist Disarticulation Or Below Elbow Single Wall Socket Friction Wrist Flexible Elbow Hinges	MN	$1,072.39	
L6582	RB	Preparatory Wrist Disarticulation Or Below Elbow Single Wall Socket Friction Wrist Flexible Elbow Hinges	MN	MP	
L6584	NU	Preparatory Elbow Disarticulation Or Above Elbow Single Wall Plastic Socket Friction Wrist Locking Elbow	MN	$1,556.27	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6584	RB	Preparatory Elbow Disarticulation Or Above Elbow Single Wall Plastic Socket Friction Wrist Locking Elbow	MN	MP	
L6586	NU	Preparatory Elbow Disarticulation Or Above Elbow Single Wall Socket Friction Wrist Locking Elbow	MN	$1,440.62	
L6586	RB	Preparatory Elbow Disarticulation Or Above Elbow Single Wall Socket Friction Wrist Locking Elbow	MN	MP	
L6588	NU	Preparatory Shoulder Disarticulation Or Interscapular Thoracic Single Wall Plastic Socket Shoulder	MN	$2,281.37	
L6588	RB	Preparatory Shoulder Disarticulation Or Interscapular Thoracic Single Wall Plastic Socket Shoulder	MN	MP	
L6590	NU	Preparatory Shoulder Disarticulation Or Interscapular Thoracic Single Wall Socket Shoulder Joint	MN	$2,103.08	
L6590	RB	Preparatory Shoulder Disarticulation Or Interscapular Thoracic Single Wall Socket Shoulder Joint	MN	MP	
L6600	NU	Upper Extremity Additions Polycentric Hinge Pair	MN	$85.00	
L6605	NU	Upper Extremity Additions Single Pivot Hinge Pair	MN	$85.00	
L6610	NU	Upper Extremity Additions Flexible Metal Hinge Pair	MN	$138.73	
L6615	NU	Upper Extremity Addition Disconnect Locking Wrist Unit	MN	$60.00	
L6616	NU	Upper Extremity Addition Additional Disconnect Insert For Locking Wrist Unit Each	MN	$48.64	
L6620	NU	Upper Extremity Addition Flexion Friction Wrist Unit	MN	$284.59	
L6621	NU	Flexion/Extension Wrist W/Wo Friction, For Use W/External Powered Terminal Device	MN	$1,966.61	
L6621	RB	Flexion/Extension Wrist W/Wo Friction, For Use W/External Powered Terminal Device	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6623	NU	Upper Extremity Addition Spring Assisted Rotational Wrist W/Latch Release	MN	$544.62	
L6625	NU	Upper Extremity Addition Rotation Wrist Unit W/Cable Lock	MN	$398.82	
L6628	NU	Upper Extremity Addition Quick Disconnect Hook Adapter Otto Bock Or Equal	MN	$441.09	
L6629	NU	Upper Extremity Addition Quick Disconnect Lamination Collar W/Coupling Piece Otto Bock Or Equal	MN	$113.12	
L6630	NU	Upper Extremity Addition Stainless Steel Any Wrist	MN	$90.00	
L6632	NU	Upper Extremity Addition Latex Suspension Sleeve Each	MN	$35.00	
L6635	NU	Upper Extremity Addition Lift Assist For Elbow	MN	$120.00	
L6637	NU	Upper Extremity Additions; Nudge Control Elbow Lock	MN	$291.95	
L6640	NU	Upper Extremity Additions Shoulder Abduction Joint Pair	MN	$215.59	
L6641	NU	Upper Extremity Addition Excursion Amplifier Pulley Type	MN	$146.31	
L6642	NU	Upper Extremity Addition Excursion Amplifier Lever Type	MN	$200.33	
L6645	NU	Upper Extremity Addition Shoulder Flexion Abduction Joint Each	MN	$253.70	
L6650	NU	Upper Extremity Addition Shoulder Universal Joint Each	MN	$253.82	
L6655	NU	Upper Extremity Addition Standard Control Cable Extra	MN	$67.42	
L6660	NU	Upper Extremity Addition Heavy Duty Control	MN	$75.00	
L6665	NU	Upper Extremity Addition; Teflon Or Equal Cable Lining		$36.94	
L6670	NU	Upper Extremity Addition Hook To Hand Cable Adapter	MN	$35.00	
L6672	NU	Upper Extremity Addition Harness Chest Or Shoulder Saddle Type	MN	$125.00	
L6675	NU	Upper Extremity Addition Harness Figure Of 8 For Single	MN	$65.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Control			
L6676	NU	Upper Extremity Addition Harness Figure Of 8 For Dual Control	MN	$65.00	
L6677	RB	Upper Extremity Addition; Harness, Triple Control, Simultaneous Operation Of Terminal Device And Elbow	MN, IOC	MP	
L6677	NU	Upper Extremity Addition; Harness, Triple Control, Simultaneous Operation Of Terminal Device And Elbow	MN	$255.03	
L6680	NU	Upper Extremity Addition Test Socket Wrist Disarticulation Or Below Elbow	MN	$110.00	
L6682	NU	Upper Extremity Addition Test Socket Elbow Disarticulation Or Above Elbow	MN	$110.00	
L6684	NU	Upper Extremity Addition Test Socket Shoulder Disartic Or Interscapular Thoracic	MN	$120.00	
L6686	NU	Upper Extremity Additions; Suction Socket	MN	$442.69	
L6687	NU	Upper Extremity Additions; Frame Type Socket Below or Wrist Disarticulation	MN	$432.53	
L6688	NU	Upper Extremity Additions; Frame Type Socket Above Elbow Or Elbow Disarticulation	MN	$417.80	
L6689	NU	Upper Extremity Additions; Frame Type Socket Shoulder Disarticulation	MN	$521.48	
L6690	NU	Upper Extremity Additions; Frame Type Socket Interscapular Thoracic	MN	$546.70	
L6691	NU	Upper Extremity Addition Removable Insert Each	MN	$70.00	
L6692	NU	Upper Extremity Additions; Silicone Gel Insert Or Equal Each	MN	$424.34	
L6693	NU	Upper Extremity Addition Locking Elbow Forearm Counterbalance	MN	$1,868.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L6694	NU	Addition For Below Elbow/Above Elbow Custom	PA	$643.50	
L6695	NU	Addition For Below Elbow/Above Elbow Custom	PA	$536.24	
L6696	NU	Addition For Below Elbow/Above Elbow Custom	PA	$1,130.94	
L6697	NU	Addition For Below Elbow/Above Elbow Custom	PA	$1,130.94	
L6698	NU	Addition For Below Elbow/Above Elbow Custom	PA	$569.72	
L6706	NU	Terminal Device Mech Hook Vol Open	MN	$341.47	
L6707	NU	Terminal Device Hook Mech Vol Closing	MN	$1,232.72	
L6805	NU	Terminal Device; Modifier Wrist Flexion Unit	MN	$326.42	
L6810	NU	Terminal Device Pincher Tool Otto Bock Or Equal	MN	$152.64	
L6883	NU	Replacement Socket, Below Elbow/Wrist Disarticulation, Molded To Patient Model, For Use W/Wo External Power	MN	$1,777.20	
L6884	NU	Replacement Socket, Above Elbow Disarticulation, Molded To Patient Model, For Use W/Wo External Power	MN	$2,285.88	
L6885	NU	Replacement Socket, Shoulder Disarticulation/Interscapular Thoracic, Molded To Patient Model, For Use W/Wo External Power	MN	$2,760.02	
L7400	NU	Addition To Upper Extremity Prosthesis; Below Elbow/Wrist Disarticulation, Ultralight Material (Titanium, Carbon Fiber Or Equal)	MN	$263.52	
L7401	NU	Addition To Upper Extremity Prosthesis; Above Elbow Disarticulation, Ultralight Material (Titanium, Carbon Fiber Or Equal)	MN	$295.00	
L7402	NU	Addition To Upper Extremity Prosthesis; Shoulder Disarticulation/Interscapular Thoracic, Ultralight Material (Titanium, Carbon Fiber Or Equal)	MN	$318.59	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L7403	NU	Addition To Upper Extremity Prosthesis; Below Elbow/Wrist Disarticulation, Acrylic Material	MN	$316.62	
L7404	NU	Addition To Upper Extremity Prosthesis; Above Elbow Disarticulation, Acrylic Material	MN	$477.08	
L7405	NU	Addition To Upper Extremity Prosthesis; Shoulder Disarticulation/Interscapular Thoracic, Acrylic Material	MN	$624.99	
L7499	NU	Upper Extremity Prosthesis Not Otherwise Specified	PA	MP	
L7600	NU	Prosthetic Donning Sleeve, Any Material, Each	MN, IOC	MP	
L8000	NU	Breast Prosthesis Mastectomy Bra	MN	$28.00	3 per 12 months
L8020	NU LT	Breast Prosthesis, Mastectomy Form	PC	$175.00	1 every 6 months
L8020	NU RT	Breast Prosthesis Mastectomy Form	PC	$175.00	1 every 6 months
L8030	NU LT	Breast Prosthesis, Silicone or Equal	PC	$306.33	1 every 24 months
L8030	NU RT	Breast Prosthesis, Silicone or Equal	PC	$306.33	1 every 24 months
L8031	NU LT	Breast Prosthesis W/Adhesive	PC	$306.33	1 every 24 months
L8031	NU RT	Breast Prosthesis W/Adhesive	PC	$306.33	1 every 24 months
L8400	NU	Prosthetic Sheath Below Knee Each	MN	$13.00	
L8410	NU	Prosthetic Sheath Above Knee Each	MN	$15.00	
L8415	NU	Prosthetic Sheath Upper Limb Each	MN	$18.24	
L8417	NU	Prosthetic Sheath/Sock Including A Gel Cushion Layer Below Knee Or Above Knee Each	MN	$56.44	
L8420	NU	Prosthetic Sock Multiple Ply; Below Knee Each	MN	$16.15	
L8430	NU	Prosthetic Sock Multiple Ply; Above Knee Each	MN	$18.33	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
L8435	NU	Prosthetic Sock Multiple Ply Upper Limb Each	MN	$18.67	
L8440	NU	Prosthetic Shrinker Below Knee Each	MN	$20.00	
L8460	NU	Prosthetic Shrinker Above Knee Each	MN	$49.00	
L8465	NU	Prosthetic Shrinker Upper Limb Each	MN	$20.00	
L8470	NU	Prosthetic Sock Single Ply Fitting; Below Knee Each	MN	$5.00	
L8480	NU	Prosthetic Sock Single Ply Fitting; Above Knee Each	MN	$7.00	
L8485	NU	Prosthetic Sock Single Ply Fitting; Upper Limb Each	MN	$10.00	
L8499	NU	Unlisted Procedure For Miscellaneous Prosthetic Services	PA	MP	
L8500	NU	Artificial Larynx	MN	$601.85	
L8500	RB	Artificial Larynx	MN	MP	
L8501	NU	Tracheostomy Speaking Valve	MN	$96.88	
L8505	NU	Artificial Larynx Replacement Batter/Accessory Any Type	MN, IOC	MP	
L8511	NU	Indwelling Trach Insert	MNF	$58.40	
L8512	NU	Gel Cap For Trach Voice Prost	MNF	$1.73	
L8513	NU	Trach Pros Cleaning Device	MNF	$4.17	
L8514	NU	Repl Trach Puncture Dilator	MNF	$75.70	
TOTAL PARENTERAL NUTRITION					
B4164	NU	Parenteral Nutrition Solution: Carbohydrates (Dextrose) 50% Or Less (500ml=1 Unit) -Homemix	PC	$15.08	
B4168	NU	Parenteral Nutrition Solution; Amino Acid 3.5% (500 Ml = 1 Unit) - Homemix	PC	$21.96	
B4172	NU	Parenteral Nutrition Solution; Amino Acid 5.5% Through 7% (500 Ml = 1 Unit) - Homemix	PC	$42.51	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
B4176	NU	Parenteral Nutrition Solution; Amino Acid 7% Through 8.5% (500 Ml = 1 Unit) - Homemix	PC	$42.51	
B4178	NU	Parenteral Nutrition Solution: Amino Acid Greater Than 8.5% (500 Ml = 1 Unit) - Homemix	PC	$51.04	
B4180	NU	Parenteral Nutrition Solution; Carbohydrates (Dextrose) Greater Than 50% (500 Ml=1 Unit) - Homemix	PC	$21.61	
B4185	NU	Parenteral Nutrition Solution, Per 10 Grams Lipids	PC	$11.36	
B4189	NU	Com Amino Acid & Carb W/Elect Trace Ele & Vita In Pre Any Stren 10 to 51 Grams Of Protein - Premix	PC	$157.66	
B4193	NU	Com Amino Acid & Carb W/Elect Trace Ele & Vita In Pre Any Stren 52 to 73 Grams Of Protein - Premix	PC	$203.73	
B4197	NU	Com Amino Acid & Carb W/Electr Trace Ele & Vitamin Pre Any Stren 74 to 100 Grams Of Protein - Premix	PC	$248.02	
B4199	NU	Com Amino Acid & Carb W/Electr Trace Ele & Vitamin Pre Any Stren Over 100 Grams Or Protein - Premix	PC	$283.42	
B4216	NU	Parenteral Nutrition; Additives (Vitamins Trace Elements Heparin Electrolytes) - Homemix; Per Day	PC	$6.85	
B4220	NU	Parenteral Nutrition Supply Kit - Premix; Per Day	PC	$7.10	1/day
B4222	NU	Parenteral Nutrition Supply Kit - Homemix Per Day	PC	$8.75	1/day
B4224	NU	Parenteral Nutrition Administration Kit Per Day	PC	$22.19	1/day
B5000	NU	Par Nut Sol;Com Amino Acid & Carb W/Electr Trace Ele & Vita In Pre Any Stren Renal-Amirosyn Rf Nephramine, Renamine - Premix	PC	$10.54	
B5100	NU	Hepatic-Freamine HBC Hepatamine - Premix	PC	$4.12	
B5200	NU	Stress-Branch Chain Amino Acids - Premix	IOC/PC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
B9004	RR	Parenteral Nutrition Infusion Pump Portable	PC	$354.30	Rent to purchase. Reimubursement not to exceed $2,238.01.
B9006	RR	Parenteral Nutrition Infusion Pump Stationary	PC	$354.30	Rent to purchase. Reimubursement not to exceed $2,238.01.
B9999	NU	NOC For Parenteral Supplies	PC, IOC	MP	
WALKERS					
E0130	NU	Walker Rigid (Pickup) Adjustable Or Fixed Height	PC	$50.00	
E0130	RR	Walker Rigid (Pickup) Adjustable Or Fixed Height	PC	$5.00	
E0135	NU	Walker Folding (Pickup) Adjustable Or Fixed Height	PC	$73.22	
E0135	RR	Walker Folding (Pickup) Adjustable Or Fixed Height	PC	$7.32	
E0140	NU	Walker W/Trunk Support Adjust Or Fxd Height Any Type	PC	$315.01	
E0140	RB	Walker W/Trunk Support Adjust Or Fxd Height Any Type	MN, IOC	MP	
E0140	RR	Walker W/Trunk Support Adjust Or Fxd Height Any Type	PC	$31.50	
E0141	NU	Rigid Wheeled Walker Adj/Fx	PC	$63.00	
E0141	RR	Rigid Wheeled Walker Adj/Fx	PC	$6.30	
E0143	NU	Walker Folding Wheeled W/o S	PC	$105.00	
E0143	RR	Walker Folding Wheeled W/o S	PC	$10.50	
E0147	NU	Walker Variable Wheel Resist	PC	$501.99	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0147	RR	Walker Variable Wheel Resist	PC	$50.20	
E0148	NU	Walker Heavy Duty W/o Wheels Rigid Or Folding Any Type Each	PC	$110.96	
E0148	RR	Walker Heavy Duty W/o Wheels Rigid Or Folding Any Type Each	PC	$11.11	
E0149	NU	Heavy Duty Wheeled Walker	PC	$194.93	
E0149	RR	Heavy Duty Wheeled Walker	PC	$19.49	
E0154	NU	Platform Attachment Walker Each		$61.58	
E0154	RR	Platform Attachment Walker Each		$7.48	
E0155	NU	Wheel Attachment Rigid Pick-Up Walker Per Pair		$23.43	
E0156	NU	Seat Attachment Walker		$18.00	
E0157	NU	Crutch Attachment Walker Each		$60.81	
E0157	RR	Crutch Attachment Walker Each		$6.76	
E0158	NU	Leg Extensions For A Walker Per Set Of Four (4)		$22.60	
E0159	NU	Brake Attachment For Wheeled Walker Replacement Each		$15.60	
WHEELCHAIR ACCESSORIES					
E0705	NU	Transfer Boar Or Device, Any Type, Each	MN	$43.34	
E0705	NU SC	Transfer Boar Or Device, Any Type, Each	PA	$43.34	
E0950	NU	Tray	MN	$79.96	
E0950	NU SC	Tray	PA	$79.96	
E0950	RB	Tray	MN	$79.96	
E0950	RB SC	Tray	MN	$79.96	
E0951	NU	Heel Loop/Holder Any Type W/Wo Ankle Strap Each	MN	$14.00	
E0951	NU SC	Heel Loop/Holder Any Type W/Wo Ankle Strap Each	PA	$14.00	
E0951	RB	Heel Loop/Holder Any Type W/Wo Ankle Strap Each	MN	$14.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0951	RB SC	Heel Loop/Holder Any Type W/Wo Ankle Strap Each	MN	$14.00	
E0952	NU	Toe Loop/Holder Any Type Each	MN	$14.00	
E0952	NU SC	Toe Loop/Holder Any Type Each	PA	$14.00	
E0952	RB	Toe Loop/Holder Any Type Each	MN	$14.00	
E0952	RB SC	Toe Loop/Holder Any Type Each	MN	$14.00	
E0955	NU	Headrest Cushioned Any Type Including Fxd Mntg Wheelchair Access	MN	$182.97	
E0955	NU SC	Headrest Cushioned Any Type Including Fxd Mntg Wheelchair Access	PA	$182.97	
E0955	RB	Headrest Cushioned Any Type Including Fxd Mntg Wheelchair Access	MN	$182.97	
E0955	RB SC	Headrest Cushioned Any Type Including Fxd Mntg Wheelchair Access	MN	$182.97	
E0956	NU	Lateral Trunk Or Hip Support W/C Access	MN	$89.21	
E0956	NU SC	Lateral Trunk Or Hip Support W/C Access	PA	$89.21	
E0956	RB	Lateral Trunk Or Hip Support W/C Access	MN	$89.21	
E0956	RB SC	Lateral Trunk Or Hip Support W/C Access	MN	$89.21	
E0957	NU	Medial Thigh Support Any Typed Including Fsd Mntg W/C Access	MN	$124.83	
E0957	NU SC	Medial Thigh Support Any Typed Including Fsd Mntg W/C Access	PA	$124.83	
E0957	RB	Medial Thigh Support Any Typed Including Fsd Mntg W/C Access	MN	$124.83	
E0957	RB SC	Medial Thigh Support Any Typed Including Fsd Mntg W/C Access	MN	$124.83	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0958	NU	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	MN	$481.00	
E0958	NU SC	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	PA	$481.00	
E0958	RB	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	MN	$650.00	
E0958	RB SC	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	PA	$650.00	
E0958	RR	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	MN	$40.08	
E0958	RR SC	Wheelchair Attachment To Convert Any Wheelchair To One Arm Drive	MN	$40.08	
E0959	NU	Manual Wheelchair Accessory, Adapter For Amputee, Each	MN	$41.19	
E0959	NU SC	Manual Wheelchair Accessory, Adapter For Amputee, Each	PA	$41.19	
E0959	RB	Manual Wheelchair Accessory, Adapter For Amputee, Each	MN	$41.19	
E0959	RB SC	Manual Wheelchair Accessory, Adapter For Amputee, Each	MN	$41.19	
E0959	RR	Manual Wheelchair Accessory, Adapter For Amputee, Each	MN	$4.45	
E0959	RR SC	Manual Wheelchair Accessory, Adapter For Amputee, Each	MN	$4.45	
E0960	NU	W/C Shoulder Harness/Strap	MN	$82.34	
E0960	NU SC	W/C Shoulder Harness/Strap	PA	$82.34	
E0960	RB	W/C Shoulder Harness/Strap	MN	$82.34	
E0960	RB SC	W/C Shoulder Harness/Strap	MN	$82.34	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0961	NU	Brake Extension For Wheelchair	MN	$14.00	
E0961	NU SC	Brake Extension For Wheelchair	PA	$14.00	
E0961	RB	Brake Extension For Wheelchair	MN	$14.00	
E0961	RB SC	Brake Extension For Wheelchair	MN	$14.00	
E0966	NU	Hook On Head Rest Extension	MN	$62.00	
E0966	NU SC	Hook On Head Rest Extension	PA	$62.00	
E0966	RB	Hook On Head Rest Extension	MN	$62.00	
E0966	RB SC	Hook On Head Rest Extension	MN	$62.00	
E0966	RR	Hook On Head Rest Extension	MN	$7.00	
E0966	RR SC	Hook On Head Rest Extension	MN	$7.00	
E0967	NU	Hand Rim W/Projections Any Type Replacement	MN	$68.97	
E0967	NU SC	Hand Rim W/Projections Any Type Replacement	PA	$68.97	
E0967	RB	Hand Rim W/Projections Any Type Replacement	MN	$68.97	
E0967	RB SC	Hand Rim W/Projections Any Type Replacement	MN	$68.97	
E0968	NU	Commode Seat Wheelchair	MN	$190.79	
E0968	NU SC	Commode Seat Wheelchair	PA	$190.79	
E0968	RB	Commode Seat Wheelchair	MN	$190.79	
E0968	RB SC	Commode Seat Wheelchair	MN	$190.79	
E0968	RR	Commode Seat Wheelchair	MN	$15.90	
E0968	RR SC	Commode Seat Wheelchair	MN	$15.90	
E0969	NU	Wheelchair Narrowing Device	MN	$132.48	
E0969	NU SC	Wheelchair Narrowing Device	PA	$132.48	
E0969	RB	Wheelchair Narrowing Device	MN	$132.48	
E0969	RB SC	Wheelchair Narrowing Device	MN	$132.48	
E0970	NU	No.2 Footplates Except For Elevating Leg Rest	MN	$40.00	
E0970	NU SC	No.2 Footplates Except For Elevating Leg Rest	PA	$40.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0970	RB	No.2 Footplates Except For Elevating Leg Rest	MN	$40.00	
