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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

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

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

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

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

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

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

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

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

1.1.A(2)  MO HealthNet for Kids

ME CODE  DESCRIPTION

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

60  Newborns (infants under age 1 born to a MO HealthNet or managed care participant).
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40, 62</td>
<td>Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.</td>
</tr>
<tr>
<td>07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70</td>
<td>Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.</td>
</tr>
<tr>
<td>36, 56</td>
<td>Children who receive a federal adoption subsidy payment.</td>
</tr>
<tr>
<td>71, 72</td>
<td>Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)</td>
</tr>
<tr>
<td>73</td>
<td>Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.</td>
</tr>
<tr>
<td>74</td>
<td>Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.</td>
</tr>
<tr>
<td>75</td>
<td>Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families must pay a monthly premium. There is a premium.</td>
</tr>
</tbody>
</table>
Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.

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

ME CODE DESCRIPTION
58 Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility.

59 Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did not qualify for regular MO HealthNet benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter.

NOTE: Providers should encourage women with a TEMP card to apply for regular MO HealthNet.

1.1.A(4) Voluntary Placement Agreement for Children

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

1.1.A(5) State Funded MO HealthNet

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

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

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

57  Children who receive a state only adoption subsidy payment.

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

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

1.1.A(6)  MO Rx

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

1.1.A(7)  Women’s Health Services

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

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

1.1.A(8) ME Codes Not in Use

The following ME codes are not currently in use:

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

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

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

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

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

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

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

1.2.A FORMAT OF MO HEALTHNET ID CARD

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

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

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

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

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

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

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

1.2.C(5) Presumptive Eligibility for Children

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

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

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

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

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

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

PRODUCTION : 09/08/2022
ME code 88 identifies children receiving coverage under a VPA.

1.2.D  THIRD PARTY INSURANCE COVERAGE

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

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

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

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

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

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

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

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

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

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

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

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

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

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

### 1.4.A NEWBORN INELIGIBILITY

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

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

### 1.4.B NEWBORN ADOPTION

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

### 1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

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

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

### 1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

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

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

#### 1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

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

<table>
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<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package. Providers should refer to Section 13 of the applicable provider manual for specific restrictions or guidelines.

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

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

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

- Group 5 consists of uninsured children.

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

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

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the managed care program because they receive SSI disability payments, who meet the SSI disability definition as determined by the Department of Social Services, or who receive adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the managed care program. The option is entirely up to the
1.5.C(1) **Home Birth Services for the MO HealthNet Managed Care Program**

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

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

1.5.D **HOSPICE BENEFICIARIES**

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

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

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

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

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

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual must:

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

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

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

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

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

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

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

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

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

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

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

1.5.G TEMP PARTICIPANTS

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

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

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

1.5.G(1) TEMP ID Card

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

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

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

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

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

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

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

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

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

1.5.1(1) Eligibility Criteria

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

• Screened by a Missouri BCCCP Provider;

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

The BCCT MO HealthNet Application must be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be approved, if the woman was eligible. Coverage cannot begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.
1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

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

1.5.J(3) Premium Payment and Collection Process

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

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

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

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

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

1.5.J(4) Termination of Coverage

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

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

The Balanced Budget Act of 1997 (The Act) created Section 1920A of the Social Security Act which gives states the option of providing a period of presumptive eligibility to children when a qualified entity determines their family income is below the state's applicable MO HealthNet or SCHIP limit. This allows these children to receive medical care before they have formally applied for MO HealthNet for Kids. Missouri selected this option and effective March 10, 2003, children under the age of 19 may be determined eligible for benefits on a temporary basis prior to having a formal eligibility determination completed.
Presumptive eligible children are identified by ME code 87. These children receive the full range of MO HealthNet for Kids covered services subject to the benefits and limitations specified in each MO HealthNet provider manual. These children are NOT enrolled in managed care health plans but receive all services on a fee-for-service basis as long as they are eligible under ME code 87.

1.5.K(1) Eligibility Determination

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

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

1.5.K(2) MO HealthNet for Kids Coverage

Children determined presumptively eligible for MO HealthNet for Kids receive the same coverage during the presumptive period. The children active under Presumptive Eligibility for Children are not enrolled in managed care. While the children must obtain their presumptive determination from a Qualified Entity (QE), once eligible, they can obtain covered services from any enrolled MO HealthNet fee-for-service provider. Coverage begins on the date the QE makes the presumptive eligibility determination and coverage ends on the later of:
• the 5th day after the Presumptive Eligibility for Children determination date;
• the day a MO HealthNet for Kids application is approved or rejected; or
• if no MO HealthNet for Kids application is made, the last date of the month following the month of the presumptive eligibility determination.

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

- Infants living with the inmate in the public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release (except when reporting to a public institution for overnight stay); or
- Individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (for example, transfer to a community residence).
All specific eligibility groups, including children, pregnant women, and elderly, blind or disabled are considered to determine if the individual meets all eligibility factors of the program for which they are applying.

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

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

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

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

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

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

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

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

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

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

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

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

1.6.B SPENDDOWN

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

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

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

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

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

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1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6)   Spenddown Pay-In Option

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

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

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

1.6.B(7)   Prior Quarter Coverage

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

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

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

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

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

### 1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

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

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

1.7.A NEW APPROVAL LETTER

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

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

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

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

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

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

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

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

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

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

**1.7.E PRIOR AUTHORIZATION REQUEST DENIAL**

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

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

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

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

**1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER**

A participant may send written correspondence to:

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

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

**1.8 TRANSPLANT PROGRAM**

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

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

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

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

1.8.B PATIENT SELECTION CRITERIA

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

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

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

1.8.C CORNEAL TRANSPLANTS

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

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

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

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

1.8.E MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

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

END OF SECTION

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

2.1.C PROVIDER ENROLLMENT ADDRESS

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

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit

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2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

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

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

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

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

2.2 NOTIFICATION OF CHANGES

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

### 2.3 RETENTION OF RECORDS

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

#### 2.3.A ADEQUATE DOCUMENTATION

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

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

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

### 2.4 NONDISCRIMINATION POLICY STATEMENT

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

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

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

### 2.6 FRAUD AND ABUSE

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

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

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

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

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

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

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

2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

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

2.7 OVERPAYMENTS

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

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

2.8 POSTPAYMENT REVIEW

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

2.9 PREPAYMENT REVIEW

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

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

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

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

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

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

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

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

All payments are direct deposited.

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

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

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

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

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2.11 NATIONAL CORRECT CODING INITIATIVE

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

Providers can find the current NCCI edits online at: https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits.
SECTION 3 - STAKEHOLDER SERVICES

3.1 PROVIDER SERVICES

The MHD has various units to assist providers with questions regarding proper claims filing, claims resolution and disposition, payment problems, participant eligibility verification, prior authorization status, coverage inquiries, and proper billing methods and procedures. Additionally, the Missouri Medicaid Audit and Compliance Unit (MMAC) assists providers with enrollment as an MHD provider, enrollment questions and verifications. Assistance can be obtained by contacting the appropriate unit.

3.1.A MHD TECHNICAL HELP DESK

The MHD Technical Help Desk provides assistance in establishing the required electronic claims and Remittance Advice (RA) formats, network communication, Health Insurance Portability and Accountability (HIPAA) trading partner agreements, and Internet billing service.

This help desk is for use by Fee-For-Service providers, electronic billers, and Managed Care health plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

• Front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission, as well as assistance in the use and maintenance of billing software developed by the MHD.
• Front-line assistance accessibility to electronic claim submission for all providers via the Internet.
• Front-line assistance to Managed Care health plans in establishing required electronic formats, network communications, and ongoing operations.
• Front-line assistance to providers in submitting claim attachments via the Internet.

3.2 Missouri Medicaid Audit & Compliance (MMAC)

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating and preventing fraud, waste, and abuse. MMAC can be contacted at (573) 751-3399, or access the webpage at http://mmac.mo.gov/.
3.2A PROVIDER ENROLLMENT UNIT

The MMAC Provider Enrollment Unit processes provider enrollment packets, enrollment applications, and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained by emailing the unit at mmac.providerenrollment@dss.mo.gov.

3.3 PROVIDER COMMUNICATIONS UNIT

The Provider Communications Unit responds to specific provider inquiries concerning MHD eligibility and coverage, claim filing instructions, concerns and questions regarding proper claim filing, claims resolution and disposition, and billing errors. The dedicated telephone number is (573) 751-2896.

Current, old or lost RAs can be obtained from the MHD electronic billing website at www.emomed.com.

- In the section "File Management," the provider can request and print a current RA by selecting "Printable Remittance Advice."
- To retrieve an older RA, select "Request Aged RAs," fill out the required information and submit. The next day, the RA will be under "Printable Aged RAs."
- The requested RA will remain in the system for 5 days.

Providers can verify participant eligibility, check amount information, claim information, provider enrollment status and participant annual review date by calling the Provider Communications Unit, by emailing from the eMOMED Contact tab or by utilizing the Interactive Voice Response (IVR) system.

3.3A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

The Interactive Voice Response (IVR) system at (573) 751-2896 allows an active MO HealthNet provider five Main inquiry options:

1. For MO HealthNet Participant Eligibility, Press 1.
2. For Check Amount Information, Press 2.
3. For Claim Information, Press 3.
4. For Provider Enrollment Status, Press 4.
5. For Participant Annual Review Date, Press 5.

The IVR system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service that occurred during their period of enrollment as an active MO HealthNet provider. The 10-digit
National Provider Identification (NPI) number must be entered each time any of the IVR options are accessed.

*The provider should listen to all eligibility information, particularly the sub-options.*

**Main Option 1. Participant Eligibility**

The caller is prompted to enter the following information:
- Provider’s 10 digit NPI number.
- 8-digit MO HealthNet participant's ID (MO HealthNet Identification Number), or 9-digit Social Security Number (SSN) or case-head ID.
- If the inquiry is by the SSN, once the 9-digit SSN is entered, the IVR prompts for the Date of Birth.
- 6-digit Date of birth (mm/dd/yy).
- Dependent date of birth (if inquiry by case-head ID).
- Once the participant’s ID is entered, the IVR prompts for dates of service.
- First date of service (mm/dd/yy): Enter in the 6-digit first date of service.
- Last date of service (mm/dd/yy): Enter the 6-digit last date of service.
- Upon entry of dates of service, the IVR retrieves coverage information.

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may not exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may not inquire on dates that exceed one year, prior to the current date. The caller is limited to ten inquiries per call.

The caller is given standard MO HealthNet eligibility coverage information, including the Medicaid Eligibility (ME) code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits.

The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under Qualified Medicare Beneficiary (QMB) or the Presumptive Eligibility (TEMP) Program. Please reference all the applicable sections of the provider’s program manual for QMB and TEMP provisions.

Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a Sub-Option menu.

The Sub-Options menu options include:
- For Health plan and Lock-in Information, Press 1.
- For eye glass and eye exam information, Press 2.
For Third Party Liability Information, Press 3.
For Medicare and QMB Information, Press 4.
For MO HealthNet ID, Name, spelling of name and eligibility information, Press 5.
For Confirmation Number, Press 6.
For Another MO HealthNet Participant, Press 7.
To Return to the Main Menu, Press 8.
To End this Call, Press 9.
To speak with a MO HealthNet specialist, Press 0.

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

Sub-Option 1. Health Plan and Lock-in Information

The Health plan and Lock-in Option sub-option 1, if applicable, provides the health plan lock-in information, Primary Care Provider (PCP) lock-in, and other applicable provider lock-in information.

If no lock-in exists for participant, the IVR will state that the participant is not locked in on the date of service requested.

If lock-in exists, then IVR will read up to three records to the caller.

• If health plan lock-in exists, the IVR states the health plan name for services on the applicable dates.
  o “This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Area Code (XXX-XXX-XXXX on file).”

• If PCP lock-in exists, the IVR states the provider’s name and phone number for services on the applicable dates.
  o “This participant is locked into Provider (Provider Name) for services on (from date) through (to date). The participant’s primary care provider is (PCP Name). The lock-in provider’s phone number is Area Code (XXX-XXX-XXXX on file).”

This information is also available on www.emomed.com.

Sub-Option 2. Eye Glass and Eye Exam Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

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

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

The provider can access claim status information, including processing status, denial, and approved status.
Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID. 

Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.

Once 6 digit number is entered, the IVR prompts for the type of claim.

> o If Drug claim is selected, then IVR prompts for prescription number entry.

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

> If claim is in process:

> > o The IVR reads that the claim accessed with this date of service is being processed.

> If claim is denied:

> > o The IVR will read up to five Explanation of Benefits (EOB) applicable codes.
> The claim accessed with this date of service has been denied with EOB (EOB Code 1-5).
> > o After EOB codes are read, the IVR prompts to hear EOB descriptions.
> > o Press 1 for EOB Description. If the caller presses 1, the IVR will read the EOB descriptions for the EOB codes (up to five).

> IVR then reads RA information. If the claim is denied, the IVR reads that the claim accessed with this date of service is denied on the (RA Number) Remittance Advice dated (RA Date).

> If claim is approved for payment:

> > The IVR reads that the claim accessed with this date of service has been approved for payment.

> If claim paid and the claim is being recouped or adjusted, the IVR reads for more information, speak with a MO HealthNet Specialist.

> If claim paid, the IVR will read that the claim accessed with this date of service was paid on the (RA Number) Remittance Advice dated (RA Date) in the amount of (RA Amount).

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

> For another Claim inquiry, Press 1. If the caller presses 1, IVR goes back to Provider Claim Inquiry.

> To repeat the information that you just heard, Press 2. If the caller presses 2, IVR repeats Response information.

> To speak with a MO HealthNet specialist, Press 0.

> If the caller presses 3, IVR goes back to the Main Menu.

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

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

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

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

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

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

**Main Option 5. Participant Annual Review Date**

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

The caller is prompted to enter the following information.

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

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

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

After valid or error response IVR then reads menu options.

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

Transfer Routine

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

Number of Inquiries

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

3.3.A(1) Using the Telephone Key Pad

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

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

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

- Review the provider manual and bulletins before calling the IVR.
- Have all material related to the problem (such as RA, claim forms, and participant information) available for discussion.
- Have the provider’s NPI number available.
- Limit the call to three questions. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.
- Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

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

### 3.3.C INTERNET

Providers may submit claims on the internet via the MHD web based electronic claims filing system. The website address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please access the application http://manuals.momed.com/Application.html and select the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The internet inquiry options, located at www.emomed.com, include the same inquiry options available through the IVR system (without limited number of inquiry restrictions). Providers are encouraged to use www.emomed.com as the first option, prior to accessing the IVR. The provider will be able to read and review the data and results, instead of having to call to hear the results. All the same functions and additional functions compared to the IVR are available and include: eligibility verification by Participant ID, case head ID and child's date of birth, or Social Security Number and date of birth, claim status, and check inquiry, provider enrollment status, and participant annual review date. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.
Providers also have the capability to receive and download their RAs from www.emomed.com. Access to this information is restricted to users with authorization. In addition to the RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this website (www.emomed.com) include: claim submission, claim attachment submission, inquiries on claim status, attachment status, and check amounts, and credit adjustment(s). Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

3.3.D WRITTEN INQUIRIES

Letters directed to the MHD are answered by MO HealthNet specialists in the Provider Communications Unit. Written or telephone responses are provided to all inquiries. A provider who encounters a complex billing problem, numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage, or wishes to submit a complaint should submit the inquiry or complaint in writing to:

Provider Communications Unit
MO HealthNet Division
P.O. Box 5500
Jefferson City, MO 65102-5500

A written inquiry should state the problem as clearly as possible and should include the following:

- Provider's name
- NPI number
- Address
- Telephone number
- MO HealthNet participant's full name
- MO HealthNet participant’s identification number
- MO HealthNet participant’s birthdate
- A copy of all pertinent information such as the following:
  - Remittance Advice forms
  - Invoices
  - Applicable Participant Information
  - Form letters
- Timely filing documentation must be included with the written inquiry, if applicable.
3.4 PROVIDER EDUCATION UNIT

The Provider Education Unit serves as a communication and assistance liaison between the MHD and the provider community. Provider Education Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MHD. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to educate providers and other groups on proper billing methods and procedures for MHD claims. The representatives provide assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, and Webinar trainings for individuals and associations to provide instructions on procedures, policy changes, and benefit changes, which affect the provider community.

The Provider Education Unit can be contacted for training information and scheduling via telephone at (573) 751-6683 or email at mhd.provtrain@dss.mo.gov. Providers can visit the Provider Participation page at http://dss.mo.gov/mhd/providers to schedule training.

3.5 PARTICIPANT SERVICES

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services, unpaid medical bills, premium collections questions, and payment information. The Participant Services Number is (800) 392-2161 or (573) 751-6527.

