SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

Program limits may require prior authorization or medical necessity. Reference Section 14.5 for specific requirements on medical necessity. Reference Section 7, Medical Necessity, and Section 8, Prior Authorization, for sample forms and general instructions on completing the forms.

Please be aware that when a specific 5-digit procedure code requires an attachment, and that same procedure code exists with a modifier, such as 50 bilateral, any attachment requirements applicable to the 5-digit code remain a positive requirement for the code with the modifier. Refer to the MO HealthNet fee schedule for the required attachment(s) for surgical procedures.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Sections 15, Billing Instructions, and 16, Medicare/MO HealthNet Crossover Claims, for further information. Refer to Sections 1-11 and 20 for general program documentation requirements.

14.1 REQUIRED ATTACHMENTS

When submitting claims requiring attachments, be sure to:

- include the correct attachment(s) for the service being billed (some procedures require more than one attachment).
- staple the attachment to the claim to which it applies.
- check that the name of the participant is the same on both the attachment and the claim.
- attach a legible copy if *not* submitting an original.
- check that all required information and signatures appear on the attachment.
- check that the dates of service on the claim are consistent with dates on the attachment.

Some claim attachments required for payment of certain services are separately processed from the claim form. Refer to Section 23, Claims Attachment Submissions, for specific information.

14.1.A RESUBMISSIONS

When a claim requiring an attachment is resubmitted, *the provider must include a legible copy of the attachment with the resubmitted claim*. The fiscal agent *cannot* match the new submission to the attachment sent with the previous claim.

14.1.B HOW TO ORDER ATTACHMENTS

Attachments may be requested by completing the Forms Request.

14.2 CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

The Certification of Medical Necessity for Abortion form is required for every abortion performed when the life of the mother would be endangered if the fetus were carried to term, as specified in Public Law 105-78 (1997), or if the pregnancy is the result of rape or incest. Refer to Section 13.21 for additional information and specific guidelines on the abortion policy.

Refer to the MO HealthNet fee schedule for a list of procedures that require attachments.

14.2.A INSTRUCTIONS FOR COMPLETING THE CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

The fields on the form are self-explanatory. The Certification of Medical Necessity for Abortion form *must* be completed in full and the signature of the performing physician *must* be original. A signature by the performing physician's authorized representative is *not* acceptable. Medical documentation to support the information on the medical necessity form *must* be attached to the form. Claims for abortion services may *not* be billed electronically.

To order a supply of the Certification of Medical Necessity for Abortion forms, use the Forms Request or contact the Provider Relations Unit at (573) 751-2896.

14.3 ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

The Acknowledgement of Receipt of Hysterectomy Information form is required when a hysterectomy procedure is performed. This form is required regardless of the age of the woman. Information regarding hysterectomies is provided in Section 13.20. Refer to the MO HealthNet fee schedule for the procedures that require attachments. It is the hospital's responsibility to obtain the necessary certification from the performing physician. The hospital is also required to send a copy of the completed form whenever one of the identified procedures is performed unless an exemption applies. The Acknowledgement of Receipt of Hysterectomy Information form is separately processed from the claim form. This attachment should be mailed separately to:

Infocrossing Healthcare Services
P.O. Box 5900
Jefferson City, MO 695102

Refer to Section 23, Claim Attachment Submissions, for specific instructions.

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

The (Sterilization) Consent Form *may not* be used instead of the Acknowledgement of Receipt of Hysterectomy Information form.

The paragraph at the bottom of the form indicates that the form *must* be signed by the individual or her representative prior to the surgery, but there are no time limits. The Centers for Medicare & Medicaid Services (CMS) has given guidelines on this policy that in exceptional cases, the individual or her representative may sign the form after surgery if the patient or representative was informed of the hysterectomy procedure prior to the surgery.

Instructions for completing the Acknowledgement of Receipt of Hysterectomy Information form can be found on the back of the form.

14.3.A EXCEPTIONS

There are exception situations in which this form is *not* required; however, other physician certification is required in these situations.

Exceptions to the requirement for an Acknowledgement of Receipt of Hysterectomy Information form may be made in the following situations:

- **The individual was already sterile before the hysterectomy**. The physician who performs the hysterectomy *must* certify in writing that the individual was already sterile at the time of the hysterectomy and *must* state the cause of the sterility. This *must* be documented by an operative report or admit and discharge summary attached to the claim for payment.
- **The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is *not* possible.** The physician *must* certify in writing to this effect and include a description of the nature of the emergency.
- **The individual was retroactively found eligible for the period when surgery was performed.** If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. The physician who performed the hysterectomy *must* certify in writing that one of the following situations occurred:
    - The individual was informed before the operation that the hysterectomy will make her permanently incapable of reproducing and the procedure is *not* excluded from MO HealthNet coverage under "A";
    - The individual was already sterile before the hysterectomy; or
    - The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was *not* possible. A description of the nature of the emergency *must* be included.

