# SECTION 13 - BENEFITS AND LIMITATIONS

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This section contains specific information regarding the benefits and limitations of the Physician Program.

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

Participant eligibility information is included in Section 1 and participant nonliability is addressed in Section 13.1.D.

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

## 13.1 PROVIDER PARTICIPATION

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

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

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

## 13.2 LOCK-IN PARTICIPANTS

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

In order for outpatient hospital services or physician services to be payable for a participant who is locked-in to a physician or hospital different from the billing provider, one of the following exceptions *must* apply:

1. Emergency services. If emergency services are provided, completed progress notes from the participant's medical record must be attached to the claim when it is submitted for payment explaining the emergency.

2. Participants are locked-in to another provider for administrative purposes, e.g., abuse, overutilization, etc. These participants *must* be referred by the lock-in provider for services. The PI-118 referral form is to be completed and signed by the Authorized Lock-In Provider when a referral to another provider is medically necessary. The referral is valid for a maximum of 30 days. The referral form *must* be submitted with each claim in order for the performing provider to receive payment. Provider numbers begin with the provider type of the individual provider, e.g., physician, clinic, pharmacy, etc. For further explanation of the Lock-In Program and a copy and explanation of the Medical Referral Form of Restricted Participant (PI-118) form, refer to Section 1.

Also see Section 13.32, MO HealthNet Managed Care Program, for additional information on restrictions to specific providers as a result of enrollment in a MO HealthNet Managed Care health plan.

## 13.3 PRESUMPTIVE ELIGIBILITY PROGRAM (TEMP)

Reference Section 1.5.J for information on TEMP participants.

### 13.3. A TEMP BENEFIT LIMITATIONS

The TEMP card and letter may only be used to obtain *ambulatory prenatal services*.

The diagnosis on the claim form *must* be a pregnancy/prenatal diagnosis (V22—V23.9 or V28—V28.9).

If the TEMP participant is provided illness care, the illness diagnosis code *must* appear as the primary diagnosis code. However, a pregnancy/prenatal diagnosis code *must* also appear on the claim form.

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

### 13.3. B FULL MO HEALTHNET ELIGIBILITY AFTER TEMP

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

## 13.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

A child born to a woman who is eligible for and receiving MO HealthNet benefits on the date the child is born is automatically eligible for MO HealthNet. Coverage begins with the date of birth and extends until the child's first birthday. Reference Section 1 for detailed information regarding automatic newborn eligibility.

## 13.5 QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM

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

### 13.5. A HOW THE QMB PROGRAM AFFECTS PROVIDERS

It is important for providers to understand the difference between the services MO HealthNet reimburses for those individuals with QMB only and for those with QMB and MO HealthNet eligibility.

- For a QMB only participant, MO HealthNet only reimburses providers for Medicare deductible and coinsurance amounts as well as Medicare Part C deductible, coinsurance and copayment amounts for services covered by Medicare, including providers of services *not* currently covered by MO HealthNet such as chiropractors and independent therapists. MO HealthNet *does not* reimburse for non-Medicare services, such as prescription drugs, eyeglasses, most dental services, adult day health care, personal care services, most eye exams performed by an optometrist or nursing care services *not* covered by Medicare. The medical eligibility code of the participant is "55."
- A QMB and MO HealthNet eligible participant may receive all services (within limitations) covered by MO HealthNet and provided by enrolled providers. MO HealthNet also covers all Medicare deductible and coinsurance amounts as well as Medicare Part C Deductible, coinsurance and copayments amounts for services provided by providers who may or may not participate in MO HealthNet. Reference Section 1 for further information.

## 13.6 THIRD PARTY LIABILITY (TPL)

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

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

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

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

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

## 13. 7 SERVICE MODIFIERS

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

| MODIFIER | DESCRIPTION |
|---|---|
| 26 | Professional Component |
| 54 | Surgical Care Only |
| 55 | Postoperative Management Only |
| 80 | Assistant Surgeon |
| AA | Anesthesia service performed personally by anesthesiologist |
| QK | Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals |
| QX | CRNA/AA service; with medical direction by a physician |
| QZ | CRNA service; without medical direction by a physician |
| TC | Technical Component |
| UC | EPSDT Referral for Follow-up Care (required if EPSDT referral is made) |

## 13. 8 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM, ALSO KNOWN AS EPSDT

Refer to Section 9 for complete information regarding EPSDT.

## 13. 9 LEAD SCREENING AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM

Reference Section 9 for complete information.

## 13. 10 EXPANDED EPSDT/HCY SERVICES

As a result of the Omnibus Reconciliation Act of 1989 (OBRA 89) mandate, medically necessary items or services that the Social Security Act permits to be covered under MO HealthNet and are necessary to treat or ameliorate defects, physical and mental illness or conditions identified by an HCY screen are covered by MO HealthNet regardless of whether or not the services are covered under the MO HealthNet state plan. Some services require prior authorization. For more information, reference the Therapy Manual, Section 13.

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

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

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

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

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

**Psychiatric Services:** Reference Section 13.47.

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

## 13.11 MO HEALTHNET HEALTHY CHILDREN AND YOUTH PAMPHLET

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

## 13. 12 PREVENTIVE MEDICINE SERVICES

The purpose of the HCY Program is to ensure a comprehensive, preventive health care program for all MO HealthNet eligible individuals who are under the age of 21 years. HCY is designed to link the child and family to an ongoing health care delivery system. The HCY Program provides early and periodic medical/dental screenings, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening. Reference Section 9 for additional information on the HCY Program.

### 13. 12. A VACCINE FOR CHILDREN (VFC) PROGRAM

Through the Vaccine for Children (VFC) Program, federally provided vaccines are available at no cost to public and private providers for eligible children ages 0 through 18 years of age. Children that meet at least one of the following criteria are eligible for VFC vaccine:

- MO HEALTHNET ENROLLED—means a child enrolled in the MO HealthNet Program
- UNINSURED—means a child has no health insurance coverage
- NATIVE AMERICAN/ALASKAN NATIVE—means those children as defined in the Indian Health Services Act
- UNDERINSURED—means the child has some type of health insurance, but the benefit plan does *not* include vaccinations. The child *must* be vaccinated in a Federally Qualified Health Clinic (FQHC) or a Rural Health Clinic (RHC).

MO HealthNet enrolled providers *must* participate in the VFC Program administered by the Missouri Department of Health and Senior Services and *must* use the free vaccine when administering vaccine to qualified MO HealthNet eligible children. Providers may bill for the administration of the free vaccine by using the appropriate procedure code(s) found in **VFC Administration Codes**. Providers must not use any additional administration procedure code. The MO HealthNet reimbursement for the administration is $5.00 per component. The administration fee(s) may be billed in addition to a Healthy Children and Youth (HCY) screen, a preventive medicine service, or in addition to an office visit if a service other than administration of a vaccine was provided to the child. Providers enrolled as Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) *must not* bill an additional administration fee for any vaccine.

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

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

### 13. 12.A (1) VFC for MO HealthNet Managed Care Participants

MO HealthNet Managed Care health plans and their providers *must* use the VFC vaccine for MO HealthNet Managed Care participants. The health plans do *not* receive an additional administration fee as reimbursement is included in the health plan's capitation payment. Health plans may have different payment arrangements with their providers and the VFC administration fee may be included in the capitation payment from the health plan to the provider. However, the health plan reimbursement to public health departments should be $5.00 per vaccine component unless otherwise regulated. Providers should contact the appropriate MO HealthNet Managed Care health plan for correct billing procedures.

### 13. 12.A (2) Immunizations Outside VFC Guidelines

If an immunization is given to a MO HealthNet participant who does *not* meet the VFC guidelines, use the standard procedure for billing injections. Providers should bill on the Pharmacy Claim form using the national drug code (NDC). Refer to Section 13.24.B for additional billing information.

### 13. 12.A (3) Vaccine Shortages

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

## 13. 12.B ILLNESS CARE

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

### 13. 12.C SCHOOL/ATHLETIC PHYSICALS

A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis code V20.2, should be used. This also applies for other school physicals when required as conditions for entry into or continuance in the educational process. Use the appropriate Preventive Medicine code with the appropriate modifiers. Reference Section 9.5 for the appropriate modifiers.

## 13. 13 REPORTING CHILD ABUSE CASES

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

## 13. 14 SAFE-CARE EXAMINATIONS

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

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

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

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

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

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

The laboratory studies for sexual or physical abuse, when requested or ordered by a MO HealthNet enrolled SAFE trained provider, for all MO HealthNet children (MO HealthNet Managed Care enrolled and fee-for-service MO HealthNet) *must* be billed using the following procedure code(s):

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

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

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

### 13. 14.A SAFE-CARE EXAMINATION FORMS

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

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

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

SAFE-CARE providers may use the electronic form instead of the paper form. This eliminates the need for providers to send paper copies to the Missouri Department of Health and Senior Services (DHSS) for data collection. For additional information on the electronic system, please contact the SAFE-CARE Network at (573) 526-4405.

## 13. 15 BUREAU OF SPECIAL HEALTH CARE NEEDS: AREA/DISTRICT OFFICES AND COUNTY LISTINGS

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

## 13. 16 PARTICIPANT COPAY

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

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

### 13. 16. A PROVIDER RESPONSIBILITY TO COLLECT COPAY AMOUNTS

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

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

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

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

### 13. 16.B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS

Unless otherwise exempted (Refer to Section 13.17.B(2)) it is the responsibility of the participant to pay the required copay amount due. Whether or not the participant has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service.

#### 13. 16.B (1) Copay Amounts

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

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

#### 13. 16.B (2) Exemptions to the Copay Amount

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

- Services provided to participants under 19 years of age; or participants receiving MO HealthNet under the following categories of assistance: ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87,and 88;
- Services provided to participants residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital; or participants receiving MO HealthNet under the following categories of assistance: ME codes 23 and 41;
- Services provided to participants who have both Medicare and MO HealthNet, if Medicare covers the service and provides payment for it; or participants receiving MO HealthNet under the following category of assistance: ME code 55;
- Emergency or transfer inpatient hospital admission;
- Emergency services provided in an outpatient clinic or emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;
- Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;
- Services provided to pregnant women who are receiving MO HealthNet under the following categories of assistance only: ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to foster care participants who are receiving MO HealthNet under the following categories: ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Services identified as medically necessary through an EPSDT screen;
- Services provided to persons receiving MO HealthNet under a category of assistance for the blind: ME codes 02, 03, 12, and 15;
- Services provided to MO HealthNet Managed Care enrollees;
- Mental Health services provided by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an

alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;

- Family planning services;
- MO HealthNet waiver services;
- Hospice services; and
- Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by the person's physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility or skilled nursing facility.

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

- Services related to an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen. *(Diagnosis code V20.2, V20.31, V20.32 or an EPSDT condition code must appear on the claim form and/or the participant must be age 18 and under on the date of service.)*
- Emergency services (*Condition Code AJ & Emergency Indicator)*;
- Drugs and services specifically identified as relating to family planning services *(Drug class or family planning indicator and/or family planning diagnosis codes)*;
- Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy *(pregnancy diagnosis code)*;
- Therapy services in an emergency room or outpatient hospital setting. (Physical therapy, Chemotherapy, Radiation therapy, Psychology/ Counseling and Renal Dialysis) (Condition code AJ and exempt therapy procedure codes).

## 13. 17 SUPERVISION

### 13. 17. A PHYSICIAN'S OFFICE/INDEPENDENT CLINICS

Services and supplies rendered in a private practice setting are considered incidental to a physician's professional services (and therefore billable by the physician) only when there is direct personal supervision by the physician. This rule applies to services of auxiliary

personnel *employed by* the physician and working under the physician's supervision such as nurses, technicians, therapists, physician assistants and other aides.