E0970	RB SC	No.2 Footplates Except For Elevating Leg Rest	MN	$40.00	
E0971	NU	Anti-Tipping Device Wheelchairs	MN	$34.00	
E0971	NU SC	Anti-Tipping Device Wheelchairs	PA	$34.00	
E0971	RB	Anti-Tipping Device Wheelchairs	MN	$34.00	
E0971	RB SC	Anti-Tipping Device Wheelchairs	MN	$34.00	
E0973	NU	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	MN	$81.50	
E0973	NU SC	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	PA	$81.50	
E0973	RB	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	MN	$81.50	
E0973	RB SC	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	MN	$81.50	
E0973	RR	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	MN	$8.00	
E0973	RR SC	Adjustable Height Detachable Arms Desk Or Full Length Wheelchair, each	MN	$8.00	
E0974	NU	"Grade-Aid" (Device To Prevent Rolling Back On An Incline) For Wheelchair	MN	$70.00	
E0974	NU SC	"Grade-Aid" (Device To Prevent Rolling Back On An Incline) For Wheelchair	PA	$70.00	
E0974	RB	"Grade-Aid" (Device To Prevent Rolling Back On An Incline) For Wheelchair	MN	$70.00	
E0974	RB SC	"Grade-Aid" (Device To Prevent Rolling Back On An Incline) For Wheelchair	MN	$70.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0978	NU	Positioning Belt/Safety Belt/Pelvic Strap Each W/C Access	MN	$32.84	
E0978	NU SC	Positioning Belt/Safety Belt/Pelvic Strap Each W/C Access	PA	$32.84	
E0978	RB	Positioning Belt/Safety Belt/Pelvic Strap Each W/C Access	MN	$32.84	
E0978	RB SC	Positioning Belt/Safety Belt/Pelvic Strap Each W/C Access	MN	$32.84	
E0980	NU	Safety Vest Wheelchair	MN	$20.96	
E0980	NU SC	Safety Vest Wheelchair	PA	$20.96	
E0980	RB	Safety Vest Wheelchair	MN	$20.96	
E0980	RB SC	Safety Vest Wheelchair	MN	$20.96	
E0981	RB	Seat Upholstery Replacement	MN	$38.75	
E0981	RB SC	Seat Upholstery Replacement	MN	$38.75	
E0982	RB	Back Upholstery Replacement	MN	$46.63	
E0982	RB SC	Back Upholstery Replacement	MN	$46.63	
E0983	NU	Add Power Joystick	PA	$2,623.22	
E0983	NU SC	Add Power Joystick	PA	$2,623.22	
E0983	RB	Add Power Joystick	PA	$2,623.22	
E0983	RB SC	Add Power Joystick	PA	$2,623.22	
E0984	NU	Add Power Tiller	PA	$1,910.58	
E0984	NU SC	Add Power Tiller	PA	$1,910.58	
E0984	RB	Add Power Tiller	MN	$1,910.58	
E0984	RB SC	Add Power Tiller	MN	$1,910.58	
E0986	NU	Push Activated Power Assist Each W/C Access	PA	$4,864.24	
E0986	NU SC	Push Activated Power Assist Each W/C Access	PA	$4,864.24	
E0986	RB	Push Activated Power Assist Each W/C Access	MN	$4,864.24	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0986	RB SC	Push Activated Power Assist Each W/C Access	PA	$4,864.24	
E0988	NU	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	PA	$3,258.00	
E0988	NU SC	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	PA	$3,258.00	
E0988	RB	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	MN	$3,258.00	
E0988	RB SC	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	MN	$3,258.00	
E0988	RR	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	PA	$271.50	
E0988	RR SC	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	PA	$271.50	
E0990	NU	Elevating Leg Rest Each	MN	$90.33	
E0990	NU SC	Elevating Leg Rest Each	PA	$90.33	
E0990	RB	Elevating Leg Rest Each	MN	$90.33	
E0990	RB SC	Elevating Leg Rest Each	MN	$90.33	
K0195	RR	Elevating Leg Rest, Pair (For Use W/Rental Wheelchair Base)	MN	$18.40	
K0195	RR SC	Elevating Leg Rest, Pair (For Use W/Rental Wheelchair Base)	PA	$18.40	
E0992	NU	Solid Seat Insert	MN	$76.00	
E0992	NU SC	Solid Seat Insert	PA	$76.00	
E0992	RB	Solid Seat Insert	MN	$76.00	
E0992	RB SC	Solid Seat Insert	MN	$76.00	
E0994	NU	Arm Rest Each	MN	$17.63	
E0994	NU SC	Arm Rest Each	PA	$17.63	
E0994	RB	Arm Rest Each	MN	$17.63	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E0994	RB SC	Arm Rest Each	MN	$17.63	
E0995	NU	Calf Rest Each	MN	$27.51	
E0995	RB	Calf Rest Each	MN	$27.51	
E0995	RB SC	Calf Rest Each	MN	$27.51	
E1002	NU	Pwr Seat Tilt	PA	$3,668.16	
E1002	NU SC	Pwr Seat Tilt	PA	$3,668.16	
E1002	RB	Pwr Seat Tilt	MN	$3,668.16	
E1002	RB SC	Pwr Seat Tilt	MN	$3,668.16	
E1003	NU	Pwr Seat Recline	PA	$3,974.13	
E1003	NU SC	Pwr Seat Recline	PA	$3,974.13	
E1003	RB	Pwr Seat Recline	MN	$3,974.13	
E1003	RB SC	Pwr Seat Recline	MN	$3,974.13	
E1004	NU	Pwr Seat Recline Mech	PA	$4,406.49	
E1004	NU SC	Pwr Seat Recline Mech	PA	$4,406.49	
E1004	RB	Pwr Seat Recline Mech	MN	$4,406.49	
E1004	RB SC	Pwr Seat Recline Mech	MN	$4,406.49	
E1005	NU	Pwr Seat Recline Pwr	PA	$4,769.68	
E1005	NU SC	Pwr Seat Recline Pwr	PA	$4,769.68	
E1005	RB	Pwr Seat Recline Pwr	MN	$4,769.68	
E1005	RB SC	Pwr Seat Recline Pwr	MN	$4,769.68	
E1006	NU	Pwr Seat Combo W/o Shear	PA	$5,842.41	
E1006	NU SC	Pwr Seat Combo W/o Shear	PA	$5,842.41	
E1006	RB	Pwr Seat Combo W/o Shear	MN	$5,842.41	
E1006	RB SC	Pwr Seat Combo W/o Shear	MN	$5,842.41	
E1007	NU	Pwr Seat Comvo W/Shear	PA	$7,910.85	
E1007	NU SC	Pwr Seat Comvo W/Shear	PA	$7,910.85	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1007	RB	Pwr Seat Comvo W/Shear	MN	$7,910.85	
E1007	RB SC	Pwr Seat Comvo W/Shear	MN	$7,910.85	
E1008	NU	Pwr Seat Combo Pwr Shear	PA	$7,911.56	
E1008	NU SC	Pwr Seat Combo Pwr Shear	PA	$7,911.56	
E1008	RB	Pwr Seat Combo Pwr Shear	MN	$7,911.56	
E1008	RB SC	Pwr Seat Combo Pwr Shear	MN	$7,911.56	
E1009	NU	Add Mech Leg Elevation	PA	MP	
E1009	NU SC	Add Mech Leg Elevation	PA	MP	
E1009	RB	Add Mech Leg Elevation	PA	MP	
E1009	RB SC	Add Mech Leg Elevation	PA	MP	
E1010	NU	Addition To Power Seating System Power Leg Elevation	PA	$1,035.13	
E1010	NU SC	Addition To Power Seating System Power Leg Elevation	PA	$1,035.13	
E1010	RB	Addition To Power Seating System Power Leg Elevation	MN	$1,035.13	
E1010	RB SC	Addition To Power Seating System Power Leg Elevation	MN	$1,035.13	
E1011	NU	Mod To Pediatric Sz Chair Width Adjustment Package	PA	MP	
E1011	NU SC	Mod To Pediatric Sz Chair Width Adjustment Package	PA	MP	
E1011	RB	Mod To Pediatric Sz Chair Width Adjustment Package	MN	MP	
E1011	RB SC	Mod To Pediatric Sz Chair Width Adjustment Package	MN	MP	
E1014	NU	Reclining Back For Pediatric Sz Chair	PA	$365.14	
E1014	NU SC	Reclining Back For Pediatric Sz Chair	PA	$365.14	
E1014	RB	Reclinig Back For Pediatric Sz Chair	MN	$365.14	
E1014	RB SC	Reclining Back For Pediatric Sz Chair	MN	$365.14	
E1015	NU	Shock Absorber For Man W/C	MN	$114.70	
E1015	NU SC	Shock Absorber For Man W/C	PA	$114.70	
E1015	RB	Shock Absorber For Man W/C	MN	$114.70	
E1015	RB SC	Shock Absorber For Man W/C	MN	$114.70	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1016	NU	Shock Absorber For Power W/C	MN	$118.84	
E1016	NU SC	Shock Absorber For Power W/C	PA	$118.84	
E1016	RB	Shock Absorber For Power W/C	MN	$118.84	
E1016	RB SC	Shock Absorber For Power W/C	MN	$118.84	
E1017	NU	Hd Shck Absrbr For Hd Man Wc	MN	MP	
E1017	NU SC	Hd Shck Absrbr For Hd Man Wc	PA	MP	
E1017	RB	Hd Shck Absrbr For Hd Man Wc	MN	MP	
E1017	RB SC	Hd Shck Absrbr For Hd Man Wc	MN	MP	
E1018	NU	Hd Shck Absrber For Hd Powwc	PA	MP	
E1018	NU SC	Hd Shck Absrber For Hd Powwc	PA	MP	
E1018	RB	Hd Shck Absrber For Hd Powwc	MN	MP	
E1018	RB SC	Hd Shck Absrber For Hd Powwc	MN	MP	
E1020	NU	Residual Limb Support System	MN	$220.29	
E1020	NU SC	Residual Limb Support System	PA	$220.29	
E1020	RB	Residual Limb Support System	MN	$220.29	
E1020	RB SC	Residual Limb Support System	MN	$220.29	
E1028	NU	W/C Manual Swingaway Retract/Remov Mntgy Hardware For Joystick Other Control Interface Or Post Accessory	MN	$186.92	
E1028	NU SC	W/C Manual Swingaway Retract/Remov Mntgy Hardware For Joystick Other Control Interface Or Post Accessory	PA	$186.92	
E1028	RB	W/C Manual Swingaway Retract/Remov Mntgy Hardware For Joystick Other Control Interface Or Post Accessory	MN	$186.92	
E1028	RB SC	W/C Manual Swingaway Retract/Remov Mntgy Hardware For Joystick Other Control Interface Or Post Accessory	MN	$186.92	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1029	NU	W/C Vent Tray Fixed	MN	$334.43	
E1029	NU SC	W/C Vent Tray Fixed	PA	$334.43	
E1029	RB	W/C Vent Tray Fixed	MN	$334.43	
E1029	RB SC	W/C Vent Tray Fixed	MN	$334.43	
E1030	NU	W/C Vent Tray Gimbaled	MN	$1,054.57	
E1030	NU SC	W/C Vent Tray Gimbaled	PA	$1,054.57	
E1030	RB	W/C Vent Tray Gimbaled	MN	$1,054.57	
E1030	RB SC	W/C Vent Tray Gimbaled	MN	$1,054.57	
E1066	RB	Battery Charger	MN	$200.00	
E1227	NU	Special Height Arms For Wheelchair	MN	$277.50	
E1227	NU SC	Special Height Arms For Wheelchair	PA	$277.50	
E1227	RB	Special Height Arms For Wheelchair	MN	$277.50	
E1227	RB SC	Special Height Arms For Wheelchair	MN	$277.50	
E1228	NU	Special Back Height For Wheelchair	MN	$294.26	
E1228	NU SC	Special Back Height For Wheelchair	PA	$294.26	
E1228	RB	Special Back Height For Wheelchair	MN	$294.26	
E1228	RB SC	Special Back Height For Wheelchair	MN	$294.26	
E1296	NU	Special Wheelchair Seat Height From Floor	PA	$386.00	
E1296	NU SC	Special Wheelchair Seat Height From Floor	PA	$386.00	
E1296	RB	Special Wheelchair Seat Height From Floor	PA	$386.00	
E1296	RB SC	Special Wheelchair Seat Height From Floor	PA	$386.00	
E1297	NU	Special Wheelchair Seat Depth By Upholstery	PA	$83.00	
E1297	NU SC	Special Wheelchair Seat Depth By Upholstery	PA	$83.00	
E1297	RB	Special Wheelchair Seat Depth By Upholstery	PA	$83.00	
E1297	RB SC	Special Wheelchair Seat Depth By Upholstery	PA	$83.00	
E1298	NU	Special Wheelchair Seat Depth And/Or Width By	PA	$417.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Construction			
E1298	NU SC	Special Wheelchair Seat Depth And/Or Width By Construction	PA	$417.00	
E1298	RB	Special Wheelchair Seat Depth And/Or Width By Construction	PA	$417.00	
E1298	RB SC	Special Wheelchair Seat Depth And/Or Width By Construction	PA	$417.00	
E2201	NU	Man W/C Acc Seat W>=20"<24"	PA	$373.10	
E2201	NU SC	Man W/C Acc Seat W>=20"<24"	PA	$373.10	
E2201	RB	Man W/C Acc Seat W>=20"<24"	PA	$373.10	
E2201	RB SC	Man W/C Acc Seat W>=20"<24"	PA	$373.10	
E2202	NU	Seat Width 24-27 Inches	PA	$473.98	
E2202	NU SC	Seat Width 24-27 Inches	PA	$473.98	
E2202	RB	Seat Width 24-27 Inches	PA	$473.98	
E2202	RB SC	Seat Width 24-27 Inches	PA	$473.98	
E2203	NU	Frame Depth Less Than 22 Inches	PA	$479.05	
E2203	NU SC	Frame Depth Less Than 22 Inches	PA	$479.05	
E2203	RB	Frame Depth Less Than 22 Inches	PA	$479.05	
E2203	RB SC	Frame Depth Less Than 22 Inches	PA	$479.05	
E2204	NU	Frame Dept 22 To 25 Inches	PA	$813.40	
E2204	NU SC	Frame Dept 22 To 25 Inches	PA	$813.40	
E2204	RB	Frame Dept 22 To 25 Inches	PA	$813.40	
E2204	RB SC	Frame Dept 22 To 25 Inches	PA	$813.40	
E2205	RB	Wc Access Handrim W/o Projections Any Type Replacement	MN	$32.67	
E2205	RB SC	Wc Access Handrim W/o Projections Any Type Replacement	MN	$32.67	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2206	NU	Wheel Lock Assembly Complete Each	MN	$40.68	
E2206	RB	Wheel Lock Assembly Complete Each	MN	$40.68	
E2206	RB SC	Wheel Lock Assembly Complete Each	MN	$40.68	
E2207	NU	Wheelchair Accessory, Crutch And Cane Holder, Each	MN	$39.44	
E2207	NU SC	Wheelchair Accessory, Crutch And Cane Holder, Each	PA	$39.44	
E2207	RB	Wheelchair Accessory, Crutch And Cane Holder, Each	MN	$39.44	
E2207	RB SC	Wheelchair Accessory, Crutch And Cane Holder, Each	MN	$39.44	
E2208	NU	Wheelchair Accessory, Cylinder Tank Carrier, Each	MN	$107.50	
E2208	NU SC	Wheelchair Accessory, Cylinder Tank Carrier, Each	PA	$107.50	
E2208	RB	Wheelchair Accessory, Cylinder Tank Carrier, Each	MN	$107.50	
E2208	RB SC	Wheelchair Accessory, Cylinder Tank Carrier, Each	MN	$107.50	
E2209	NU	Wheelchair Accessory, Arm Trough, Each	MN	$96.98	
E2209	NU SC	Wheelchair Accessory, Arm Trough, Each	PA	$96.98	
E2209	RB	Wheelchair Accessory, Arm Trough, Each	MN	$96.98	
E2209	RB SC	Wheelchair Accessory, Arm Trough, Each	MN	$96.98	
E2210	RB	Wheelchair Accessory, Bearings, Any Type, Replacement Only, Each	MN	$5.93	
E2210	RB SC	Wheelchair Accessory, Bearings, Any Type, Replacement Only, Each	MN	$5.93	
E2211	NU	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	MN	$27.00	
E2211	NU SC	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	PA	$27.00	
E2211	RB	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	MN	$27.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2211	RB SC	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	MN	$27.00	
E2212	NU	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	MN	$5.88	
E2212	NU SC	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	PA	$5.88	
E2212	RB	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	MN	$5.88	
E2212	RB SC	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	MN	$5.88	
E2213	NU	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	MN	$30.41	
E2213	NU SC	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	PA	$30.41	
E2213	RB	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	MN	$30.41	
E2213	RB SC	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	MN	$30.41	
E2214	NU	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MN	$36.00	
E2214	NU SC	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	PA	$36.00	
E2214	RB	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MN	$36.00	
E2214	RB SC	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MN	$36.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2214	NU SC	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	PA	$36.00	
E2214	RB	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MN	$36.00	
E2214	RB SC	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MN	$36.00	
E2215	NU	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	MN	$10.08	
E2215	NU SC	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	PA	$10.08	
E2215	RB	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	MN	$10.08	
E2215	RB SC	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	MN	$10.08	
E2216	NU	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MN	MP	
E2216	NU SC	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	PA	MP	
E2216	RB	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MN	MP	
E2216	RB SC	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MN	MP	
E2217	NU	Manual Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Each	MN	MP	
E2217	NU SC	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	PA	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2217	RB	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MN	MP	
E2217	RB SC	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MN	MP	
E2218	NU	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	MN	MP	
E2218	NU SC	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	PA	MP	
E2218	RB	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	MN	MP	
E2218	RB SC	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	MN	MP	
E2219	NU	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	MN	$41.85	
E2219	NU SC	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	PA	$41.85	
E2219	RB	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	MN	$41.85	
E2219	RB SC	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	MN	$41.85	
E2220	NU	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size Each	MN	$27.48	
E2220	NU SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size Each	PA	$27.48	
E2220	RB	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size Each	MN	$27.48	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2220	RB SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size Each	MN	$27.48	
E2221	NU	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	MN	$25.55	
E2221	NU SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	PA	$25.55	
E2221	RB	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	MN	$25.55	
E2221	RB SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	MN	$25.55	
E2222	NU	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel, Any Size, Each	MN	$21.06	
E2222	NU SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel, Any Size, Each	PA	$21.06	
E2222	RB	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel, Any Size, Each	MN	$21.06	
E2222	RB SC	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel, Any Size, Each	MN	$21.06	
E2224	NU	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	MN	$98.06	
E2224	NU SC	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	PA	$98.06	
E2224	RB	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	MN	$98.06	
E2224	RB SC	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	MN	$98.06	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2225	RB	Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	MN	$17.40	
E2225	RB SC	Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	MN	$17.40	
E2226	RB	Manual Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	MN	$37.94	
E2226	RB SC	Manual Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	MN	$37.94	
E2228	NU	Manual Wheelchair Accessory, Wheel Brake	PA	MP	
E2228	NU SC	Manual Wheelchair Accessory, Wheel Brake	PA	MP	
E2228	RB	Manual Wheelchair Accessory, Wheel Brake	MN	MP	
E2228	RB SC	Manual Wheelchair Accessory, Wheel Brake	MN	MP	
E2231	NU	Manual Wheelchair Accessory, Solid Seat Support Base (Replaces Sling Seat)	MN	$161.36	
E2231	NU SC	Manual Wheelchair Accessory, Solid Seat Support Base, (Replaces Sling Seat)	PA	$161.36	
E2231	RB	Manual Wheelchair Accessory, Solid Seat Support Base, (Replaces Sling Seat)	MN	$161.36	