Providers may direct participants to the MO HealthNet Participant Services Unit when they need assistance in any of the above-mentioned situations. For example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

When participants have problems or questions concerning their MO HealthNet coverage, they should be directed to call or write to the Participant Services Unit at:

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

All calls or correspondence from providers are referred to the Provider Communications Unit. Please do not give participants the Provider Communications’ telephone number.
3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is not received within 60 days, providers should call the Provider Communications Unit at 573-751-2896, to discuss submission of a new claim or status of the previously submitted claim. However, providers should not resubmit a new claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of the claim. Reference the Provider Manuals Section 17 for further discussion of the RA and Suspended Claims.

3.7 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MHD website at www.dss.mo.gov/mhd/providers/index.htm. Choose the “MO HealthNet forms” link in the right column.

3.8 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MHD billing site at www.emomed.com. Most claims that require attachments may also be submitted at this site.

Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in the Provider Manuals Section 15. NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:
• (Sterilization) Consent Form.
• Acknowledgment of Receipt of Hysterectomy Information.
• Medical Referral Form of Restricted Participant (PI-118).
• Certificate of Medical Necessity (for Durable Medical Equipment providers only).

These attachments may not be submitted via the Internet when additional documentation is required. The web site address for these submissions is www.emomed.com.

3.10 Pharmacy & Clinical Services Unit
This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by emailing MHD.ClinicalServices@dss.mo.gov, or visit the MHD webpage at http://dss.mo.gov/mhd/cs/.

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

3.11 Pharmacy and Medical Pre-certification Help Desk

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

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

3.12 Third Party Liability (TPL)

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

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

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

4.1.B MEDICARE/MO HEALTHNET CLAIMS

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

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

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

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

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

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

4.2.A CLAIMS FILED AND DENIED

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

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

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

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

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Six-Month Time Limit: 181 days.

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

5.1 GENERAL INFORMATION

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

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

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

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

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

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

Federal and state regulations require that insurance benefits or amounts resulting from litigation are to be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. See 42 CFR 433 subpart D and RSMo 208.215 for further reference. In essence, MO HealthNet does not and should not pay a claim for medical
expenses until the provider submits documentation that all available third party resources have considered the claim for payment. Exceptions to this rule are discussed later in this section of the provider manual.

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

5.1.B THIRD PARTY LIABILITY FOR MANAGED CARE ENROLLEES

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

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

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

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

If a claim is cost-avoided, the establishment of liability takes place when the managed care health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.
If the probable existence of a Third Party Resource (TPR) *cannot* be established or third party benefits are *not* available at the time the claim is filed, the managed care health plan *must* pay the full amount allowed under the managed care health plan's payment schedule.

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

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

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

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

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

The managed care health plan shall immediately report to the MO HealthNet Division any cases involving a potential TPR resulting from any of the above circumstances. The managed care health plan shall cooperate fully with the MO HealthNet Division in all collection efforts. If the managed care health plan or any of its subcontractors receive reimbursement as a result of a listed TPR, that payment *must* be forwarded to the MO HealthNet Division immediately upon receipt.
IMPORTANT: Contact the MO HealthNet Division, Third Party Liability Unit, at (573) 751-2005 for questions about Third Party Liability.

5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR

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

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

5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

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

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

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

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

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

5.2.A TPL INFORMATION

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

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

5.2.B SOLICITATION OF TPR INFORMATION

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

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse’s employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.
• Tricare or veteran’s benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the “Improved Pension Program,” effective in 1979.

• If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency requirement for aliens or refugees) and the Part B premium be paid. Individuals who have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)

• If the participant is disabled, coverage may exist under Medicare, Worker’s Compensation, or other disability insurance carriers.

• If the participant is an over age disabled dependent (in or out of school), coverage may exist as an over age dependent on most group plans.

• If the participant is in school, coverage may exist through group plans.

• A relative may be paying for health insurance premiums on behalf of the participant.

5.3 INSURANCE COVERAGE CODES

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

AC Accident
AM Ambulance
CA Cancer
CC Nursing Home Custodial Care
DE Dental
DM Durable Medical Equipment
HH Home Health
HI Inpatient Hospital
HO Outpatient Hospital—includes outpatient and other diagnostic services
HP Hospice
IN Hospital Indemnity—refers to those policies where benefits cannot be assigned and it is not an income replacement policy
MA  Medicare Supplement Part A
MB  Medicare Supplement Part B
MD  Physician—coverage includes services provided and billed by a health care professional
MH  Medicare Replacement HMO
PS  Psychiatric—physician coverage includes services provided and billed by a health care professional
RX  Pharmacy
SC  Nursing Home Skilled Care
SU  Surgical
VI  Vision

5.4 COMMERCIAL HEALTH CARE PLANS

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

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

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

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

At the time the provider obtains MO HealthNet and third party resource information from the child’s caretaker, the provider should ask whether this type of resource exists. Medical support is a primary resource.

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

By accepting MO HealthNet reimbursement, the provider gives up the right to collect any additional amounts due from the insurance resource. Federal regulation requires any excess amounts collected by the MO HealthNet agency be distributed to the participant/policyholder.

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

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

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

5.6.A EXCEPTION TO TIMELY FILING LIMIT

The 12-month initial filing rule can be extended if a third party payer, after making a payment to a provider, being satisfied that the payment is proper and correct, later reverses the payment determination, sometimes after 12 months have elapsed, and requests the provider to return the payment. Because TPL was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the State agency. The problem occurs when the provider, after having repaid the
third party, wishes to file the claim with MO HealthNet, and is unable to do so because more than 12 months have elapsed since the date of service. Under this set of circumstances, the provider may file a claim with the MO HealthNet agency later than 12 months from the date of service. The provider must submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling.

5.6.B TPR CLAIM PAYMENT DENIAL

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

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

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

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

5.7 THIRD PARTY LIABILITY BYPASS

There are certain claims that are not subjected to Third Party Liability edits in the MO HealthNet payment system. These claims are paid subject to all other claim submission requirements being met. MO HealthNet seeks recovery from the third party resource after MO HealthNet reimbursement has been made to the provider. If the third party resource reimburses MO HealthNet more than the maximum MO HealthNet allowable, by federal regulation this overpayment must be forwarded to the participant/policyholder.
The provider may choose not to pursue the third party resource and submit a claim to MO HealthNet. The provider’s payment is limited to the maximum MO HealthNet allowable. The following services bypass Third Party Liability edits in the MO HealthNet claims payment system:

- The claim is for personal care or homemaker/chore services.
- The claim is for intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is related to preventative pediatric care.

## 5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

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

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

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

## 5.9 LIABILITY AND CASUALTY INSURANCE

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

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

The state monitors possible accident-related claims to determine if another party may be liable; therefore, information given on the claim form is very important in assisting the state in researching accident cases. 13 CSR 4.030 and 13 CSR 4.040 requires the provider to report the contingent liability to the MO HealthNet Division.
Often the final determination of liability is not made until long after the accident. In these instances, claims for services may be billed directly to MO HealthNet prior to final determination of liability; however, it is important that MO HealthNet be notified of the following:

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

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

5.9.A TPL RECOVERY ACTION

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

5.9.B LIENS

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

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

5.9.C TIMELY FILING LIMITS

MO HealthNet timely filing rules are not extended past specified limits, if a provider chooses to pursue the potentially liable third party for payment. If a court rules there is no liability or the provider is not reimbursed in full or in part because of a limited settlement amount, the provider may not bill the participant for the amounts in question even if MO HealthNet's timely filing limits have been exceeded.
5.9.D ACCIDENTS WITHOUT TPL

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

Examples are:

• An accidental injury (e.g., laceration, cut, broken bone) occurs as a result of the participant's own action.

• A MO HealthNet participant is driving (or riding in) an uninsured motor vehicle that is involved in a one vehicle accident and the participant or driver has no uninsured motorist insurance coverage.

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

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

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

• If an attorney is involved, the provider should obtain the full name of the attorney.

• In addition, the provider should obtain the name of any liable party, the liable insurance company name, address and policy number.

• Prior to releasing bills or medical records to the participant, the provider must either contact the MO HealthNet Division, Third Party Liability Unit, P.O. Box 6500, Jefferson City, MO 65102-6500, (573) 751-2005, or complete a MO HealthNet Accident Report or MO HealthNet Insurance Resource Report as applicable. If the participant requires copies of bills or medical records for a reason other than third party liability, it is not necessary to contact the Third Party Liability Unit or complete the forms referenced above.

• Prior to releasing bills or medical records to the participant, the provider must stamp or write across the bill, “Paid by MO HealthNet” or “Filed with MO HealthNet” in compliance with 13 CSR 70-3.040.

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

If the provider receives payment from a third party resource after receiving MO HealthNet reimbursement for the covered service, the provider must promptly submit an Individual Adjustment Request form to MO HealthNet for the partial or full recovery of the MO HealthNet payment. The
amount to be refunded must be the full amount of the other resource payment, not to exceed the amount of the MO HealthNet payment. Refer to Section 6 for information regarding adjustments.

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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

MO HealthNet Division  
TPL Unit - HIPP Section  
P.O. Box 6500  
Jefferson City, MO 65102-6500

or by calling (573) 751-2005.

5.13 definitions of common health insurance terminology

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

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

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

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

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

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

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

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

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

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

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

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

TRADITIONAL INSURANCE PLAN: Provides first-dollar coverage with usually three categories of benefits: (1) hospital, (2) medical/surgical, and (3) supplemental major medical, which provides for protection for medical care not covered under the first two categories. Variations and riders to these plans may offer coverage for maternity care, prescription drugs, home and office visits, and other medical expenses.
SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the ICN of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and select the highlighted ‘submit claim’ button. The claim has now been submitted for payment.
6.2.B(2)(ii)  Copy Claim – Original

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

6.2.B(2)(iii)  Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

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

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

Providers should submit the Provider Initiated Self Disclosure Report Form for overpaid claims that are older than 24 months from the DOS. Be sure to complete all of the fields listed on the form.
MMAC encourages providers and entities to establish and implement a compliance integrity plan. MMAC also encourages providers and entities to self-disclose or report findings, along with funds to compensate for the errors or a suggested repayment plan, which requires MMAC approval, to the address below:

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

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

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

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

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

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

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

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

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FIELD NUMBER & NAME                  INSTRUCTIONS FOR COMPLETION

1. Patient Name                      Enter last name, first name and middle initial as shown on the ID card.

2. Participant MO HealthNet ID Number Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant’s ID card or letter of eligibility.

3. Procedure/Revenue Codes           Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).

4. Description of Item/Service       For each procedure/revenue code listed, describe in detail the service or item being provided.

5. Reason for Service                For each procedure/revenue code listed, state clearly the medical necessity for this service/item.
6. Months Item Needed (DME only)  
   For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).

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

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

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

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

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

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

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

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

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

  A PA Request form may be printed and completed by hand or the form may be completed in Adobe and then printed. To enter information into a field, either click in the field or tab to the
field and complete the information. When all the fields are completed, print the PA Request and send to the address listed above.

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

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

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

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

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

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

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

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

### 8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>EXPLANATION OF FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date of the disposition letter</td>
</tr>
<tr>
<td>Request Number (No.)</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>Receipt Date</td>
<td>Date the Prior Authorization (PA) Request was received by the fiscal agent</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Authorized NPI number, name and address</td>
</tr>
<tr>
<td>Participant</td>
<td>Participant's DCN, name, date of birth and sex</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>The procedure code</td>
</tr>
<tr>
<td>Modifier</td>
<td>The modifier(s)</td>
</tr>
<tr>
<td>Authorization Dates</td>
<td>The authorized from and thru dates</td>
</tr>
<tr>
<td>Units</td>
<td>The units requested, units authorized (if approved), units used</td>
</tr>
<tr>
<td>Dollars</td>
<td>The dollar amount requested, dollar amount authorized (if approved), dollar amount used</td>
</tr>
<tr>
<td>Status</td>
<td>The status codes of the PA Request</td>
</tr>
</tbody>
</table>

The status codes are:

- A—Approved
- C—Closed
- D—Denied
- I—Incomplete

Reason

The applicable EOB reason(s)

Comments

Comments by the consultant which may explain denials or make notations referencing specific procedure code(s)

Physician/Provider Signature

Signature of provider when submitting a Request for Change
8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

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

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

• Increase or decrease requested units or dollars.

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

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

• Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

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

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

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

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

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

The written request *must* include:

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

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

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

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

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

END OF SECTION  
TOP OF PAGE  

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

9.3 DIAGNOSIS CODE

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

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

9.4 INTERPERIODIC SCREENS

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

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

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

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

9.5 FULL HCY/EPSDT SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381EP-99385EP</td>
<td>Full Medical Screening</td>
</tr>
</tbody>
</table>

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A full HCY/EPSDT screen includes the following:

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

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

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

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

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

PROCEDURE CODE DESCRIPTION

99429 59 Developmental/Mental/Behavioral Health partial screen

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

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

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

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

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

9.6.A(1) Qualified Providers

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

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Speech/language therapist;
- Physical therapist
- Occupational therapist; or
• Professional counselors, social workers, marital and family therapists, and psychologists.
  *only infants age 0-2 months; and females age 15-20 years

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

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

The HCY unclothed physical and history includes the following:

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

9.6.B(1)  Qualified Providers

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

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

9.6.C  VISION SCREENING

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9942952</td>
<td>Vision Screening</td>
</tr>
</tbody>
</table>

| 9942952UC | Vision Screening with Referral |
This screen can include observations for blinking, tracking, corneal light reflex, pupillary response, ocular movements. To test for visual acuity, use the Cover test for children under 3 years of age. For children over 3 years of age utilize the Snellen Vision Chart.

9.6.C(1) Qualified Providers

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

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

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

9.6.D HEARING SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429EP</td>
<td>HCY Hearing Screen</td>
</tr>
<tr>
<td>99429EPUC</td>
<td>HCY Hearing Screen with Referral</td>
</tr>
</tbody>
</table>

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

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

9.6.D(1) Qualified Providers

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

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

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

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

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

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

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

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

9.6.E(1) Qualified Providers

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

9.6. F ALL PARTIAL SCREENERS

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

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

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

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

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

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

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

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

**SIGNS AND SYMPTOMS**

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

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

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

EXPOSURE PATHWAYS

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

ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
Painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline

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

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

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

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

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

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

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

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

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

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

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

### 9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

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

(Capillary specimen or venous blood samples.)

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

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

### 9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

#### 9.7.E(1) Blood Lead Level <10 µg/dL

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

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

9.7.E(2) Blood Lead Level 10-19 µg/dL

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

Recommended Interventions:

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

*Retesting must always be completed using venous blood.

9.7.E(3) Blood Lead Level 20-44 µg/dL

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

Recommended Interventions:

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

*Retesting must always be completed using venous blood.

9.7.E(4) Blood Lead Level 45-69 µg/dL

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

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

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.
- A child with a confirmed blood lead level greater than 44 µg/dL should be treated promptly with appropriate chelating agents and not returned to an environment where lead hazard exposure may continue until it is controlled.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.
  * Retesting must always be completed using venous blood.

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

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

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

Recommended Interventions:

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

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

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

  * Retesting must always be completed using venous blood.