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

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

**13. 17.A (1) Physician Assistant**

Physician assistant services must be billed by a supervising physician using modifier AR (Physician provider services in a physician scarcity area/physician assistant services). This will allow the MO HealthNet Division (MHD) to track the volume and type of services provided by physician assistants.

Physician assistant services will also be reimbursed when provided in a hospital setting. The services must also be billed using modifier AR by a supervising physician.

Supervising physicians must be present a minimum of 66% of the clinic's hours and or in the same hospital facility 66 % of the time for practice supervision and collaboration, and physician assistants must practice within 30 miles of the supervising physician. The supervising physician must be readily available in person or via telecommunication during the time the physician assistant is providing patient care.

**13. 17.A. (2) Nurse Practitioner Services**

Nurse practitioner services billed by a supervising physician are only billable when there is direct personal supervision by the physician. Direct personal supervision does not mean that the physician must be present in the same room with the auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the

nurse practitioner is performing the service. Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

Nurse practitioners may enroll as providers with MHD. The policy above is only for those nurse practitioner services billed by a supervising physician.

### 13. 17.B RESIDENTS IN TEACHING/CLINICAL SETTING

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

### 13. 17.C MEDICARE PRIMARY CARE EXCEPTION

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

#### 13. 17.C (1) Resident Requirements

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

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

#### 13. 17.C (2) Teaching Physician Requirements

Teaching physicians submitting claims under this exception may *not* supervise more than four residents at a time and *must* be immediately available if needed. The teaching physician *must* have no other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident. The teaching physician *must* have the primary medical responsibility for patients cared for by the residents, ensure that the care provided was reasonable

and necessary, review the care provided by the resident during or immediately after each visit, and document the extent of his/her own participation in the review and direction of the services furnished to each patient.

**13. 17 C (3) Location of Services**

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

**13. 17 C (4) Billing Guidelines**

The GE modifier *must* be used to denote services provided under the primary care exception. The primary care exception applies only to specific low and mid-level E/M codes for both new and established patients. The new patient Current Procedural Terminology Codes (CPT) codes to which the exception applies are 99201, 99202, and 99203. The established patient CPT codes are 99211, 99212, and 99213.

## 13. 17.D PUBLIC HEALTH DEPARTMENT CLINICS AND PLANNED PARENTHOOD CLINICS

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

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

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

policy also does *not* apply to psychiatric services wherever provided. The policy in those situations continues to require that the services be personally provided by the physician.

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

## 13. 18 DEFINITIONS AND LEVELS OF SERVICE

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

## 13. 19 PLACE OF SERVICE

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

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

## 13. 20 OFFICE OR OTHER OUTPATIENT SERVICES

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

### 13. 20. A LIMITATIONS TO OFFICE/OUTPATIENT SERVICES

- Office/outpatient services are to be used for "illness" care and are limited to one visit per participant per provider per day. Additional medically necessary visits on the same day may be covered if a properly completed Certificate of Medical Necessity form is attached to the claim and approved by the medical consultant. (See Section 7 for instructions on completion of the Certificate of Medical Necessity form.)
- An office/outpatient physician visit includes, but is *not* limited to, the following:
    - Examining the patient and obtaining a medical history for symptoms or indications of an illness or medical condition. For children's examinations as

required for school education purposes, reference Section 13.13. Reference Section 9 for information on Healthy Children and Youth (HCY) screenings;

- Administering injections;
- Preparing bacterial, fungal and cytopathology smear(s) and cultures;
- Obtaining specimens (urine, blood, etc.);
- Using any instrument to examine and/or diagnose the illness or condition;
- Fitting a diaphragm;
- Removing an IUD;
- Furnishing supplies (e.g., gowns, drapes, gloves, urine cups, swabs, etc.) (Reference Section 19.5 for billable supplies);
- Preparing medical records and all required forms.

- An office/outpatient service may *not* be billed on the same date of service as a home visit, subsequent hospital visit, consultation, preventive medicine services, HCY screening, or nursing home visit. (An office visit may be billed on the same date of service as a hospital admission if the office visit is not related to the hospital admission. All office/outpatient services provided by the admitting physician in conjunction with the admission are considered part of the initial hospital care.)
- An office/outpatient visit may *not* be billed on the same date of service as any of the psychotherapy visits. (Reference Section 13.57 for information on psychiatric services)
- An office visit is *not* covered if the only service is to obtain a prescription, the need for which has been determined previously.
- An office/outpatient visit may only be billed on the same date of service as a physical medicine modality or procedure when an office/outpatient visit service is provided. (If planned therapy is the only service received, an office/outpatient visit should *not* be billed in addition to the therapy procedure.)
- Procedure code 99201 (new patient) or 99211 (established patient) may be billed for the administration of an injection if the injection does *not* have an administration procedure code.
- "New patient" office/outpatient services are limited to one per provider for each participant. Visits subsequent to the "new patient" office/outpatient services *must* be coded as "established patient" office/outpatient services as defined in the CPT procedural coding book.

- Healthy Children and Youth (HCY), also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT), full and partial screenings are covered in accordance with the periodicity schedule and procedures outlined in Section 9 of this manual.
- A “new patient,” office/outpatient, for a physician in a group or clinic is defined as one that has *not* been seen by another member of the group who has the same specialty. Subsequent services *must* be coded as “established patient” services.

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

Procedure code 99218, 99219 or 99220 may be used in the outpatient setting (POS 22) for the initial history and physical workup prior to outpatient surgery.

NOTE: These procedure codes are *not* to be used for any other service provided in the outpatient setting. (Reference Office/Outpatient Evaluation and Management codes 99201-99215 for other physician services provided in an outpatient setting.)

## 13. 21 SPECIAL SERVICES AND REPORTS

### 13. 21.A PHYSICIAN SERVICES—AFTER HOURS

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

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

### 13. 21.B PHYSICIAN SERVICES—SUNDAYS/HOLIDAYS

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

The following holidays are recognized:

- Memorial Day

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

## 13. 21.C CRITICAL CARE SERVICES

### 13. 21.C (1) Newborn Care

See **Section 13.70**.

### 13. 21.C (2) Critical Care Services

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

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

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

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

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

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

**13. 21.C (3) Initial Care Services**

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

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

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

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

## 13. 22 OFFICE MEDICAL SUPPLY CODES

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

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

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

## 13. 23 PRESCRIPTION DRUGS

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

A list of manufacturers that have entered into a rebate agreement with the Federal Government (along with the first five digits of the NDC number by which products may be identified), can be found in Drug Company Contact Information. Products for which the first five digits of NDC numbers are *not* included on the list are *not* reimbursable under the MO HealthNet Pharmacy Program and are *not* available through any prior authorization program. The federal Centers for Medicare & Medicaid Services (CMS) have required that participating manufacturers identify products which are affected by the Drug Efficacy Study Implementation (DESI). CMS has instructed state Medicaid programs that products identified as such are *not* subject to federal financial participation and are therefore *not* reimbursable under the MO HealthNet Pharmacy Program.

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

### 13. 23. A PRESCRIBING LONG-TERM MAINTENANCE DRUGS

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

### 13. 23. B INJECTIONS AND IMMUNIZATIONS

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

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

Providers may bill procedure code(s) 90460-90461 or 90471-90472 for the administration of vaccines/toxoids. If a significant separately identifiable Evaluation and Management (E/M) service is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration code. Rural Health Clinics (RHCs) (provider based) and Federally Qualified Health Centers (FQHCs) may *not* separately bill for the administration of an injection regardless of whether or not there is an encounter with a core service provider.

The costs for these services are to be included in the RHC and FQHC cost reports. These procedure codes do *not* apply to the immunizations included in the Vaccine for Children VFC) Program. Providers should use the appropriate VFC Administration Codes to bill for the administration of VFC immunizations.

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

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

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

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

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

or

4. Usual and customary charge.

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

The Omnibus Budget Reconciliation Act of 1990 provides that a rebate *must* be paid for products of manufacturers participating in the National Rebate Agreement. These rebates are paid by the manufacturer to state Medicaid programs on the basis of NDC specific utilization data. Therefore, it is essential that providers submit claims utilizing the precise 11 digit NDC found on the package from which the product is administered.

### 13. 23.C RABIES TREATMENT

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

### 13. 23.D CHEMOTHERAPY

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

### 13. 23.E HERCEPTIN

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

### 13. 23.F EXCEPTIONS TO BILLING ON THE PHARMACY CLAIM

The following exceptions apply in specific instances:

- Ambulatory Surgical Centers (Specialty B5) *must NOT* bill separately for injections, as the facility payment includes all supplies and equipment.
- Mental Health Regional Centers (Specialty 56) are restricted to annual assessments and daily specialized services only.
- Public Health Department Clinics *must* bill on the professional claim in accordance with special instructions for vaccines provided by the Centers for Disease Control and Prevention (CDC). Contact the Provider Relations Communication Unit at (573) 751-2896 for more information. All other (purchased) vaccines *must* be billed on the Pharmacy Claim.

### 13. 23.G CLAIM FILING FOR INJECTABLE MEDICATIONS

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

- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) *must* be billed by exact cubic centimeters or milliliters (cc or ml) dispensed, even if the quantity includes a decimal (e.g., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill is 1.5 mls).

- Single dose syringes and single does vials *must* be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Ointments *must* be billed per number of grams even if the quantity includes a decimal.

- Eye drops *must* be billed per number of cubic centimeters or milliliters (cc or ml) in each bottle even if the quantity includes a decimal.
- Powder filled vials and syringes that require reconstitution *must* be billed by the number of vials.
- Combination products, which consist of devices and drugs, designed to be used together, are to be billed as a kit for example Copaxone, Pegasys).
- The product Herceptin, by Genentech, *must* be billed by milligram rather than by vial.
- Immunizations and vaccines *must* be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

### 13. 23.H INFUSION THERAPY

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

The services of the physician supervising infusion therapy in the inpatient or outpatient hospital setting are to be billed using the appropriate Evaluation and Management procedure codes. Infusion therapy by nurses in an inpatient or outpatient setting is included in the facility charge and is *not* separately billable (e.g., chemotherapy, antibiotic therapy, hydration therapy, immune globulin therapy, IV rate change, pitocin, etc.).

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

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

## 13. 24 EMERGENCY SERVICES

Emergency medical services are defined as those health care items and services furnished or required to evaluate and treat a sudden and unforeseen situation or occurrence or a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably

be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

1. death; or
2. placing the patient's health in serious jeopardy; or
3. permanent impairment of bodily functions; or
4. serious dysfunction of any bodily organ or part; or
5. serious harm to an individual or others due to an alcohol or drug abuse emergency; or
6. injury to self or bodily harm to others; or
7. with respect to a pregnant woman who is having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or, (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

## 13. 25 OUT-OF-STATE, NONEMERGENCY SERVICES

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

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

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

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

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

The written request *must* include:

1. A brief past medical history.
2. Services attempted in Missouri.

3. Where the services are being requested and who will provide them.
4. Why services can't be done in Missouri.

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

### 13. 25.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

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

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

## 13. 26 CONSULTATIONS

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

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

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

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

### 13. 26.A OFFICE OR OTHER OUTPATIENT CONSULTATIONS

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

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

### 13. 26.B. GUIDELINES FOR THE USE OF CONSULTATIONS

MO HealthNet has established the following guidelines concerning consultations:

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

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

## 13. 27 CONCURRENT CARE

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

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

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

## 13. 28 ADULT PHYSICALS

One adult “preventive” examination/physical, including a well woman exam (ages 21 and older) per 12 months is covered by MO HealthNet. Physicals are also covered when required as a condition of employment. Diagnosis code V70.0, “routine general medical examination at a health care facility”, or diagnosis code V72.3, "gynecological examination", should be used and billed under the appropriate preventative medicine procedure code (99385-99387 or 99395-99397).