E2231	RB SC	Manual Wheelchair Accessory, Solid Seat Support Base, (Replaces Sling Seat)	MN	$161.36	
E2291	NU	Back Planar For Ped W/C Including Fxd Attach Hardware	PA	MP	
E2291	NU SC	Back Planar For Ped W/C Including Fxd Attach Hardware	PA	MP	
E2291	RB	Back Planar For Ped W/C Including Fxd Attach Hardware	MN	MP	
E2291	RB SC	Back Planar For Ped W/C Including Fxd Attach Hardware	MN	MP	
E2292	NU	Seat Planar Ped Sz W/C Includes Fxd Attaching Hardware	PA	MP	
E2292	NU SC	Seat Planar Ped Sz W/C Includes Fxd Attaching Hardware	PA	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2292	RB	Seat Planar Ped Sz W/C Includes Fxd Attaching Hardware	MN	MP	
E2292	RB SC	Seat Planar Ped Sz W/C Includes Fxd Attaching Hardware	MN	MP	
E2293	NU	Ped Sz W/C Back Contoured Fixed Attaching	PA	MP	
E2293	NU SC	Ped Sz W/C Back Contoured Fixed Attaching	PA	MP	
E2293	RB	Ped Sz W/C Back Contoured Fixed Attaching	MN	MP	
E2293	RB SC	Ped Sz W/C Back Contoured Fixed Attaching	MN	MP	
E2294	NU	Seat Contoured Ped Sz W/C Including Fxd Attaching	PA	MP	
E2294	NU SC	Seat Contoured Ped Sz W/C Including Fxd Attaching	PA	MP	
E2294	RB	Seat Contoured Ped Sz W/C Including Fxd Attaching Hardware	MN	MP	
E2294	RB SC	Seat Contoured Ped Sz W/C Including Fxd Attaching Hardware	MN	MP	
E2295	NU	Manual Wheelchair Accessory, For Pediatric Size Wheelchiar, Dynamic Seating	PA, IOC	MP	
E2295	RB	Manual Wheelchair Accessory, for Pediatric Size Wheelchiar, Dynamic Seating	MN, IOC	MP	
E2310	NU	Electro Connect Between Controller	PA	$1,059.07	
E2310	NU SC	Electro Connect Between Controller	PA	$1,059.07	
E2310	RB	Electro Connect Between Controller	MN	$1,059.07	
E2310	RB SC	Electro Connect Between Controller	MN	$1,059.07	
E2311	NU	Electro Connect Between 2 System Motors	PA	$2,144.13	
E2311	NU SC	Electro Connect Between 2 System Motors	PA	$2,144.13	
E2311	RB	Electro Connect Between 2 System Motors	MN	$2,144.13	
E2311	RB SC	Electro Connect Between 2 System Motors	MN	$2,144.13	
E2312	NU	Mini-Proportional Remote Joystick	PA	$2,016.71	
E2312	NU SC	Mini-Proportional Remote Joystick	PA	$2,016.71	
E2312	RB	Mini-Proportional Remote Joystick	MN	$2,117.55	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2312	RB SC	Mini-Proportional Remote Joystick	MN	$2,117.55	
E2313	NU	Power Wheelchair Harness For Upgrade To Expandable Controller	PA	$320.26	
E2313	NU SC	Power Wheelchair Harness For Upgrade To Expandable Controller	PA	$320.26	
E2313	RB	Power Wheelchair Harness For Upgrade To Expandable Controller	MN	$320.26	
E2313	RB SC	Power Wheelchair Harness For Upgrade To Expandable Controller	MN	$320.26	
E2321	NU	Hand Interface Joystick	PA	$1,438.14	
E2321	NU SC	Hand Interface Joystick	PA	$1,438.14	
E2321	RB	Hand Interface Joystick	MN	$1,438.14	
E2321	RB SC	Hand Interface Joystick	MN	$1,438.14	
E2322	NU	Mult Mech Switches	PA	$1,276.38	
E2322	NU SC	Mult Mech Switches	PA	$1,276.38	
E2322	RB	Mult Mech Switches	MN	$1,276.38	
E2322	RB SC	Mult Mech Switches	MN	$1,276.38	
E2323	NU	Special Joystick Handle	MN	$62.59	
E2323	NU SC	Special Joystick Handle	PA	$62.59	
E2323	RB	Special Joystick Handle	MN	$62.59	
E2323	RB SC	Special Joystick Handle	MN	$62.59	
E2324	NU	Chin Cup Interface	MN	$39.66	
E2324	NU SC	Chin Cup Interface	PA	$39.66	
E2324	RB	Chin Cup Interface	MN	$39.66	
E2324	RB SC	Chin Cup Interface	MN	$39.66	
E2325	NU	Sip And Puff Interface	PA	$1,218.88	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2325	NU SC	Sip And Puff Interface	PA	$1,218.88	
E2325	RB	Sip And Puff Interface	MN	$1,218.88	
E2325	RB SC	Sip And Puff Interface	PA	$1,218.88	
E2326	NU	Breath Tube Kit	MN	$314.16	
E2326	NU SC	Breath Tube Kit	PA	$314.16	
E2326	RB	Breath Tube Kit	MN	$314.16	
E2326	RB SC	Breath Tube Kit	MN	$314.16	
E2327	NU	Head Control Interface Mechanical	PA	$2,364.20	
E2327	NU SC	Head Control Interface Mechanical	PA	$2,364.20	
E2327	RB	Head Control Interface Mechanical	MN	$2,364.20	
E2327	RB SC	Head Control Interface Mechanical	MN	$2,364.20	
E2328	NU	Head Extremity Control Interface Electronic	PA	$4,484.56	
E2328	NU SC	Head Extremity Control Interface Electronic	PA	$4,484.56	
E2328	RB	Head Extremity Control Interface Electronic	MN	$4,484.56	
E2328	RB SC	Head Extremity Control Interface Electronic	MN	$4,484.56	
E2329	NU	Head Control Nonproportional	PA	$1,598.35	
E2329	NU SC	Head Control Nonproportional	PA	$1,598.35	
E2329	RB	Head Control Nonproportional	MN	$1,598.35	
E2329	RB SC	Head Control Nonproportional	MN	$1,598.35	
E2330	NU	Head Control Proximity Switch	PA	$3,096.99	
E2330	NU SC	Head Control Proximity Switch	PA	$3,096.99	
E2330	RB	Head Control Proximity Switch	MN	$3,096.99	
E2330	RB SC	Head Control Proximity Switch	MN	$3,096.99	
E2331	NU	Attendant Control	PA	MP	
E2331	NU SC	Attendant Control	PA	MP	
E2331	RB	Attendant Control	PA	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2331	RB SC	Attendant Control	PA	MP	
E2340	NU	W/C Width 20-23 Inch Seat Frame	PA	$358.36	
E2340	NU SC	W/C Width 20-23 Inch Seat Frame	PA	$358.36	
E2340	RB	W/C Width 20-23 Inch Seat Frame	PA	$358.36	
E2340	RB SC	W/C Width 20-23 Inch Seat Frame	PA	$358.36	
E2341	NU	W/C Width 24-27 Inch Seat Frame	PA	$537.58	
E2341	NU SC	W/C Width 24-27 Inch Seat Frame	PA	$537.58	
E2341	RB	W/C Width 24-27 Inch Seat Frame	PA	$537.58	
E2341	RB SC	W/C Width 24-27 Inch Seat Frame	PA	$537.58	
E2342	NU	W/C Depth 20-21 Inch Seat Frame	PA	$447.98	
E2342	NU SC	W/C Depth 20-21 Inch Seat Frame	PA	$447.98	
E2342	RB	W/C Depth 20-21 Inch Seat Frame	PA	$447.98	
E2342	RB SC	W/C Depth 20-21 Inch Seat Frame	PA	$447.98	
E2343	NU	W/C Depth 22-25 Inch Seat Frame	PA	$716.78	
E2343	NU SC	W/C Depth 22-25 Inch Seat Frame	PA	$716.78	
E2343	RB	W/C Depth 22-25 Inch Seat Frame	PA	$716.78	
E2343	RB SC	W/C Depth 22-25 Inch Seat Frame	PA	$716.78	
E2351	NU	Electronic Sgd Interface	PA	$632.26	
E2351	NU SC	Electronic Sgd Interface	PA	$632.26	
E2351	RB	Electronic Sgd Interface	MN	$632.26	
E2351	RB SC	Electronic Sgd Interface	MN	$632.26	
E2359	NU	PWC Access Group 34 Sealed Lead Acid Battery Each (Gel)		$187.04	
E2359	NU SC	PWC Access Group 34 Sealed Lead Acid Battery Each (Gel)		$187.04	
E2359	RB	PWC Access Group 34 Sealed Lead Acid Battery Each (Gel)		$187.04	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2359	RB SC	PWC Access Group 34 Sealed Lead Acid Battery Each (Gel)		$187.04	
E2360	NU	22 Nf Non-Sealed Lead Acid Battery Each		$109.96	
E2360	NU SC	22 Nf Non-Sealed Lead Acid Battery Each	PA	$109.96	
E2360	RB	22 Nf Non-Sealed Lead Acid Battery Each		$109.96	
E2360	RB SC	22 Nf Non-Sealed Lead Acid Battery Each		$109.96	
E2361	NU	22 Nf Sealed Lead Acid Battery Each		$126.22	
E2361	NU SC	22 Nf Sealed Lead Acid Battery Each	PA	$126.22	
E2361	RB	22 Nf Sealed Lead Acid Battery Each		$126.22	
E2361	RB SC	22 Nf Sealed Lead Acid Battery Each		$126.22	
E2362	NU	Group 24 Non-Sealed Lead Acid Battery Each		$91.98	
E2362	NU SC	Group 24 Non-Sealed Lead Acid Battery Each	PA	$91.98	
E2362	RB	Group 24 Non-Sealed Lead Acid Battery Each		$91.98	
E2362	RB SC	Group 24 Non-Sealed Lead Acid Battery Each		$91.98	
E2363	NU	Group 24 Sealed Lead Acid Battery Each		$168.33	
E2363	NU SC	Group 24 Sealed Lead Acid Battery Each	PA	$168.33	
E2363	RB	Group 24 Sealed Lead Acid Battery Each		$168.33	
E2363	RB SC	Group 24 Sealed Lead Acid Battery Each		$168.33	
E2364	NU	U-1 Non-Sealed Lead Acid Battery		$109.96	
E2364	NU SC	U-1 Non-Sealed Lead Acid Battery	PA	$109.96	
E2364	RB	U-1 Non-Sealed Lead Acid Battery		$109.96	
E2364	RB SC	U-1 Non-Sealed Lead Acid Battery		$109.96	
E2365	NU	U-1 Sealed Lead Acid Battery Each		$101.51	
E2365	NU SC	U-1 Sealed Lead Acid Battery Each	PA	$101.51	
E2365	RB	U-1 Sealed Lead Acid Battery Each		$101.51	
E2365	RB SC	U-1 Sealed Lead Acid Battery Each		$101.51	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2366	NU	Battery Charger Single Mode		$238.58	
E2366	RB	Battery Charger Single Mode		$238.58	
E2366	RB SC	Battery Charger Single Mode		$238.58	
E2367	RB	Battery Charger Dual Mode		$263.62	
E2367	RB SC	Battery Charger Dual Mode		$263.62	
E2368	RB	Motor Replacement For Power Chair	MN	$467.50	
E2368	RB SC	Motor Replacement For Power Chair	MN	$467.50	
E2369	RB	Gear Box Replacement For Power Chair	MN	$407.20	
E2369	RB SC	Gear Box Replacement For Power Chair	MN	$407.20	
E2370	RB	Motor And Gear Box Combo Replacement Power Chair	MN	$726.57	
E2370	RB SC	Motor And Gear Box Combo Replacement Power Chair	MN	$726.57	
E2371	NU	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	MN	$136.42	
E2371	NU SC	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	PA	$136.42	
E2371	RB	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	MN	$136.42	
E2371	RB SC	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	MN	$136.42	
E2372	NU	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	MN	MP	
E2372	NU SC	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	PA	MP	
E2372	RB	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2372	RB SC	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	MN	MP	
E2373	NU	Hand Chin Control	MN	$702.98	
E2373	NU SC	Hand Chin Control	PA	$702.98	
E2373	RB	Hand Chin Control	MN	$738.13	
E2373	RB SC	Hand Chin Control	MN	$738.13	
E2374	RB	Hand Chin Control	MN	$483.29	
E2374	RB SC	Hand Chin Control	MN	$483.29	
E2375	RB	PWC Accessory, Non-Expandable Controller	MN	$775.19	
E2375	RB SC	PWC Accessory, Non-Expandable Controller	MN	$775.19	
E2376	RB	PWC Accessory, Expandable Controller	MN	$1,214.75	
E2376	RB SC	PWC Accessory, Expandable Controller	MN	$1,214.75	
E2377	NU	PWC Accessory, Expandable Controller	PA	$439.57	
E2377	NU SC	PWC Accessory, Expandable Controller	PA	$439.57	
E2377	RB	PWC Accessory, Expandable Controller	MN	$439.57	
E2377	RB SC	PWC Accessory, Expandable Controller	MN	$439.57	
E2378	RB	PWC Actuator Replacement	PA	MP	
E2378	RB SC	PWC Actuator Replacement	PA	MP	
E2381	RB	PWC Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	MN	$68.94	
E2381	RB SC	PWC Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	MN	$68.94	
E2382	RB	Tube For Pneumatic Tire Wheel, Any Size, Replacement Only	MN	$18.80	
E2382	RB SC	Tube For Pneumatic Tire Wheel, Any Size, Replacement Only	MN	$18.80	
E2383	RB	Insert For Pneumatic Tire Wheel (Removable)	MN	$137.45	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2383	RB SC	Insert For Pneumatic Tire Wheel (Removable)	MN	$137.45	
E2384	RB	Pneumatic Caster Tire	MN	$73.22	
E2384	RB SC	Pneumatic Caster Tire	MN	$73.22	
E2385	RB	Tube for Pneumatic Caster Tire	MN	$44.80	
E2385	RB SC	Tube for Pneumatic Caster Tire	MN	$44.80	
E2386	RB	Foam Filled Drive Wheel Tire	MN	$136.21	
E2386	RB SC	Foam Filled Drive Wheel Tire	MN	$136.21	
E2387	RB	Foam Filled Caster Tire	MN	$60.21	
E2387	RB SC	Foam Filled Caster Tire	MN	$60.21	
E2388	RB	Foam Drive Wheel Tire	MN, IOC	$45.60	
E2388	RB SC	Foam Drive Wheel Tire	MN	$45.60	
E2389	RB	Foam Caster Tire	MN, IOC	$24.76	
E2389	RB SC	Foam Caster Tire	MN	$24.76	
E2390	RB	Solid (Rubber/Plastic) Drive Wheel Tire	MN, IOC	$38.72	
E2390	RB SC	Solid (Rubber/Plastic) Drive Wheel Tire	MN	$38.72	
E2391	RB	Solid (Rubber/Plastic) Caster Tire	MN	$18.55	
E2391	RB SC	Solid (Rubber/Plastic) Caster Tire	MN	$18.55	
E2392	RB	Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel	MN	$48.76	
E2392	RB SC	Solid (Rubber/Plastic) Caster Tire W/Integrated Wheel	MN	$48.76	
E2394	RB	Drive Wheel Excludes Tire	MN	$69.46	
E2394	RB SC	Drive Wheel Excludes Tire	MN	$69.46	
E2395	RB	Caster Wheel Excludes Tire	MN	$49.37	
E2395	RB SC	Caster Wheel Excludes Tire	MN	$49.37	
E2396	RB	Caster W/A Fork	MN	$60.19	
E2396	RB SC	Caster W/A Fork	MN	$60.19	
E2397	NU	Power Wheelchair Accessory, Lithium-Based Battery,	IOC	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Each			
E2397	NU SC	Power Wheelchair Accessory, Lithium-Based Battery, Each	PA	MP	
E2397	RB	Power Wheelchair Accessory, Lithium-Based Battery, Each	IOC	MP	
E2397	RB SC	Power Wheelchair Accessory, Lithium-Based Battery, Each	IOC	MP	
E2601	NU	Wheelchair Seat Cushion Width Less Than 22 In Any Depth	PA	$55.35	
E2601	NU SC	Wheelchair Seat Cushion Width Less Than 22 In Any Depth	PA	$55.35	
E2601	RB	Wheelchair Seat Cushion Width Less Than 22 In Any Depth	MN	$55.35	
E2601	RB SC	Wheelchair Seat Cushion Width Less Than 22 In Any Depth	MN	$55.35	
E2602	NU	Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	PA	$108.06	
E2602	NU SC	Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	PA	$108.06	
E2602	RB	Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MN	$108.06	
E2602	RB SC	Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MN	$108.06	
E2603	NU	Wheelchair Seat Cushion Skin Protection Width Less Than 22 In Any Depth	PA	$137.19	
E2603	NU SC	Wheelchair Seat Cushion Skin Protection Width Less Than 22 In Any Depth	PA	$137.19	
E2603	RB	Wheelchair Seat Cushion Skin Protection Width Less Than 22 In Any Depth	MN	$137.19	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2603	RB SC	Wheelchair Seat Cushion Skin Protection Width Less Than 22 In Any Depth	MN	$137.19	
E2604	NU	Wheelchair Seat Cushion Skin Protect Width 22 Inches Or Greater	PA	$170.51	
E2604	NU SC	Wheelchair Seat Cushion Skin Protect Width 22 Inches Or Greater	PA	$170.51	
E2604	RB	Wheelchair Seat Cushion Skin Protect Width 22 Inches Or Greater	MN	$170.51	
E2604	RB SC	Wheelchair Seat Cushion Skin Protect Width 22 Inches Or Greater	MN	$170.51	
E2605	NU	Seat Cushion Positioning Width Less Than 22 Inches Any Depth	PA	$243.60	
E2605	NU SC	Seat Cushion Positioning Width Less Than 22 Inches Any Depth	PA	$243.60	
E2605	RB	Seat Cushion Positioning Width Less Than 22 Inches Any Depth	MN	$243.60	
E2605	RB SC	Seat Cushion Positioning Width Less Than 22 Inches Any Depth	MN	$243.60	
E2606	NU	Seat Cushion Width 22 Inches Or Greater Any Depth	PA	$380.04	
E2606	NU SC	Seat Cushion Width 22 Inches Or Greater Any Depth	PA	$380.04	
E2606	RB	Seat Cushion Width 22 Inches Or Greater Any Depth	MN	$380.04	
E2606	RB SC	Seat Cushion Width 22 Inches Or Greater Any Depth	MN	$380.04	
E2607	NU	Skin Protection & Positioning Seat Cushion Width Less Than 22 Inches	PA	$262.31	
E2607	NU SC	Skin Protection & Positioning Seat Cushion Width Less Than 22 Inches	PA	$262.31	
E2607	RB	Skin Protection & Positioning Seat Cushion Width Less Than 22 Inches	MN	$262.31	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2607	RB SC	Skin Protection & Positioning Seat Cushion Width Less Than 22 Inches	MN	$262.31	
E2608	NU	Skin Protection And Positioning Seat Cushion Width 22 Inches Or Greater, Any Depth	PA	$315.02	
E2608	NU SC	Skin Protection And Positioning Seat Cushion Width 22 Inches Or Greater, Any Depth	PA	$315.02	
E2608	RB	Skin Protection And Positioning Seat Cushion Width 22 Inches Or Greater, Any Depth	MN	$315.02	
E2608	RB SC	Skin Protection And Positioning Seat Cushion Width 22 Inches Or Greater, Any Depth	MN	$315.02	
E2609	NU	Custom Fabricated Seat Cushion Any Size	PA	MP	Maximum reimbursement of $1,300.00.
E2609	NU SC	Custom Fabricated Seat Cushion Any Size	PA	MP	Maximum reimbursement of $1,300.00.
E2609	RB	Custom Fabricated Seat Cushion Any Size	PA	MP	Maximum reimbursement of $1,300.00.
E2609	RB SC	Custom Fabricated Seat Cushion Any Size	PA	MP	Maximum reimbursement of $1,300.00.
E2611	NU	Back Cushion Width Less Than 22 Inches Any Height	PA	$282.68	
E2611	NU SC	Back Cushion Width Less Than 22 Inches Any Height	PA	$282.68	
E2611	RB	Back Cushion Width Less Than 22 Inches Any Height	MN	$282.68	
E2611	RB SC	Back Cushion Width Less Than 22 Inches Any Height	MN	$282.68	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2612	NU	Back Cushion Width 22 Inches Or Greater Any Height	PA	$382.40	
E2612	NU SC	Back Cushion Width 22 Inches Or Greater Any Height	PA	$382.40	
E2612	RB	Back Cushion Width 22 Inches Or Greater Any Height	MN	$382.40	
E2612	RB SC	Back Cushion Width 22 Inches Or Greater Any Height	MN	$382.40	
E2613	NU	Back Cushion Posterior Width Less Than 22 Inches	PA	$355.70	
E2613	NU SC	Back Cushion Posterior Width Less Than 22 Inches	PA	$355.70	
E2613	RB	Back Cushion Posterior Width Less Than 22 Inches	MN	$355.70	
E2613	RB SC	Back Cushion Posterior Width Less Than 22 Inches	MN	$355.70	
E2614	NU	Back Cushion Posterior Width 22 Inches Or Greater	PA	$492.26	
E2614	NU SC	Back Cushion Posterior Width 22 Inches Or Greater	PA	$492.26	
E2614	RB	Back Cushion Posterior Width 22 Inches Or Greater	MN	$492.26	
E2614	RB SC	Back Cushion Posterior Width 22 Inches Or Greater	MN	$492.26	
E2615	NU	Back Cushion Posterior-Lateral Width Less Than 22 Inches	PA	$409.35	
E2615	NU SC	Back Cushion Posterior-Lateral Width Less Than 22 Inches	PA	$409.35	
E2615	RB	Back Cushion Posterior-Lateral Width Less Than 22 Inches	MN	$409.35	
E2615	RB SC	Back Cushion Posterior-Lateral Width Less Than 22 Inches	MN	$409.35	
E2616	NU	Back Cushion Posterior-Lateral Width 22 Inches	PA	$550.76	
E2616	NU SC	Back Cushion Posterior-Lateral Width 22 Inches	PA	$550.76	
E2616	RB	Back Cushion Posterior-Lateral Width 22 Inches	MN	$550.76	
E2616	RB SC	Back Cushion Posterior-Lateral Width 22 Inches	MN	$550.76	
E2617	NU	Custom Fabricated Back Cushion Any Size Including Any Type	PA	MP	Maximum reimbursement is $1,300.00.