9.7.F  COORDINATION WITH OTHER AGENCIES

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

9.7.G  ENVIRONMENTAL LEAD INVESTIGATION

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

9.7.G(1)  Environmental Lead Investigation

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

The purpose of the environmental lead investigation is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels. Environmental lead investigations are to be conducted by licensed lead risk assessors who have been approved by the Missouri Department of Health and Senior Services. Approved licensed lead risk assessors shall comply with the Missouri Department of Health and Senior Services Lead Manual and applicable State laws.
All licensed lead risk assessors must be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children must also be enrolled as a MO HealthNet provider. Lead risk assessors must use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

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

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

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

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

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

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

9.7.H ABATEMENT

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

9.7.I LEAD CASE MANAGEMENT

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

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

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

<table>
<thead>
<tr>
<th>Laboratory Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mercy Hospital</td>
<td>2401 Gillham Rd. Kansas City, MO 64108</td>
</tr>
<tr>
<td>Kneibert Clinic, LLC PO Box</td>
<td>PO Box 220 Poplar Bluff, MO 63902</td>
</tr>
<tr>
<td>Hannibal Clinic Lab</td>
<td>LabCorp Holdings-Kansas City 1706 N. Corrington</td>
</tr>
<tr>
<td>St. Louis, MO 63120</td>
<td>Kansas City, MO 64120</td>
</tr>
<tr>
<td>Kansas City Health Department Lab</td>
<td>2400 Troost, LL#100 Kansas City, MO 64108</td>
</tr>
<tr>
<td>Physicians Reference Laboratory</td>
<td>7800 W. 110 St. Overland, MO 66210</td>
</tr>
<tr>
<td>Missouri State Public Health Laboratory</td>
<td>101 Chestnut St. Jefferson City, MO 65101</td>
</tr>
<tr>
<td>Quest Diagnostics</td>
<td>11636 Administration St. Louis, MO 63146</td>
</tr>
<tr>
<td>Springfield-Greene County Public Health</td>
<td>227 E. Chestnut Springfield, MO 65802</td>
</tr>
<tr>
<td>St. Francis Medical Center</td>
<td>211 St. Francis Drive Cape Girardeau, MO 63703</td>
</tr>
<tr>
<td>St. Luke’s Hospital Dept. of Pathology</td>
<td>4401 Wornall Kansas City, MO</td>
</tr>
<tr>
<td>St. Louis County Environmental Health Lab</td>
<td>111 S. Meramec Clayton, MO 63105</td>
</tr>
<tr>
<td>University of MO-Columbia Hospital &amp; Clinics</td>
<td>One Hospital Drive Columbia, MO 65212</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Laboratory Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arup Laboratories</td>
<td>500 Chipeta Way Salt Lake City, UT 84108</td>
</tr>
<tr>
<td>Esa</td>
<td>22 Alpha Rd. Chelmsford, MA 01824</td>
</tr>
<tr>
<td>Iowa Hygenic Lab</td>
<td>Wallace State Office Building Iowa Methodist Medical Center 1200 Pleasant St.</td>
</tr>
<tr>
<td>University of MO-Columbia Hospital &amp; Clinics</td>
<td></td>
</tr>
</tbody>
</table>

**PRODUCTION : 09/08/2022**
9.8 HCY CASE MANAGEMENT

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

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

9.9 IMMUNIZATIONS

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

9.9.A VACCINE FOR CHILDREN (VFC)

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

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

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

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

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

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

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

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

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td></td>
</tr>
<tr>
<td>3 Years</td>
<td></td>
</tr>
<tr>
<td>Time Period</td>
<td>Years</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>3-4 Days</td>
<td>4 Years</td>
</tr>
<tr>
<td>By 1 Month</td>
<td>5 Years</td>
</tr>
<tr>
<td>2 Months</td>
<td>6 Years</td>
</tr>
<tr>
<td>4 Months</td>
<td>7 Years</td>
</tr>
<tr>
<td>6 Months</td>
<td>8 Years</td>
</tr>
<tr>
<td>9 Months</td>
<td>9 Years</td>
</tr>
<tr>
<td>12 Months</td>
<td>10 Years</td>
</tr>
<tr>
<td>15 Months</td>
<td>11 Years</td>
</tr>
<tr>
<td>18 Months</td>
<td>12 Years</td>
</tr>
<tr>
<td>24 Months</td>
<td>13 Years</td>
</tr>
<tr>
<td>30 Months</td>
<td>14 Years</td>
</tr>
<tr>
<td></td>
<td>15 Years</td>
</tr>
<tr>
<td></td>
<td>16 Years</td>
</tr>
<tr>
<td></td>
<td>17 Years</td>
</tr>
<tr>
<td></td>
<td>18 Years</td>
</tr>
<tr>
<td></td>
<td>19 Years</td>
</tr>
<tr>
<td></td>
<td>20 Years</td>
</tr>
</tbody>
</table>

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

**9.11.A DENTAL SCREENING SCHEDULE**
- Twice a year from age 6 months to 21 years.

**9.11.B VISION SCREENING SCHEDULE**
- Once a year from age 3 to 21 years.

**9.11.C HEARING SCREENING SCHEDULE**
- Once a year from age 3 to 21 years.
9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

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

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

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

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

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

9.13 PARTICIPANT NON LIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.15 STATE-ONLY FUNDED PARTICIPANTS

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

9.16 MO HEALTHNET MANAGED CARE

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

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

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

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

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

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

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

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

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

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

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

### 9.17 ORDERING HCY LEAD SCREENING GUIDE

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

10.1 FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

It is important to correctly identify family planning services by both diagnosis and procedure code, since the federal financial participation rate of the payment for these procedures is 90% (rather than the normal rate of approximately 60%). The remaining percentage is funded by state general revenue.

Family planning services for which the higher federal financial participation rate is available are elective sterilizations and birth control products including drugs, non-biodegradable drug delivery implant system, IUDs, and diaphragms.

Providers must mark the family planning field whenever a procedure or service is performed that relates to family planning.

- Professional Claim Form: Mark Field #24H “FP” if the service relates to family planning. This goes in the white section of the field.
- UB-04: Code A4 should be entered in Fields #18-24 of the UB-04 if any part of the claim (inpatient or outpatient service) relates to family planning. The occurrence code (C1 or C3) must be in Field #18, followed by A4, if appropriate, in Fields #19-24.
- All family planning services must have a diagnosis code within the ranges of Z30.011 – Z30.9.

10.2 COVERED SERVICES

A physician may charge the appropriate Evaluation and Management (E/M) procedure code that includes one (1) or more of the following services: obtaining a medical history, pelvic examination, breast examination, and the preparation of smears, for example, a Pap smear, bacterial smear.

NOTE: MO HealthNet payment for screening and interpretation of a Pap smear can only be made to a clinic or certified independent laboratory employing an approved pathologist (cytologist) or to an individual pathologist (cytologist). All providers of laboratory services must have a Clinical Laboratory Improvements Act (CLIA) certificate.
10.2.A LONG-ACTING REVERSIBLE CONTRACEPTION (LARC) DEVICES

The MO HealthNet Division (MHD) will allow separate reimbursement for long-acting reversible contraception (LARC) devices inserted during an inpatient hospital stay for a delivery. LARC devices, including intrauterine devices (IUDs) and birth control implants, are defined as implantable devices that remain effective for several years to prevent pregnancies. Separate reimbursement applies to the LARC device only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital per diem rate.

To receive separate reimbursement for LARC devices inserted during inpatient hospital stays for delivery, providers can submit an outpatient or pharmacy claim with the most appropriate National Drug Code (NDC). Providers will receive their inpatient per diem rate in addition to being reimbursed separately for the LARC device.

MHD currently has a Fiscal Edit in place to prevent duplicate billing of non-oral contraceptive products. Providers are responsible for checking criteria to confirm their patient’s eligibility for a LARC device prior to billing MHD. The criteria for non-oral contraceptive products are available at: http://dss.mo.gov/mhd/cs/pharmacy/pdf/non-oral-contraceptives.pdf Login to CyberAcess to check the patient’s history or contact the MHD helpdesk at 800-392-8030 for confirmation. Claims for separate reimbursement of the LARC device are subject to post-payment review.

The outpatient reimbursement methodology for covered LARC implantations remains unchanged.

10.2.A(1) Intrauterine Device (IUD)

• The fee for procedure code 58300, insertion of an IUD, includes the physician’s fee.

• Procedure code 58301, removal of an IUD, includes the physician’s fee for removal of the IUD.

10.2.A(2) Non-biodegradable Drug Delivery Implant System

MO HealthNet covers the non-biodegradable drug delivery implant system.

The following procedure codes are for insertion only, removal only, or removal with reininsertion only and do not include reimbursement for the device.

11981 Insert Non-Bio Drug Del Implant
11982 Remove Non-Bio Drug Del Implant

11983 Remove/Reinsert Non-Bio Drug Del Implant

The E/M procedure code may not be billed in addition to any of the non-biodegradable drug delivery implant system procedure codes, as it is included in the reimbursement for insertion and/or removal.

10.2.B ORAL CONTRACEPTION (BIRTH CONTROL PILL)

Prescribed oral contraceptives may be reimbursed by MO HealthNet through the Pharmacy Program. Additional information can be found in Section 10.2.B. of the Pharmacy Provider Manual.

10.2.C DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an E/M procedure code. The cost of the cervical cap may be billed using supply code A4261. The cost of the diaphragms may be billed using supply code A4266. An invoice indicating the type and cost of the diaphragm or cervical cap must be attached to the claim for manual pricing or a pharmacy claim form with the NDC can be submitted.

10.2.D STERILIZATIONS

For family planning purposes, sterilizations 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.

10.2.D(1) Consent Form

The following procedures require that a (Sterilization) Consent Form be completed and submitted:

55250, 58565, 58600, 58605, 58611, 58615, 58670, 58671

The (Sterilization) Consent Form should be completed and submitted separately from a claim to Wipro Infocrossing either by mail or via the Internet. Reference Section 23 of this manual for additional information. Any claim for a sterilization procedure performed that does not have a signed, Missouri-approved (Sterilization) Consent Form is denied in accordance with mandated regulations set forth by the Centers for Medicare & Medicaid Services. All fields must be legible.

For any emergency voluntary sterilization service provided in non-bordering states for which a consent form is required, a consent form approved for use in another state
may be accepted, providing it includes all the federally prescribed content and the same required information that the Missouri-approved form contains.

The (Sterilization) Consent Form, as described above, must be completed and signed by the participant at least 31 days, but not more than 180 days, prior to the date of the sterilization procedure. There must be 30 days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days.

The only exceptions to these time requirements are for situations involving premature delivery or emergency abdominal surgery.

- **Premature delivery:** The (Sterilization) Consent Form must be completed and signed by the participant at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. Expected date of delivery is required on the (Sterilization) Consent Form. (This also applies to consent forms used in lieu of the Missouri-approved (Sterilization) Consent Form for services provided in non-bordering states.)

- **Emergency abdominal surgery:** The (Sterilization) Consent Form must be completed and signed by the participant at least 72 hours prior to sterilization. The nature of the emergency abdominal surgery must be documented on the (Sterilization) Consent Form. (This also applies to consent forms used in lieu of the Missouri-approved (Sterilization) Consent Form for services provided in non-bordering states.)

**10.2.D(2) Informed Consent**

Informed consent has been given only if the person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure and if that person provided a copy of the (Sterilization) Consent Form to the individual to be sterilized.

The person obtaining consent has met the informed consent requirement if he/she orally provided all the following information or advice:

- The individual has been advised that he/she is free to withhold or withdraw consent to this procedure at any time before the sterilization. This decision does not affect the right to future care or treatment, and it does not cause the loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.

- The individual has been given a description of available alternative methods of family planning and birth control.
• The individual has been advised that the sterilization procedure is considered permanent and irreversible.

• The individual has been given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing.

• The individual has been advised of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthetic to be used.

• The individual has been given a full description of the benefits or advantages that may be expected as a result of the sterilization.

• The individual has been advised that the sterilization will not be performed for at least 30 days after the date the (Sterilization) Consent Form is signed, except under the circumstances specified on the form under Premature Delivery or Emergency Abdominal Surgery.

• For blind, deaf, or otherwise handicapped participants, suitable arrangements were made to ensure that all the information in this list was effectively communicated.

• An interpreter was provided if the individual to be sterilized did not understand either the language used on the (Sterilization) Consent Form or the language used by the person obtaining consent.

• The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.

Informed consent for a sterilization procedure may not be obtained from a participant under the following conditions:

• The participant is in labor or childbirth.
• The participant is seeking to obtain or is obtaining an abortion.

• The participant is under the influence of alcohol or other substances that affect the individual’s state of awareness.

The (Sterilization) Consent Form must be signed and dated by:
• The individual to be sterilized. (The (Sterilization) Consent Form must be signed and dated at the same time. The form will not be returned to the provider for addition of the participants missing signature or date.) If either of these requirements is not met, the procedure will be denied.
• The interpreter (if one was necessary).
• The person who obtained the consent (on or after the date of the participant signature).
• The physician who performed the sterilization.

All applicable items of the (Sterilization) Consent Form must be completely filled out.

The physician’s statement on the (Sterilization) Consent Form must be signed and dated by the physician who performed the sterilization on or after the date the sterilization procedure was performed. The date of the sterilization must match the date of service on the claim form.

The participant must:

• Be at least 21 years old at the time consent is obtained. There are no exceptions (42 CFR 441.253).
• Not be a mentally incompetent individual or an institutionalized individual (42 CFR 441.251).
• Have voluntarily given informed consent, in accordance with mandated regulations set forth by the Centers for Medicare & Medicaid Services and requirements by the Department of Social Services.

10.2.D(3) Definitions

Mentally Incompetent Individual:

• An individual who has been declared mentally incompetent for any purpose by a federal, state, or local court of competent jurisdiction unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Institutionalized Individual:

• An individual who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness.
• An individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
10.3 SERVICES NOT COVERED UNDER FAMILY PLANNING

- Condoms and devices or supplies available as non-prescribed, over-the-counter products are not covered services.
- Reversal of sterilization procedure is not covered.
- Abortions are not to be reported as family planning services.
- Hysterectomies for the purpose of family planning are not covered.

END OF SECTION
TOP OF SECTION
SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

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

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

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

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

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

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

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

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

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are not enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does not appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health
"OPT OUT" POPULATIONS: The Department of Social Services allows participants the option of choosing to receive services on a Fee-For-Service basis or through the MO HealthNet Managed Care Program. Participants are eligible to opt out if they are in the following classifications:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
- Described in Section 501(a)(1)(D) of the Act (children with special health care needs); or
- Described in Section 1902 €(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a)).

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

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

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

Managed Care Health Plan members fall into four groups:

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

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

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

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care–OAA), and 01 (Old Age Assistance-OAA);
- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;
- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
• AIDS Waiver participants (individuals twenty-one (21) years of age and over);
• Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
• Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
• Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
• Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
• Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women’s health services for one year plus 60 days, regardless of income level;
• Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
• Individuals with ME code 81 (Temporary Assignment Category);
• Individuals eligible under ME code 82 (MoRx);
• Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
• Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and
• Individuals eligible under ME code 88 (Voluntary Placement).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

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

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

The MO HealthNet Managed Care member must be told in advance of furnishing the service by the non- Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant must sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non- MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.
MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans must provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the Fee-For-Service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan’s administration of health care benefits.

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

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

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

- Inpatient hospital services
- Outpatient hospital services
- Emergency medical, behavioral health, and post-stabilization care services
- Ambulatory surgical center, birthing center
- Asthma education and in-home environmental assessments
- Physician services (including advanced practice nurse and certified nurse midwife)
- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME Codes 73-75, and 97
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.
- Durable medical equipment (including but not limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers,
diabetic supplies and equipment) and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP)

- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. Personal care/advanced personal care

- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), one pair of eyeglasses every two years (during any 24 month period of time), and replacement lens(es) when there is a .50 or greater change.

- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care Health Plan or through the local public health agency and paid by the MO HealthNet Managed Care Health Plan)
  - Screening, diagnosis and treatment of sexually transmitted diseases
  - HIV screening and diagnostic services
  - Screening, diagnosis and treatment of tuberculosis
  - Childhood immunizations
  - Childhood lead poisoning prevention services, including screening, diagnosis and treatment

- Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but not be limited to:
  - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
  - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs
    - Crisis intervention/access services
    - Alternative services that are reasonable, cost effective and related to the member's treatment plan
    - Referral for screening to receive case management services.
    - Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments.
    - Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment
with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.

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

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

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

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

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

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

• Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions

• Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
  • Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
  • Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure.
  • The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.

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

• Pharmacy services.

• Home birth services.

• Targeted Case Management for Behavioral Health Services.

11.8 QUALITY OF CARE

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

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS
Participants who are included in the MO HealthNet Managed Care Program are identified on eMOMED or the IVR system when verifying eligibility. The response received identifies the name and telephone number of the participant’s selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member’s primary care provider (PCP). For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan must have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan must have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

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

11.9.A NON-BILLING MO HEALTHNET PROVIDER

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

11.10 EMERGENCY SERVICES

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

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

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

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

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

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

11.11.A ELIGIBILITY FOR PACE

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

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

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

Individuals not eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

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

11.11.D PACE COVERED SERVICES

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

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

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

12.1 The Basis for Establishing a Rate of Payment

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

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

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

Under a fee schedule each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. In determining what this fee should be, the MHD considers the following information when applicable:

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

The MHD then determines a maximum allowable fee for the service based upon all applicable information and current appropriated funds. Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

12.2 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Services

Reimbursement for CSTAR services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MHD to be a reasonable fee, consistent with
efficiency, economy, and quality of care. Providers may not bill the MO HealthNet program at a higher rate than they charge their private pay participants. Payment for covered services is the lower of the provider’s actual billed usual and customary charge, or the maximum allowable per unit of service.

12.3 On-Line Fee Schedule

MHD fee schedules identify covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The online Fee Schedule is updated quarterly and is intended as a reference not a guarantee for payment.

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

Refer to Section 13 for program specific benefits and limitations.