## 13. 29 MO HEALTHNET MANAGED CARE PROGRAM

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

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

# 13. 30 HOSPITAL SERVICES

## 13. 30.A PHYSICIAN SERVICES

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

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

### 13. 30.A (1) Hospital Salaried Physicians

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

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

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

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

## 13. 30. B HOSPITAL CARE

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

## 13. 30. C LIMITATIONS

- Inpatient hospital lengths of stay are limited to the lesser of:
    - the number of medically necessary days billed by the hospital; or

- the number of days approved through admission and continued stay reviews based on the diagnosis/age/surgery limitations.

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

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

## 13. 31 INPATIENT HOSPITAL CERTIFICATION REVIEWS

Inpatient hospital admissions *must* be certified as medically necessary and appropriate before MO HealthNet reimburses for inpatient services. All MO HealthNet enrolled hospitals in Missouri and bordering states are subject to this admission certification requirement. The State's inpatient review authority will receive all the appropriate information necessary to review admissions subject to admission certification. Reference Section 1328 of the Hospital Manual for more information on Inpatient Hospital Certification Reviews.

## 13.32 ANESTHESIA SERVICES

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

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

AA - Anesthesia service performed personally by anesthesiologist

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

QZ - CRNA service without medical direction by a physician

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

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

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

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

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| 99143 | 99144 | 99145 | 99148 | 99149 | 99150 |

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

### 13.32. A GENERAL ANESTHESIA FOR CT SCANS

There may be an occasional need for anesthesia during CT scan services as a result of medically necessary circumstances, e.g., hyperactive child, intellectually disabled individual, etc. Procedure code 76499, unlisted diagnostic radiologic procedure, may be billed. A copy of the anesthesia report is required and is manually priced by the state medical consultant. Procedure code 01922, with the appropriate modifier may be billed.

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

### 13. 32.B CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

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

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

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

#### 13.32.B (1) Inpatient Hospital Services

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

#### 13.32.B (2) Outpatient Hospital Services

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

The billing provider may be the hospital if the CRNA is hospital salaried or contractually compensated. If the CRNA is employed by a physician, the physician may bill for those services using the appropriate modifier. CRNAs who are self-

employed and have no financial compensation from the hospital may bill for outpatient hospital services under their own provider identifier, also using the appropriate modifier.

### 13.32.C MEDICAL DIRECTION BY ANESTHESIOLOGIST

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

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

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

#### 13. 32.C (1) Concurrent Medical Direction

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

For each patient, the physician:

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

A physician who is concurrently directing the administration of anesthesia should ordinarily *not* be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area or periodic monitoring of an obstetrical patient does *not* substantially diminish the scope of control exercised by the physician. However, if the physician leaves the

immediate area of the operating suite for other than a short duration or devotes extensive time to other patients or situations, medical direction ends.

### 13. 32.C (2) Supervision Billing Guidelines

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

### 13. 32.D ANESTHESIOLOGISTS IN A GROUP PRACTICE

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

### 13. 32.E ANESTHESIOLOGIST SERVICES (DENTAL) ASC

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

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

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

### 13. 32. F ANESTHESIA SERVICES FOR MULTIPLE SURGERIES

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

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

### 13. 32.G CALCULATION OF ANESTHESIA SERVICES

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

- The **base rate** (the **relative value** x the **conversion factor** appropriate for the provider type) is reflected as the "payment amount" in the pricing file**. This is *not* the total reimbursement amount, but is used in the calculation**.
- **Anesthesia time unit(s):** Each 15-minute unit of anesthesia is equal to a time unit of 1. For instance, an anesthesia service (i.e., administration or supervision) of one hour constitutes a unit value of 4. **However, the total number of minutes of anesthesia (60) *must* be shown on the professional claim. The system converts into units.**

Anesthesia time begins with participant preparation for anesthesia and ends when the participant leaves the operating room and is safely under customary postoperative supervision in the recovery room. One unit, 15 minutes, is allowed for anesthesia induction time prior to surgery. No allowance is made after the surgery ends and the participant is transferred to the recovery room.

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

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

### 13. 32. H QUALIFYING CIRCUMSTANCES FOR ANESTHESIA

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

| PROC CODE | DESCRIPTION |
|---|---|
| 99100 ..... | Anesthesia for patient of extreme age, under one year and over seventy. |
| 99116 ..... | Anesthesia complicated by utilization of total body hypothermia. |
| 99135 ..... | Anesthesia complicated by utilization of controlled |

hypotension.

99140 ..... Anesthesia complicated by emergency conditions (specify).

An emergency is defined in Section 13.24.

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

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

## 13. 32. I ANESTHESIA NONCOVERED SERVICES

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

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

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

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

### 13. 32.I (1) Anesthesiologist Assistant (AA)

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

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

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

- Obtaining a comprehensive patient history, performing relevant elements of a physical exam and presenting the history to the supervising anesthesiologist;

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

An AA is prohibited from the following:

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

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

When the anesthesiologist personally performs a service, the procedure should be billed using the AA modifier. No separate payment is allowed for supervision by the anesthesiologist, nor for the AA's service, regardless of whether or not the AA

is independently enrolled as a MO HealthNet provider. A separate payment for the AA is only payable if documentation is attached showing that it was medically necessary for both the anesthesiologist and the AA to be involved. If the AA service was *not* medically necessary, recoupment of the AA service may be made.

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

## 13. 33 SURGERY

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

### 13. 33. A ORTHOPEDIC SURGERY—CASTING, REMOVAL, MATERIALS

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

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

Reference the appropriate HCPCS codes for cast supplies.

### 13. 33.B ELECTROMAGNETIC TREATMENT OF FRACTURES USING NONINVASIVE OSTEOGENESIS STIMULATOR DEVICE

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

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

*This procedure requires prior authorization*.

The patient's history, general medical information, prior orthopedic history, present diagnosis and condition and prescription measurements *must* be visible on the corporate (supplier) orthopedic prescription form signed by the prescribing physician. The prescription form and a Prior Authorization Request form *must* be submitted for review by the state medical

consultant and returned to the supplier dispensing the stimulator, indicating approval or denial. Refer to Section 8 for information on prior authorization request procedures.

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

### 13. 33.C ROUTINE FOOT CARE/DEBRIDEMENT OF NAILS

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

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

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

Refer to Section 13.73 for information on limitations for certain podiatry services.

### 13. 33. D ASSISTANT SURGEON

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

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

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

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

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

Only physicians may be considered assistant surgeons.

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

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

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

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

### 13. 33. E CO-SURGEON'S SERVICES (TWO SURGEONS)

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

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

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

The surgeon and co-surgeon *must* file separate claims, each using his/her own individual MO HealthNet provider number. The surgical procedure code together with modifier 62 (Two Surgeons) should be shown on both claims. The name of both surgeons *must* appear on the claim form in the "description" area.

### 13. 33. F MULTIPLE SURGICAL PROCEDURES

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

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

- The major, secondary and tertiary procedures should be indicated on the claim form using appropriate CPT codes.
- A copy of the Operative Report may be attached to claims for multiple surgeries to provide additional information. If *not* attached, a copy may be requested to assist with the claim processing.

Claims for multiple surgeries are allowed according to the following:

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

#### 13. 33.F (1) Exception to Multiple Surgical Procedures

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

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

### 13. 33.G ABORTIONS

In accordance with Public Law 105-78 (1997), relating to abortions, MO HealthNet payment is only available for abortions performed when the life of the mother would be endangered if the fetus were carried to term or that the pregnancy is the result of an act of rape or incest.

In these situations the physician *must* complete the Certification of Medical Necessity for Abortion form certifying the medical necessity of the procedure. The definition of a medically necessary abortion is when the performing physician has found and certified in writing on the Certification of Medical Necessity for Abortion form, that on the basis of the physician's professional judgment:

1. the pregnancy is the result of an act of rape or incest; or
2. the woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by the performing physician, place the woman in danger of death unless an abortion is performed.

The physician *must* certify that in the physician's professional judgment this service meets the above criteria based on full consideration of all factors described in the medical records and attached to the claim form, e.g., physician's office medical records, emergency room report, history and physical, ultrasound interpretation report, physician's progress notes, consultant reports, laboratory reports, operative report, pathology report.

The Certification of Medical Necessity for Abortion form *must* be personally signed and dated by the performing physician. A facsimile signature or signature of the physician's authorized representative is *not* acceptable. Each provider submitting a claim for abortion services (e.g., physician, inpatient hospital, outpatient hospital, clinic) *must* attach a completed certification form with an original signature. All relevant documentation *must* be attached with the Certification of Medical Necessity for Abortion form to the claim form when submitted for processing. Reference Section 14.

For missed or spontaneous abortions (miscarriages) see Certificate of Medical Necessity form in Section 7 and 14.

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

### 13. 33.H HYSTERECTOMIES

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

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

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

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

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

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

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

**13. 33.H (1)Acknowledgement of Receipt of Hysterectomy Information**

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

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

Requirements concerning hysterectomies apply to an individual of any age.

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

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

### 13. 33.I STERILIZATIONS

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

For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and *must* always be reported as family planning services.

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

### 13. 33.J MORBID OBESITY TREATMENT

Morbid obesity, as defined by the American Medical Association (AMA) is a Body Mass Index (BMI) greater than 40. The treatment of obesity is covered by MO HealthNet (MHD) when the treatment is an integral and necessary course of treatment for a concurrent or complicating medical treatment. The following codes for bariatric surgery, gastric bypass, gastroplasty, and laparoscopy are covered codes by MHD for patients with a BMI of greater than 40 and a co-morbid condition(s). These services must be prior authorized. Refer to section 8 of the physician's manual to review MHD's prior authorization policy.

43644 43645 43659 43770 43845 43846 43847 43848

The following are covered codes by MHD for patients with a BMI of greater than 40 and a co-morbid condition(s), but do not require a prior authorization request.

43771 43772 43773 43774

## 13. 34 POSTOPERATIVE CARE

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

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

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

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

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

### 13. 34.A PHYSICIAN SERVICES SUBJECT TO POSTOPERATIVE RESTRICTION

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

Office or Other Outpatient Services

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

Home Medical Services

| | | | | | |
|---|---|---|---|---|---|
| 99341 | 99342 | 99343 | 99344 | 99345 | 99347 |
| 99348 | 99349 | 99350 | | | |

Hospital Inpatient Services

| | | | | | |
|---|---|---|---|---|---|
| 99231 | 99232 | 99233 | 99234 | 99235 | 99236 |
| 99238 | 99239 | | | | |

Nursing Facility Care

| | | | | | |
|---|---|---|---|---|---|
| 99304 | 99305 | 99306 | 99307 | 99308 | 99309 |
| 99310 | 99315 | 99316 | 99318 | | |

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

| | | | | | |
|---|---|---|---|---|---|
| 99324 | 99325 | 99326 | 99327 | 99328 | 99334 |
| 99335 | 99336 | 99337 | | | |

Emergency Department Services

| | | | | |
|---|---|---|---|---|
| 99281 | 99282 | 99283 | 99284 | 99285 |

Unlisted Evaluation and Management Services

99499

Preventive Medicine Services

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

Ophthalmologist

| | | | |
|---|---|---|---|
| 92002 | 92004 | 92012 | 92014 |

Special Services Codes

| | | | | |
|---|---|---|---|---|
| 99050 | 99051 | 99053 | 99056 | 99058 |

### 13. 34.B EXCEPTIONS

Exceptions to the postoperative care policy may be reimbursed for complications or extenuating circumstances that have been documented and determined to be exempt by the state medical consultant. In addition, the following services are exempted from the postoperative policy limitations:

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

### 13. 34.C POSTOPERATIVE CARE—OTHER THAN THE SURGEON

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

## 13. 35 SEPARATE/INCIDENTAL PROCEDURES

Some procedures are commonly carried out as an integral part of a total service and as such do *not* warrant a separate identification. However, when such a procedure is performed independently of, and is *not* immediately related to other services, it may be listed as “separate procedure.” Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure. Attach copies of the operative report(s) for the medical consultant's review.