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E2617	NU SC	Custom Fabricated Back Cushion Any Size Including Any Type	PA	MP	Maximum reimbursement is $1,300.00.
E2617	RB	Custom Fabricated Back Cushion Any Size Including Any Type	PA	MP	Maximum reimbursement is $1,300.00.
E2617	RB SC	Custom Fabricated Back Cushion Any Size Including Any Type	PA	MP	Maximum reimbursement is $1,300.00.
E2619	NU	Replacement Cover For Seat Or Back Cushion For Chair	MN	$46.44	
E2619	NU SC	Replacement Cover For Seat Or Back Cushion For Chair	PA	$46.44	
E2619	RB	Replacement Cover For Seat Or Back Cushion For Chair	MN	$46.44	
E2619	RB SC	Replacement Cover For Seat Or Back Cushion For Chair	MN	$46.44	
E2620	NU	Positioning Back Cushion Planar Back W/Lateral Supports	PA	$495.67	
E2620	NU SC	Positioning Back Cushion Planar Back W/Lateral Supports	PA	$495.67	
E2620	RB	Positioning Back Cushion Planar Back W/Lateral Supports	MN	$495.67	
E2620	RB SC	Positioning Back Cushion Planar Back W/Lateral Supports	MN	$495.67	
E2621	NU	Positioning Back Cushion Planar Back W/Lateral Supports	PA	$520.16	
E2621	NU SC	Positioning Back Cushion Planar Back W/Lateral Supports	PA	$520.16	
E2621	RB	Positioning Back Cushion Planar Back W/Lateral Supports	MN	$520.16	
E2621	RB SC	Positioning Back Cushion Planar Back W/Lateral	MN	$520.16	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Supports			
E2622	NU	Adj Skin Pro W/c Cus Wd <22 In	PA	$299.98	
E2622	RB	Adj Skin Pro W/c Cus Wd <22 In	MN	$299.98	
E2622	NU SC	Adj Skin Pro W/c Cus Wd <22 In	PA	$299.98	
E2622	RB SC	Adj Skin Pro W/c Cus Wd <22 In	MN	$299.98	
E2623	NU	Adj Skin Pro W/c Cus Wd >=22 In	PA	$381.71	
E2623	RB	Adj Skin Pro W/c Cus Wd >=22 In	MN	$381.71	
E2623	NU SC	Adj Skin Pro W/c Cus Wd >=22 In	PA	$381.71	
E2623	RB SC	Adj Skin Pro W/c Cus Wd >=22 In	MN	$381.71	
E2624	NU	Adj Skin Pro/Pos Cus <22 In	PA	$302.44	
E2624	RB	Adj Skin Pro/Pos Cus <22 In	MN	$302.44	
E2624	NU SC	Adj Skin Pro/Pos Cus <22 In	PA	$302.44	
E2624	RB SC	Adj Skin Pro/Pos Cus <22 In	MN	$302.44	
E2625	NU	Adj Skin Pro/Pos W/c Cus >=22 In	PA	$382.87	
E2625	RB	Adj Skin Pro/Pos W/c Cus >=22 In	MN	$382.87	
E2625	NU SC	Adj Skin Pro/Pos W/c Cus >=22 In	PA	$382.87	
E2625	RB SC	Adj Skin Pro/Pos W/c Cus >=22 In	MN	$382.87	
K0015	NU	Detachable Non-Adjustable Height Armrest Each		$164.44	
K0015	RB	Detachable Non-Adjustable Height Armrest Each		$164.44	
K0015	RB SC	Detachable Non-Adjustable Height Armrest Each		$164.44	
K0017	NU	Detachable Adjustable Height Armrest; Base Each	MN	$46.25	
K0017	RB	Detachable Adjustable Height Armrest; Base Each	MN	$46.25	
K0017	RB SC	Detachable Adjustable Height Armrest; Base Each	MN	$46.25	
K0018	NU	Detachable Adjustable Height Armrest Upper Portion Each	MN	$25.84	
K0018	RB	Detachable Adjustable Height Armrest Upper Portion	MN	$25.84	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
		Each			
K0018	RB SC	Detachable Adjustable Height Armrest Upper Portion Each	MN	$25.84	
K0019	NU	Arm Pad Each	MN	$15.60	
K0019	RB	Arm Pad Each	MN	$15.60	
K0019	RB SC	Arm Pad Each	MN	$15.60	
K0020	NU	Fixed Adjustable Height Armrest Pair	MN	$42.05	
K0020	NU SC	Fixed Adjustable Height Armrest Pair	PA	$42.05	
K0020	RB	Fixed Adjustable Height Armrest Pair	MN	$42.05	
K0020	RB SC	Fixed Adjustable Height Armrest Pair	MN	$42.05	
K0037	NU	High Mount Flip-Up Foot Rest Each	MN	$43.58	
K0037	NU SC	High Mount Flip-Up Foot Rest Each	PA	$43.58	
K0037	RB	High Mount Flip-Up Foot Rest Each	MN	$43.58	
K0037	RB SC	High Mount Flip-Up Foot Rest Each	MN	$43.58	
K0038	NU	Leg Strap Each	MN	$21.96	
K0038	NU SC	Leg Strap Each	PA	$21.96	
K0038	RB	Leg Strap Each	MN	$21.96	
K0038	RB SC	Leg Strap Each	MN	$21.96	
K0039	NU	Leg Strap H Style Each	MN	$48.76	
K0039	NU SC	Leg Strap H Style Each	PA	$48.76	
K0039	RB	Leg Strap H Style Each	MN	$48.76	
K0039	RB SC	Leg Strap H Style Each	MN	$48.76	
K0040	NU	Adjustable Angle Footplate Each	MN	$67.58	
K0040	NU SC	Adjustable Angle Footplate Each	PA	$67.58	
K0040	RB	Adjustable Angle Footplate Each	MN	$67.58	
K0040	RB SC	Adjustable Angle Footplate Each	MN	$67.58	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0041	NU	Large Size Footplate Each	MN	$47.89	
K0041	NU SC	Large Size Footplate Each	PA	$47.89	
K0041	RB	Large Size Footplate Each	MN	$47.89	
K0041	RB SC	Large Size Footplate Each	MN	$47.89	
K0042	NU	Standard Size Footplate Each	MN	$28.02	
K0042	RB	Standard Size Footplate Each	MN	$28.02	
K0042	RB SC	Standard Size Footplate Each	MN	$28.02	
K0043	NU	Foot Rest Lower Extension Tube Each	MN	$17.67	
K0043	RB	Foot Rest Lower Extension Tube Each	MN	$17.67	
K0043	RB SC	Foot Rest Lower Extension Tube Each	MN	$17.67	
K0044	NU	Foot Rest Upper Hanger Bracket Each	MN	$15.06	
K0044	RB	Foot Rest Upper Hanger Bracket Each	MN	$15.06	
K0044	RB SC	Foot Rest Upper Hanger Bracket Each	MN	$15.06	
K0045	NU	Foot Rest Complete Assembly	MN	$47.65	
K0045	RB	Foot Rest Complete Assembly	MN	$47.65	
K0045	RB SC	Foot Rest Complete Assembly	MN	$47.65	
K0046	NU	Elevating Leg Rest; Lower Extension Tube Each	MN	$17.67	
K0046	RB	Elevating Leg Rest; Lower Extension Tube Each	MN	$17.67	
K0046	RB SC	Elevating Leg Rest; Lower Extension Tube Each	MN	$17.67	
K0047	NU	Elevating Leg Rest; Upper Hanging Bracket Each	MN	$69.21	
K0047	RB	Elevating Leg Rest; Upper Hanging Bracket Each	MN	$69.21	
K0047	RB SC	Elevating Leg Rest; Upper Hanging Bracket Each	MN	$69.21	
K0050	NU	Ratchet Assembly	MN	$29.41	
K0050	NU SC	Ratchet Assembly	PA	$29.41	
K0050	RB	Ratchet Assembly	MN	$29.41	
K0050	RB SC	Ratchet Assembly	MN	$29.41	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0051	NU	Cam Release Assembly Foot Rest Or Leg Rest Each	MN	$47.61	
K0051	NU SC	Cam Release Assembly Foot Rest Or Leg Rest Each	PA	$47.61	
K0051	RB	Cam Release Assembly Foot Rest Or Leg Rest Each	MN	$47.61	
K0051	RB SC	Cam Release Assembly Foot Rest Or Leg Rest Each	MN	$47.61	
K0052	NU	Swingaway Detachable Foot Rests S Each	MN	$83.66	
K0052	RB	Swingaway Detachable Foot Rests S Each	MN	$83.66	
K0052	RB SC	Swingaway Detachable Foot Rests S Each	MN	$83.66	
K0053	NU	Elevating Foot Rests Articulating (Telescoping) Each	MN	$92.32	
K0053	NU SC	Elevating Foot Rests Articulating (Telescoping) Each	PA	$92.32	
K0053	RB	Elevating Foot Rests Articulating (Telescoping) Each	MN	$92.32	
K0053	RB SC	Elevating Foot Rests Articulating (Telescoping) Each	MN	$92.32	
K0056	NU	Seat Ht Less Than 17" Or Equal To/Greater Than 21"For High Strength Lt Wt/Ultra-LtWt Wheelchair	MN	$95.10	
K0056	NU SC	Seat Ht Less Than 17" Or Equal To/Greater Than 21"For High Strength Lt Wt/Ultra-LtWt Wheelchair	PA	$95.10	
K0056	RB	Seat Ht Less Than 17" Or Equal To/Greater Than 21"For High Strength Lt Wt/Ultra-LtWt Wheelchair	MN	$95.10	
K0056	RB SC	Seat Ht Less Than 17" Or Equal To/Greater Than 21"For High Strength Lt Wt/Ultra-LtWt Wheelchair	MN	$95.10	
K0065	NU	Spoke Protectors Each	MN	$44.46	
K0065	NU SC	Spoke Protectors Each	PA	$44.46	
K0065	RB	Spoke Protectors Each	MN	$44.46	
K0065	RB SC	Spoke Protectors Each	MN	$44.46	
K0069	NU	Rear Wheel Assembly Complete; W/Solid Tire Spokes Or Molded Each	MN	$99.92	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0069	NU SC	Rear Wheel Assembly Complete; W/Solid Tire Spokes Or Molded Each	PA	$99.92	
K0069	RB	Rear Wheel Assembly Complete; W/Solid Tire Spokes Or Molded Each	MN	$99.92	
K0069	RB SC	Rear Wheel Assembly Complete; W/Solid Tire Spokes Or Molded Each	MN	$99.92	
K0070	NU	Rear Wheel Assembly Complete; W/Pneumatic Tire Spokes Or Molded Each	MN	$183.16	
K0070	NU SC	Rear Wheel Assembly Complete; W/Pneumatic Tire Spokes Or Molded Each	PA	$183.16	
K0070	RB	Rear Wheel Assembly Complete; W/Pneumatic Tire Spokes Or Molded Each	MN	$183.16	
K0070	RB SC	Rear Wheel Assembly Complete; W/Pneumatic Tire Spokes Or Molded Each	MN	$183.16	
K0071	NU	Front Caster Assembly Complete; W/Pneumatic Tire Each	MN	$109.25	
K0071	NU SC	Front Caster Assembly Complete; W/Pneumatic Tire Each	PA	$109.25	
K0071	RB	Front Caster Assembly Complete; W/Pneumatic Tire Each	MN	$109.25	
K0071	RB SC	Front Caster Assembly Complete; W/Pneumatic Tire Each	MN	$109.25	
K0072	NU	Front Caster Assembly Complete; W/Semi-Pneumatic Tire Each	MN	$65.76	
K0072	NU SC	Front Caster Assembly Complete; W/Semi-Pneumatic Tire Each	PA	$65.76	
K0072	RB	Front Caster Assembly Complete; W/Semi-Pneumatic Tire Each	MN	$65.76	
K0072	RB SC	Front Caster Assembly Complete; W/Semi-Pneumatic Tire Each	MN	$65.76	
K0073	NU	Caster Pin Lock Each	MN	$34.30	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0073	NU SC	Caster Pin Lock Each	PA	$34.30	
K0073	RB	Caster Pin Lock Each	MN	$34.30	
K0073	RB SC	Caster Pin Lock Each	MN	$34.30	
K0077	NU	Front Caster Assembly Complete W/Solid Tire Each	MN	$55.79	
K0077	NU SC	Front Caster Assembly Complete W/Solid Tire Each	PA	$55.79	
K0077	RB	Front Caster Assembly Complete W/Solid Tire Each	MN	$55.79	
K0077	RB SC	Front Caster Assembly Complete W/Solid Tire Each	MN	$55.79	
K0098	NU	Drive Belt For Power Wheelchair	MN	$24.46	
K0098	NU SC	Drive Belt For Power Wheelchair	PA	$24.46	
K0098	RB	Drive Belt For Power Wheelchair	MN	$24.46	
K0098	RB SC	Drive Belt For Power Wheelchair	MN	$24.46	
K0105	NU	IV Hanger Each	MN	$90.45	
K0105	NU SC	IV Hanger Each	PA	$90.45	
K0105	RB	IV Hanger Each	MN	$90.45	
K0105	RB SC	IV Hanger Each	MN	$90.45	
K0108	NU	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	
K0108	NU SC	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	
K0108	RB	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	
K0108	RB SC	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	
K0108	RR	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	
K0108	RR SC	Wheelchair Component Or Accessory Not Otherwise Specified	PA	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0733	NU	PWC 12 to 24 AMP Hour Sealed Lead Acid Battery (E.G. Gel Cell, Absorb)	MN	$27.34	
K0733	NU SC	PWC 12 to 24 AMP Hour Sealed Lead Acid Battery (E.G. Gel Cell, Absorb)	PA	$27.34	
K0733	RB	PWC 12 to 24 AMP Hour Sealed Lead Acid Battery (E.G. Gel Cell, Absorb)	MN	$27.34	
K0733	RB SC	PWC 12 to 24 AMP Hour Sealed Lead Acid Battery (E.G. Gel Cell, Absorb)	MN	$27.34	
K0734	NU	Skin Protection WC Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	PA	$299.98	
K0734	NU SC	Skin Protection WC Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	PA	$299.98	
K0734	RB	Skin Protection WC Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MN	$299.98	
K0734	RB SC	Skin Protection WC Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MN	$299.98	
K0735	NU	Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	PA	$381.71	
K0735	NU SC	Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	PA	$381.71	
K0735	RB	Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MN	$381.71	
K0735	RB SC	Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MN	$381.71	
K0736	NU	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	PA	$302.44	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0736	NU SC	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	PA	$302.44	
K0736	RB	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MN	$302.44	
K0736	RB SC	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MN	$302.44	
K0737	NU	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	PA	$382.87	
K0737	NU SC	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	PA	$382.87	
K0737	RB	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MN	$382.87	
K0737	RB SC	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MN	$382.87	
WHEELCHAIRS-GERIATRIC CHAIR					
E1031	NU	Geriatric Chair	MN	$410.00	
E1031	RB	Geriatric Chair	MN	MP	
E1031	RR	Geriatric Chair	MN	$50.51	
WHEELCHAIRS-HEAVY DUTY					
K0006	RB	Heavy Duty Wheelchair	MN	MP	
K0006	RB SC	Heavy Duty Wheelchair	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0006	RR	Heavy Duty Wheelchair	MN	$109.73	Rent to purchase. Reimbursement not to exceed $1316.81.
K0006	RR SC	Heavy Duty Wheelchair	PA	$109.73	Rent to purchase. Reimbursement not to exceed $1316.81.
K0007	RB	Extra Heavy Duty Wheelchair	MN	MP	
K0007	RB SC	Extra Heavy Duty Wheelchair	MN	MP	
K0007	RR	Extra Heavy Duty Wheelchair	MN	$156.19	Rent to purchase. Reimbursement not to exceed 1874.25.
K0007	RR SC	Extra Heavy Duty Wheelchair	PA	$156.19	Rent to purchase. Reimbursement not to exceed 1874.25.
WHEELCHAIRS-HIGH STRENGTH LIGHT WEIGHT					
K0004	RB	High Strength Ltwt Whlchr	MN	MP	
K0004	RB SC	High Strength Ltwt Whlchr	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0004	RR	High Strength Ltwt Whlchr	MN	$116.94	Rent to purchase. Reimbursement not to exceed $1403.22
K0004	RR SC	High Strength Ltwt Whlchr	PA	$116.94	Rent to purchase. Reimbursement not to exceed $1403.22
WHEELCHAIRS-LIGHT WEIGHT					
K0003	RB	Lightweight Wheelchair	MN	MP	
K0003	RB SC	Lightweight Wheelchair	MN	MP	
K0003	RR	Lightweight Wheelchair	MN	$74.81	Rent to purchase. Reimbursement not to exceed $897.72.
K0003	RR SC	Lightweight Wheelchair	PA	$74.81	Rent to purchase. Reimbursement not to exceed $897.72.
K0005	NU	Ultralightweight Wheelchair	PA	$1,848.76	
K0005	NU SC	Ultralightweight Wheelchair	PA	$1,848.76	
K0005	RB	Ultralightweight Wheelchair	MN	MP	
K0005	RB SC	Ultralightweight Wheelchair	MN	MP	
K0005	RR	Ultralightweight Wheelchair	PA	$184.86	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0005	RR SC	Ultralightweight Wheelchair	PA	$184.86	
WHEELCHAIRS-PEDIATRIC CHAIR					
E1229	NU	Nos Pediatric Size Wheelchair	PA	MP	
E1229	NU SC	Nos Pediatric Size Wheelchair	PA	MP	
E1229	RB	Nos Pediatric Size Wheelchair	MN	MP	
E1229	RB SC	Nos Pediatric Size Wheelchair	MN	MP	
E1229	RR	Nos Pediatric Size Wheelchair	PA	MP	
E1229	RR SC	Nos Pediatric Size Wheelchair	PA	MP	
E1231	NU	Rigid Ped W/C Tilt-In-Space	PA	MP	
E1231	RB	Rigid Ped W/C Tilt-In-Space	MN	MP	
E1232	NU	Folding Ped Wc Tilt-In-Space	PA	MP	
E1232	NU SC	Folding Ped Wc Tilt-In-Space	PA	MP	
E1232	RB	Folding Ped Wc Tilt-In-Space	MN	MP	
E1232	RB SC	Folding Ped Wc Tilt-In-Space	MN	MP	
E1233	NU	Rig Ped Wc Tltnspc W/o Seat	PA	MP	
E1233	NU SC	Rig Ped Wc Tltnspc W/o Seat	PA	MP	
E1233	RB	Rig Ped Wc Tltnspc W/o Seat	MN	MP	
E1233	RB SC	Rig Ped Wc Tltnspc W/o Seat	MN	MP	
E1234	NU	Fld Ped Wc Tltnspc W/o Seat	PA	MP	
E1234	NU SC	Fld Ped Wc Tltnspc W/o Seat	PA	MP	
E1234	RB	Fld Ped Wc Tltnspc W/o Seat	MN	MP	
E1234	RB SC	Fld Ped Wc Tltnspc W/o Seat	MN	MP	
E1235	NU	Rigid Ped Wc Adjustable	PA	MP	
E1235	NU SC	Rigid Ped Wc Adjustable	PA	MP	
E1235	RB	Rigid Ped Wc Adjustable	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1235	RB SC	Rigid Ped Wc Adjustable	MN	MP	
E1236	NU	Folding Ped Wc Adjustable	PA	MP	
E1236	NU SC	Folding Ped Wc Adjustable	PA	MP	
E1236	RB	Folding Ped Wc Adjustable	MN	MP	
E1236	RB SC	Folding Ped Wc Adjustable	MN	MP	
E1236	RR	Folding Ped Wc Adjustable	PA	MP	
E1237	NU	Rgd Ped Wc Adjstabl W/o Seat	PA	MP	
E1237	NU SC	Rgd Ped Wc Adjstabl W/o Seat	PA	MP	
E1237	RB	Rgd Ped Wc Adjstabl W/o Seat	MN	MP	
E1237	RB SC	Rgd Ped Wc Adjstabl W/o Seat	MN	MP	
E1238	NU	Fld Ped Wc Adjstabl W/o Seat	PA	MP	
E1238	NU SC	Fld Ped Wc Adjstabl W/o Seat	PA	MP	
E1238	RB	Fld Ped Wc Adjstabl W/o Seat	MN	MP	
E1238	RB SC	Fld Ped Wc Adjstabl W/o Seat	MN	MP	
E1239	NU	Nos Pediatric Sz W/Ch Power	PA	MP	
E1239	NU SC	Nos Pediatric Sz W/Ch Power	PA	MP	
E1239	RB	Nos Pediatric Sz W/Ch Power	MN	MP	
E1239	RB SC	Nos Pediatric Sz W/Ch Power	MN	MP	
E1239	RR	Nos Pediatric Sz W/Ch Power	PA	MP	
E1239	RR SC	Nos Pediatric Sz W/Ch Power	PA	MP	
WHEELCHAIRS-POWER CHAIR					
K0813	NU	Pwc Gp 1 Std Port Seat/Back	PA	$2,106.79	