12.4 Medicare/MO HealthNet Reimbursement (Crossover Claims)

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider. This does not apply to the CSTAR Program.

12.5 Participant Copay

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

12.6 A MO HealthNet Managed Health Care Delivery System Method of Reimbursement

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

CSTAR services are not included as a plan benefit in MO HealthNet’s Managed Care program. CSTAR services to managed health care enrollees may be reimbursed by MO HealthNet on a fee-for-service basis.
SECTION 13—Benefits and Limitations

13.1 General Information

Effective January 1, 1991, MO HealthNet added coverage for Comprehensive Substance Treatment and Rehabilitation (CSTAR), an outpatient substance use disorder (SUD) treatment program. Coverage is targeted to individuals eligible for MO HealthNet benefits who are assessed as needing SUD treatment. Services include, but are not limited to, assessment, treatment, and community support. Services are provided based upon a diagnosis from a qualified physician or licensed mental health professional (LMHP). Reimbursement by MO HealthNet is limited to qualified MO HealthNet-enrolled CSTAR providers. This section provides the general benefits and limitations for the program. Further detail is found in 9 CSR 30-3.100 through CSR 30-3.192, as well as clinical bulletins or other guidance documents issued by the Department of Mental Health (DMH), Division of Behavioral Health (DBH).

13.2 Provider Participation

To participate in the MO HealthNet CSTAR Program, the organization must satisfy the following requirements:

1. Be certified as a CSTAR provider by DMH in accordance with 9 CSR 10-7.010 through CSR 10-7.140 and 9 CSR 30-3.100 through CSR 30-3.192 and 9 CSR 10-5.190 through 9 CSR 10-5.230;
2. Obtain a CSTAR Provider Contract with DMH;
3. Comply with all applicable State and Federal laws in order to receive federal funds including, but not limited to, civil rights and regulations in the delivery of services. It is the provider’s responsibility to review the civil rights information via the Internet;
4. Complete necessary Provider Enrollment documents and agreements required by the Missouri Medicaid Audit and Compliance Unit (MMAC). These documents can be requested by contacting the DMH, DBH, Fiscal Unit at 573-751-4942. Upon completion of the Provider Enrollment documents and agreements, these documents must be submitted to DMH, P.O. Box 687, Jefferson City, MO 65102;
5. Agree to maintain auditable program records reflecting services provided, individuals’ progress in treatment, number of individuals served and related demographic information, and other relevant program records for six (6) years or if a minor, three (3) years after the individual reaches legal age as determined by Missouri law, or longer if specified by a contract with DMH;
6. Allow the Department of Social Services (DSS) or its authorized representative (such as MMAC, DMH) to inspect and examine its premises and records that relate to the provision of services under this program; and
7. Employ and retain qualified staff to render the services covered through the MO HealthNet CSTAR Program or any additional State or Federal regulations.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.
The DMH, through an interagency agreement with the DSS, MMAC, reviews all requests for participation in the CSTAR Program and provides validation of the applicant’s certification status to MMAC. The MMAC Unit, based upon review of the application and certification by DMH, approves or denies the application request.

The Provider Enrollment Section must be notified in writing of any changes in the CSTAR National Provider Identifier (NPI) status. The notification must include the provider number and the requested change. Examples of changes are: address or telephone number, Social Security number to a Tax Payer I.D. number, or certification status.

Specific information about MO HealthNet participation requirements for the CSTAR Program can be obtained from the Missouri Medicaid Audit and Compliance Unit Provider Enrollment Section, P.O. Box 6500, Jefferson City, Missouri 65102 or e-mail MMAC.providerenrollment@dss.mo.gov

13.3 Participant Eligibility

The participant must have MO HealthNet coverage for each date a service is rendered in order for reimbursement to be made to a provider. Participants in state only funded MO HealthNet programs, and those in programs with benefit packages restricted to specified services, are not eligible to receive CSTAR benefits.

The state only funded ME codes not eligible to receive CSTAR benefits are 02, 08, 52, 57, 59, 64, 65, 82, 0F, and 5A (refer to Section 1 for descriptions).

The ME codes with restricted benefit packages not eligible to receive CSTAR benefits are 55, 58, 59, 80, 82, 89, 91, 92, 93 and 94.

13.4 Participant Copay

The MO HealthNet Division (MHD) does not require a copay for any services at this time. Providers will be notified when copays are reinstated.

13.5 Participant Nonliability

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

13.6 Adequate Documentation

All services provided must be adequately documented in the individual’s medical/clinical record. 13 CSR 70-3.030(2)(A) defines “adequate documentation” and “adequate medical records” as follows:
1. Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

2. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/individual specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the information specified in section 13.6.A of this manual. Contemporaneous means at the time the service was performed or within five (5) business days of the time the service was provided.

Collaborative documentation is billable and is time spent documenting service interventions collaboratively with the individual during the course of the service activity/intervention. Collaborative documentation occurs when the individual is engaged with the service provider/practitioner and this process is integrated into the service session. It is done collaboratively with the individual and involves sharing the assessment, treatment plan, or documentation with the individual as it is being written by the service provider to assure a consistent understanding as to what was accomplished during the service session.

Collaborative documentation is not typing or writing notes during the entire treatment session or taking time at the end of a session to write a note in front of an individual while waiting to leave and they are uninvolved. The individual must be actively involved and engaged in writing the note, including seeing and having input into the note. Providers utilizing collaborative documentation must have policies and procedures addressing its use.

Documents retained by CSTAR providers must include the treatment plan and the clinical records. Information must be sufficient to disclose the actual provider of the service, quantity, quality, appropriateness, and timeliness of services provided under the agreement.

13.6.A Documentation Requirements

Reimbursement for each date of service requires the following documentation be present in the individual’s medical/clinical record:

1. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
2. MO HealthNet identification number (DSS Departmental Client Number – DCN);
3. An accurate, complete, and legible description of each service(s) provided;
4. Name, title, credential, and signature with date of the MO HealthNet enrolled provider delivering the service. Services provided by an individual under the direction or supervision of a MO HealthNet provider are not reimbursed by MO
HealthNet. Services provided by a person not enrolled with MO HealthNet are not reimbursed by MO HealthNet;
5. The name of the referring entity, when applicable;
6. The date of service (month/day/year);
7. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s), the actual begin and end time taken to deliver the service (for example, 4:00 p.m. – 4:30 p.m.) must be documented. When billing Medication Services using CPT Evaluation/Management (E/M) procedure codes, clock time is not required, unless the provider spends over fifty percent (50%) of the time on counseling and/or care coordination and uses the actual clock time as the key factor to determine which E/M code to bill.;
8. The setting in which the service was rendered;
9. The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. The individual treatment plan must be approved and signed by a licensed diagnostician;
10. The need for the service(s) in relationship to the MO HealthNet participant's treatment plan;
11. The MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes); and
12. For applicable programs, adequate invoices, trip tickets/reports, activity log sheets.

The requirements listed above represent minimal elements for maintaining adequate documentation required by MO HealthNet. Additional documentation may be needed to satisfy the requirements of outside reviews or delivery of a specific CSTAR service. If additional documentation is required for a specific service, it will be included with the service description in this manual.

Employee records (excluding health records) and training records of staff shall be maintained in a separate location from the medical/clinical records of individuals receiving services.

A provider’s failure to furnish, reveal, and retain adequate documentation for services billed to MO HealthNet can result in the recovery of the payments for services not adequately documented and can result in sanctions to the provider’s participation in the MO HealthNet Program. This policy continues to be applicable in the event the provider discontinues as an active participating MO HealthNet enrolled provider as the result of a change of ownership or any other circumstance.

13.7 Enrollment and Billing

To be eligible for reimbursement of services delivered, the provider must enroll the individual for CSTAR services by inputting required information into the DMH Customer Information, Management and Outcomes Reporting System (CIMOR).

All billings to the MHD for MO HealthNet eligible CSTAR services are electronically submitted to DMH through CIMOR. Billing information is electronically submitted by DMH to MHD for processing and reimbursement.
13.8 Authorization of CSTAR Services

All providers of services for which Title XIX Medicaid funding is requested must receive authorization from DMH to provide CSTAR services. CSTAR services must meet all criteria established in this section to be eligible for reimbursement. Reference Section 14 for more information.

13.9 Place of Service

A CSTAR provider may provide care in the following places of service (POS):

- 03 - School (Adolescent CSTAR Outpatient Rehabilitation only in schools, with limitations)
- 11 - Office
- 12 - Home
- 99 - Other

13.10 General Limitations

The following general limitations apply to all MO HealthNet services provided through the CSTAR Program:

1. The services must be medically necessary*; and the service must relate to the diagnosis of an SUD, or in the case of withdrawal management services, the diagnosis of alcohol and/or drug intoxication, or withdrawal;
2. The services must be rendered by or under the direction or recommendation of a physician or licensed mental health professional (LMHP) who participates in the development and approval of the treatment plan;
3. The services must be rendered by appropriate and qualified staff as defined in section 13.11 and as specified elsewhere in this manual;
4. The services must be reasonable for the treatment of an individual’s specific SUD diagnosis; and
5. All other payers, e.g., Veterans Administration and third party insurance, must be billed prior to billing MO HealthNet when applicable.
6. CSTAR services are not covered by MO HealthNet for persons who are receiving psychiatric inpatient hospital treatment or who are residents of a MO HealthNet participating nursing facility, however, services are covered on the day of admission and day of discharge from those types of settings.
7. Services are not covered for persons who are receiving inpatient hospital treatment for a physical health condition.

Services are not covered for persons who are incarcerated in a public institution, such as county jail, juvenile detention setting, or an institution for mental diseases.

Family therapy and family conference are billed under the case number of the individual enrolled in CSTAR. Other services that may be eligible to be billed directly on behalf of family members or
other natural supports are group and/or individual collateral dependent counseling. Community support services provided to or on behalf of the children of women in treatment, who are defined as collateral dependents, are billed as Community Support under the child’s case number. If family members are not MO HealthNet eligible, their services are not reimbursable by MO HealthNet.

*”Medically necessary” means health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

13.11 CSTAR Qualified Providers of Service

13.11.A Adolescent Treatment Team

A physician, registered nurse (RN) or licensed practical nurse (LPN), qualified addiction professional (QAP), qualified mental health professional (QMHP), associate substance use counselor, community support specialist (CSS), and treatment technicians.

13.11.B Advanced Practice Registered Nurse (APRN)

A licensed RN certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified nurse anesthetist, or certified clinical nurse specialist under state law. When providing Medication Management, an APRN must be in a collaborating practice arrangement with a licensed physician.

13.11.C Assistant Physician

A person licensed as an assistant physician under Missouri law who performs tasks that might otherwise be performed by a licensed physician. Assistant physicians must have a collaborating practice arrangement with a physician licensed in Missouri.

13.11.D Associate Substance Use Counselor

A trainee that meets the requirements set forth by the Missouri Credentialing Board (MCB) or the appropriate board of professional registration within the Department of Insurance, Financial Institutions, and Professional Registration.

A Qualified Addiction Professional (QAP) who has completed the MCB Clinical Supervision Training must supervise an associate substance use counselor. Clinical supervision must focus on improving the quality of treatment delivered through improving counseling skills, competencies, and effectiveness of persons supervised. All counselor functions performed by an associate substance use counselor shall be performed pursuant to the supervisor’s control, oversight, guidance, and full professional responsibility.

Documentation that must be countersigned includes treatment plans, treatment plan updates, and discharge summaries.
13.11.E Certified Peer Specialist

An individual in recovery from mental illness and/or SUD with at least a high school diploma or equivalent who meets the applicable training and credentialing required by the MCB.

A Certified Peer Specialist must be supervised by a QAP or Qualified Mental Health Professional (QMHP).

13.11.F Community Support Specialist (CSS)

An individual meeting one (1) of the following qualifications:

1. A qualified mental health professional (QMHP) as defined in this manual;
2. A qualified addiction professional (QAP) as defined in this manual;
3. An individual with a bachelor’s degree in a human services field which includes, but is not limited to social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family sciences, counseling, child development, gerontology, sociology, human services, behavioral science, and rehabilitation counseling;
4. An individual with any four- (4-) year degree and two (2) years of qualifying experience;
5. An individual with any four- (4-) year combination of higher education and qualifying experience;
6. An individual with four (4) years of qualifying experience; or
7. An individual with an Associate of Applied Science in Behavioral Health Support degree from an approved institution.

Qualifying experience must include delivery of service to individuals with mental illness, SUD, or intellectual and/or developmental disabilities (IDD). Experience must include at least one (1) of the following:

1. Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;
2. Teaching and modeling for individuals how to cope and manage psychiatric, developmental, or substance use issues while encouraging the use of natural resources;
3. Supporting individuals in their efforts to find and maintain housing, employment, and/or to function appropriately in family, school, and community settings;
4. Assisting individuals to achieve the goals and objectives on their individual treatment plan.

CSSs must complete the necessary orientation and training requirements specified by the DMH, and must be supervised by one (1) of the following:

1. A QAP,
2. A QMHP;
3. Staff meeting the qualifications of a CSS with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions specified in section 13.14.E(2) of this manual.

It is the responsibility of the provider to clearly document how the employee meets qualifications based on the above criteria.


A family member of a child/youth (17 years of age and younger) who had or currently has a behavioral/emotional disorder or an SUD, has a high school diploma or equivalent, has completed training as required by department policy, and is supervised a QAP or QMHP.

13.11.H Group Rehabilitation Support Specialist

An individual who:

1. Is suited by education, background, knowledge, or experience to present the information being discussed; and
2. Demonstrates competency and skill in facilitating group discussion.

Group rehabilitation support specialists must be supervised by a QAP or QMHP.

13.11.I Licensed Mental Health Professional (for diagnosis)

1. A physician licensed or provisionally licensed under Missouri law to furnish services within their scope of practice;
2. A psychologist licensed or provisionally licensed as a psychologist under Missouri law to furnish services within their scope of practice;
3. A resident physician, including resident psychiatrist;
4. A professional counselor licensed or provisionally licensed under Missouri law to practice counseling;
5. A clinical social worker licensed or provisionally licensed under Missouri law to practice social work;
6. A master social worker under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker;
7. A marital and family therapist licensed or provisionally licensed under Missouri law to provide marriage and family services;
8. Advanced practice registered nurse (APRN), an RN who is currently recognized by the board of nursing as an APRN;
9. A licensed assistant physician under Missouri state law;
10. A licensed physician assistant under Missouri state law.

These professions are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. However,
individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

13.11.J Licensed Practical Nurse

A person licensed as a practical nurse under Missouri law to furnish services within their scope of practice.

13.11.K Licensed Marital and Family Therapist

A person licensed or provisionally licensed as a marital and family therapist under Missouri law to furnish services within their scope of practice act.

13.11.L Physician

An individual licensed as a physician under Missouri law to furnish services within their scope of practice.

13.11.M Physician Assistant

A person who has graduated from a physician assistant program accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation or by its successor agency, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician under Missouri law.

13.11.N Psychiatrist

A licensed physician who is a psychiatrist and delivers services within their scope of practice.

13.11.O Psychologist

An individual licensed or provisionally licensed as a psychologist under Missouri law to furnish services within their scope of practice.

13.11.P Qualified Addiction Professional

One of the following:

1. A physician licensed or provisionally licensed under Missouri law;
2. An individual who meets the applicable training and credentialing required by the Missouri Credentialing Board for any of the following positions:
   A. Certified Alcohol and Drug Counselor (CADC)
A majority of the program's staff who provide individual and group counseling shall be QAPs.

13.11.Q Qualified Mental Health Professional

One of the following:

1. An individual licensed or provisionally licensed as a physician under Missouri law to furnish services within their scope of practice;
2. An individual licensed or provisionally licensed as a psychologist under Missouri law to furnish services within their scope of practice;
3. A resident physician including resident psychiatrist;
4. A professional counselor licensed or provisionally licensed under Missouri law to practice counseling;
5. A clinical social worker with a master's degree in social work from an accredited program and with specialized training in mental health services;
6. A psychiatric nurse, i.e. a registered nurse with at least two (2) years of experience in a psychiatric setting or a master's degree in psychiatric nursing;
7. An individual possessing a master's degree in counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, social work, or family therapy or related field who has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional;
8. An occupational therapist certified by the National Board for Certification in Occupational Therapy registered in Missouri, has a bachelor's degree, and has completed a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting.
9. A licensed assistant physician under Missouri state law;
10. A licensed physician assistant under Missouri state law; or
11. Advanced practice registered nurse, a registered nurse who is currently recognized by the board of nursing as an advanced practice registered nurse; or
12. A psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy, is a board-certified pharmacist (BCPP) through the Board of Pharmaceutical Specialties, or a registered pharmacist currently in a psychopharmacology residency where the service has been supervised by a board-certified psychiatric pharmacist.
13.11.R Registered Nurse (RN)

An individual licensed as an RN under Missouri law to furnish services within their scope of practice.