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

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

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

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

- Anoscopy, proctosigmoidoscopy, sigmoidoscopy, prior to diagnostic or therapeutic colonoscopy.
- Application of cast with open or closed reduction of a fracture.
- Application of dressing, casts and/or splints with tendon repair.
- Biopsy of breast prior to a mastectomy.

- Biopsy of mesentery, omentum and peritoneum when performed with another abdominal surgery.
- Control of postoperative bleeding (e.g., tonsillectomy, removal of prostate (TUR), hemorrhoidectomy, hysterectomy, etc.)
- Debridement (simple) of an open wound prior to skin graft or repair of laceration.
- Diagnostic dilation and curettage (uterus), salpingo-oophorectomy prior to hysterectomy, same day.
- Diagnostic endoscopy; preceding surgery, same day, using the same approach and the same instruments.
- Exploratory laparotomy when it is the route of entry for another abdominal surgery.
- Insertion of T-tube, Penrose drain, Foley catheter, chest tube, hemivac, etc., during surgery and removal after.
- Iridotomy or iridectomy when performed with cataract extraction.
- Laminotomy, craniotomy or thoracotomy, preceding surgery, same approach, same day.
- Laparoscopy preceding laparotomy.
- Local or regional anesthesia by surgeon or obstetrician.
- Lysis of abdominal adhesions, when another abdominal surgery (e.g., colon resection, hysterectomy, etc.) is performed.
- Mobilization of the intestine during abdominal surgery.
- Obtaining a donor graft.
- Pharyngoscopy, laryngoscopy, tracheoscopy, when performed with bronchoscopy or esophagoscopy with upper gastrointestinal endoscopy.
- Removal of packs (e.g., nasal, uterine, etc.) after insertion.
- Urethral catheterization and calibration preceding cystourethroscopy.
- Ureteral endoscopy preceding renal endoscopy through established nephrostomy.

## 13. 36 UNLISTED SERVICE OR PROCEDURE

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

the procedure, and the time, effort and equipment necessary to provide the service. All claims are manually reviewed by the state medical consultant for appropriateness and payment.

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

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

## 13. 37 LIMITING CERTAIN SURGICAL PROCEDURES TO OTHER THAN AN INPATIENT BASIS

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

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

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

## 13. 38 NONCOVERED SERVICES

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

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

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

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

- Abortions (except as specifically outlined in Section 13.33.G);

- Acupuncture;
- Ambulance service to the physician's office;
- Autopsy (postmortem examination);
- Ballistocardiogram;
- Biofeedback services;
- Clinical studies, trials, testing, experimental and investigational medical procedures, drugs, equipment, etc;
- Contact lenses;
- Cosmetic surgery directed at improving appearance (e.g., augmented mammoplasty, face lifts, rhinoplasty, etc.);
- Ear piercing;
- Foot care (routine) (Foot care for diabetes mellitus and other peripheral vascular diseases are *not* considered routine and are covered);
- Garter belts, elastic stockings, Jobst and pressure garments for hand and arms, Spenco boots and other foot coverings;
- Hair transplants;
- Implantation of nuclear-powered pacemaker;
- Keloids, excision of (unexposed areas of body);
- Necropsy (Autopsy);
- Occupational therapy services (age 21 and over);
- Orthopedic shoes or supportive devices for the feet for ages 21 and over (orthopedic shoes when an integral part of the brace may be obtained through the Durable Medical Equipment Program);
- Penile prostheses or insertion of;
- Personal comfort items;
- Preparation of special reports sent to insurance companies;
- Psychiatric reports for court evaluation or juvenile court;
- Reimbursement for medical direction or supervision of students in a teaching, training or other setting;
- Salpingoplasty;
- Services by psychologists, social workers or other mental health workers, for ages 21 and over, even when performed under the supervision of a psychiatrist;

- Services rendered anywhere when a physician is *not* in attendance and in direct supervision of the service except where exempt as stated in Section 13.17;
- Sex therapy;
- Speech therapy (except as training in use of an artificial larynx) (age 21 and over);
- Tattoos, removal of;
- Treatment of infertility;
- Surgical procedures for gender change such as:
  - Hysterectomy
  - Mammoplasty
  - Mastectomy
  - Orchiectomy
  - Penectomy
  - Penile construction
  - Release of vaginal adhesions
  - Revision of labia
  - Vaginal dilation
  - Vaginal reconstruction
  - Vaginoplasty;
- Treatment of impotence;
- Tuboplasty vasovasostomy (sterilization reversal);
- Vials of insulin (covered under Pharmacy Program);
- Vitamin injections (Reference Section 13.24.F for exceptions);
- Weight control.

## 13. 39 NON-ALLOWABLE SERVICES

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

- Administration of medication/injection (if the patient is examined/treated as the service is included in the office/outpatient visit or other procedure performed);
- Assistant surgery fees for surgeries/procedures identified by Medicare as non-payable;

- Canceled or “no show’ practitioner appointments;
- Cast removal when the cast was applied by the same physician;
- Catheterization for a urine specimen in the office;
- Claim filing;
- Debridement of a laceration and abrasion with immediate primary closure of wound;
- Drawing fees;
- Follow-up visits for interpretation of tuberculin tests, PPD or Tine (office visit within two to five days of the test);
- Handling and/or conveyance of specimen to an independent laboratory for interpretation;
- Hospital visits for the same patient, same date of service as another medical procedure billed by that physician;
- Incidental surgical procedures performed through the same incision;
- Incorrect billing;
- Intralesional injections;
- Local anesthesia;
- Medical testimony;
- Office visits to obtain a prescription, the need of which had already been ascertained;
- Postage;
- Professional fees for “Clinical Diagnostic Laboratory Procedures”;
- Removal or placement of sutures by the operating physician/surgeon;
- Routine postoperative care following a surgery or procedure;
- Services *not* directly related to the participant’s diagnosis, symptoms or medical history, or services in excess of those deemed medically necessary to treat the patient’s condition;
- Services considered part of a MO HealthNet covered service/procedure;
- Services or supplies covered through another MO HealthNet Program;
- Services or supplies furnished free of charge by any governmental body (e.g., injectable material, etc.);
- Telephone calls;
- Venipuncture for the purpose of obtaining a blood specimen.

## 13. 40 RADIOLOGY

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

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

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

### 13. 40. A RADIOLOGY SERVICES

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

- *Must* be billed on a professional claim;
- May *never* be billed with inpatient or outpatient POS;
- May be billed by physician, clinic, FQHC, Provider Based RHC, Independent Diagnostic Testing Facility (IDTF), independent radiologist or independent x-ray service;
- Referring physician must be reported if the billing provider is an independent radiologist, IDTF or is a provider with a specialty of radiology/radiation therapy.

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

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

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

- *Must* be billed on a professional claim for physician or IDTF billing;
- *Must* be billed on UB-04 claim for outpatient hospital billing;

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

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

High-tech and cardiac imaging procedure codes require precertification. These services are exempt from the precertification requirement when performed in emergency situations or while the participant in outpatient observation. Medicare covered services provided on participants with active Medicare Part B are also exempt from the precertification requirement. **Participants with Medicare Part C coverage and do not have QMB benefits are required to obtain a precertification.**

A list of procedure codes requiring precertification can be found at www.medsolutions.com/our_difference/index.html.

### 13.40.B (1) Initiating Precertification Requests

All requests *must* be initiated by an enrolled MO HealthNet provider and approved by MHD. Requests for precertification may be made by using the Web tool - Cyber Access or by calling the MO HealthNet Call Center at (800) 392-8030, option 5. In order to be approved, requests *must* meet the clinical edit criteria established by the MO HealthNet Division contractor, MedSolutions, Inc (MSI). Clinical guidelines for the above listed codes are available at www.medsolutions.com/our_difference/index.html.

An approved precertification request does *not* guarantee payment. The provider *must* verify participant eligibility on the date of service using the Interactive Voice Response (IVR) system at (573) 751-2896 or by logging on to the MO HealthNet Web portal at www.emomed.com.

### 13.40.B (2) Certification Approval Time Frame

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

### 13.40.C ACCURACY ASSESSMENT

Enrolled MO HealthNet providers that perform any of the procedures listed on the MSI Web portal at www.medsolutions.com/our_difference/index.html must complete an Accuracy Assessment questionnaire. This assessment questionnaire must be completed by each provider location that will be performing and billing for any of the above mentioned high-tech and/or cardiac imaging procedures for MO HealthNet eligible participants. The goal of the assessment is to ensure the participant is treated at a high quality facility with current and well maintained equipment and the procedures are performed by licensed, qualified technicians. Providers will be approved for one or more procedures and locations in accordance with the results of their assessment questionnaire, within their submitted scope of practice. If you have questions concerning the questionnaire and approval process, please contact the MedSolutions Accuracy Management Department at (800) 457-2759 or by email at accuracymgmt@medsolutions.com.

### 13.40.D PARTICIPANT APPEAL RIGHTS

When a precertification request is denied, the participant receives a letter outlining the reason for the denial and the procedure for appeal. A State Fair Hearing may be requested by the participant, in writing, to:

MO HealthNet Division
Participant Services Unit (PSU)
P.O.Box 6500
Jefferson City, MO 65102-3535.

The participant may also call the Participant Services Agent at (800) 392-2161 toll free, or (573) 751-6527. The participant *must* contact PSU within 90 days of the date of the denial letter to request a hearing. After 90 days, requests to appeal are denied.

### 13.40. E COMPLETE RADIOLOGICAL PROCEDURES

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

When a *single physician* performs the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series (reference the Surgery Section of the *Physicians' Current Procedural Terminology (CPT)*), *must* be used in addition to the appropriate "radiological supervision and interpretation" procedure code. Payment to a single physician for interventional radiologic procedures or diagnostic studies

involving injection of contrast media includes all unusual pre-injection and post-injection services; e.g., necessary local anesthesia, placement of needle or catheters, injection of contrast media, supervision of the study and interpretation of results.

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

### 13.40.F TESTING AGENTS USED DURING RADIOLOGIC PROCEDURES

#### 13.40.F(1) Contrast Materials and Radiopharmaceuticals

Contrast materials and radiopharmaceuticals used in radiologic procedures may be billed separately using the appropriate HCPCS procedure code **and/or** the National Drug Code (NDC) representing the materials or agent used in the procedure. If available, MO HealthNet would prefer the NDC for reporting purposes. If the material or agent used does not have an NDC, the appropriate HCPCS procedure code alone is acceptable. All HCPCS procedure codes for contrast materials and radiopharmaceuticals are manually priced and must be billed with the manufacturer's invoice of cost attached to the claim.

### 13. 40.G MOBILE X-RAY UNIT

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

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

### 13. 40. H RADIATION ONCOLOGY

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

### 13. 40.H (1)Consultation: Clinical Management (Radiation Oncology)

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

### 13. 40.H (2)Manual Pricing (Radiation Oncology)

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

### 13. 40.H (3)Clinical Treatment Planning (Radiation Oncology)

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

### 13. 40.H (4)Clinical Treatment Management (Radiation Oncology)

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

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

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

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

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

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

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

**13. 40.H (5)Clinical Brachytherapy**

Clinical brachytherapy requires the use of either natural or man-made radioelements applied into or around a treatment field of interest. The supervision

of radioelements and dose interpretation is performed solely by the therapeutic radiologist. Clinical brachytherapy services include admission to the hospital and the daily visit(s).

## 13. 40.I INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

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

### 13. 40.I (1) Supervision

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

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

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

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

### 13. 40.I (2) Non-Physician Personnel

Any non-physician personnel used by the IDTF to perform tests *must* demonstrate the basic qualifications to perform the tests and have training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician *must* be certified by an appropriate national credentialing body. Non-physician practitioners

may *not* supervise diagnostic testing performed by others. The IDTF *must* maintain documentation available for review that the requirements are met.