K0813	NU SC	Pwc Gp 1 Std Port Seat/Back	PA	$2,106.79	
K0813	RB	Pwc Gp 1 Std Port Seat/Back	MN	MP	
K0813	RB SC	Pwc Gp 1 Std Port Seat/Back	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0813	RR	Pwc Gp 1 Std Port Seat/Back	PA	$175.57	
K0813	RR SC	Pwc Gp 1 Std Port Seat/Back	PA	$175.57	
K0814	NU	Pwc Gp 1 Std Port Cap Chair	PA	$2,696.69	
K0814	NU SC	Pwc Gp 1 Std Port Cap Chair	PA	$2,696.69	
K0814	RB	Pwc Gp 1 Std Port Cap Chair	MN	MP	
K0814	RB SC	Pwc Gp 1 Std Port Cap Chair	MN	MP	
K0814	RR	Pwc Gp 1 Std Port Cap Chair	PA	$224.72	
K0814	RR SC	Pwc Gp 1 Std Port Cap Chair	PA	$224.72	
K0815	NU	Pwc Gp 1 Std Seat/Back	PA	$3,070.92	
K0815	NU SC	Pwc Gp 1 Std Seat/Back	PA	$3,070.92	
K0815	RB	Pwc Gp 1 Std Seat/Back	MN	MP	
K0815	RB SC	Pwc Gp 1 Std Seat/Back	MN	MP	
K0815	RR	Pwc Gp 1 Std Seat/Back	PA	$255.91	
K0815	RR SC	Pwc Gp 1 Std Seat/Back	PA	$255.91	
K0816	NU	Pwc Gp 1 Std Cap Chair	PA	$2,940.84	
K0816	NU SC	Pwc Gp 1 Std Cap Chair	PA	$2,940.84	
K0816	RB	Pwc Gp 1 Std Cap Chair	MN	MP	
K0816	RB SC	Pwc Gp 1 Std Cap Chair	MN	MP	
K0816	RR	Pwc Gp 1 Std Cap Chair	PA	$245.07	
K0816	RR SC	Pwc Gp 1 Std Cap Chair	PA	$245.07	
K0820	NU	Pwc Gp 2 Std Port Seat/Back	PA	$2,250.19	
K0820	NU SC	Pwc Gp 2 Std Port Seat/Back	PA	$2,250.19	
K0820	RB	Pwc Gp 2 Std Port Seat/Back	MN	MP	
K0820	RB SC	Pwc Gp 2 Std Port Seat/Back	MN	MP	
K0820	RR	Pwc Gp 2 Std Port Seat/Back	PA	$187.52	
K0820	RR SC	Pwc Gp 2 Std Port Seat/Back	PA	$187.52	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0821	NU	Pwc Gp 2 Std Port Cap Chair	PA	$2,888.73	
K0821	NU SC	Pwc Gp 2 Std Port Cap Chair	PA	$2,888.73	
K0821	RB	Pwc Gp 2 Std Port Cap Chair	MN	MP	
K0821	RB SC	Pwc Gp 2 Std Port Cap Chair	MN	MP	
K0821	RR	Pwc Gp 2 Std Port Cap Chair	PA	$240.73	
K0821	RR SC	Pwc Gp 2 Std Port Cap Chair	PA	$240.73	
K0822	NU	Pwc Gp 2 Std Seat/Back	PA	$2,900.00	
K0822	NU SC	Pwc Gp 2 Std Seat/Back	PA	$2,900.00	
K0822	RB	Pwc Gp 2 Std Seat/Back	MN	MP	
K0822	RB SC	Pwc Gp 2 Std Seat/Back	MN	MP	
K0822	RR	Pwc Gp 2 Std Seat/Back	PA	$241.67	
K0822	RR SC	Pwc Gp 2 Std Seat/Back	PA	$241.67	
K0823	NU	Pwc Gp 2 Std Cap Chair	PA	$2,900.00	
K0823	NU SC	Pwc Gp 2 Std Cap Chair	PA	$2,900.00	
K0823	RB	Pwc Gp 2 Std Cap Chair	MN	MP	
K0823	RB SC	Pwc Gp 2 Std Cap Chair	MN	MP	
K0823	RR	Pwc Gp 2 Std Cap Chair	PA	$241.67	
K0823	RR SC	Pwc Gp 2 Std Cap Chair	PA	$241.67	
K0824	NU	Pwc Gp 2 Hd Seat/Back	PA	$4,229.21	
K0824	NU SC	Pwc Gp 2 Hd Seat/Back	PA	$4,229.21	
K0824	RB	Pwc Gp 2 Hd Seat/Back	MN	MP	
K0824	RB SC	Pwc Gp 2 Hd Seat/Back	MN	MP	
K0824	RR	Pwc Gp 2 Hd Seat/Back	PA	$352.43	
K0824	RR SC	Pwc Gp 2 Hd Seat/Back	PA	$352.43	
K0825	NU	Pwc Gp 2 Hd Cap Chair	PA	$3,871.58	
K0825	NU SC	Pwc Gp 2 Hd Cap Chair	PA	$3,871.58	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0825	RB	Pwc Gp 2 Hd Cap Chair	MN	MP	
K0825	RB SC	Pwc Gp 2 Hd Cap Chair	MN	MP	
K0825	RR	Pwc Gp 2 Hd Cap Chair	PA	$322.63	
K0825	RR SC	Pwc Gp 2 Hd Cap Chair	PA	$322.63	
K0826	NU	Pwc Gp 2 Vhd Seat/Back	PA	$5,475.12	
K0826	NU SC	Pwc Gp 2 Vhd Seat/Back	PA	$5,475.12	
K0826	RB	Pwc Gp 2 Vhd Seat/Back	MN	MP	
K0826	RB SC	Pwc Gp 2 Vhd Seat/Back	MN	MP	
K0826	RR	Pwc Gp 2 Vhd Seat/Back	PA	$456.26	
K0826	RR SC	Pwc Gp 2 Vhd Seat/Back	PA	$456.26	
K0827	NU	Pwc Gp Vhd Cap Chair	PA	$4,655.64	
K0827	NU SC	Pwc Gp Vhd Cap Chair	PA	$4,655.64	
K0827	RB	Pwc Gp Vhd Cap Chair	MN	MP	
K0827	RB SC	Pwc Gp Vhd Cap Chair	MN	MP	
K0827	RR	Pwc Gp Vhd Cap Chair	PA	$387.97	
K0827	RR SC	Pwc Gp Vhd Cap Chair	PA	$387.97	
K0828	NU	Pwc Gp 2 Xtra Hd Seat/Back	PA	$6,033.08	
K0828	NU SC	Pwc Gp 2 Xtra Hd Seat/Back	PA	$6,033.08	
K0828	RB	Pwc Gp 2 Xtra Hd Seat/Back	MN	MP	
K0828	RB SC	Pwc Gp 2 Xtra Hd Seat/Back	MN	MP	
K0828	RR	Pwc Gp 2 Xtra Hd Seat/Back	PA	$502.76	
K0828	RR SC	Pwc Gp 2 Xtra Hd Seat/Back	PA	$502.76	
K0829	NU	Pwc Gp 2 Xtra Hd Cap Chair	PA	$5,540.06	
K0829	NU SC	Pwc Gp 2 Xtra Hd Cap Chair	PA	$5,540.06	
K0829	RB	Pwc Gp 2 Xtra Hd Cap Chair	MN	MP	
K0829	RB SC	Pwc Gp 2 Xtra Hd Cap Chair	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0829	RR	Pwc Gp 2 Xtra Hd Cap Chair	PA	$461.67	
K0829	RR SC	Pwc Gp 2 Xtra Hd Cap Chair	PA	$461.67	
K0835	NU	Pwc Gp2 Std Sing Pow Opt S/B	PA	$3,543.38	
K0835	NU SC	Pwc Gp2 Std Sing Pow Opt S/B	PA	$3,543.38	
K0835	RB	Pwc Gp2 Std Sing Pow Opt S/B	MN	MP	
K0835	RB SC	Pwc Gp2 Std Sing Pow Opt S/B	MN	MP	
K0835	RR	Pwc Gp2 Std Sing Pow Opt S/B	PA	$295.28	
K0835	RR SC	Pwc Gp2 Std Sing Pow Opt S/B	PA	$295.28	
K0836	NU	Pwc Gp2 Std Sing Pow Opt Cap	PA	$3,674.53	
K0836	NU SC	Pwc Gp2 Std Sing Pow Opt Cap	PA	$3,674.53	
K0836	RB	Pwc Gp2 Std Sing Pow Opt Cap	MN	MP	
K0836	RB SC	Pwc Gp2 Std Sing Pow Opt Cap	MN	MP	
K0836	RR	Pwc Gp2 Std Sing Pow Opt Cap	PA	$306.21	
K0836	RR SC	Pwc Gp2 Std Sing Pow Opt Cap	PA	$306.21	
K0837	NU	Pwc Gp 2 Hd Sing Pow Opt S/B	PA	$4,229.21	
K0837	NU SC	Pwc Gp 2 Hd Sing Pow Opt S/B	PA	$4,229.21	
K0837	RB	Pwc Gp 2 Hd Sing Pow Opt S/B	MN	MP	
K0837	RB SC	Pwc Gp 2 Hd Sing Pow Opt S/B	MN	MP	
K0837	RR	Pwc Gp 2 Hd Sing Pow Opt S/B	PA	$352.43	
K0837	RR SC	Pwc Gp 2 Hd Sing Pow Opt S/B	PA	$352.43	
K0838	NU	Pwc Gp 2 Hd Sing Pow Opt Cap	PA	$3,783.48	
K0838	NU SC	Pwc Gp 2 Hd Sing Pow Opt Cap	PA	$3,783.48	
K0838	RB	Pwc Gp 2 Hd Sing Pow Opt Cap	MN	MP	
K0838	RB SC	Pwc Gp 2 Hd Sing Pow Opt Cap	MN	MP	
K0838	RR	Pwc Gp 2 Hd Sing Pow Opt Cap	PA	$315.29	
K0838	RR SC	Pwc Gp 2 Hd Sing Pow Opt Cap	PA	$315.29	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0839	NU	Pwc Gp2 Vhd Sing Pow Opt S/B	PA	$5,475.12	
K0839	NU SC	Pwc Gp2 Vhd Sing Pow Opt S/B	PA	$5,475.12	
K0839	RB	Pwc Gp2 Vhd Sing Pow Opt S/B	MN	MP	
K0839	RB SC	Pwc Gp2 Vhd Sing Pow Opt S/B	MN	MP	
K0839	RR	Pwc Gp2 Vhd Sing Pow Opt S/B	PA	$456.26	
K0839	RR SC	Pwc Gp2 Vhd Sing Pow Opt S/B	PA	$456.26	
K0840	NU	Pwc Gp2 Xhd Sing Pow Opt S/B	PA	$8,295.14	
K0840	NU SC	Pwc Gp2 Xhd Sing Pow Opt S/B	PA	$8,295.14	
K0840	RB	Pwc Gp2 Xhd Sing Pow Opt S/B	MN	MP	
K0840	RB SC	Pwc Gp2 Xhd Sing Pow Opt S/B	MN	MP	
K0840	RR	Pwc Gp2 Xhd Sing Pow Opt S/B	PA	$691.26	
K0840	RR SC	Pwc Gp2 Xhd Sing Pow Opt S/B	PA	$691.26	
K0841	NU	Pwc Gp2 Std Mult Pow Opt S/B	PA	$3,771.51	
K0841	NU SC	Pwc Gp2 Std Mult Pow Opt S/B	PA	$3,771.51	
K0841	RB	Pwc Gp2 Std Mult Pow Opt S/B	MN	MP	
K0841	RB SC	Pwc Gp2 Std Mult Pow Opt S/B	MN	MP	
K0841	RR	Pwc Gp2 Std Mult Pow Opt S/B	PA	$314.29	
K0841	RR SC	Pwc Gp2 Std Mult Pow Opt S/B	PA	$314.29	
K0842	NU	Pwc Gp2 Std Mult Pow Opt Cap	PA	$3,771.51	
K0842	NU SC	Pwc Gp2 Std Mult Pow Opt Cap	PA	$3,771.51	
K0842	RB	Pwc Gp2 Std Mult Pow Opt Cap	MN	MP	
K0842	RB SC	Pwc Gp2 Std Mult Pow Opt Cap	MN	MP	
K0842	RR	Pwc Gp2 Std Mult Pow Opt Cap	PA	$314.29	
K0842	RR SC	Pwc Gp2 Std Mult Pow Opt Cap	PA	$314.29	
K0843	NU	Pwc Gp2 Hd Mult Pow Opt S/B	PA	$4,540.90	
K0843	NU SC	Pwc Gp2 Hd Mult Pow Opt S/B	PA	$4,540.90	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0843	RB	Pwc Gp2 Hd Mult Pow Opt S/B	MN	MP	
K0843	RB SC	Pwc Gp2 Hd Mult Pow Opt S/B	MN	MP	
K0843	RR	Pwc Gp2 Hd Mult Pow Opt S/B	PA	$378.41	
K0843	RR SC	Pwc Gp2 Hd Mult Pow Opt S/B	PA	$378.41	
K0848	NU	Pwc Gp 3 Std Seat/Back	PA	$4,782.40	
K0848	NU SC	Pwc Gp 3 Std Seat/Back	PA	$4,782.40	
K0848	RB	Pwc Gp 3 Std Seat/Back	MN	MP	
K0848	RB SC	Pwc Gp 3 Std Seat/Back	MN	MP	
K0848	RR	Pwc Gp 3 Std Seat/Back	PA	$398.53	
K0848	RR SC	Pwc Gp 3 Std Seat/Back	PA	$398.53	
K0849	NU	Pwc Gp 3 Std Cap Chair	PA	$4,598.00	
K0849	NU SC	Pwc Gp 3 Std Cap Chair	PA	$4,598.00	
K0849	RB	Pwc Gp 3 Std Cap Chair	MN	MP	
K0849	RB SC	Pwc Gp 3 Std Cap Chair	MN	MP	
K0849	RR	Pwc Gp 3 Std Cap Chair	PA	$383.17	
K0849	RR SC	Pwc Gp 3 Std Cap Chair	PA	$383.17	
K0850	NU	Pwc Gp 3 Hd Seat/Back	PA	$5,547.50	
K0850	NU SC	Pwc Gp 3 Hd Seat/Back	PA	$5,547.50	
K0850	RB	Pwc Gp 3 Hd Seat/Back	MN	MP	
K0850	RB SC	Pwc Gp 3 Hd Seat/Back	MN	MP	
K0850	RR	Pwc Gp 3 Hd Seat/Back	PA	$462.29	
K0850	RR SC	Pwc Gp 3 Hd Seat/Back	PA	$462.29	
K0851	NU	Pwc Gp 3 Hd Cap Chair	PA	$5,333.80	
K0851	NU SC	Pwc Gp 3 Hd Cap Chair	PA	$5,333.80	
K0851	RB	Pwc Gp 3 Hd Cap Chair	MN	MP	
K0851	RB SC	Pwc Gp 3 Hd Cap Chair	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0851	RR	Pwc Gp 3 Hd Cap Chair	PA	$444.48	
K0851	RR SC	Pwc Gp 3 Hd Cap Chair	PA	$444.48	
K0852	NU	Pwc Gp 3 Vhd Seat/Back	PA	$6,409.80	
K0852	NU SC	Pwc Gp 3 Vhd Seat/Back	PA	$6,409.80	
K0852	RB	Pwc Gp 3 Vhd Seat/Back	MN	MP	
K0852	RB SC	Pwc Gp 3 Vhd Seat/Back	MN	MP	
K0852	RR	Pwc Gp 3 Vhd Seat/Back	PA	$534.15	
K0852	RR SC	Pwc Gp 3 Vhd Seat/Back	PA	$534.15	
K0853	NU	Pwc Gp 3 Vhd Cap Chair	PA	$6,584.40	
K0853	NU SC	Pwc Gp 3 Vhd Cap Chair	PA	$6,584.40	
K0853	RB	Pwc Gp 3 Vhd Cap Chair	MN	MP	
K0853	RB SC	Pwc Gp 3 Vhd Cap Chair	MN	MP	
K0853	RR	Pwc Gp 3 Vhd Cap Chair	PA	$548.70	
K0853	RR SC	Pwc Gp 3 Vhd Cap Chair	PA	$548.70	
K0854	NU	Pwc Gp 3 Xhd Seat/Back	PA	$8,722.90	
K0854	NU SC	Pwc Gp 3 Xhd Seat/Back	PA	$8,722.90	
K0854	RB	Pwc Gp 3 Xhd Seat/Back	MN	MP	
K0854	RB SC	Pwc Gp 3 Xhd Seat/Back	MN	MP	
K0854	RR	Pwc Gp 3 Xhd Seat/Back	PA	$726.91	
K0854	RR SC	Pwc Gp 3 Xhd Seat/Back	PA	$726.91	
K0855	NU	Pwc Gp 3 Xhd Cap Chair	PA	$8,240.10	
K0855	NU SC	Pwc Gp 3 Xhd Cap Chair	PA	$8,240.10	
K0855	RB	Pwc Gp 3 Xhd Cap Chair	MN	MP	
K0855	RB SC	Pwc Gp 3 Xhd Cap Chair	MN	MP	
K0855	RR	Pwc Gp 3 Xhd Cap Chair	PA	$686.68	
K0855	RR SC	Pwc Gp3 Xhd Cap Chair	PA	$686.68	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0856	NU	Pwc Gp3 Std Sing Pow Opt S/B	PA	$5,133.40	
K0856	NU SC	Pwc Gp3 Std Sing Pow Opt S/B	PA	$5,133.40	
K0856	RB	Pwc Gp3 Std Sing Pow Opt S/B	MN	MP	
K0856	RB SC	Pwc Gp3 Std Sing Pow Opt S/B	MN	MP	
K0856	RR	Pwc Gp3 Std Sing Pow Opt S/B	PA	$427.78	
K0856	RR SC	Pwc Gp3 Std Sing Pow Opt S/B	PA	$427.78	
K0857	NU	Pwc Gp3 Std Sing Pow Opt Cap	PA	$5,236.30	
K0857	NU SC	Pwc Gp3 Std Sing Pow Opt Cap	PA	$5,236.30	
K0857	RB	Pwc Gp3 Std Sing Pow Opt Cap	MN	MP	
K0857	RB SC	Pwc Gp3 Std Sing Pow Opt Cap	MN	MP	
K0857	RR	Pwc Gp3 Std Sing Pow Opt Cap	PA	$436.36	
K0857	RR SC	Pwc Gp3 Std Sing Pow Opt Cap	PA	$436.36	
K0858	NU	Pwc Gp3 Hd Sing Pow Opt S/B	PA	$6,369.00	
K0858	NU SC	Pwc Gp3 Hd Sing Pow Opt S/B	PA	$6,369.00	
K0858	RB	Pwc Gp3 Hd Sing Pow Opt S/B	MN	MP	
K0858	RB SC	Pwc Gp3 Hd Sing Pow Opt S/B	MN	MP	
K0858	RR	Pwc Gp3 Hd Sing Pow Opt S/B	PA	$530.75	
K0858	RR SC	Pwc Gp3 Hd Sing Pow Opt S/B	PA	$530.75	
K0859	NU	Pwc Gp3 Hd Sing Pow Opt Cap	PA	$6,074.10	
K0859	NU SC	Pwc Gp3 Hd Sing Pow Opt Cap	PA	$6,074.10	
K0859	RB	Pwc Gp3 Hd Sing Pow Opt Cap	MN	MP	
K0859	RB SC	Pwc Gp3 Hd Sing Pow Opt Cap	MN	MP	
K0859	RR	Pwc Gp3 Hd Sing Pow Opt Cap	PA	$506.17	
K0859	RR SC	Pwc Gp3 Hd Sing Pow Opt Cap	PA	$506.17	
K0860	NU	Pwc Gp3 Vhd Sing Pow Opt S/B	PA	$9,099.00	
K0860	NU SC	Pwc Gp3 Vhd Sing Pow Opt S/B	PA	$9,099.00	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0860	RB	Pwc Gp3 Vhd Sing Pow Opt S/B	MN	MP	
K0860	RB SC	Pwc Gp3 Vhd Sing Pow Opt S/B	MN	MP	
K0860	RR	Pwc Gp3 Vhd Sing Pow Opt S/B	PA	$758.25	
K0860	RR SC	Pwc Gp3 Vhd Sing Pow Opt S/B	PA	$758.25	
K0861	NU	Pwc Gp3 Std Mult Pow Opt S/B	PA	$5,141.70	
K0861	NU SC	Pwc Gp3 Std Mult Pow Opt S/B	PA	$5,141.70	
K0861	RB	Pwc Gp3 Std Mult Pow Opt S/B	MN	MP	
K0861	RB SC	Pwc Gp3 Std Mult Pow Opt S/B	MN	MP	
K0861	RR	Pwc Gp3 Std Mult Pow Opt S/B	PA	$428.47	
K0861	RR SC	Pwc Gp3 Std Mult Pow Opt S/B	PA	$428.47	
K0862	NU	Pwc Gp3 Hd Mult Pow Opt S/B	PA	$6,369.00	
K0862	NU SC	Pwc Gp3 Hd Mult Pow Opt S/B	PA	$6,369.00	
K0862	RB	Pwc Gp3 Hd Mult Pow Opt S/B	MN	MP	
K0862	RB SC	Pwc Gp3 Hd Mult Pow Opt S/B	MN	MP	
K0862	RR	Pwc Gp3 Hd Mult Pow Opt S/B	PA	$530.75	
K0862	RR SC	Pwc Gp3 Hd Mult Pow Opt S/B	PA	$530.75	
K0863	NU	Pwc Gp3 Vhd Mult Pow Opt S/B	PA	$9,099.00	
K0863	NU SC	Pwc Gp3 Vhd Mult Pow Opt S/B	PA	$9,099.00	
K0863	RB	Pwc Gp3 Vhd Mult Pow Opt S/B	MN	MP	
K0863	RB SC	Pwc Gp3 Vhd Mult Pow Opt S/B	MN	MP	
K0863	RR	Pwc Gp3 Vhd Mult Pow Opt S/B	PA	$758.25	
K0863	RR SC	Pwc Gp3 Vhd Mult Pow Opt S/B	PA	$758.25	
K0864	NU	Pwc Gp3 Xhd Mult Pow Opt S/B	PA	$10,827.90	
K0864	NU SC	Pwc Gp3 Xhd Mult Pow Opt S/B	PA	$10,827.90	
K0864	RB	Pwc Gp3 Xhd Mult Pow Opt S/B	MN	MP	
K0864	RB SC	Pwc Gp3 Xhd Mult Pow Opt S/B	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0864	RR	Pwc Gp3 Xhd Mult Pow Opt S/B	PA	$902.33	
K0864	RR SC	Pwc Gp3 Xhd Mult Pow Opt S/B	PA	$902.33	
K0868	NU	Pwc Gp 4 Std Seat/Back	PA	MP	
K0868	NU SC	Pwc Gp 4 Std Seat/Back	PA	MP	
K0868	RB	Pwc Gp 4 Std Seat/Back	MN	MP	
K0868	RB SC	Pwc Gp 4 Std Seat/Back	MN	MP	
K0869	NU	Pwc Gp 4 Std Cap Chair	PA	MP	
K0869	NU SC	Pwc Gp 4 Std Cap Chair	PA	MP	
K0869	RB	Pwc Gp 4 Std Cap Chair	MN	MP	
K0869	RB SC	Pwc Gp 4 Std Cap Chair	MN	MP	
K0870	NU	Pwc Gp 4 Hd Seat/Back	PA	MP	
K0870	NU SC	Pwc Gp 4 Hd Seat/Back	PA	MP	
K0870	RB	Pwc Gp 4 Hd Seat/Back	MN	MP	
K0870	RB SC	Pwc Gp 4 Hd Seat/Back	MN	MP	
K0871	NU	Pwc Gp 4 Vhd Seat/Back	PA	MP	
K0871	NU SC	Pwc Gp 4 Vhd Seat/Back	PA	MP	
K0871	RB	Pwc Gp 4 Vhd Seat/Back	MN	MP	
K0871	RB SC	Pwc Gp 4 Vhd Seat/Back	MN	MP	
K0877	NU	Pwc Gp4 Std Sing Pow Opt S/B	PA	MP	
K0877	NU SC	Pwc Gp4 Std Sing Pow Opt S/B	PA	MP	
K0877	RB	Pwc Gp4 Std Sing Pow Opt S/B	MN	MP	
K0877	RB SC	Pwc Gp4 Std Sing Pow Opt S/B	MN	MP	
K0878	NU	Pwc Gp4 Std Sing Pow Opt Cap	PA	MP	
K0878	NU SC	Pwc Gp4 Std Sing Pow Opt Cap	PA	MP	
K0878	RB	Pwc Gp4 Std Sing Pow Opt Cap	MN	MP	
K0878	RB SC	Pwc Gp4 Std Sing Pow Opt Cap	MN	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0879	NU	Pwc Gp4 Hd Sing Pow Opt S/B	PA	MP	
K0879	NU SC	Pwc Gp4 Hd Sing Pow Opt S/B	PA	MP	
K0879	RB	Pwc Gp4 Hd Sing Pow Opt S/B	MN	MP	
K0879	RB SC	Pwc Gp4 Hd Sing Pow Opt S/B	MN	MP	
K0880	NU	Pwc Gp4 Vhd Sing Pow Opt S/B	PA	MP	
K0880	NU SC	Pwc Gp4 Vhd Sing Pow Opt S/B	PA	MP	
K0880	RB	Pwc Gp4 Vhd Sing Pow Opt S/B	MN	MP	
K0880	RB SC	Pwc Gp4 Vhd Sing Pow Opt S/B	MN	MP	
K0884	NU	Pwc Gp4 Std Mult Pow Opt S/B	PA	MP	
K0884	NU SC	Pwc Gp4 Std Mult Pow Opt S/B	PA	MP	
K0884	RB	Pwc Gp4 Std Mult Pow Opt S/B	MN	MP	
K0884	RB SC	Pwc Gp4 Std Mult Pow Opt S/B	MN	MP	
K0885	NU	Pwc Gp4 Std Mult Pow Opt Cap	PA	MP	
K0885	NU SC	Pwc Gp4 Std Mult Pow Opt Cap	PA	MP	
K0885	RB	Pwc Gp4 Std Mult Pow Opt Cap	MN	MP	
K0885	RB SC	Pwc Gp4 Std Mult Pow Opt Cap	MN	MP	
K0886	NU	Pwc Gp4 Hd Mult Pow S/B	PA	MP	
K0886	NU SC	Pwc Gp4 Hd Mult Pow S/B	PA	MP	
K0886	RB	Pwc Gp4 Hd Mult Pow S/B	MN	MP	
K0886	RB SC	Pwc Gp4 Hd Mult Pow S/B	MN	MP	
K0890	NU	Pwc Gp5 Ped Sing Pow Opt S/B	PA	MP	
K0890	NU SC	Pwc Gp5 Ped Sing Pow Opt S/B	PA	MP	
K0890	RB	Pwc Gp5 Ped Sing Pow Opt S/B	MN	MP	
K0890	RB SC	Pwc Gp5 Ped Sing Pow Opt S/B	MN	MP	
K0891	NU	Pwc Gp5 Ped Mult Pow Opt S/B	PA	MP	
K0891	NU SC	Pwc Gp5 Ped Mult Pow Opt S/B	PA	MP	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0891	RB	Pwc Gp5 Ped Mult Pow Opt S/B	MN	MP	
K0891	RB SC	Pwc Gp5 Ped Mult Pow Opt S/B	MN	MP	
K0898	NU	Power Wheelchair Noc	PA	MP	
K0898	NU SC	Power Wheelchair Noc	PA	MP	
K0898	RB	Power Wheelchair Noc	MN	MP	
K0898	RB SC	Power Wheelchair Noc	MN	MP	
WHEELCHAIRS-RECLINING					
E1225	NU	Manual Semi Reclining Back Recline Greater Than 15	PA	$316.68	
E1225	NU SC	Manual Semi Reclining Back Recline Greater Than 15	PA	$316.68	
E1226	NU	Manual Fully Reclining Back Recline Greater Than 80	PA	$463.80	
E1226	NU SC	Manual Fully Reclining Back Recline Greater Than 80	PA	$463.80	
WHEELCHAIRS-REPAIR OF EQUIPMENT					
K0739	RB	Repair Or Nonroutine Service For DME Other Than Oxygen Equipment Requiring Skill Of Technician, Labor Component, Per 15 Minutes	MN	$6.75	
K0739	RB SC	Repair Or Nonroutine Service For DME Other Than Oxygen Equipment Requiring Skill Of Technician, Labor Component, Per 15 Minutes	MN	$6.75	
Z0160	RB	Repair Of Equipment Replace Or Repair Minor Parts	MN	MP	
Z0160	RB SC	Repair Of Equipment Replace Or Repair Minor Parts	MN	MP	
WHEELCHAIRS-SCOOTER					