13.11.S Substance Use Recovery Aide

An individual with specific training related to withdrawal management who provides continuous supervision and ensures safety of individuals receiving care. Substance use recovery aides are supervised by nursing staff on duty in the medically monitored withdrawal setting.

13.11.T Treatment Technician

Individual suited by education, background, or experience who is under the supervision of a QMHP or QAP, and meets the following minimum requirements:

1. Has received training on topics being presented; and
2. Demonstrates competency and skill in educational techniques.

13.12 Levels of Care and General Service Delivery Requirements

Outpatient services vary in the intensity and duration of services offered based on the needs of the individual.

**Level I:** Community-based Primary Treatment is the most structured, intensive, and short-term service delivery option with services offered on a frequent, almost daily basis. Unless contraindicated by the individual's medical, emotional, legal and/or family circumstances, and unless residential support is provided and/or if otherwise authorized by DMH, structured services shall be offered at least five (5) days per week with the opportunity to participate in at least twenty-five (25) hours of structured service per week. At least one (1) hour of service per week shall be individual counseling. Additional individual counseling shall be provided in accordance with the individual’s needs.

**Level II:** Intensive Outpatient Rehabilitation provides intermediate structure, intensity, and duration of treatment and rehabilitation, with services offered multiple times per week. Unless otherwise authorized by DMH, a minimum of ten (10) hours of structured services shall be offered per week of which at least one (1) hour shall be individual counseling, unless contraindicated by the individual's medical, emotional, legal and/or family circumstances.

**Level III:** Supported recovery provides treatment and rehabilitation on a regularly scheduled basis, with services offered on approximately a weekly basis as clinically indicated. Unless otherwise authorized by DMH, a minimum of three (3) hours of...
structured service shall be offered per week. Each individual shall be expected to participate in a combination of services deemed clinically necessary.

Services shall be offered in a manner that provides individualized treatment options with service intensity in accordance with the needs, progress, and outcomes of each person served. An individual can move between care modalities over time in accordance with symptoms, progress, outcomes, and other clinical factors. The duration of services in each care modality shall be individualized based on the individual's needs. An individual may be transferred to more intensive services if there is a continuing inability to make progress toward treatment and rehabilitation goals.

The primary objective of the CSTAR program is to provide services that align with the National Outcome Measures (NOMs), established by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NOMs have been defined to embody meaningful, real life outcomes for individuals who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. The primary NOMs domains and their associated outcome measures are:

1. **Reduced Morbidity**: Abstinence from alcohol and drug use, including decreased use of substances of misuse;
2. **Employment/Education**: Increased/retained employment or return to/stay in school;
3. **Crime and Criminal Justice**: Decreased criminal justice involvement, incarcerations, alcohol-related car crashes and injuries, alcohol and drug-related crime;
4. **Stability in Housing**: Increased stability in housing;
5. **Social Connectedness**: Increased social supports/social connectedness (i.e., personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports); and
6. **Retention**: Increased retention in substance use treatment, access to evidence-based programs стратегий.

The program shall implement a service delivery model consistent with the NOMs, the current state of addiction knowledge, evidence-based practices, and generally accepted best practice standards for individual service. This service delivery model should be applied to address the specific needs and goals of each individual.

Priority for admission to CSTAR shall be given to:

1. Women who are pregnant and use intravenous (IV) drugs shall receive immediate admission;
2. Women who are pregnant, or postpartum, up to six (6) months after delivery;
3. Individuals who use intravenous (IV) drugs;
4. Women who have children and are at risk of losing custody or are attempting to regain custody;
5. Persons Individuals who test positive for the human immunodeficiency virus (HIV);
6. Individuals determined to be high risk and are referred for treatment by Department of Corrections’ institutions and the Division of Probation and Parole via the designated referral form and protocol, as well as individuals referred from federal.
correctional institutions. High-risk referrals shall be assessed and admitted within five (5) working days of initial contact or scheduled release date, including weekends and holidays;

7. Individuals who are applying for or receiving Temporary Assistance for Needy Families (TANF) and are referred for treatment by the Department of Social Services, Family Support Division, via the designated electronic referral process and protocol.

13.12.A Eligibility for Services

Services shall be provided in accordance with general eligibility criteria including a diagnosis of an SUD (not including tobacco use disorder) in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM 5-TR) of the American Psychiatric Association and absence of the need for withdrawal management services (for outpatient treatment levels only; eligibility for withdrawal management services are described in section 13.12.B).

Decisions regarding the treatment modality, intensity, and duration of services are based on the needs of the individual including, but not limited to:

1. Need for personal safety and protection from harm;
2. Severity of the behavioral health disorder;
3. Emotional and behavioral functioning and need for structure;
4. Social, family, and community functioning;
5. Readiness to change;
6. Availability of peer and social supports for recovery/resiliency;
7. Ability to avoid high risk behaviors; and
8. Ability to cooperate with and benefit from the services offered.

Services shall be developmentally appropriate and responsive to the individual’s social/cultural situation and any linguistic/communication needs.

Coordination of care is demonstrated when services and supports are being provided by multiple agencies or programs.

To the fullest extent possible, individuals are responsible for action steps to achieve their goals. Services and supports provided by staff should be readily available to help individuals achieve their goals and objectives.

Individuals eligible for the SUD Disease Management (DM) project are not required to have one of the specific diagnoses listed in Section 18 of the CSTAR Program Manual.

NOTE: An individual may not be denied services solely because of a return to substance use after prior treatment or withdrawal from treatment against advice on a previous occasion.

An individual may enter the CSTAR program at any service intensity commensurate with their level of bio-psychosocial function, including degree of substance use and available support systems.

The following criteria are used to guide service intensity based on individual needs:

**Level I: Community-Based Primary Treatment:**

1. Evidence that the individual cannot stop substance use without close monitoring and structured support; and
2. Need for daily or almost daily treatment services.

**Level II: Intensive Outpatient Rehabilitation:**

1. Abstinence from drug and/or alcohol use or decrease in harmful use of substances; and
2. Absence of crisis that cannot be resolved by community support services;

**Level III: Supported Recovery:**

1. Presence of adequate resources to support oneself in community;
2. Absence of crisis that cannot be resolved by community support services;
3. Lack of a need for intensive or structured treatment;
4. Involvement in the community, such as family, church, employer; and
5. Presence of recovery supports in the family and/or community.

**Medically Monitored Withdrawal Management**

1. Presence of significant intoxication, impairment or withdrawal; and,
2. Requirement of supervision and monitoring of physical and mental status to ensure safety; and, one or more of the following additional criteria are met:
   A. Impaired ability to minimally care for self;
   B. Lack of a supportive, safe environment which increases risk of continued use of substances;
   C. Requirement of ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal; or
   D. Presence of a likelihood of harm to self or others.

**13.12.C Discharge Criteria**

Each individual’s length of stay in outpatient services shall be based on their needs and progress in achieving treatment goals. Criteria to consider in determining successful completion and discharge from outpatient treatment includes, but is not limited to, the individual’s ability to—
1. Recognize and understand his/her substance use disorder and its resulting impact on family members/natural supports, impairments on health and social functioning, and other societal consequences;
2. Demonstrate an absence of an immediate or a recurring crisis that poses a substantial risk for a return to use of substances;
3. Stabilize emotional dysregulation, when applicable, such as not experiencing serious psychiatric symptoms, and taking medication as prescribed, etc.;
4. Demonstrate independent living skills;
5. Implement a plan to prevent return to use of substances; and
6. Develop family and/or social networks which support recovery/resiliency and a continuing recovery plan.

Discharges prior to an individual accomplishing treatment goals shall be documented in the individual record, including the rationale for discharge.

For withdrawal management services, an individual may be discharged and/or transferred to outpatient rehabilitation services when they are physically and mentally able to function without the supervision, monitoring and support of this service. Every effort should be made to promote continued participation in treatment and recovery efforts.

13.12.D Services for Family Members/Natural Supports

Services shall be available to family members/natural supports of individuals participating in SUD treatment and rehabilitation. Available services shall include—

1. Family therapy;
2. Family conference; and
3. Collateral dependent counseling (individual and group).

Family members/natural supports shall be informed of available services/supports.

Community support may be delivered on behalf of children/youth who are considered collateral dependents of women enrolled in a Women and Children’s CSTAR program.

Group services may include family members and the primary individual engaged in treatment when indicated by the goals, content, and methods of the group.

To be eligible for services as part of the primary individual’s family/natural support, the following eligibility must be met:

1. Family/family members, persons who comprise a household or are otherwise related by marriage or ancestry to the individual served, or an individual’s chosen family which may include unrelated loved ones with whom the individual develops a significant personal bond, who are affected by the behavioral health disorder of the individual served;
2. Assessment as clinically appropriate for treatment as a collateral dependent and treatment with a member of a family system; and
3. Determination that treatment is not in conflict with the primary individual’s treatment goals.

13.12.D(1) Women and Their Children

The DMH offers a specialized CSTAR Program for women and their children. This rehabilitation program shall provide SUD treatment solely to women and their children.

Services may be offered with or without residential support in accordance with eligibility criteria specified elsewhere in this manual.

Treatment occurs in the context of a family systems model. The program shall address therapeutic issues relevant to women and shall address their specific needs. Each program also provides therapeutic activities designed for the benefit of children who accompany their mothers into treatment.

Therapeutic issues relevant to women shall include, but are not limited to—

1. Parenting and child development;
2. Life skills;
3. Family programs;
4. Facilitation of supervised parent-child bonding;
5. Educational remediation and support;
6. Employment readiness services;
7. Co-occurring disorder services, including access to psychological and pharmacological treatments for mental health disorders;
8. Linkages with legal and child welfare systems, including reunification with children if applicable;
9. Education and linkage to eating disorder and nutrition services;
10. Housing support efforts and referrals;
11. Medication services, including access to approved medication to treat substance use disorders for women who are pregnant or breastfeeding; and
12. Recovery support and community support services that address long-term recovery needs such as domestic violence services, career counseling, legal services, and transportation services.

Therapeutic issues relevant to children shall include age-appropriate activities, training, and guidance to meet the following goals:

1. Build self-esteem and self-awareness;
2. Learn to identify and express feelings;
3. Learn healthy social engagement, peer relationships, social pressure skills, and teamwork;
4. Develop decision-making skills;
5. Understand substance use disorders and its effects on the family;
6. Learn self-management (impulse control, stress management) and goal setting;
7. Learn safety practices such as personal space, boundaries, and personal safety;
8. Address developmental needs;
9. Learn and practice nonviolent ways to resolve conflict; and
10. Provide education on preventing alcohol, tobacco, and other drug use.

13.12.D(2) Adolescent Services

The DMH also offers a specialized CSTAR program solely to individuals between the ages of 12 and 17 years inclusive (exceptions to age criteria may be authorized through the DMH clinical review process) and their families. The following principles and philosophies shall be reflected in services directed to adolescents:

1. Adolescents are effectively treated in therapeutic environments that are programmatically and physically separate from treatment services for adults;
2. Services shall maintain youth in the family and community setting, when clinically appropriate;
3. Services shall support the family and engage the family in a recovery and change process. If family is not engaged in the process, the reason(s) must be documented.
4. Services to the family shall be directed toward understanding and supporting the youth’s recovery process, including identifying and intervening with parental substance use/misuse, improving parenting and communication skills within the family, and facilitating improved family function;
5. A cooperative team approach shall be utilized in order to provide a consistent environment and therapeutic milieu; and
6. Cooperation and coordination with other agencies serving the needs of the adolescent and their family members/natural supports shall be documented.

Service delivery shall address recovery/resiliency skill development including, but not limited to—

1. Drug and alcohol prevention and education;
2. Assertiveness training;
3. Conflict resolution skills;
4. Anger management;
5. Social network development;
6. Leisure time management;
7. Problem-solving skills;
8. Adolescent development;
9. Sexuality; and
10. Trauma.

For adolescents enrolled in Level II or Level III services, a selection of CSTAR services may be provided within the school setting. An agreement for the provision of such services must be arranged by and between the CSTAR provider and the local school system.
CSTAR services delivered in the school setting shall be limited to three (3) hours/12 units per week total.

CSTAR services that may be delivered in school settings are limited to the following:

1. Intake Assessment (H0001)
2. Behavioral Health Assessment (H0002 and H0002 GT)
3. Community Support (H2015)
4. Individual Counseling (H0004, H0004 HH, H0004 ST, and H0004 UK)
5. Group Counseling (H0005 HM, H0005 HN, H0005 UK, H0005 HM GT, H0005 HN GT, and H0005 UK GT)
6. HIV Pre-Testing and Post-Testing Counseling (H0047 and H0047 TS)
7. Medication Services Support – RN (T1002), LPN (T1003 and T1003 GT)
8. Family Therapy/Conference (T1006 and T1006 52)

13.13 Covered Services

CSTAR services must be billed using the appropriate modifiers listed below. Refer to Section 19 for a concise list of procedure codes and the corresponding modifiers.

13.13.A Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>AF</td>
<td>Provided by a specialty physician (psychiatrist)</td>
</tr>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>EP</td>
<td>EPSDT program (children and adolescents under 21 years old)</td>
</tr>
<tr>
<td>GC</td>
<td>Resident</td>
</tr>
<tr>
<td>GQ</td>
<td>Via asynchronous telecommunications system</td>
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<tr>
<td>GT</td>
<td>Services delivered via Telemedicine (Please reference Section 19 of this manual for services that can be provided via telemedicine)</td>
</tr>
<tr>
<td>HH</td>
<td>Co-Occurring</td>
</tr>
<tr>
<td>HM</td>
<td>Less than bachelor’s level (provided by an associate SUD counselor)</td>
</tr>
<tr>
<td>HN</td>
<td>Less than bachelor’s level (provided by a QAP</td>
</tr>
<tr>
<td>SA</td>
<td>APRN</td>
</tr>
<tr>
<td>ST</td>
<td>Related to trauma or injury</td>
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<tr>
<td>TS</td>
<td>Follow up services</td>
</tr>
</tbody>
</table>
Services provided on behalf of the client to someone other than the client (collateral relationship)

13.13.B Outcome Measures and Instruments

A DMH CSTAR provider shall measure outcomes for individuals and shall collect data related to the outcomes. In order to promote consistency and the wider applicability of outcome data, DMH may require, at its option, the use of designated outcome measures and instruments. The required use of particular measures or instruments shall be applicable only to services funded by DMH.

13.13.C Transportation

Transportation may be provided or arranged by the CSTAR program, except as listed below, to promote participation in treatment and rehabilitation services and to access other recovery resources and supports in the community.

Non-emergency medical transportation (NEMT) is available for individuals eligible for MO HealthNet benefits for the following services:

1. Intake Assessment;
2. Assessment Update;
3. Adolescent Global Assessment of Individual Needs (GAIN); or
4. Medication Services (delivered by physician, psychiatrist, APRN, physician assistant, or assistant physician).

See Section 22 for additional information regarding NEMT benefits for MO HealthNet eligible participants.


Qualitative (presumptive) and semi-quantitative drug screening tests are covered by the MO HealthNet Program. The MO HealthNet program only covers quantitative (definitive) or “confirmative” tests (i.e., 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 and if the physician has documented the medical necessity in the patient medical record.

Please reference the Physician’s Manual for more information on drug screenings.

13.14 CSTAR Covered Services
The following CSTAR services are covered for individuals who are eligible for MO HealthNet benefits, when medically necessary and the diagnosis is related to an SUD (not including tobacco use disorder).


13.14.A(1) Description and Documentation of Eligibility Determination

Eligibility determination may be completed to expedite the admission process and requires confirmation of an eligible diagnosis as evidenced by a signature from a licensed diagnostician (see section 13.11.J of this manual) prior to delivering CSTAR services. The eligibility determination shall be documented in accordance with DMH regulations, unless otherwise directed by DMH. This documentation must include, but is not limited to, the following:

1. Presenting problem and referral source;
2. Brief history of previous addiction/psychiatric treatment, including type of admission;
3. Current medications;
4. Current substance use (must support diagnosis);
5. Current mental health symptoms;
6. Current medical conditions;
7. Diagnoses, including substance use and mental disorders, medical conditions, and notation for psychosocial and contextual factors;
8. Functional assessment using a department-approved instrument;
9. Identification of urgent needs including suicide risk, personal safety, and risk to others;
10. Initial treatment recommendations;
11. Initial treatment goals to meet immediate needs within the first forty-five (45) days of service; and;
12. Signature with date and title/credential of service providers determining eligibility are required.