**13. 40.I (3) Ordering of Tests**

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

**13. 40.I (4) Multi-State Entities**

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

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

**13. 40. J NON-COVERED SERVICES**

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

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

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

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

## 13. 41 PATHOLOGY AND LABORATORY

### 13. 41.A CLINICAL DIAGNOSTIC LABORATORY PROCEDURE REIMBURSEMENT

Section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369) contains guidelines for reimbursement for certain clinical diagnostic laboratory services and is applicable to physicians (individual or group practice), independent laboratories and outpatient hospitals.

These guidelines contain a requirement that MO HealthNet reimbursement may *not* exceed the national limitation amount.

### 13. 41.A (1) Outside Laboratory Reimbursement

An outside laboratory performing outpatient laboratory services *must* bill MO HealthNet for the services when the laboratory is an enrolled MO HealthNet provider. A hospital may bill MO HealthNet for outpatient laboratory services performed by a non-MO HealthNet enrolled outside laboratory. The billing hospital *must* keep in their files the appropriate CLIA certification for the outside laboratory performing the services.

## 13. 41.B CLIA REQUIREMENTS

Under the Clinical Laboratory Improvement Amendments Act (CLIA) of 1988, all laboratory sites, including independent laboratories, hospitals, physician offices, nursing homes, etc., as defined at 42 CFR 493.2, *must* have either a CLIA Certificate of Waiver or Certificate of Registration to legally perform clinical laboratory testing anywhere in the United States; or be exempt by virtue of the fact that the lab is licensed by an approved state program.

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

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

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

### 13. 41.B (1) Laboratory Test Codes that Include Preparation Only

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

## 13. 41.C LABORATORY SERVICES

The following information provides billing guidelines for laboratory services.

### 13. 41.C (1) Professional and Technical Component, Lab Service

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

### 13. 41.C (2) Professional Component, Laboratory

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

### 13. 41.C (3) Technical Component, Laboratory

- When billing for clinical diagnostic laboratory procedures, the technical component is the only appropriate component to bill;
- *Must* be billed on a professional claim for physician billing;
- May only be billed by provider who processes the specimen;
- *Must* be billed on UB-04 claim form for outpatient hospital billing;

- The technical component may never be billed for services provided on an inpatient basis;
- May be billed by physician/pathologist or independent laboratory (when CLIA certified);
- Referring physician's NPI is required when biller is independent laboratory;
- Diagnosis required.

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

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

### 13. 41.D MULTI-TEST LABORATORY PANELS

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

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

### 13.41. E DRUG SCREENING TESTS

Qualitative and semi-quantitative drug screening tests are covered by the MO HealthNet Program. Refer to the CPT book for appropriate procedure codes to reflect testing on single or multiple drug classes. A drug screen test reports what drug classes (e.g., tricyclic antidepressants, phenothiazines, amphetamines, benzodiazepines, barbiturates, cannabinoids, methadone, opiates) are present (qualitative) and may provide an estimate (semi-quantitative) of the concentration. An initial drug screen or preliminary test that yields qualitative or semi-quantitative results must be reported with an appropriate drug testing procedure code

categorized as such in the CPT book. Codes in the Therapeutic Drug Assay or Chemistry Sections of the CPT book may not be used to report qualitative or semi-quantitative drug screening and preliminary test results. Physician offices may bill for initial drug screens performed at point of care (e.g., by use of CLIA waived test devices) or independent and/or hospital laboratories may bill for screenings they performed, but both cannot be billed. It shall be the responsibility of the ordering physician to coordinate with the performing laboratory for the billing of drug screen tests.

Providers should not routinely bill for the quantification of drug classes. Providers should only bill for the quantification of a drug class or a confirmatory drug test (i.e., billing procedure codes from the Therapeutic Drug Assay or Chemistry sections of the CPT book) if there is a positive screen for the drug class to be quantified.

### 13. 41. F HIV/AIDS TESTING

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

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

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

### 13. 41.G LEAD SCREENING

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

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

### 13. 41.H HEMOSTASIS

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

### 13. 41.I SKIN TESTING

#### 13. 41.I (1) Tuberculosis (TB) Test

Tuberculosis (TB) intradermal test is a covered MO HealthNet service. This procedure is exempt from the CLIA requirements. Providers *must* bill for the medication used during the test through the Pharmacy Claim form on the Web portal at www.emomed.com, or other electronic equivalent, using the national drug code (NDC). The test itself is billed with the appropriate CPT code.

#### 13. 41.I (2) Allergy Sensitivity Tests

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

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

#### 13. 41.I (3) Allergen Immunotherapy

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

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

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

**13. 41. I (4) Radioallergosorbent Tests**

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

## 13. 41. J SMEARS AND CULTURES

The following identifies covered and non-covered services:

- Covered for the diagnosis and treatment of acute infection.
- Bacterial, fungi, microplasma, endotoxin, tissue, virus, tubercle cultures, etc., are covered.
- Sensitivity studies are covered.
- Wet and dry mount smears are covered.
- Thayer-Martin used in venereal disease testing is *not* covered.
- Bacterial smear and cultures of the same area on the same date of service are non-covered. Only the culture is payable.

## 13. 41. K CARCINOEMBRYONIC ANTIGENS (CEA TESTS)

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

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

## 13. 41. L URINALYSIS

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

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

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

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

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

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

### 13. 41.M PAP SMEARS

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

### 13. 41.N CYTOPATHOLOGY

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

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

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

### 13. 41. O THERAPEUTIC APHERESIS (PLASMA AND/OR CELL EXCHANGE)

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

## 13. 42 HOSPICE

The hospice benefit is designed to meet the needs of patients with terminal illnesses and to help their families cope with the problems and feelings related to this difficult time. Hospice care is an

approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care.

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

### 13. 42. A ACCESS TO MO HEALTHNET SERVICES FOR HOSPICE ENROLLEES

When a participant elects hospice services, the hospice provides or arranges for all care, supplies, equipment and medicines related to the terminal illness. MO HealthNet reimburses the hospice provider who then reimburses the provider of the service(s).

Services *not* related to the terminal illness are available from any MO HealthNet participating provider of the participant's choice. In this instance the provider of the service is reimbursed directly by the MO HealthNet Program.

### 13. 42.B IDENTIFICATION OF HOSPICE ENROLLEES

Services related to the terminal illness *must* be billed by, and reimbursed to, the hospice provider elected by the participant. Therefore, it is important that all providers be able to readily identify participants who have elected hospice services.

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

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

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

### 13. 42.C ATTENDING PHYSICIAN

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

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

## 13. 43 PHYSICIAN SERVICES IN NURSING HOMES

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

### 13. 43.A TITLE XIX PATIENTS IN NURSING FACILITIES (NF)

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

### 13. 43.B NURSING FACILITY PATIENTS (NOT TITLE XIX)

- There *must* be a medical examination at the time of admission or within 30 days prior to admission, then annually thereafter.

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

## 13. 44 NURSING FACILITY SERVICES

Two subcategories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients. Comprehensive assessments may be performed at one or more sites in the assessment process: the hospital, office, nursing facility, domiciliary/non-nursing facility or patient's home.

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

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

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

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

## 13. 45 SCREENING POTENTIAL NURSING HOME PLACEMENTS

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

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

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

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

### 13. 45.A PREADMISSION SCREENING

The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires states to have in effect a preadmission screening program for mentally ill (MI), intellectually disabled (ID) and developmentally disabled (DD) individuals who are potential residents of Title XIX certified beds. The intent of OBRA is to assure that the mentally ill, intellectually disabled and developmentally disabled are placed in appropriate settings and receive services appropriate for their condition.

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

#### 13. 45.A (1) Limitations

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

## 13. 46 ADVANCE HEALTH CARE DIRECTIVES

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

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

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

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

## 13. 47 PSYCHIATRY

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

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

Reimbursement for psychiatric services is made only to the psychiatrist who actually performs the service.

### 13.47. A BEHAVIORAL HEALTH SERVICES IN A NURSING HOME

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

### 13.47. B PSYCHIATRIC TREATMENT PLAN

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

### 13. 47. C ELECTROCONVULSIVE THERAPY

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

### 13. 47. D DEFINITION OF PSYCHIATRIC EMERGENCY ADMISSION FOR CHILDREN

It is important for psychiatric hospitals serving children and youth 20 years of age and under to determine whether or not an admission is an emergency. The type of admission determines if the certification of need for inpatient services and the medical/psychiatric/social evaluation *must* be made by an independent team or by the hospital's interdisciplinary team. Information may be requested from the attending physician as part of this review.

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

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

### 13. 47.E LIMITATIONS

- Telephone consultations are non-allowable.
- Team management/staffing are non-allowable.
- Only one of the following is covered on a single date of service:
  - office/outpatient visit;
  - home visits (including residential care facility and school);
  - hospital visit;

- psychotherapy (individual or group);
- psychiatric diagnostic;
- electroconvulsive therapy;
- narcosynthesis; or
- psychiatric medication check.

- Psychiatric services are *not* covered for diagnoses relating to intellectual disabilities.
- Subsequent hospital visits, using the appropriate level of service, may be allowed on the days that the patient is actually seen but therapy is *not* done.
- A provider may *not* bill a combination of a time measured psychotherapy code (such as 90832) with a psychotherapy code including a time measure psychotherapy code (such as 90834) on the same date of service.
- Group therapy (90853) may *not* be billed on the same date of service as family therapy (90846 or 90847) unless the participant is inpatient, in a residential treatment facility or custodial care facility.

### 13. 47.F SERVICES PROVIDED IN GROUP HOME, HOME AND SCHOOL

A group home is a child care facility, which approximates a family setting, provides access to community activities and resources and provides care to no more than 2-12 children. When providing therapy to a group of children in a group home, 90853 is billed with place of service 99.

Group therapy is *not* covered in the home (place of service 12) for a family unit living under the same roof. If therapy is provided to a family unit, family therapy *must* be billed. Settings which do *not* necessarily approximate a family setting, but whose purpose is to provide one shelter for a group of individuals (home or pregnant teens), group therapy is billed instead of family therapy with a place of service 99.

Services provided in a public school *must* be billed using place of service 03. Services provided in a private school setting *must* be billed using place of service 97.

Modifier U8 *must* be used when submitting claims for place of service 12 (home) or 99 (other).

## 13. 48 DIALYSIS

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

Hemodialysis is a process of removing waste products, toxins and excess fluids from the blood. The patient's blood is diverted from a blood vessel by way of a cannula into a dialyzer, or dialyzer

machine, where it is treated and then returned to the patient's circulation by another tube inserted into a different blood vessel.

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

## 13. 48.A PHYSICIAN SERVICES (DIALYSIS)

### 13. 48.A (1) Monthly End State Renal Disease (ESRD)

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

### 13. 48.A (2) Daily ESRD Services

If the physician is *not* involved in continuous supervision of the patient, or becomes involved late in the month, daily visits *must* be billed. When billing supervision for less than a full month (procedure code 90951-90967, based on the patient's age), identify the first day of dialysis to the last day of dialysis. The number of units *must* equal the number of days within the range of dates. If treatment periods within a month are interrupted (i.e., hospitalization), bill on separate lines for each continuous period using these same guidelines. Daily visits are *not* to be billed for ongoing/monthly supervision.

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

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

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

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

### 13. 48.A (3) Hemodialysis/Miscellaneous Dialysis Services

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

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

## 13. 48. B FREESTANDING DIALYSIS CENTERS

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

## 13. 48. C CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) AND HEMODIALYSIS IN THE HOME

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

### 13. 48.C (1) Reimbursement of Dialysis Facility Training Fee

A training fee of $500.00 per patient (regardless of the length of training), is payable to the dialysis facility that has responsibility for furnishing training to the patient. Dialysis and hemodialysis training services and supplies include personnel services (including home visits, if necessary), dialysis supplies, parenteral items routinely used in dialysis, training manuals and materials and routine laboratory tests.