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
K0800	NU	Pov Group 1 Std Up To 300lbs	PA	$1,129.01	
K0800	RB	Pov Group 1 Std Up To 300lbs	MN	MP	
K0800	RR	Pov Group 1 Std Up To 300lbs	PA	$94.08	
K0801	NU	Pov Group 1 Hd 301-450 Lbs	PA	$1,820.20	
K0801	RB	Pov Group 1 Hd 301-450 Lbs	MN	MP	
K0801	RR	Pov Group 1 Hd 301-450 Lbs	PA	$151.68	
K0802	NU	Pov Group 1 Vhd 451-600 Lbs	PA	$2,059.88	
K0802	RB	Pov Group 1 Vhd 451-600 Lbs	MN	MP	
K0802	RR	Pov Group 1 Vhd 451-600 Lbs	PA	$171.66	
K0806	NU	Pov Group 2 Std Up To 300lbs	PA	$1,365.80	
K0806	RB	Pov Group 2 Std Up To 300lbs	MN	MP	
K0806	RR	Pov Group 2 Std Up To 300lbs	PA	$113.82	
K0807	NU	Pov Group 2 Hd 301-450 Lbs	PA	$2,072.44	
K0807	RB	Pov Group 2 Hd 301-450 Lbs	MN	MP	
K0807	RR	Pov Group 2 Hd 301-450 Lbs	PA	$172.70	
K0808	NU	Pov Group 2 Vhd 451-600 Lbs	PA	$3,206.50	
K0808	RB	Pov Group 2 Vhd 451-600 Lbs	MN	MP	
K0808	RR	Pov Group 2 Vhd 451-600 Lbs	PA	$267.21	
K0812	NU	Power Operated Vehicle Noc	PA	MP	
K0812	RB	Power Operated Vehicle Noc	MN	MP	
WHEELCHAIRS-STANDARD AND MANUAL					
E1161	NU	Manual Adult Wc W/Tiltinspace	PA	$1,900.00	
E1161	NU SC	Manual Adult Wc W/Tiltinspace	PA	$1,900.00	
E1161	RB	Manual Adult Wc W/Tiltinspace	MN	MP	
E1161	RB SC	Manual Adult Wc W/Tiltinspace	MN	MP	
E1161	RR	Manual Adult Wc W/Tiltinspace	PA	$158.33	