13.14.A(2) Qualified Providers of Eligibility Determination

The CSTAR eligibility determination requires confirmation of an eligible diagnosis from a licensed diagnostician (see section 13.11.J of this manual) prior to delivering CSTAR services. This service is provided by a licensed diagnostician or a QAP or QMHP followed by a sign off by a licensed diagnostician. The date of the licensed diagnostician’s signature is the date eligibility has been determined. For a list of qualified providers, refer to section 13.11.K.

13.14.B Comprehensive Assessment
13.14.B(1) Service Description and Documentation for Comprehensive Assessment

A comprehensive assessment shall be completed for each individual to determine service needs, guide development of the individualized treatment plan, and determine progress and outcomes.

Documentation for completion of the comprehensive assessment must include, but is not limited to:

1. Basic information (demographics, age, language spoken);
2. Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause them to seek services;
3. Risk assessment for determining emergent, urgent, or routine need for services (suicide, safety, risk to others);
4. Trauma history (experienced and/or witnessed, abuse, neglect, violence, sexual assault);
5. Substance use treatment history and current use including alcohol, tobacco and/or other drugs. For children/youth prenatal exposure to alcohol, tobacco or other substances;
6. Mental status;
7. Mental health treatment history;
8. Medication information including current medications, medication allergies/ adverse reactions, efficacy of current or previously used medications;
9. Physical health summary (health screen, current primary care, vision and dentist, date of last examinations, current medical concerns, body mass index, tobacco use status, and exercise level. Immunizations for children/youth and medical concerns expressed by family members that may impact the child/youth;
10. Assessed needs based on functioning (challenges, problems in daily living, barriers, and obstacles);
11. Risk-taking behaviors including child/youth risk behaviors;
12. Living situation including living accommodations (where and with whom), financial state, guardianship, need for assistive technology, and parental/guardian custodial status for children/youth;
13. Family, including cultural identity and current and past family life experiences. For family functioning/dynamics, relationships and current issues/concerns impacting children/youth;
14. Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech, hearing and language, emotional, behavioral, and intellectual functioning, and self-care abilities;
15. Spiritual beliefs/religious orientation;
16. Sexuality, including current sexual activity, safe sex practices, and sexual orientation;
17. Need for and availability of social, community, and natural supports/resources such as friends, pets, meaningful activities, leisure/recreation interests, self-help groups, resources from other agencies, and interactions with peers including child/youth and family;
18. Legal involvement history;
19. Legal status such as guardianship, representative payee, conservatorship, and probation/parole;
20. Education, including intellectual functioning, literacy level, learning impairments, attendance, and achievement;
21. Employment, including current work status, work history, interest in working, and work skills;
22. Status as a current or former member of the U.S. Armed Forces;
23. Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders, and psychological/social adjustment to disabilities and/or disorders;
24. Diagnosis(es);
25. Individual’s expression of service preferences;
26. Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities, and barriers; and
27. Signature with date and title/credential of staff completing the assessment.

In order to promote consistency in clinical practice, service documentation, and outcome measurement, DMH may require the use of designated instruments in the screening, assessment and treatment process. The required use of particular instruments shall be applicable only to services funded by DMH.

The unit of service is one (1) complete comprehensive assessment which includes the completion of the required process and written documentation, including the treatment plan.

Consent to Treatment. Each individual served or a parent/guardian must provide informed, written consent to treatment. A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record. Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.

13.14.B(2) Qualified Providers of the Comprehensive Assessment

The CSTAR comprehensive assessment is the systematic collection of information regarding an individual’s current situation, symptoms, status, and background. An interview between an individual and a QAP or QMHP is required. Other trained staff may assist in the gathering of assessment data. However, a QAP or QMHP must review and interpret the assessment information, conduct an interview with the individual being served, and
**Develop Treatment Recommendations.** As part of the assessment, a diagnosis **must** be rendered following a diagnostic interview by a licensed diagnostician.

### 13.14.B(3) Treatment Plan

The treatment plan and treatment plan updates shall be documented in accordance with DMH regulations, unless otherwise directed by DMH.

A treatment plan must be developed for each individual admitted to CSTAR within forty-five (45) days of eligibility determination. The individual shall directly participate in the development of the treatment plan which shall reflect their unique needs and goals and include, but not be limited to:

1. Identifying information;
2. Goals expressed by the person served, with input from family members/natural supports, as appropriate, that are measurable, achievable, time-specific with start date, strength/skill based, and include supports/resources needed to meet goals and potential barriers to achieving goals;
3. Specific treatment objectives that include a start date, are understandable to the individual served, and, sufficiently specific to assess progress, responsive to the disability or concern, and reflective of age, development, culture, and ethnicity;
4. Specific interventions and services, action steps of the individual served and his or her family/natural supports, duration and frequency of interventions/services, and persons responsible for the intervention/service;
5. Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CSTAR program to be addressed through referral/services with another community organization;
6. Anticipated discharge and continuing recovery planning which includes, but is not limited to, criteria for service conclusion, how will the individual served and/or parent/guardian and clinician know treatment goals have been accomplished; and;
7. Signature, date and credentials of staff completing the treatment plan, including the licensed diagnostician.

Service delivery shall be consistent with the current state of knowledge of SUD treatment and best practices in the following areas:

1. Provision of educational information about the progressive nature of addiction and the disease model, principles and availability of self-help groups, medications for the treatment of addictions, and health and nutrition;
2. Support of personal recovery process, recognizing thought distortions and behavior, promoting self-awareness and self-esteem, encouraging personal responsibility, and constructively using leisure time;
3. Skill development, such as communication skills, stress reduction and management, coping with trauma, conflict resolution, decision-making, assertiveness training, and parenting;
4. Promotion of positive family relationships and family recovery/resiliency; and
5. Relapse recognition, prevention, and recovery.

13.14.B(4) Treatment Plan Updates

Each individual shall directly participate in the review of the treatment plan.

Treatment plan reviews shall be completed at least quarterly, and may be updated utilizing a department-approved functional assessment instrument or functional update. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

1. Documentation of the quarterly treatment plan/functional update includes, but is not limited to:

   A. Barriers, issues or problems identified by the individual, family/natural supports, parent/guardian, and/or staff that identify the need for focused services;
   B. Brief explanation of any change or progress in the daily living functional abilities in the previous ninety (90) days; and,
   C. Brief summary of subsequent changes that will be made to the treatment plan as a result of conducting this treatment plan/functional update.

At a minimum, the treatment plan update must be signed by the QAP. Other staff who participated in the update may also sign the plan. The signature of a licensed diagnostician is not required on the treatment plan update.


Requirements for completion of the intake (initial) comprehensive assessment—

1. The assessment shall be completed within thirty (30) days of the date of eligibility determination for individuals admitted to outpatient services and within seven (7) calendar days of the date of eligibility determination for individuals admitted to treatment with residential support.
2. If an individual completes treatment or leaves treatment and subsequently is readmitted to the same provider, that provider may bill for a new intake assessment if it has been more than six (6) months since the last intake assessment. If the individual is readmitted to the same provider within six
(6) months, the provider may update the existing assessment and bill one (1) unit of assessment and diagnostic update.

3. If an individual completes treatment or leaves treatment and subsequently is readmitted to a different provider, the admitting provider may bill for a new assessment, unless the individual was also at this same provider within the prior six (6) month period.

4. Intake assessments shall only be billed for the primary individual being admitted to the CSTAR program.

5. For the screening and assessment of dependent children in Women and Children’s CSTAR programs, billing is limited to a maximum of six (6) units. All documentation must support the time billed for this service.

13.14.B(6) Intake Assessment Using the ASI-MV or BHI-MV.

For adult programs, the contractor may administer the ASI-MV® or BHI-MV® instrument as a component of the individual assessment.


This comprehensive assessment, utilizing an instrument approved by DMH is used in the specialized CSTAR Program for Adolescents and may only be billed by certified CSTAR adolescent providers.


This service is an alcohol and substance use assessment to determine the need for treatment support and is verified by the physician’s signature. It is limited to two (2) units per admission to Level 1 services. A unit of service is defined as fifteen (15) minutes.

13.14.B(9) Procedure Codes for CSTAR Eligibility Determination and Assessments

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<thead>
<tr>
<th>PROCEDURE</th>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tr>
<td>H0001</td>
<td>Intake Assessment</td>
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<tr>
<td>H0001 GQ</td>
<td>Intake Assessment (using ASI-MV or BHI-MV ®)</td>
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<tr>
<td></td>
<td>Intake Assessment (using ASI-MV or BHI-MV ®) (Telemedicine)</td>
<td></td>
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<tr>
<td>H0001 GQ GT</td>
<td>Physician Certification (Telemedicine)</td>
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<tr>
<td>H0001 EP</td>
<td>Adolescent Intake Assessment</td>
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<tr>
<td>H0001 AM</td>
<td>Physician Certification</td>
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<tr>
<td>H0001 GT AM</td>
<td>Physician Certification (Telemedicine)</td>
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<tr>
<td>H0002</td>
<td>Behavioral Health Assessment (Eligibility Determination)</td>
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</tbody>
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13.14.C  Assessment and Diagnostic Update

13.14.C(1)  Description of Service for Assessment and Diagnostic Update

The purpose of this service is to assess the current bio-psychosocial functioning for an individual who previously received a comprehensive intake assessment in the prior six (6) months. The unit of service is the update event. This assessment and diagnostic update shall:

1. Include an assessment of the individual's current substance use;
2. Document needs and strengths; and,
3. Include a treatment plan and a diagnosis in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM 5-TR) of the American Psychiatric Association.

The assessment and diagnostic update is a partial assessment that is only authorized when an individual is readmitted or transferred to a CSTAR program within six (6) months from the date of prior treatment at the same SUD treatment organization that previously completed an intake assessment. The assessment and diagnostic update is authorized instead of the intake assessment when the above situation applies.

13.14.C(2)  Qualified Providers of the Assessment and Diagnostic Update

A QAP or QMHP must review and interpret the assessment information, conduct an interview with the individual, and update treatment recommendations. A new diagnostic evaluation must be rendered by a licensed diagnostician.


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13.14.D(1)  Description of Service for Day Treatment

Day treatment combines group rehabilitative support with medically necessary activities that are both structured and therapeutic and focus on providing opportunities for individuals to apply and practice healthy skills, decision-making and appropriate expression of thoughts and feelings. This service is designed to assist the individual with compensating for, or eliminating functional deficits, and
interpersonal and/or environmental barriers associated with SUDs. The intent is to restore, to the fullest extent possible, the individual to an active and productive member of his or her family, community, and/or culture. This service is provided in a group setting.

Day treatment is a comprehensive package of services consistent with the individual's treatment plan which are designed to achieve and promote recovery from a substance use disorder and improve functioning. Core components are group rehabilitative support (see Section 13.14.H) and therapeutic structured activities. These services are offered a minimum of five (five) days per week with a minimum of twenty-five (25) hours of structured programming each week. This service is only available in Community-based Primary Treatment.

A unit of service is a one (1) hour increment of direct contact with individuals by qualified providers.

13.14.D(2) Key Service Functions of Day Treatment

Key service functions of day treatment may include, but are not limited to:

1. Providing group rehabilitative support, based on individualized needs and treatment plans, designed to promote an understanding of the relevance of the nature, course and treatment of substance use disorders, to assist individuals in understanding individual recovery needs and how they can restore functionality;
2. Assisting in the development and implementation of lifestyle changes needed to cope with the side effects of addiction or psychotropic medications, and/or to promote recovery from the disabilities, negative symptoms, and/or functional deficits associated with the substance use disorder; and
3. Assisting with the restoration of skills and use of resources to address symptoms that interfere with activities of daily living and community integration.


The ratio of individuals served to staff for day treatment must not exceed one (1) staff to thirty (30) individuals (1:30).

The team consists of Group Rehabilitative Support Specialists and Day Treatment Technicians. At least one QAP or QMHP must be present at all times when day treatment services are in operation and individuals are in the day treatment facility. On evenings, weekends, and holidays, a QAP or QMHP may provide on-call coverage rather than being physically present at the treatment facility. On-call coverage must be prompt and responsive to an individuals’ needs.

Group rehabilitative support shall *not* be billed as a separate service while an individual is in day treatment.


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13.14.E(1) Description of Community Support Services

A comprehensive service designed to reduce the disability resulting from mental illness, emotional disorders, and/or SUDs, restore functional skills of daily living, build natural supports and solution-oriented interventions intended to achieve the recovery identified in the goals and/or objectives as set forth in the individualized treatment plan.

This service may be provided to the individual’s family members/natural supports when such services are for the direct benefit of the individual, in accordance with the individual’s needs and treatment goals identified in the individualized treatment plan, and for assisting in the individual’s recovery. Most contact occurs in community locations where the person lives, works, attends school, and/or socializes.

To the extent the individual is able to participate, periodic observation and monitoring shall take place in his/her home or other community location as stipulated in the individual treatment plan. Exceptions shall be documented.

Observation and monitoring shall be documented including, but not limited to:

1. Assessment of the individual’s mental health status and/or substance use;
2. Safety and home care; and
3. Functional abilities and skill transference related to activities of daily living including educating, demonstrating, observing, and practicing skills in his/her natural environment.

Community Support for adolescents is designed to coordinate and provide services and resources to adolescents and their families as necessary to promote resiliency. The focus is on teaching/modeling developmentally appropriate skills, necessary for positive self-esteem, a sense of identity, positive relationships with family and peers, social competence, and success in school. The specific skills and supports are addressed on an individualized treatment plan and are based on...
the life domains that the adolescent/family have identified as being impacted directly or indirectly by their serious emotional disturbance, or SUD, or both. A key in promoting resiliency is building on the strengths of the adolescent’s natural support system which is also a key element of the treatment plan.

A unit of service is fifteen (15) minute increments.

13.14.E(2) Key Service Functions of Community Support

Key service functions include, but are not limited to:

1. Developing recovery goals and identifying needs, strengths, skills, resources and supports and teaching individuals how to use them to support recovery, identifying barriers to recovery, and assisting individuals in the development and implementation of plans to overcome them;
2. Helping individuals restore skills and resources negatively impacted by their substance use and/or co-occurring mental illness or emotional disorder including, but not limited to:
   A. Seeking or successfully maintaining employment or volunteering including, but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance;
   B. Maintaining success in school including, but not limited to, communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identifying and addressing behaviors that interfere with school performance; and
   C. Obtaining and maintaining housing in the least restrictive setting including, but not limited to, issues related to nutrition, meal preparation, and personal responsibility;
3. Supporting and assisting individuals experiencing crises to access needed treatment services to resolve the crisis.
4. Continuing recovery planning and discharge planning with individuals receiving CSTAR services who are hospitalized for a medical or behavioral health condition;
5. Assisting individuals, other natural supports, and referral sources in identifying risk factors related to relapse in mental illness and/or SUDs, developing strategies to prevent relapse, and advising and otherwise assisting individuals in implementing those strategies;
6. Promoting the development of positive support systems by providing information to family members/natural supports, as appropriate, regarding the individual’s mental illness, emotional disorders, and/or SUDs, and
ways they can be of support to their family members’ recovery. Such activities must be directed toward the primary well-being and benefit of the individual;

7. Developing and advising individuals on implementing lifestyle changes needed to cope with the side effects of psychotropic and/or addiction treatment medications, and/or to promote recovery/resiliency from the disabilities, negative symptoms, and/or functional deficits associated with a mental illness, emotional disorder, and/or SUD; and

8. Advising individuals on maintaining a healthy lifestyle, including but not limited to, recognizing the physical and physiological signs of stress, creating a self-defined daily routine that includes adequate sleep and rest, walking or exercise, appropriate levels of activity and productivity, involvement in creative or structured activities that counteract negative stress responses, learning to assume personal responsibility and care for minor illnesses, and knowing when professional medical attention is needed.


Community Support service limitations—

1. The maximum billable for any one (1) individual per day is twenty-four (24) units. Additional units may be authorized through Clinical Review.

2. The CSTAR provider shall ensure that an adequate number of qualified staff are available to provide community support services and functions.

Caseload size may vary according to the acuity, symptom complexity, and needs of participants. An individual or the parent/guardian has the right to request an independent review by the CSTAR director if they believe individual needs are not being met. If the CSTAR director deems it necessary, caseload size or other changes may be implemented. The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by individuals. The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

13.14.E(4) Qualified Providers of Community Support

Community Support shall be provided by a Community Support Specialist (CSS.) Reference Section 13.11.F for a description of a CSS.