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

Procedure code 90993 "Dialysis training, patient, including helper where applicable, any mode, course *not* completed, per training session" *must* be billed by

the dialysis facility using place of service 65, and the number of training sessions completed as the quantity.

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

### 13. 48. D DIALYSIS AND HEMODIALYSIS SERVICES IN THE HOME

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

12-Home

31-Skilled Nursing Facility

32-Nursing Facility

33-Custodial Care Facility

54-Intermediate Care Facility/Mentally Retarded

The maximum allowable reimbursement for home dialysis/hemodialysis services is $1,495.00 per month regardless of the frequency of the treatments. Reimbursement for claims processed over this dollar amount is reduced or denied. The following guidelines provide specific billing information:

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

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

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

### 13. 48.D (1) Items and Services Included in the Composite Rate

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

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

| | |
|---|---|
| Every Month | |
| BUN | Total Protein |
| Creatinine | Albumin |
| Sodium | Alk. Phosphatase |
| Potassium | LDH |
| C02 | SGOT |
| Calcium | Hct |
| Magnesium | Hgb |
| Phosphate | Dialysate Protein |
| Every 3 Months | |
| WBC | |
| RBC | |
| Platelet count | |
| Every 6 Months | |

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

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

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

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

### 13. 48.E HOSPITAL-BASED DIALYSIS CLINICS

#### 13.48. E (1) Outpatient or Home Services

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

## 13. 49 OPHTHALMOLOGY/OPTICAL

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

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

### 13.49. A BILLING OPHTHALMOLOGY SERVICES

- To bill general ophthalmological services use 92002-92014.
- To bill special ophthalmologic services use 92015-92140.
- To bill hospital, emergency department and other institutional medical services, use the codes from the Evaluation and Management Services section (99221-99233 and

99281-99285) unless specific ophthalmological codes (92002-92499) are more appropriate.

- To report surgical services, see surgery, eye and ocular adnexa (65091, etc.).

# 13. 50 OTORHINOLARYNGOLOGY

## 13. 50.A VESTIBULAR FUNCTION TESTS

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

## 13. 50.B AUDIOLOGY

### 13. 50.B (1) Audiologist Employed by a Physician

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

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

### 13. 50.B (2) Audiologists in Private Practice

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

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

### 13.50.B (3) Diagnostic Audiology Services

Procedure codes 92552 (Pure tone audiometry, threshold; air only), 92553 (Pure tone audiometry, threshold; air and bone), 92556 (Pure tone audiometry, threshold; with speech recognition), 92557 (Comprehensive audiometry threshold evaluation and speech recognition, 92553 and 92556 combined), 92567 (Typanometry,

impedance testing), and 92568 (Acoustic reflex testing; threshold) is covered for individuals 21 and over when performed by an audiologist (provider type 33). These procedure codes must be billed with an SC modifier (Medically necessary service or supply) and must be ordered by a physician.

## 13. 51 CARDIOVASCULAR

### 13. 51.A ELECTROCARDIOGRAM (EKG) (ECG)

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

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

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

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

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

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

### 13. 51. B CARDIAC REHABILITATION

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

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician and:

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

## 13. 52 PHYSICAL MEDICINE

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

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

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

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

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

### 13. 52.A MODALITIES AND PROCEDURES

- A limited level of service (99211) may be billed on the same date of service for follow-up therapy.
- A “special report” describing the procedure *must* accompany the claim for procedure code 97039, unlisted modality (specify) and 97139, unlisted procedure (specify).
- Diathermy (97024) is noncovered for the treatment of asthma, bronchitis, etc.
- Spinalator treatment is noncovered.
- Massage therapy (97124) is only paid if used in conjunction with another physical therapy procedure.
- Electrical stimulation (97014) is covered for the treatment of spasticity, incapacitating muscle spasm and semiparesis.
- Manipulation of spine requiring anesthesia, any region (22505), does *not* include evaluation and management services (99201-99215 or 99221-99233).
- Procedure code 97010 (application of hot or cold packs) is *not* covered. Payment for application of hot and cold packs is bundled into payment for all other services including, but *not* limited to, office visits and physical therapy. The patient *cannot* be billed separately for this service.

## 13. 53 NERVOUS SYSTEM

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

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

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

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

## 13. 54 DIGESTIVE SYSTEM

### 13. 54. A NUTRITIONAL SUPPLEMENTS

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

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

### 13. 54.B TOTAL PARENTERAL NUTRITION (TPN)

Cutdown placement of central venous catheter, for the parenteral administration of greater than customary amounts of nutrients into a large central vein for those patients who *cannot*

eat, and a constant vascular access for those patients requiring venipuncture(s) who have no peripheral access available, are covered services under the Physician Program.

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

**13. 54.B (1) TPN for Nursing Facility Residents**

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

## 13.55 OBESITY

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

Procedures for bariatric surgery (43770) gastroplasty, stomach (43659) and gastric bypass for morbid obesity (43846, 43847 and 43848) are covered surgical procedures when performed as treatment for a concurrent or complicating medical condition and *must be prior authorized.* A Prior Authorization Request form and supporting documentation, if appropriate, *must* be submitted to the fiscal agent, Wipro Infocrossing Healthcare Services, for processing. Refer to Section 8 for additional information.

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

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

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

## 13. 56 CASE MANAGEMENT

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

## 13. 56.A CASE MANAGEMENT ENROLLMENT CRITERIA

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

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

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

  knowledge of:

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

  and the ability to:

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

- educate clients regarding their health conditions and implications of risk factors.

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

### 13. 56. B CASE MANAGEMENT FOR PREGNANT WOMEN

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

#### 13. 56.B (1) Risk Appraisal

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

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

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

Only MO HealthNet participating providers who meet the prenatal case management criteria, as established by the MO HealthNet Division, (reference Section 13.57. A) are eligible for reimbursement of prenatal case management services for participants considered "at risk" as a result of the appraisal.

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

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

### 13. 56.B (2) Procedure Code for Risk Appraisal

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

| PROC CODE | DESCRIPTION |
|---|---|
| H1000 | Risk Appraisal, Pregnant Women |

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

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

### 13. 56.B (3) Procedure Codes for Case Management for Pregnant Women

| PROC CODE | DESCRIPTION |
|---|---|
| H1001TS..... | Prenatal care, at risk enhanced service; antepartum management; follow up service |
| H1001..... | Prenatal care, at risk enhanced service; antepartum management<br>Limited to one per participant per provider per calendar month. |
| H1004..... | Prenatal care, at risk enhanced service; |

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

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

Case management services are exempt from cost sharing.

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

### 13. 56. C HEALTHY CHILDREN AND YOUTH (HCY) CASE MANAGEMENT

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

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

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

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

### 13. 56.C (1) Initial Month—HCY Case Management

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

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

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

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

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

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

### 13. 56.C (3) Prior Authorization Process for HCY Case Management

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

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

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

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

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

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

### 13. 56.C (4) HCY Case Management Assessment and Care Plan

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

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

## 13. 56.D LEAD CASE MANAGEMENT FOR CHILDREN SERVICES

Children with 1 blood lead level of 20 µg/dL or greater, or who have had 2 venous tests at least 3 months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services the lead case management agency *must* be an enrolled provider with MO HealthNet Division. The following procedure codes have been established for billing lead case management. Prior authorization is *not* required:

| PROC CODE | DESCRIPTION |
|---|---|
| T1016UA | Lead Case Management, with Initial Visit |
| T1016UATS | Lead Case Management, Subsequent Months |

- T1016UA—Lead Case Management, with Initial Visit

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

- T1016UATS—Lead Case Management, Subsequent Months

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

  AND

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

  - Blood lead level remains less than 15 µg/dL for at least 6 months
  - Lead hazards have been removed; and
  - There are no new exposures

  Other reasons for discharge may include:

  - Blood lead level remains below 20 µg/dL for 1 year. This closure reason is intended for use in cases where all efforts to reduce a child's blood lead level have been made (i.e, hazards in the home environment have been reduced, personal hygiene, nutritional, and housekeeping behaviors have been appropriately modified, etc.), yet the child's body burden of lead causes the child's blood lead level to consistently remain between 15-20 µg/dL.
  - Refusal of service
  - The child is older than 72 months of age
  - Unable to locate

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

### 13. 56.D (1) Documentation of Lead Case Management Services

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

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

### 13. 56.D (2) Additional Lead Case Management Services

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

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

## 13. 57 OBSTETRIC SERVICES

### 13. 57.A OBSTETRIC PANEL

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

## 13. 57.B ULTRASOUND EXAMS (SONOGRAMS) IN PREGNANCY

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

Ultrasounds provided in excess of three during any one rolling year *must* be medically necessary. All services *must* be adequately recorded in the patient's record and *must* demonstrate appropriateness of use in proper diagnosis, management and treatment of pregnancy-complicating or potentially complicating conditions.

Denied services may *not* be submitted for exception consideration; however, a medical review of a denied service may be requested. Referring physicians are encouraged to include information regarding the patient's diagnosis for use by the billing provider.

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

This policy of limitation applies only to program reimbursement for the service. It does *not* apply to the exercise of medical judgment as to need.

### 13. 57.B (1) Ultrasound Indication Checklist

- First day of last menstrual period (LMP) *not* known within one week;
- Prior still birth;
- Use of fertility drugs for this pregnancy;
- Menstrual cycle length varies more than two weeks;
- Size/date discrepancy; three weeks;
- Prior small-for-gestational-age (SGA) baby;
- Diabetes Mellitus;
- Chronic hypertension;
- Chronic renal disease;
- Suspected pelvic disease;
- Suspected pelvic mass;
- Suspected fetal demise;
- Suspected ectopic pregnancy;
- Suspected molar pregnancy;

- Suspected twin pregnancy;
- Suspected Intrauterine Growth Retardation (IUGR);
- Amniocentesis;
- Cervical cerclage;
- Vaginal bleeding; undetermined etiology;
- Abnormal Maternal Serum Alpha-feto Protein (MSAFP) screen;
- Fetal malpresentation;
- Suspected abruptio placenta;
- Suspected oligo/polyhydramnios;
- Suspected macrosomia;
- Preeclampsia;
- Preterm labor;
- Premature rupture of membrane (PROM);
- Suspected placenta previa;
- Post-date pregnancy;
- Suspected fetal anomaly;
- Other (requires definition).

**13. 57.B (2) Noncovered Ultrasound Services**

- Routine screening of *all* pregnant women.
- Use of any apparatus in auscultation of fetal heart tones.

## 13. 57.C FETAL CONTRACTION STRESS TEST (59020) AND FETAL NON-STRESS TEST (59025)

The total component (both the professional and technical components of the procedure) for fetal stress and non-stress procedures are covered when performed in an office/clinic setting.

Use the 26 modifier when only the professional component is performed in an inpatient, outpatient or office/clinic setting.

Modifier TC is used when only the technical component is performed in an outpatient or office/clinic setting. If performed inpatient, payment for this charge is included in the per diem rate paid to the hospital.

### 13. 57. D "PRENATAL VISIT"—DEFINITION

A "prenatal visit" is defined as a face-to-face visit with the pregnant MO HealthNet participant at which time all of the following services *must* be performed:

- Patient's weight
- Blood pressure
- Urine check
- Fetal heart tone (FHT) attempt
- Fundal height
- Interim history

A telephone call is *not* a prenatal visit/contact, nor is a WIC referral or other visit for any other reason *not* directly related to the pregnancy, e.g., treatment for cold, allergy shot, etc.