Proc Code	Modifier	Description	Reimbursement Guidelines	Allowed Amount	Limits qty/days and Comments
E1161	RR SC	Manual Adult Wc W/Tiltinspace	PA	$158.33	
K0001	RB	Standard Wheelchair	MN	MP	
K0001	RB SC	Standard Wheelchair	MN	MP	
K0001	RR	Standard Wheelchair	MN	$44.98	Rent to purchase. Reimbursement not to exceed $539.76.
K0001	RR SC	Standard Wheelchair	PA	$44.98	Rent to purchase. Reimbursement not to exceed $539.76.
K0002	RB	Stnd Hemi (Low Seat) Wheelchair	MN	MP	
K0002	RB SC	Stnd Hemi (Low Seat) Wheelchair	MN	MP	
K0002	RR	Stnd Hemi (Low Seat) Wheelchair	MN	$69.10	Rent to purchase. Reimbursement not to exceed $829.20
K0002	RR SC	Stnd Hemi (Low Seat) Wheelchair	PA	$69.10	Rent to purchase. Reimbursement not to exceed $829.20
K0009	NU	Other Manual Wheelchair/Base	PA	MP	
K0009	NU SC	Other Manual Wheelchair/Base	PA	MP	
K0009	RB	Other Manual Wheelchair/Base	MN	MP	
K0009	RB SC	Other Manual Wheelchair/Base	MN	MP	