In order to bill for community support, written documentation must be maintained in the individual’s clinical record for each community support session, service, or
activity (see Section 13.6 of this manual). Additional documentation must include:

1. Phone contacts; and/or
2. Pertinent/significant information reported by family members/natural supports regarding a change in the individual’s condition and/or an unusual or unexpected occurrence in his/her life.


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### 13.14.F Individual Counseling

#### 13.14.F(1) Service Description for Individual Counseling

Individual counseling is a structured and goal-oriented therapeutic interaction to resolve issues related to the use of alcohol and/or other drugs that interfere with the individual’s functioning. This includes, but is not limited to, evidence-based or promising practices such as motivational interviewing (MI), cognitive behavioral therapy (CBT), and trauma-specific services.

1. Motivational Interviewing (MI) is a goal-oriented, person-centered counseling style for eliciting behavioral change by helping individuals to explore and resolve ambivalence. This approach upholds four principals which are expressing empathy and avoiding arguing; developing discrepancy; rolling with resistance; and supporting self-efficacy.
2. Cognitive Behavioral Therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, SUDs, marital problems, eating disorders, and severe mental illness. CBT usually involves efforts to change thinking patterns.

A unit of service is fifteen (15) minute increments.

#### 13.14.F(2) Key Service Functions of Individual Counseling

Key service functions of individual counseling may include, but are *not* limited to:

1. Exploration of an identified problem and its impact on individual functioning;
2. Examination of attitudes and feelings, and behaviors that promote recovery and improved functioning;
3. Identification and consideration of alternatives and structured problem-solving;
4. Discussion of skills to aid in making positive decisions;
5. Application of information presented in the program to the individual’s life situations to promote recovery and improved functioning; and
6. Discussion of harm reduction strategies to reduce substance use, lower health risk complications, such as hepatitis C, and reduce overdose deaths.

13.14.F(3) Qualified Providers of Individual Counseling

Individual counseling shall be provided by a QAP, QMHP, an Associate Substance Use counselor, LMHP, or an intern/practicum student as specified in 9 CSR 10-7.110(5).

13.14.F(4) Trauma Individual Counseling

Trauma individual counseling is defined as counseling provided to the primary individual in accordance with the treatment plan to resolve issues related to psychological trauma in the context of SUDs. Personal safety and empowerment of the individual must be addressed.

Trauma individual counseling shall be provided by a licensed mental health professional (LMHP). Qualified staff must have specialized trauma training and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.


Co-occurring disorder individual counseling is structured and goal-oriented therapeutic interaction between an individual and a counselor designed to identify and resolve issues related to substance use and co-occurring mental illness.

Co-occurring disorder individual counseling shall be provided by—

1. An LMHP; or
2. A person certified by the Missouri Credentialing Board (MCB) as a professional working in co-occurring disorders who is practicing within their current competence.


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PRODUCTION : 09/08/2022

13.14.G(1) Service Description for Group Counseling

Group counseling is a goal-oriented therapeutic interaction between a counselor and two (2) or more individuals based on needs and goals specified in individual treatment plans. Services shall be designed to promote individual functioning and recovery through personal disclosure and interpersonal interaction among group members. This service can include trauma-related symptoms, co-occurring behavioral health, and SUDs.

Evidence-based practices, such as motivational interviewing and cognitive behavioral therapy shall be utilized by appropriately trained staff.

The unit of service is fifteen (15) minute increments.

13.14.G(2) Key Service Functions of Group Counseling

Key service functions of group counseling include, but are not limited to:

1. Facilitate individual disclosure of substance use-related issues which permits generalization of the issues to the larger group;
2. Promote recognition of thought distortions and behaviors and teaching strategies that support non-use of alcohol and/or other drugs that interfere with the individual’s functioning;
3. Prepare individuals to cope with physical, cognitive, and emotional symptoms of craving alcohol and/or other drugs;
4. Encourage and model productive and positive interpersonal communication;
5. Develop motivation and action by group members through peer influence, structured confrontation, and constructive feedback; and
6. Discussion of harm reduction strategies to reduce substance use, lower health risk complications, such as hepatitis C, and reduce overdose deaths.

13.14.G(3) Qualified Providers of Group Counseling

Group counseling services shall be provided by a QAP, LMHP, QMHP, an associate substance use counselor, or an intern/practicum student as specified in 9 CSR 10-7.110(5).


For each group session, a group log or documentation in the individual record (paper or electronic) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of group,
each individual’s in and out time, and the signature, date, and title/credential of the staff member providing the service. Signature stamps shall not be used.


Group averages are calculated per site.

The usual and customary group size is twelve (12) individuals. The size of group counseling sessions cannot exceed an average of twelve (12) individuals, per calendar month, per facilitator, per group.


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Group rehabilitative support consists of facilitated group discussions, based on individual needs and treatment plan goals, designed to promote an understanding of the relevance of the nature, course, and treatment of SUDs, to assist individuals in understanding their recovery needs and how they can restore functionality.

The unit of service is fifteen (15) minute increments.


Key service functions of group rehabilitative support may include, but are not limited to:

1. Classroom style didactic lecture to present information about a topic and its relationship to substance use;
2. Presentation of audio-visual materials that are educational in nature with required follow-up discussion, and are relevant to the individual’s needs and treatment plan. Instructional aids shall be incorporated to enhance understanding and promote discussion and interaction among individuals. Aids may include, but are not limited to, videos or other electronic media,
worksheets, and informational handouts and shall not comprise more than twenty percent (20%) of group rehabilitative support sessions;
3. Promotion of discussion and questions about the topic presented to the individuals in attendance; and
4. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning.

The agency must develop a schedule and curriculum for delivery of group rehabilitative support addressing topics and material relevant to the individuals served. Individuals should only attend groups with topics that are relevant for their needs based on the assessment and the interventions recommended on their individual treatment plan.


Group rehabilitative support shall be provided by a Group Rehabilitation Support Specialist who is present throughout the session and—

1. Is suited by education, background, or experience to present the information being discussed;
2. Demonstrates competency and skill in facilitating group discussions; and
3. Has knowledge of the topic(s) being taught.


A group log or documentation in the individual record (paper or electronic format) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual’s in and out time, and the signature, date, and title of the staff member providing the service. Signature stamps shall not be used.

A separate record for a family member is not required if group rehabilitative support is the only service provided by a program that is funded by/contracted with the department. Documentation of group rehabilitative support sessions and the participating family member(s) shall be maintained.


Group rehabilitative support service limitations—

1. Group Rehabilitative Support shall not be billed for individuals receiving day treatment (Level I) services, unless otherwise authorized by DMH; and
2. The size of group rehabilitative support cannot exceed an average of thirty (30) individuals, during a calendar month, per facilitator, per group. Group averages are calculated per site.

Trauma group rehabilitative support shall consist of the presentation of recovery and trauma-related information and its application to individuals along with group discussion in accordance with individualized treatment plans. Groups are gender-specific.

Trauma group rehabilitative support must be provided by staff with specialized training in trauma and substance use.

Group size shall not exceed an average of thirty (30) individuals during a calendar month, per facilitator, per group. Group averages are calculated per site.


A group log or documentation in the individual record (paper or electronic format) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual’s in and out time, and the signature, date, and title of the staff member providing the service. Signature stamps shall not be used.


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13.14.I(1) Service Description for Family Therapy

Service consists of counseling or family based therapeutic interventions such as role playing, psychoeducational discussions) for the primary individual and/or one or more family members/natural supports. It is designed to address and resolve patterns of dysfunctional communication and interactions that have become engrained over time, particularly as it relates to the impact of substance use. It is delivered by specialized staff in accordance with the primary individual’s treatment plan. One or more family members/natural supports of the individual must be present. Service can be offered to members of a single family, or members of multiple families dealing with similar issues.
Services to the individual’s family members/natural supports is for the direct benefit of the individual, in accordance with the individual’s needs and treatment goals identified in the treatment plan, and for the purpose of assisting in the individual’s recovery.

The unit of service is 15-minute increments of direct contact with an individual by a qualified provider.

13.14.I(2)  Key Service Functions of Family Therapy

Key service functions of family therapy include, but are not limited to—

1. Utilization of generally accepted principles of family therapy to influence family interaction patterns;
2. Examination of family interaction styles and confronting patterns of dysfunctional behavior, and strengthening communication patterns that promote healthy family function;
3. Facilitation of family participation in family self-help recovery groups;
4. Development and application of skills and strategies for improvement in family functioning; and,
5. Promotion of healthy family interactions independent of formal helping systems.

13.14.I(3)  Qualified Providers of Family Therapy

Family therapy shall be provided by a person who—

1. Is licensed in Missouri as a marital and family therapist; or
2. Has a degree in marriage and family therapy, psychology, social work, or counseling; and—
   A. Has at least one (1) year of supervised experience in family therapy and has specialized training in family therapy; or
   B. Receives close supervision from a professional who meets the requirements of 1. and 2. above; or
3. A QAP who receives close supervision from a professional who meets the requirements of 1. and 2. above.


Family therapy service limitations—

1. In any calendar month, for fifty percent (50%) of an individual's family therapy, the primary individual must be present, in addition to one (1) or more family members/natural supports. Family members below the age of twelve (12) can be counted as one (1) of the required family members when the child is shown as having the requisite social and verbal skills to participate in and benefit from the service.
2. Driving time to and from the individual’s home for the purpose of in-home therapy or assessment is not reimbursable.


The service episode note documenting family therapy must clearly state the relationship of the family members/natural supports to the individual receiving MO HealthNet/CSTAR services.


Family conference is a substance use intervention service that enlists the support of the individual’s natural support system through meeting with family members, referral sources, and other natural supports about the individual’s treatment plan, continuing recovery plan, and discharge plan. The service must include the individual served and be for his/her direct benefit in accordance with the needs and goals identified in the individual’s treatment plan and for assisting in the individual’s recovery.

13.14.J(2) Key Service Functions of Family Conference

Key service functions include, but are not limited to:

1. Communicating about issues in the individual’s home that are barriers to achieving treatment plan goals;
2. Identifying relapse triggers and establishing a continuing recovery plan;
3. Participating in continuing recovery and discharge planning conferences; and,
4. Assessing the need for family therapy or other referrals to support the family system.

Family conference does not replace family therapy, which continues to be a more specialized clinical service delivered by qualified personnel as established in section 13.14.I(3) above. The unit of service is fifteen (15) minute increments.

13.14.J(3) Qualified Providers of Family Conference

Family conference is provided by a QAP, QMHP, LMHP, or an Associate Substance Use Counselor.


This service is limited to a maximum of eight (8) units per week, per individual. Additional units may be authorized through Clinical Review.

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13.14.K(1) Service Description for Collateral Dependent Counseling

Collateral dependent counseling is the planned, goal-oriented therapeutic interaction with an individual, or group of individuals, to address dysfunctional behaviors and life patterns associated with being a family member/natural support of an individual who has a substance use disorder and is currently participating in treatment.

Collateral contacts are a source of information regarding the individual’s health, safety, functional needs, or effectiveness of the individual’s plan for services. Communication with a collateral contact may be made face to face, by phone, or by telehealth platforms.

Examples of collateral contacts that can be utilized to promote the recovery of an individual in services include, but are not limited to:

1. Family members;
2. Therapeutic providers from other agencies providing services;
3. Pediatricians, family doctors, clinics, medical care specialists, other health care providers;
4. Pharmacy staff;
5. Legal agency affiliates (probation or parole officers);
6. Education facilities; and
7. Legal guardians.

The unit of service is fifteen (15) minutes.

13.14.K(2) Key Service Functions of Collateral Dependent Counseling

Key service functions of collateral dependent counseling include, but are not limited to—

1. Exploration of SUDs and its impact on the family member’s functioning;
2. Development of coping skills and personal responsibility for changing one's own dysfunctional patterns in relationships;
3. Examination of attitudes, feelings, and long-term consequences of living with a person with anSUD;
4. Identification and consideration of alternatives and structured problem-solving;
5. Productive and functional decision-making; and
6. Development of motivation and action by group members through peer support, structured confrontation, and constructive feedback.

13.14.K(3) Qualified Provider of Collateral Dependent Counseling

Individual and group collateral dependent counseling shall be provided by a person who meets requirements as a marital and family therapist (reference Section 13.11.M or QAP practicing within their current competence.

For specialized Women and Children CSTAR programs, wherein the screening of dependent children is required, individual collateral dependent counseling may be billed to conduct the screening and subsequent assessment activities.


Collateral dependent counseling service limitations—

1. This service is only provided to an individual who is a member of the primary individual’s family when such services are for the direct benefit of the individual, in accordance with his/her needs and goals identified in the treatment plan, and for assisting in the individual’s recovery. The primary individual is not present in collateral dependent counseling. Collateral dependent group counseling may consist of up to twelve (12) family members of multiple primary individuals’ families.
2. Collateral dependent counseling may be provided to children five (5) years and younger only when the child is shown to have the requisite social and verbal skills to participate in and benefit from the service.
3. The size of group collateral dependent counseling sessions that include only family members shall not exceed an average of twelve (12) individuals per calendar month, per facilitator, per group. Sessions may involve family members of multiple individuals engaged in treatment.


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PRODUCTION : 09/08/2022
13.14.L  Medication Services

13.14.L(1) Description for Medication Services

A medication service consists of a goal-oriented interaction to assess the appropriateness of medications in an individual’s treatment, periodic evaluation/reevaluation of the efficacy of prescribed medications, and ongoing management of a medication regimen within the context of the individual’s treatment plan.

13.14.L(2) Key Service Functions of Medication Service

Key service functions of medication services include, but are not limited to:

1. Assessment of the individual’s presenting condition;
2. Mental status exam;
3. Review of symptoms and screening for medication side effects;
4. Review of functioning;
5. Assessment of the individual’s ability to self-administer medications;
6. Education regarding the effects of medication and its relationship to the individual’s SUD and/or mental illness; and
7. Prescription of medications, when indicated.

13.14.L(3) Qualified Providers of Medication Services

Medication services shall be provided by a licensed physician, licensed psychiatrist, physician assistant, assistant physician, or APRN who is in a collaborative practice agreement with a licensed physician.


The medication service limitations are as follows:

1. CPT procedure codes 99202-99205 and 99212-99215 are per event codes and limited to one (1) unit per day, per individual. These procedure codes may be billed on the same date of service for the same individual as any of the other procedure codes.
2. CPT procedure code 90792 is a fifteen (15) minute unit of service and is limited to two (2) hours (8 units) per day, per individual and three (3) hours, twelve (12 units), per year per individual. None of these procedure codes may be billed on the same date of service for the same individual as any of the other procedure codes.
3. Medication services may be provided via Telemedicine.

Please refer to Section 19 of the CSTAR Manual for a complete listing of medication services procedure codes. Use of the appropriate E/M code based upon the complexity of the visit, and that documentation supports the level chosen.


This service consists of medical and other consultative services provided by an RN or LPN for the purposes of monitoring and managing an individual’s health needs while taking medications.

13.14.M(2) Qualified Providers of Medication Services Support

The qualified providers are a registered nurse (RN) or licensed practical nurse (LPN) licensed under Missouri law to practice nursing.


Medication Services Support limitations—

The unit of service is fifteen (15) minutes.

Medication services support may be provided to collateral dependents also enrolled in the CSTAR program and such units are billed to the mother’s episode of care.


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Withdrawal management is the process of withdrawing an individual from a specific psychoactive substance (alcohol, illegal substances, and/or prescription medications) in a safe and effective manner to restore the individual to the functionality of someone not under the influence of substances or alcohol. This
service consists of the provision of care to individuals whose intoxication or withdrawal signs and symptoms are sufficiently severe to require twenty-four (24) hour supervised medical care and monitoring; however, the full resources of a hospital setting are not necessary. This service is provided in a residential setting, of sixteen (16) beds or less, certified by the DMH; however, this service does not include the provision of room and board.

The unit of service for medically monitored withdrawal management is one (1) day. The day the individual is admitted to medically monitored withdrawal management counts as day one. Thereafter, every day the individual is present past midnight will count as an additional day.


1. Medically supervised monitoring of vital signs, health status, and withdrawal symptoms;
2. Medication management; and
3. Referral to ongoing treatment following successful detoxification.

13.14.N(3) Provider Eligibility

1. Providers must be certified by the DMH to provide Medically Monitored Withdrawal Management services in accordance with 9 CSR 30-3.120;
2. Providers must be contracted with the DMH to provide CSTAR services; and
3. The full resources of a general acute hospital must be available through a written local agreement in the event hospitalization of an individual is required during the withdrawal management process.