14.4 INVOICE FOR MANUALLY PRICED PROCEDURES

An invoice should be attached to the claim for payment of certain procedures that *must* be manually priced by the State Medical Consultant. As some procedures involve up-front costs to the provider for some material/supply, it is helpful if an invoice is attached outlining pertinent information regarding the material/supply.

The following are examples of procedures that should include an invoice.

J7190	Factor VIII (non-heat treated) Always indicate "1" unit on the claim form and attach invoice indicating the number of units.
J7194	Factor IX Always indicate "1" unit on the claim form and attach invoice indicating the number of units.
A9195	Medical and Surgical Supplies (IUD/Diaphragm only)
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
A9699	Supply of Therapeutic Radiopharmaceuticals
L8614	Cochlear Implant Device

14.5 CERTIFICATE OF MEDICAL NECESSITY

Effective July 1, 2005, the medical necessity requirement was dropped for certain procedure codes, services and situations listed below. Although the Certificate of Medical Necessity form is no longer required to be submitted with the claim, the MO HealthNet policy remains the same, unless otherwise noted. Proof of medical necessity *must* be retained in the patient's file and be available upon request by the MO HealthNet Division.

- All co-surgeon services;
- All assistant surgeon services;
- 11980 (Subcutaneous hormone pellet implant);
- 15850 (Removal of sutures under anesthesia, other than local, same surgeon);
- 15851 (Removal of sutures under anesthesia, other than local, other surgeon);
- 36475 (Endovenous RF, 1st Vein);
- 36478 (Endovenous laser, 1st Vein);

- 54150 (Circumcision, using clamp or other device, newborn);
- 54160 (Circumcision, surgical excision other than clamp, device or dorsal slit, newborn);
- 92311 EP (Prescription and fitting of contact lens, corneal lens for aphakia one eye);
- 92312 EP (Prescription and fitting of contact lens, corneal lens for aphakia, both eyes);
- 92396 EP (Supply of permanent prosthesis for aphakia, contact lenses);
- Case management services limited to one per calendar month;
- Delivery codes restricted to within six months of each other;
- Delivery/Post-Partum codes within ten months of each other;
- Diabetes Self-Management Training initial visit limited to once per lifetime;
- Diabetes Self-Management Training subsequent visits limited to no more than two per rolling year;
- Initial hospital visit limitation;
- More than one 77432 (Stereotactic radiation treatment management of cerebral lesions) per rolling year;
- More than one nursing home visit by the same provider per calendar month;
- More than three ultrasounds per rolling year;
- Services for TEMP participants;
- Two prenatal consults within ten months of a global prenatal service.

14.5.A WHEN A CERTIFICATE OF MEDICAL NECESSITY IS REQUIRED

Each circumstance that requires a Certificate of Medical Necessity form is discussed separately. Refer to the MO HealthNet fee schedule for procedures that require attachments.

Section 7 of this manual provides a full explanation of the purpose of this form, including instructions for completion and a sample form.

14.5.A(1) Private Room

A private room is covered if there is a medical justification (e.g., infection control). Proof of medical necessity explaining why a private room was necessary *must* be retained in the patient's file and be available upon request by the MO HealthNet Division.

A private room is also covered if all patient rooms in a facility are private. The provider *must* contact the Provider Education Unit if all its rooms are private

rooms. Proof of medical necessity is *not* required to be retained in the patient's file in this instance.

A private room is *not* covered if requested by the patient solely for the patient's convenience. When billing for a noncovered private room, the difference between the private room and semiprivate room charge *must* be shown on the claim form in the noncovered column. It is the participant's responsibility to pay the difference between the semiprivate and the private room rate.

14.5.A(2) Sonograms

Claims for obstetrical sonograms exceeding three per participant, per rolling year *must* have the medical necessity of the additional procedures documented in the patient's medical record.

14.5.B WHEN A CERTIFICATE OF MEDICAL NECESSITY FORM MAY BE USED INSTEAD OF THE REQUIRED ATTACHMENT

There are situations that normally require specific policy documentation, but because of an unusual or emergency situation, a form could *not* be completed or is inappropriate for the situation. In these instances, a Certificate of Medical Necessity form *must* be completed fully describing the circumstances. The different types of circumstances are discussed below. Only the MO HealthNet Certificate of Medical Necessity form is acceptable.