### 13. 57.E RISK APPRAISAL FOR PREGNANT WOMEN

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

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

| PROC CODE | DESCRIPTION |
|---|---|
| H1000..... | Risk Appraisal, Pregnant Women |

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

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

All appropriate MO HealthNet participating providers are urged to perform risk appraisals on pregnant women during the initial visit and as changes in the patient's medical condition indicate. Completion of the Risk Appraisal for Pregnant Women is mandatory in order to establish the "at risk" status of the patient and to bill the global prenatal or global delivery procedure code. No additional payment is made for performing the risk appraisal as it is

included in the global reimbursement for prenatal care or delivery. The Risk Appraisal for Pregnant Women form *must* be filed in the patient's medical record.

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

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

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

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

### 13. 57.F GLOBAL PRENATAL (59425, 59426)

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, vaginitis, and a "Risk Appraisal for Pregnant Women".

If the risk appraisal determines the pregnant woman to be at risk, a referral should be made to an approved case management provider. (Reference Risk Appraisal Section 13.56.B (1).)

Only one prenatal care code, 59425 (4-6 visits) or 59426 (7 or more visits) may be billed per pregnancy. The provider *must* have seen the MO HealthNet eligible participant for four or more prenatal visits, and performed all of the "prenatal visit" services (at each visit) as defined. If a provider does more than 3 visits but the participant goes to another provider for the rest of her pregnancy, all visits *must* be billed using the appropriate office visit procedure codes, except for exempted visits/consultations as described in Section 13.57.F(1). Women with complicating conditions should be referred for consultations or specialty care, as indicated.

The global prenatal fee is reimbursable when one physician or physician group practice provides all of the patient's obstetric prenatal care. For this purpose, a physician group is defined as an obstetric clinic, there is one patient medical record, and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal care services provided within the clinic under the primary care physician's provider number as the performing provider.

When fewer than four complete prenatal visits were performed, providers *must* bill for individual dates of service, using the appropriate Evaluation and Management (E/M) code.

The date of the delivery is the date of service to be used when billing the global prenatal codes.

Providers *must* enter the date of last menstrual period (LMP) on the professional claim form when billing this procedure.

### 13. 57.F (1) Exempted Visits/Consultations

1. Entry into Care: A total of two visits may be paid by MO HealthNet to allow the initial provider (*not* providing ongoing care) to perform an initial examination, diagnose the pregnancy and make a referral to a second provider. The second provider, who then provides the remainder of the prenatal care, may bill for global prenatal/global delivery, as appropriate, if all other conditions applicable to the global billing and delivery of service are met.
2. Consultations: In addition, two consultations by referral to another MO HealthNet provider may be paid and still permit billing of the global prenatal or global delivery (by the referring physician) if all other conditions applicable to the global billing and delivery of service are met.
3. Services for High-Risk Patients: For those pregnant women who develop a high-risk condition for which more than two consultative visits by an obstetrician are required, MO HealthNet allows payment for the consultative visits in addition to the global prenatal care code billed by a previous provider. The consultative services *must* be medically necessary and properly documented. This policy is an effort to assure adequate and appropriate prenatal services for high-risk pregnant women.

### 13. 57.F (2) Global Prenatal/Delivery Transition from Fee-For-Service to MO HealthNet Managed Care

When the obstetrical care begins under a fee-for-service setting and continues into a MO HealthNet Managed Care health plan, and the Managed Care health plan reimburses the provider a global fee, the provider *must not* bill any visits to MO HealthNet fee-for-service. If a global fee is *not* received from the Managed Care health plan, the provider may bill MO HealthNet fee-for-service for each visit provided.

### 13. 57.G FETAL MONITORING-INTERNAL (59050)

The attachment of electrodes to the scalp or buttocks during the first stage of labor (the period from the onset of regular uterine contractions to full dilation and effacement of the cervix) is part of the delivery and should *not* be billed separately. During the first stage of labor, the obstetrician may be informed of severe variable decelerations and may request a consultation. The consultant may be reimbursed for this procedure.

Fetal monitoring during labor by a consultant is a MO HealthNet covered service. This procedure may only be performed on an inpatient hospital basis by a consultant.

### 13. 57. H GLOBAL PRENATAL/DELIVERY/POSTPARTUM (59400, 59510, 59610, 59618)

The fee for the global prenatal/delivery/postpartum care includes all prenatal visits, routine urinalysis testing during the prenatal period, subsequent care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, vaginitis, and a Risk Appraisal for Pregnant Women. The fee also includes the initial hospital visit, the delivery and postpartum care. If a provider does more than 3 visits but the participant goes to another provider for the rest of her pregnancy, the global prenatal/delivery/postpartum care procedure codes *cannot* be billed. Each date of service *must* be billed separately.

If the risk appraisal determines that the pregnant woman is high risk, either medically or socially, a referral should be made to a case manager of the participant's choice. Reference Section 13.56.B for information concerning Case Management for Pregnant Women.

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all of the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, there is one patient medical record, and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal, delivery and postpartum care services

provided within the clinic, using the primary care physician's provider number as the performing provider.

NOTE: Last menstrual period (LMP) is required on all claims for global and/or prenatal/delivery services.

When billing for this service, the date of delivery is the service date to be entered on the professional claim form.

A delivery diagnosis code *must* be used.

It is inappropriate to bill global delivery when the pregnancy terminates at or prior to twenty weeks gestation. Services are to be billed using the appropriate Evaluation and Management Services code(s) and/or medical/surgical procedure(s) performed.

### 13. 57. I DELIVERY ONLY (59409, 59514, 59612, 59620)

The delivery only, procedure codes are used when more than one provider is involved in the prenatal care and delivery, and the physician at delivery:

- has provided no prenatal care;
- does *not* provide postpartum care
- elects to bill fee-for-service; or
- elects to bill global prenatal for prenatal services and delivery.

Providers *must* enter the date of the last menstrual period (LMP) on the professional claim. The date of service is the delivery date. A delivery diagnosis code *must* be used.

It is inappropriate to bill a delivery code when the pregnancy terminates at or prior to 20 weeks gestation. Services are to be billed using the appropriate Evaluation and Management Services code(s) and/or medical/surgical procedure(s) performed.

### 13. 57. J DELIVERY ONLY INCLUDING POSTPARTUM CARE (59410, 59515, 59614, 59622)

The delivery only including postpartum care procedure codes are used when more than one provider is involved in the prenatal care and delivery and the physician at delivery:

- has provided no prenatal care and;
- provides the delivery and postpartum care

### 13. 57. K POSTPARTUM CARE ONLY (59430)

The postpartum care only procedure is used when the physician provides postpartum care only.

### 13. 57. L ANESTHESIA FOR DELIVERY

The anesthesiologist, CRNA and anesthesiologist providing medical direction for general anesthesia *must* bill for services using the appropriate CPT anesthesia procedure code.

### 13. 57. M MULTIPLE BIRTHS

When it is medically necessary to perform a cesarean section on a subsequent delivery after a child has been delivered vaginally, reimbursement is 100% for both deliveries. Documentation *must* be kept in the patient's file indicating the need for both procedures.

### 13. 57. N SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY 59525—LIST IN ADDITION TO 59510 OR 59515)

This procedure requires the Acknowledgement of Receipt of Hysterectomy Information form.

### 13. 57. O BILLING INSTRUCTIONS

For those situations in which services are provided in a clinic setting (e.g., public health, family planning or other group practice), caution *must* be used to assure that duplicate billing does *not* occur by the clinic provider and physician of record. When this occurs, duplicate payments may be made, resulting in subsequent recovery of the overpayments.

## 13. 58 MATERNITY STAYS AND POST-DISCHARGE HOME VISITS

Coverage through the MO HealthNet Program is available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly born child. A shorter length of hospital stay for services related to maternity and newborn care may be approved if the shorter stay meets with the approval of the attending physician after consulting with the mother. In which case, post-discharge care is required.

### 13. 58.A CRITERIA FOR EARLY DISCHARGE FOLLOWING DELIVERY

In accordance with the most current version of the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, the following criteria is considered appropriate for early discharge and subsequent home health follow-up:

- The antepartum, intrapartum and postpartum courses for both mother and baby are uncomplicated;
- Term (38-42) weeks with birth weight appropriate for gestational age;

- Vital signs for baby are normal and stable for at least 12 hours: heart rate 100-160/minute, respiratory rate <60/minute, and axillary temperature 97 to 98 degrees Fahrenheit in an open crib with appropriate clothing;
- Two successful feedings with coordinated sucking, swallowing and breathing while feeding;
- No evidence of excessive bleeding at the circumcision site for at least two hours;
- Physician examination reveals no abnormalities that require continued hospitalization;
- There is no evidence of significant jaundice in the first 24 hours;
- The mother has received instruction regarding: bottle or breast feeding, adequacy of breast feeding assessed by latch-on and swallowing, urine and stool frequency, cord, skin and infant genital care, recognition of signs of illness, common problems, jaundice, infant safety (car seat and position for sleeping) and mother verbalizes/demonstrates her knowledge, ability and confidence;
- Support person(s) available in the home to assist the mother;
- No unresolved family, environmental or social risk factors present such as: untreated parental substance abuse, history of child abuse or neglect, mental illness of parent in the home, no fixed home, untreated domestic violence, especially during this pregnancy;
- Mother has stable vital signs and is able to ambulate without vertigo;
- Initial hepatitis B vaccine is administered or appointment made for administration within the first week of life;
- Initial newborn screenings performed prior to discharge, if performed before 24 hours of milk feeding, a repeat is ordered or scheduled during the follow-up visit;
- Follow-up care within 48 hours with result reported to physician on the same day.

### 13. 58.B COVERAGE OF POST-DISCHARGE VISITS

MO HealthNet reimburses up to two post-discharge skilled nurse visits in the home within two weeks of an early inpatient discharge for a stay of less than 48 hours for a vaginal delivery and for a stay of less than 96 hours for a cesarean section delivery when provided by a home health agency. Visits *must* be physician ordered and included in a plan of care. The criteria for an early inpatient discharge and the post-discharge visits *must* be met.

The first post-discharge visit shall be provided within 48 hours of an inpatient discharge unless otherwise ordered by a physician and the second post-discharge visit, if appropriate (e.g., breast feeding *not* well established) shall be provided within two weeks of an inpatient

discharge. These services are exempt from the home-bound requirement. The post discharge visit(s) covers both the mother and newborn.

## 13. 59 NEWBORN CARE

Initial examinations have been identified as HCY screenings. The newborn's medical record *must* document that all aspects of a full HCY examination were performed. Future screenings should be billed under the appropriate screening codes according to the HCY periodicity schedule. Reference Section 9.

### 13. 59.A NEONATAL INTENSIVE CARE

Procedure codes 99468-99469 are used to report services provided by physicians directing the care of a critically ill neonate or infant in a neonatal intensive care unit (NICU). These codes represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered critically ill, the codes for Subsequent Hospital Care (99231-99233) should be utilized.

These NICU codes are to be used in addition to codes 99360 and 99465 or 99464 as appropriate, when the physician is present for the delivery and newborn resuscitation is required.

Care rendered includes management; monitoring and treatment of the patient including nutritional, metabolic and hematologic maintenance; pharmacologic control of the circulatory system; case management services; parent counseling; and personal direct supervision of the health care team.

### 13. 59.B NEWBORN CARE IN THE HOSPITAL

#### 13. 59.B (1) Initial Hospital/Birthing Center Care

The following procedure code should be used for the initial (normal) newborn examination only. This is a one-time-only code and should be billed using the infant's MO HealthNet ID number (DCN) and the date of birth as the date of service.

| PROC CODE | DESCRIPTION |
|---|---|
| 99460..... | Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant. This code should also be used for birthing room deliveries. |

### 13. 59.B (2) Subsequent Hospital/Birthing Center Care

This procedure code should be used for subsequent examinations performed in the hospital on days following the date of birth.

| PROC CODE | DESCRIPTION |
|---|---|
| 99462 ..... | Subsequent hospital care, per day, for evaluation and management of normal newborn. |

For illness or critical care, the hospital inpatient services, neonatal intensive care or critical care codes should be used. The procedure and diagnosis *must* support the use of these service codes. Reference Section 13.21.C (2).