SECTION 20-EXCEPTION PROCESS

20.1 EXCEPTION PRINCIPLE

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

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

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

20.2 REQUIREMENTS

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

- A prescriber *must* certify that MO HealthNet covered treatment or items of services appropriate to the illness or condition have been determined to be medically inappropriate or have been used and found to be ineffective in treatment of the participant for whom the exception is being requested;
- While requests may be approved, documentation verifying that all third party resource benefits have been exhausted *must* accompany claims for payment before the MO HealthNet Program pays for any item or service; for example,

  —Medicare
  —Private Insurance
  —The American Diabetes Society
  —The Veterans Administration
  —The American Cancer Society
  —A United Way Agency;

Except in the case of retroactive MO HealthNet eligibility determination, requests *must* be submitted prior to delivery of the service. Do *not* wait until after receipt of documentation of noncoverage from an alternative payor to submit the completed Exception Request form.

- Any requested medical, surgical or diagnostic service which is to be provided under the authority of the treating prescriber, *must* be listed in the most recent publication of *A Comprehensive Guide to Current Procedural Terminology,* (CPT) or the CMS-approved list of HCPCS codes. The CPT and HCPCS books may be purchased at any medical bookstore;
- Any individual for whom an exception request is made *must* be eligible for MO HealthNet on the date the item or service is provided. If requested, approval may be granted in the case of retroactive MO HealthNet eligibility determinations.
- The provider of the service *must* be an enrolled provider in the MO HealthNet Program on the date the item or service is provided;
- The item or service for which an exception is requested *must* be of a type and nature that falls within the broad scope of a medical discipline included in the MO HealthNet Program and does *not* represent a departure from the accepted standards and precepts of good medical practice. *No* consideration can be given to requests for experimental therapies or services;
- All requests for exception consideration *must* be initiated by the treating prescriber of an eligible participant and *must* be submitted as prescribed by policy of the MO HealthNet Division, 13 CSR 70-2.100;
- Requests for exception consideration *must* support and demonstrate that one (1) or more of the following conditions is met:
    1. The item or service is required to sustain the participant's life;
    2. The item or service would substantially improve the quality of life for a terminally ill patient;
    3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or
    4. The item or service is necessary to prevent a higher level of care.
- All requests *must* be made and approval granted before the requested item or service is provided. An exception to that requirement may be granted in cases in which the participant's eligibility for MO HealthNet is retroactively established or when emergency circumstances preclude the use of the established procedures for submitting a request, and a request is received *not* more than one (1) state working day following the provision of the service.

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

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

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

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

20.3 RESTRICTIONS

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

- Requests for restricted program areas. Refer to Section 1 for a list of restricted program areas.
- Requests for expanded HCY/EPSDT services (individuals under age 21). These should be directed to the HCY/EPSDT coordinator. (Reference manual Section 9).
- Requests for orthodontic services;
- Requests for inpatient hospital services;

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

20.4 REQUESTING AN EXCEPTION

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

There are two categories of exception request—emergency and nonemergency, each of which are processed differently.

20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS

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

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

20.4.B NON-EMERGENCY EXCEPTION REQUESTS

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

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

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

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.

END OF SECTION

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SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

Adult Day Health Care
Aged and Disabled Waiver
Ambulance
Ambulatory Surgical Centers
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
MRDD Waiver
Nurse Midwife
Optical
Pharmacy
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

END OF SECTION

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SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant

	cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.
Basic/Urban/ Rural Counties	As defined in 20 CSR, the following counties are categorized as: • Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City; • Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney; • Rural – All other counties.
Broker	Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.
Call Abandonment	Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Call Wait Time	Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Clean Claim	A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.
Complaint	A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.
DCN	Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.
Denial Reason	The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: • Non-covered Service

- Lack of Day's Notice
- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

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

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

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

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some

	unauthorized benefit to the entity, himself/herself, or some other person.
Free Transportation	Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Grievance (Participant)	A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are *not* limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker's personnel, or failure to respect the participant's rights.
Grievance (Transportation Provider)	A written request for further review of a transportation provider's complaint that remains unresolved after completion of the complaint process.
Inquiry	A request from a transportation provider regarding information that would clarify broker's policies and procedures, or any aspect of broker function that may be in question.
Most Appropriate	The mode of transportation that accommodates the participant's physical, mental, or medical condition.
MO HealthNet Covered Services	Covered services under the MO HealthNet program.
Medically Necessary	Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could *not* have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services *must* be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Medical Service Provider	An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans

	Administration or Shriners Hospital.
NEMT Services	Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does *not* include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.
No Vehicle Available	Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All "no vehicle available" trips shall be reported as denials in the category of no vehicle available.
Participant	A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.
Pick-up Time	The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.
Public Entity	State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.
Transportation Provider	Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.
Urgent	A serious, but *not* life threatening illness/injury. Examples include, but are *not* limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do *not* require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant's medical provider.

Will Call	An unscheduled pick-up time when the participant calls the broker or transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.

If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
    a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. Urban-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. Basic-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. Rural-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

TRAVEL STANDARDS: MAXIMUM MILEAGE

Provider/Service Type	**Urban Access County**	**Basic Access County**	**Rural Access County**
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100

Infectious Disease	25	50	100
Nephrology	25	50	100
Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100

Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45
Residential mental health treatment providers	20	30	50
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care.

The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:

- Participant eligibility; and
- MO HealthNet covered service.

22.7 COPAYMENTS

The participant is required to pay a $2.00 copayment for transportation services. The $2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
    - 03 - Aid to the blind;
    - 12 - MO HealthNet-Aid to the blind; and
    - 15 - Supplemental Nursing Care-Aid to the blind;
    - 18 - MO HealthNet for pregnant women;
    - 43 - Pregnant women-60 day assistance;
    - 44 - Pregnant women-60 day assistance-poverty;
    - 45 - Pregnant women-poverty; and
    - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a

reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.

3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.
4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a

transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.
2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of

charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.

5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.
6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.
2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive

more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

END OF SECTION

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SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

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

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

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

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

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

END OF SECTION

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