14.5.B(1) Definition of Emergency Services

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

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

14.5.B(2) Second Surgical Opinion Form

When a surgical procedure requiring a second opinion is performed as an emergency, a Certificate of Medical Necessity form, which states in detail the nature of the emergency, *must* be attached to the claim.

14.5.B(3) Lock-In Participants

Services provided to participants who are locked-in to a physician or hospital require a Medical Referral Form of Restricted Participant (PI-118) attachment from the lock-in physician or hospital unless the services are provided in response to an emergency situation. If emergency services are provided, a completed Certificate of Medical Necessity form which details the nature of the emergency *must* be attached to the claim when it is submitted for payment.

14.5.B(4) Procedures That Require Prior Authorization

When procedures that require prior authorization are performed on an emergency basis, a Certificate of Medical Necessity form fully explaining the emergency situation *must* be attached to the claim.

14.5.C WHEN A CERTIFICATE OF MEDICAL NECESSITY CANNOT BE USED

A Certificate of Medical Necessity form *cannot* be used for procedures that require the (Sterilization) Consent Form or Acknowledgement of Receipt of Hysterectomy Information form when performed as an emergency procedure. Other documentation is required in this situation. Refer to Sections 10, 13.19 and 13.20 for specific information.

14.6 SECOND SURGICAL OPINION FORM

This policy is explained in detail in Section 13.16. Instructions for completing the Second Surgical Opinion Form appear on the following pages. Procedures that require the attachment of a Second Surgical Opinion Form are listed in the MO HealthNet fee schedule.

14.6.A EXCEPTIONS

The following are exceptions to the second surgical opinion requirement.

- Medicare-MO HealthNet patients are exempt from this requirement provided Medicare makes the primary reimbursement and MO HealthNet makes reimbursement of the coinsurance and/or deductible amounts.
- Inpatient services are exempt if the participant has Medicare Part B but no Part A. Enter “Medicare Part B only” in Field #84, Remarks.
- The Second Surgical Opinion Form is *not* required if the surgeon does *not* participate in the MO HealthNet Program. The provider *must* submit a claim along with a Certificate of Medical Necessity form and indicate on the Certificate of Medical Necessity form the surgeon's full name and indicate "non-participating."

- Surgical procedures that require a Second Surgical Opinion Form are exempt if any one of them are performed incidentally to a more major surgical procedure that does *not* require a second opinion.
- If the service was performed as an emergency and a second opinion could *not* be obtained prior to rendering the service, submit a claim along with a Certificate of Medical Necessity form indicating in detail the reason for the emergency provision of service.

  Emergency requests are suspended and reviewed by a medical consultant. If the Certificate of Medical Necessity form is *not* attached, or the documentation 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 was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. If the eligibility approval letter or the Certificate of Medical Necessity form is *not* submitted, the claim is denied. See Section 7 for instructions for completing the Certificate of Medical Necessity form.

14.6.B INSTRUCTIONS FOR COMPLETING THE SECOND SURGICAL OPINION FORM

The Second Surgical Opinion Form is divided into four sections. Section 1 should be completed by the primary or first physician. Complete all fields. The patient should then take the form to the second physician who completes Section 2. *A second opinion must be obtained within 60 days after the first opinion.* The 60-day period begins with the appointment date shown in Section 1 and ends with the appointment date shown in Section 2. If the second physician does *not* agree with the primary physician and the patient wants a third opinion, then Section 3 should be completed by a third physician. *The third opinion must be obtained within 60 days of the second opinion.* Again, the appointment dates in Section 2 and Section 3 are the basis for determining the 60-day time period.

The physician who performs the surgery *must* retain the patient's medical records (history, laboratory data, x-rays, etc.) and the completed Second Surgical Opinion Form. If surgery is performed, Section 4 *must* be completed by the surgeon. *The surgery must be performed within 150 days after the primary recommendation.* The appointment date in Section 1 and the date of surgery in Section 4 are the fields that are reviewed to determine the 150-day period.

The surgeon is responsible for furnishing a copy of the Second Surgical Opinion Form to the hospital where the surgery was performed. The hospital is required to send a copy of the completed form whenever one of the identified procedures is performed unless an exemption applies. The Second Surgical Opinion Form is separately processed from the claim form. The attachment should be mailed separately to:

Infocrossing Healthcare Services
P.O. Box 5900
Jefferson City, MO 65102

Refer to Section 23, Claim Attachment Submissions, for specific instructions.