### 13. 59.B (3) Inpatient Newborn Care (99231TG, 99232TG, 99233TG)

These procedure codes are limited to services provided to newborns/infants for specific diagnosis codes (038.0-038.9, 765.00-765.07, 765.10-765.17, 769, 771.8-771.89, 773.0-773.5 and 775.6).

## 13. 59.C NEWBORN CARE (OTHER THAN HOSPITAL OR BIRTHING ROOM SETTING)

| PROC CODE | DESCRIPTION |
|---|---|
| 99461 ..... | Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center. This is a one-time-only code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service. |
| 99463 ..... | Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date. This is a one-time code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service. |

### 13. 59. D NEWBORN ENROLLMENT IN MO HEALTHNET MANAGED CARE HEALTH PLANS

A child born to a participant enrolled with a health plan is automatically enrolled with the mother's plan effective on the date of birth if the child is determined to be eligible on the date of birth.

When providing services to a newborn whose mother is enrolled with a health plan, providers are urged to contact the health plan immediately regarding any incurred charges for the child. (Reference Section 11, Managed Health Care Delivery System.)

### 13. 59. E HOME APNEA MONITORING

A home apnea monitor is covered through the Durable Medical Equipment Program for MO HealthNet eligible infants with symptoms of Sudden Infant Death Syndrome (SIDS). A Certificate of Medical Necessity form completed and signed by the physician is required every six months. The rental of the monitor is manually reviewed. The monitor *must* be prescribed by an M.D. or D.O.

## 13. 60 DIABETES SELF-MANAGEMENT TRAINING

Diabetes self-management training services are used in the management and treatment of type 1, type 2 and gestational diabetes. These services are covered when prescribed by a physician or a health care professional with prescribing authority and may be provided by a Certified Diabetes Educator (CDE), Registered Dietician (RD) or Registered Pharmacist (RPh).

Diabetes self-management training services are *not* available to adults receiving a limited benefit package.

### 13. 60.A DIABETES SELF-MANAGEMENT TRAINING ENROLLMENT CRITERIA

To provide and bill for diabetes self-management training, a provider *must* be approved and enrolled as a diabetes self-management provider with MO HealthNet. Following are the requirements to enroll as a provider under the Diabetes Self Management Training program:

Certified Diabetes Educator (CDE): *Must* hold a permanent Missouri license as a registered nurse or physician. CDE *must* also hold current certification from the National Certification Board for Diabetes Educators (NCBDE) through the American Association of Diabetes Educators (AADE). CDEs practice under the Scope of Practice for Diabetes Educators developed by AADE.

Registered Dietician (RD): *Must* hold a permanent Missouri license as a registered nurse, physician, social worker, pharmacists, registered dietician or other health care professional.

When the RD is licensed by Missouri, the RD *must* submit a copy of the license as an RD. The RD *must* also hold current certification from the Commission on Dietetic Registration through the American Dietetic Association (ADA). RDs practice under American Dietetic Association Standards of Professional Practice by the ADA.

Registered Pharmacist (RPh): *Must* hold a permanent Missouri license as licensed pharmacist and *must* have completed the National Community Pharmacists Association (NCPA) "Diabetes Care Certification Program" **OR** completed the American Pharmaceutical Association (APhA)/AADE certification program "Pharmaceutical Care for Patients with Diabetes."

Diabetes education providers employed/contracted with federally qualified health centers (FQHCs) or rural health clinics (RHCs) bill with their individual diabetes self-management training provider number with payment designated to the FQHC or RHC.

Diabetes education services provided on an inpatient basis by hospital staff are included in the hospital per diem rate.

When diabetes education services are provided in an outpatient setting by hospital staff, the CDE, RD or RPh enrolls as a diabetes self-management training provider with payment designated to the hospital on the provider enrollment forms.

### 13. 60.B DIABETES SELF-MANAGEMENT TRAINING SERVICE LIMITATIONS

Diabetes self-management training services are limited to any of the following circumstances with documentation of the need for services maintained in the provider's file:

- Initial diagnosis of diabetes;
- Any significant change in the patient's symptoms, condition or treatment.

Diabetes self-management training *must* be prescribed by a physician or health care provider with prescribing authority to the CDE, RD or RPh.

An initial assessment is reimbursed once per lifetime. The initial assessment *must* be performed by a physician or a CDE.

The initial assessment should include but *not* be limited to information from the patient on the following:

- Health and medical history;
- Use of medications;
- Diet history;
- Current mental health status;

- Use of health care delivery systems;
- Life-style practices;
- Physical and psychological factors;
- Barriers to learning; family and social supports; and
- Previous diabetes education, actual knowledge and skills.

Two subsequent visits are reimbursed per rolling year. The two subsequent visits may be individual, group or a combination of individual and group.

Any additional visits require a Certificate of Medical Necessity form from a physician or health care provider with prescribing authority documenting the need for any additional visits be kept in the patient's file.

The diabetes self-management training services for patients enrolled in MC+ are the responsibility of the health plan.

### 13. 60.B (1) Procedure Codes for Diabetes Self-Management Training

| PROC CODE | DESCRIPTION |
|---|---|
| 99205U9 . | Initial Assessment–Comprehensive Diabetes Education–Minimum 1 hour |
| G0108 ..... | Diabetes Education–Subsequent Visit–Minimum 30 minutes |
| G0109 ..... | Diabetes Education–Group Subsequent (No more than 8 persons)–Minimum 30 minutes |

### 13. 61.B (2) Diabetes Self-Management Training Billing Procedures

The diabetes self-management training services *must* be billed on a professional claim, with the appropriate procedure code.

The place of service (POS) code *must* be one of the following: 03 (School); 11 (Office); 12 (Home); 21 (Inpatient Hospital); 22 (Outpatient Hospital); or 99 (Other Unlisted Facility).

Training provided by a CDE, RD or RPh *not* employed by the hospital, *must* be billed using POS 21 (Inpatient Hospital) or 22 (Outpatient Hospital) using their own diabetes self-management training provider number.

## 13. 61 HYPERBARIC OXYGEN THERAPY (HBO) (99183)

Physician attendance and supervision of hyperbaric oxygen therapy (HBO), per session) is a covered MO HealthNet service for the professional component. Evaluation and Management services and/or procedures (e.g., wound debridement) provided in conjunction with HBO should be reported separately.

## 13. 62 PODIATRY SERVICES

Podiatrists *must* follow policy and procedure as stated in the Physician Manual. Podiatrists are limited to the services identified below:

- services that podiatrist are legally authorized to perform in the state where they are licensed;
- medical, surgical and mechanical services for the foot or any area *not* above the ankle joint.

NOTE: A podiatrist does *not* charge a copay when the service is an outpatient visit. Refer to Section 13.16 for information on cost sharing and copay.

### 13. 62.A PODIATRY LIMITATIONS

The following podiatry services are not covered for adults receiving a limited benefit package:

11719—Trimming of nondystrophic nails, any number

11720—Debridement of nail(s) by any method(s); one to five

11721—Debridement of nail(s) by any method(s); six or more

11750—Excision of nail and nail matrix, partial or complete

29540—Strapping of ankle and/or foot

## 13. 63 CIRCUMCISIONS

MO HealthNet does *not* cover nontherapeutic (elective/routine) circumcisions. Payment for circumcisions is only made when two physicians document in writing that a disease, pathology or other abnormality exists that requires a medically therapeutic circumcision. Procedure codes 54150 and 54160 require documentation in a patient's file from two physicians that a disease, pathology or other abnormality exists which requires a medically therapeutic circumcision. Procedure codes 54161, 54162, 54163 and 54164 require Prior Authorization. Documentation from two physicians that a disease, pathology or other abnormality exists that requires a medically therapeutic circumcision *must* be attached to the Prior Authorization Request.

## 13. 64 VAGUS NERVE STIMULATION

Vagus nerve stimulation is covered for patients with medically refractory partial onset epileptic seizures for whom surgery is *not* recommended or for whom surgery has failed.

The procedure is performed in the hospital and usually requires an overnight stay. Surgeons should code the implant procedure as electrode placement and neurostimulator placement. In addition, a physician (usually a neurologist) typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant. The physician should bill the following CPT codes:

95970 95974 95975

These analysis and programming procedure codes may also be billed periodically to test and reprogram the device.

The device is included in the hospital per diem if the surgery is performed in an inpatient hospital setting. If the surgery is performed in an outpatient hospital setting, the device is billable under the outpatient supply code.

## 13. 65 MISSOURI'S BREAST AND CERVICAL CANCER CONTROL PROJECT

Missouri women who are diagnosed with breast or cervical cancer under the state's Breast and Cervical Cancer Control Project may be eligible to receive treatment through the MO HealthNet Program.

Uninsured women under the age of 65 who have been screened through Missouri's Breast and Cervical Control Project and are in need of treatment for breast or cervical cancer may qualify for full MO HealthNet coverage. This includes treatment of certain precancerous conditions and early stage cancer.

### 13. 65.A ELIGIBILITY CRITERIA

To qualify for Medical Assistance based on the need for Breast or Cervical Cancer Treatment all the following criteria *must* be met:

- Screened by Missouri Breast or Cervical Cancer Treatment Provider
- Need for treatment for breast or cervical cancer including certain precancerous conditions
- Under the age of 65 years old
- Have a Social Security Number
- Citizenship or alien status

- Uninsured, or have health coverage that does *not* cover breast or cervical cancer treatment
- A Missouri resident

### 13. 65.B PRESUMPTIVE ELIGIBILITY

Presumptive eligibility determinations are made by Breast and Cervical Cancer Control Project MO HealthNet providers. When a Breast and Cervical Cancer Control Project MO HealthNet provider determines a woman is eligible for presumptive eligibility, they issue her a MO HealthNet approval letter. MO HealthNet coverage under presumptive eligibility begins on the date the Breast and Cervical Cancer Control Project provider determines the woman is in need of treatment.

### 13. 65.C MO HEALTHNET COVERAGE

MO HealthNet coverage under Breast and Cervical Cancer Treatment begins on the first day of the month of an approved application and continues until the last day of the month that the regular MO HealthNet application is approved or Breast and Cervical Cancer Treatment is no longer required, whichever is later.

Services can be obtained from enrolled MO HealthNet providers on a fee-for-service basis. Participants eligible based on the need for Breast and Cervical Cancer Treatment are *not* enrolled in managed care.

Presumptive eligibility, Breast and Cervical Cancer Treatment and regular MO HealthNet eligibility provide full MO HealthNet benefits.

For additional information and to learn where the closest Breast and Cervical Cancer Control Project provider is located call the Cancer Information Service at 1-800-CANCER which translates to (800) 422-6227.

## 13. 66 PHARMACY BENEFITS

### 13.66. A LONG-TERM CARE MAINTENANCE DRUG BILLING

Reference Pharmacy Manual Section 13.

### 13.66. B DOSE OPTIMIZATION

Reference Pharmacy Manual Section 13.

### 13.66. C DRUG PRIOR AUTHORIZATION PROCESS

Reference Pharmacy Manual Section 13.

## 13. 67 NAME CHANGE

Documentation *must* accompany claims for a participant whose name changes after a form is completed, (i.e., sterilization). For example, a letter of explanation should be submitted to document a name change due to marriage or divorce.

## 13. 68 BILATERAL PROCEDURES (50 MODIFIER)

MO HealthNet covered procedures that are performed bilaterally and are identified by Medicare Services as appropriate bilateral procedures, *must* be billed using the 50 modifier and quantity of 1. For bilateral procedures identified by Medicare Services, please reference the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU

(MPFSDB) indicators in the bilateral surgery column of the database instruct carriers how to reimburse for services. The fee schedule can be found at: http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp

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

**END OF SECTION**

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