14.7 (STERILIZATION) CONSENT FORM

A (Sterilization) Consent Form *must* be submitted in conjunction with the hospital claim whenever a voluntary sterilization procedure is performed. The (Sterilization) Consent Form is separately processed from the claim form. This attachment should be mailed separately to:

Infocrossing Healthcare Services
P.O. Box 5900
Jefferson City, MO 65102

Refer to Section 23, Claim Attachment Submissions, for specific information regarding this form. Refer to Section 13.19 for further information on sterilizations. Refer to Section 10, Family Planning, for complete information concerning sterilization procedures. That section includes instructions for completing the form, exceptions to the required attachment and a completed (Sterilization) Consent Form.

14.8 ADMISSION CERTIFICATION FORMS

All inpatient hospital admissions except for admissions of participants enrolled in an MO HealthNet Managed Care health plan, enrolled in Medicare Part A, pregnancy-related cases, deliveries and newborns require admission certification. Written or telephone contact *must* be made by the hospital, the admitting or attending physician to Health Care Excel. This procedure is explained in detail in Section 13.31. If the contact is in writing, there are four forms that can be used depending on the circumstances. One is for Preadmission (the Mail/Fax Preadmission Certification Request), one for Postadmission (the Fax Post-Admission Urgent or Emergency Certification Request), one for continued stay review (the Continued Stay Fax Request Form) and one for circumstances in which the participant has already been discharged (the Special Review Request). The Special Review Request requires the submission of certain documentation as explained on the form.

14.9 CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)

Certification of need for inpatient psychiatric services is one of the requirements for the Inpatient Psychiatric Services for Individuals Under Age 21 Program. The IM-71 form was developed to assist providers in complying with this requirement. This form or a similar one developed by the hospital *must* be in the participant's medical record and a copy sent to the Family Support Division office in the participant's county of residence. This certification is required for *psychiatric hospitals* providing services to participants under 21 years of age. This certification *is not required* for acute care hospitals providing psychiatric care to participants under 21 years of age, even though the hospital may have a psychiatric unit exempt for Medicare Prospective Payment Systems (PPS).

The status of the child or youth at the time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for certifying need for inpatient care.

Refer to Section 13.37 for a detailed explanation of this and other requirements for psychiatric services to children and youth under age 21 in a psychiatric hospital.

14.9.A INSTRUCTIONS FOR COMPLETION OF CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)

FIELD NUMBER	INSTRUCTIONS FOR COMPLETION
1. Name of Patient	Enter name of individual.
2. Case Number	Enter participant's MO HealthNet identification number (DCN).
3. Date of Admittance	Enter the date the individual was admitted.
4. Name of JCAH Certified Facility	Enter the name of the hospital.
5. Physician Team 6. Member 7. Date 8. Team Member/Title Date	The physician and a member of the independent or interdisciplinary team *must* each sign and date the certification. The signatures *must* be original. Include the title of the nonphysician team member.
9. Claimant's name or "myself"	Enter participant's name if form is signed by a parent or guardian; enter "myself" if participant signs authorization for the release of information.

10.	Authorize	Enter the name of the facility.
11.	Month/Day/Year	Enter the date of expiration of this authorization, normally *not* to exceed thirty days from date of signing.
12. 13. 14.	Claimant, Parent or Guardian Date Relationship	The participant, parent or guardian *must* sign and date the form. If parent or guardian signs here, state the relationship
15–20.	Witness, Date, Address	If participant is unable to sign his/her name, the signature may be made by mark. The signature, date, and address of two witnesses *must* then be entered.

Click here for a copy of the Certification of Need for Psychiatric Services (IM-71).

14.10 NURSING HOME FORMS

The information on nursing home forms is important to hospitals that *must* consider nursing home placement in the discharge plans of patients.

14.10.A PRE-LONG-TERM-CARE SCREENING (PLTC)—DA-13

The Pre-Long-Term-Care screening is a program aimed at making individuals aware of the broad range of choices for services and settings that are available in the long term care system. All participants considering a nursing home placement *must* be screened by a Division of Regulation and Licensure alternative services staff person unless an exemption applies. This is discussed in Section 13.9. If the individual still wants to enter a nursing home after community options have been explained, the Division of Regulation and Licensure worker will complete a LTACS Client Report (DA-13) form. This form should accompany the participant to the nursing home.

14.10.B NURSING FACILITY PRE-ADMISSION SCREENING/RESIDENT REVIEW FOR MENTAL ILLNESS/MENTAL RETARDATION OR RELATED CONDITION (DA-124C)

Section 13.9.B discusses in detail the purpose and process of preadmission screening. Briefly, nursing homes are required to screen all applicants for Title XIX certified beds to determine if the individual is known or suspected to be mentally ill (MI), mentally retarded (MR), or developmentally disabled (DD). If the applicant is known or suspected to be MI,

MR or DD and no exemption category applies or the applicant does *not* have a diagnosis of dementia, the applicant *cannot* be admitted to the certified bed until a determination regarding appropriate placement has been completed by the Department of Mental Health.

A Level I screening *must* be performed on all applicants to a certified bed in order to identify an individual suspected of being MI, MR or DD. The DA-124C form should be used to complete the Level I screening. The form may be completed by a nursing home, hospital, or physician.

- If the applicant is *not* known or suspected of being MI, MR or DD, the applicant may be admitted to the facility. The DA-124C *must* be filed in the resident's medical records.
- If the applicant is suspected of being MI, MR or DD, forms DA-124A/B, and DA-124C *must* be completed. The DA-124A/B and DA-124C *must* be sent to:

Department of Health and Senior Services
Division of Regulation and Licensure
Section of Long Term Care Regulation/Central Office Medical Review Team
(SLCR/COMRU)
P.O. Box 570
Jefferson City, MO 65102

If an exemption has been marked on the DA-124C, the person may be admitted to the nursing home before a Level II screening is performed. If no exemption applies, the person *cannot* be admitted until a Level II screening is done.

14.10.B(1) Completion of DA-124C

This form may be completed by a nursing home, hospital social worker or physician, but it *must* be signed and updated by a physician.

The form may be typed or legibly written in ink.

Instructions appear on the back of the DA-124C.

14.10.C DA-124A/B FORM

Eligibility for MO HealthNet nursing home benefits is based on MO HealthNet categorical eligibility, determined by the Family Support Division, and medical eligibility, determined by the Division of Regulation and Licensure. These determinations of eligibility *must* be made before a MO HealthNet nursing home payment can be made on behalf of a participant. A medical consultant in the Division of Regulation and Licensure makes the determination if the applicant for nursing home services needs nursing home level of care. The consultant's

determination is based on the established guidelines found in state regulation 13 CSR 15-9.030 and the information given on the DA-124 forms.

The primary responsibility for providing the information on the forms belongs to the physician who signs it. These forms should be completed as fully as possible to allow the state consultant to make a valid determination. The forms may be typed or written legibly in ink. Be certain the information is clearly imprinted on all four copies.

Most of the information requested on these forms is self-explanatory and so only a few instructions are given. If a provider has any questions concerning how to complete the forms, the provider may contact the Medical Review Unit at the Division of Regulation and Licensure, (573) 751-3082. Forms that are *not* completed fully may be returned to the entity that submitted them. To avoid having the forms returned, providers should note the following instructions:

Section A, Field #11—Give the name of the facility where the resident will be residing.

Section A, Field #13—There *must* be a PLTC number (the "R" number).

Section B, Fields #1-4—The physical information should be indicated.

Section B, Field #6—Check this field if any of the incidents listed are applicable to the resident. Be sure to include dates and types, where appropriate.

Section B, Field #8—List the drugs ordered by the physician for the patient. The medications should be appropriate to the diagnoses shown in Field #9. Give the dosage and frequency.

Section B, Field #10 and 15—Specialized nursing services should be listed that support the assessed needs indicated in Field #16.

Section B, Field #16—Completing the assessed needs field accurately is important in the determination of level of care. Be specific. For example, under "Mobility" to state, "Unable to ambulate," is *not* specific. A statement such as, "Resident requires the assistance of two to transfer" or "Resident ambulates with assistance of one and walker," is specific. Specificity under "Dietary" is, "Resident is on an 1800 calorie ADA diet and requires assistance to be fed" or "Resident needs set-up assistance but feeds self." All nine areas of assessed needs should be answered in relation to the needs of one particular resident and the assistance required for that participant. Also indicate areas in which the resident is capable of being self sufficient, if any.

Section B, Field #19—The person filling out this form *must* sign and date it.

Section B, Field #12 and Section F of the DA-124C—This section *must* be completed, signed and dated by a physician. A rubber stamp or signature by the Director of Nursing is *not* accepted.

Forms that are completed with insufficient information or are *not* specific enough are returned to the sender. This just delays processing the forms.

14.11 RISK APPRAISAL FOR PREGNANT WOMEN

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

END OF SECTION

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