1. A physician, physician assistant, assistant physician, or APRN who is on call twenty-four (24) hours per day, seven (7) days per week to provide medical evaluation and ongoing withdrawal management;
2. Licensed nursing staff must be present twenty-four (24) hours per day;
3. An RN with relevant education, experience, and competency must be available on site or by phone for twenty-four (24) hour supervision’
4. A minimum of two (2) Substance Use Recovery Aides with specific training related to withdrawal that provide continuous supervision and safety of individuals receiving care;
5. A physician, physician assistant, assistant physician, or APRN must provide medication management;
6. A physician, physician assistant, assistant physician, APRN, RN, or LPN must provide medically supervised monitoring of vital signs, and referral for ongoing treatment; and
7. All practitioners on the team may provide medically supervised monitoring of health status and withdrawal symptoms.


To be eligible for medically monitored withdrawal management services, an individual must

1. Present symptoms of intoxication, impairment, or withdrawal; and,
2. Require supervision and monitoring of physical and mental status to ensure safety.

An individual is eligible for medically monitored withdrawal management services if one (1) or more of the following additional criteria are met:

1. Significant intoxication that impairs ability to minimally care for self;
2. Significant intoxication and/or impairment and lacking a supportive, safe environment, and therefore at risk of continued use of substances;
3. Significant intoxication and/or impairment requiring ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal; or,
4. Presents a likelihood of harm to self or others as a result of intoxication, impairment, or withdrawal.

Exclusion criteria include the presence of acute medical or psychiatric conditions requiring hospitalization.

In the event the agency determines the individual is no longer appropriate to receive services in the medically monitored withdrawal management setting because of potentially acute medical needs, the agency shall refer these individuals to a hospital.


All costs associated with the provision of services to an individual while in the medically monitored withdrawal management level are included in the established per diem rate with the exception of the following:

1. Laboratory services; and
2. Prescription medications used specifically in the withdrawal process and medications prescribed for the treatment of addictions. Prescription medications must be obtained via the MO HealthNet pharmacy benefit.

Individuals must meet clinical eligibility requirements established by the DMH.

Programs that provide medically monitored withdrawal management services are limited to sixteen (16) beds or less.

Length of stay in a medically monitored withdrawal management program is limited to five (5) days. Additional days may be authorized through Clinical Review.


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13.14.O Opioid Treatment Program

13.14.O(1) Eligibility for Certification

Prior to delivering services, the organization must be certified as an opioid treatment program (OTP) by the DMH. The DMH is approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a nationally recognized accreditation body for OTPs.

The program shall comply with applicable local, state, and federal laws and regulations including those under the jurisdiction of the U.S. Food and Drug Administration (FDA), the U.S. Drug Enforcement Administration (DEA), the Department of Health and Human Services (DHHS), SAMHSA, and the Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (BNDD).

13.14.O(2) Program Administration

Each program must have a medical director who is a Missouri-licensed physician. The medical director is responsible for overseeing all medical services provided by the OTP, performing them directly or by delegating specific responsibilities to an authorized program physician and healthcare professionals functioning under his/her direct supervision.

Other responsibilities of the medical director include, but are not limited to:
1. Ensuring individuals meet admission criteria and receive the required physical examinations and laboratory testing;
2. Prescribing methadone and other FDA-approved medications to treat addiction with the individual’s input, ensuring the prescribed dosage of medication is appropriate to his/her needs;
3. Reviewing and signing each individual’s initial treatment plan and reviewing and updating the plan based on individual needs; and
4. Coordinating care and consult with each individual’s clinical treatment team on a regular basis.

The OTP shall have a program sponsor who is responsible for the general establishment, certification, accreditation, and operation of the program, ensuring it is in continuous compliance with all federal, state, and local laws and regulations related to the use of opioid agonist and partial agonist treatment medications in the treatment of opioid use disorder.

All OTP direct service and medical staff shall receive a minimum of four (4) clock hours of training every two (2) years relevant to service delivery in an opioid treatment setting.

OTPs shall maintain and implement a written diversion control plan as part of its performance improvement process. The plan shall contain specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use. Medical and administrative staff of the program shall be assigned to implement the diversion control measures and functions described in the diversion control plan.

The program shall ensure the security of its medication supply and shall account for all medications kept on site at all times, including the following:

1. Meet the requirements of the DEA and BNDD;
2. Maintain an acceptable security system, including checking the system on a quarterly basis to ensure continued safe operation;
3. Physically separate the narcotic storage and dispensing area from other parts of the facility used by individuals;
4. Implement written policies and procedures to ensure positive identification of all individuals before any medication is administered, including a minimum of two (2) forms of identification; and
5. Implement written policies and procedures for recording each individual’s medication intake and maintaining a daily medication inventory.

13.14.O(3) Eligibility and Admission Criteria for Opioid Treatment

The program shall provide treatment and rehabilitation, which includes the use of FDA-approved medications for the treatment of opioid use disorders, to individuals who demonstrate physiologic dependence to heroin and other opiates.
Programs shall ensure that admission criteria, as outlined in 9 CSR 30-3.132(5), are met for individuals enrolled in services. Exceptions for admission requirements are established in 9 CSR 30-3.132(5) for women who are pregnant, individuals released from a correctional facility with a documented history of opioid use disorder (within six (6) months after release), and individuals who have been previously treated, up to two (2) years after discharge.

If the OTP is unable to assess and admit an individual who uses intravenous drugs within forty-eight (48) hours of receiving such a request, interim services shall be available in accordance with department contract requirements.

Interim maintenance treatment, as defined in 9 CSR 30-3.132(16), shall be available for individuals who are eligible for treatment but cannot be immediately admitted to the OTP where services are being sought or through referral arrangements with another OTP.

Individuals seeking treatment who are eligible for MO HealthNet benefits and do not meet priority population criteria shall be given an appointment in a timely manner and shall not be placed on a wait list.

The program shall adhere to the admission and assessment protocol outlined in 9 CSR 30-3.132(6)—

1. Verify the individual is not enrolled in another opioid treatment program;
2. Obtain the individual’s signature for consent to treat, ensuring the individual understands all risks, benefits, and requirements;
3. Conduct a complete and fully documented physical evaluation, including results of serology and other tests (within fourteen (14) days of admission); and
4. Screen to determine the risk of undiagnosed conditions such as hepatitis C, HIV, sexually transmitted infections, cardiopulmonary disease, and sleep apnea to determine if further diagnostic testing such as laboratory analysis, a cardiogram, or others are needed.

13.14.O(4) Service Delivery in Opioid Treatment Programs

The Opioid Treatment Program (OTP) is designed to alleviate adverse physiological and psychological effects associated with an individual’s withdrawal from the sustained use of opiates. OTPs shall only utilize medications approved by the FDA for the treatment of opioid use disorder. Opioid agonist, partial agonist, and antagonist treatment medications shall be administered and dispensed by a practitioner licensed in Missouri and registered under the appropriate state and federal laws to administer or dispense opioid treatment drugs. Written policies and procedures shall be maintained to ensure dosage requirements, as specified in 9 CSR 30-3.132(2), are met.
If a prescription drug monitoring program (PDMP) is available, the program physician and other staff, as permitted, shall register and utilize the PDMP in accordance with federal, state, and local regulations. Policies and procedures shall be maintained regarding use of the PDMP information for diversion control planning.

The program shall provide a range of treatment and rehabilitation services, as defined in 9 CSR 30-3.110, to address the therapeutic needs of individuals served. Services shall include, but are not limited to:

1. Communicable disease counseling;
2. Community support;
3. Peer Support;
4. Continuing recovery and discharge planning, as defined in 9 CSR 10-7.030(8);
5. Crisis prevention and intervention;
6. Drug testing;
7. Family conference;
8. Family therapy;
9. Group counseling, including trauma and co-occurring disorders;
10. Group rehabilitative support;
11. Individual counseling, including trauma and co-occurring disorders;
12. Pre- and post-test counselling;
13. Medication services;
14. Medication services support; and
15. Medical evaluations, as specified in 9 CSR 30-3.132.

Services must be provided by qualified staff as specified in this manual and 9 CSR 30-3.110.

The program shall offer services at least six (6) days per week. Medical and psychosocial services shall be available during early morning and/or evening to ensure individuals have access to services.

All medical services shall be offered and occur simultaneously with clinical therapy, education, development of positive social supports, and ongoing treatment and rehabilitation for substance use disorders and related life problems.

OTPs shall directly provide, or make available through referral to adequate and reasonably accessible community resources, other support services including, but not limited to, rehabilitation, education, and employment for individuals who request such services or have been determined by program staff to be in need of these services.

Information and education shall be provided in areas such as community resources, substance use disorders, and behavioral health disorders.
OTPs shall provide information and education to individuals on prevention and transmission of HIV-related conditions, and provide or arrange HIV testing and pre- and post-test counseling. The program shall also provide or arrange testing for TB, hepatitis C, and sexually transmitted infections upon admission and at least annually thereafter.

The program shall arrange medical care for women during pregnancy, if necessary, and document the arrangements made and action taken by the individual.

To limit the potential for diversion of opioid agonist treatment medications to the illicit market, opioid agonist treatment medications dispensed to individuals for unsupervised approved use (take-home) shall be subject to the following requirements:

1. During the first ninety (90) days of treatment, the take-home supply is limited to a single dose each week and the individual shall ingest all other doses under appropriate supervision;
2. In the second ninety (90) days of treatment, the take-home supply is two (2) doses per week;
3. In the third ninety (90) days of treatment, the take-home supply is three (3) doses per week;
4. In the remaining months of the first year, an individual may be given a maximum six- (6-) day supply of take-home medication.
5. After one (1) year of continuous treatment, an individual may be given a maximum two- (2-) week supply of take-home medication.
6. After two (2) years of continuous treatment, an individual may be given a maximum one- (1-) month supply of take-home medication, but must make monthly visits to the program.

Treatment program decisions on dispensing opioid treatment medications to individuals for unsupervised use shall be determined by the medical director. The time in treatment requirements are minimum reference points after which an individual may be considered for take-home medication privileges. The time references do not mean an individual in treatment for a particular time has a specific right for approval of take-home medication.

Any deviation from the regulations for unsupervised use of methadone as specified in this rule requires prior approval from the state opioid treatment authority (SOTA), or his/her designee, and/or SAMHSA.

In determining which individuals may be permitted unsupervised use, the medical director shall consider the following take-home criteria in determining whether an individual is responsible in handling opioid drugs for unsupervised use:

1. Absence of recent use of substances (opioid or non-narcotic), including alcohol;
2. Regularity of program attendance;
3. Absence of serious behavioral issues at the program;
4. Absence of known recent involvement in the justice system, such as drug infractions;
5. Stability of the individual’s home environment and social relationships;
6. Length of time in comprehensive maintenance treatment;
7. Assurance that take-home medication can be safely stored within the individual’s home; and
8. Whether the rehabilitative benefit the individual derives from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

Individuals in short-term detoxification treatment or interim maintenance treatment shall not receive methadone for unsupervised use.

Determinations for unsupervised use, and the basis for such determinations, shall be documented in the individual's medical record. If it is determined that an individual is responsible in handling opioid drugs, the dispensing restrictions set forth in paragraph above of this section apply. The dispensing restrictions do not apply to buprenorphine and buprenorphine products.

Individuals who travel, but do not meet the criteria for take-home medication as specified above, should be considered for guest medication in accordance with the 2020 Guidelines for Guest Medications published by the American Association for the Treatment of Opioid Dependence, 225 Varick St., Suite 402, New York, NY 10014, (212) 566-5555.

Guest medication provides a mechanism for individuals to travel from their home program for business, pleasure, or family emergencies. It also provides an option for individuals who need to travel for a period of time that exceeds the amount of eligible take-home doses to do so within regulatory requirements. Individuals shall be on a stable dose of methadone and not be scheduled for a dose increase or decrease during guest medication, and must be medically and psychiatrically stable.

The program shall implement written policies and procedures to address continuity of care for individuals who are unable to participate in regularly scheduled visits for observed ingestion of medication due to illness, pregnancy, participation in residential treatment, incarceration, lack of transportation, or other situations. A chain-of-custody process shall be implemented to document the transportation, delivery, administration, and observation of medication when an individual is unable to report to the program as required.

The program shall use drug testing as a clinical tool for purposes such as diagnosis and treatment planning. Each individual shall have an initial toxicology test as part of the admission process. At a minimum, admission samples shall be
analyzed for opiates, methadone, marijuana, cocaine, barbiturates, benzodiazepines, buprenorphine, amphetamines, fentanyl, and alcohol.

If there is a history of misuse of prescription opioid analgesics, an expanded toxicology panel that includes these opioids shall be administered. Additional testing shall be based on individual needs and local drug use patterns and trends.

Random drug testing of each individual in maintenance treatment shall be conducted at least eight (8) times during a twelve- (12-) month period.

Individuals engaged in long-term withdrawal management shall receive an initial drug test and a monthly random test. Individuals engaged in short-term withdrawal management shall have at least one (1) initial drug test.


Written policies and procedures shall be maintained and implemented to address the needs of women who are pregnant and postpartum. Prenatal care and other gender-specific services for women who are pregnant must be provided by the OTP or by referral to an appropriate healthcare provider.

For pregnant women who are receiving methadone or buprenorphine, the program shall have written policies and procedures in place to ensure—

1. The initial dose of medication for a newly admitted woman who is pregnant, and the subsequent induction and maintenance dosing strategy, reflect the same effective dosing protocols used for all other individuals;
2. The methadone dose is carefully monitored, especially during the third (3rd) trimester when pregnancy induces changes such as the rate at which methadone is metabolized or eliminated from the system, potentially necessitating either an increased or a split dose; and
3. Women who become pregnant during treatment are maintained at their pre-pregnancy dosage, if effective, and are managed with the same dosing principles used with women who are not pregnant.

Women who are pregnant are eligible to receive ongoing maintenance treatment up to one (1) year postpartum, including evaluation of their current dose to determine if an adjustment is needed during the postpartum period. Women shall be offered education about signs and symptoms of oversedation which may occur after delivery.

Medically supervised withdrawal after pregnancy shall occur as clinically indicated and documented, or is requested by the individual. When a planned discharge occurs, OTP staff shall document the contact information of the physician or other authorized healthcare professional to whom the individual has been referred, including the reason for discharge. Mothers shall be educated about
neonatal abstinence syndrome (neonatal opioid withdrawal syndrome), its symptoms, potential effects on their infant, the benefits of breastfeeding, and need for treatment if it occurs.


Administrative withdrawal is typically involuntary and shall be used only when all other therapeutic options have been exhausted by program staff. OTPs may refer or transfer individuals to a suitable alternative treatment program, as clinically indicated. Missing scheduled appointments and/or continued drug use shall not be the sole reason for initiating involuntary withdrawal for an individual being served.

If involuntary withdrawal is initiated for an individual, the program shall follow the criteria included in the January, 2015 Federal Guidelines for Opioid Treatment Programs incorporated by reference and made a part of this rule as published by SAMHSA, Center for Substance Abuse Treatment, 1 Choke Cherry Rd., Rockville MD 20857, (877) 726-4727, publication number (SMA) PEP15-FEDGUIDEOTP.


The program shall maintain and implement written policies and procedures to ensure individuals are admitted to short- or long-term withdrawal management (as defined in 42 CFR section 8.2.) by qualified staff, such as the program physician, who determines such treatment is appropriate by applying established diagnostic criteria. Medically supervised withdrawal may be voluntary or involuntary.

The individual’s treatment plan and continuing recovery plan shall include a strategy to transition to another form of medication, if needed. Review of the risks and benefits of withdrawal from maintenance therapy shall be provided, and informed written consent shall be obtained from individuals who voluntarily choose this treatment option.

Individuals shall be educated about the risks of a recurrence of symptoms and potential for fatal overdose following medically supervised withdrawal, and be offered relapse prevention services that includes counseling, naloxone, and opioid antagonist therapy. A variety of supportive options shall be offered as part of the transition from opioid agonist therapy, such as increased counseling sessions prior to discharge, and individuals shall be encouraged to attend a twelve- (12-) step or other mutual-help program sensitive to the needs of individuals receiving treatment with medication.

Individuals with two (2) or more unsuccessful withdrawal management episodes within a twelve- (12-) month period must be assessed by the program physician for other forms of treatment. A program shall not admit an individual for more than two (2) withdrawal management episodes in one (1) year.

Voluntary medically supervised withdrawal may be initiated by the person served or the program physician in collaboration with the individual as part of individualized treatment planning.

As deemed clinically appropriate, women shall have a pregnancy test and the results reviewed prior to initiation of medically supervised withdrawal. For women who are pregnant, the physician shall not initiate withdrawal before fourteen (14) weeks or after thirty-two (32) weeks of pregnancy. If an individual experiences intolerable withdrawal symptoms or actual or potential return to use, the physician shall consider stopping the withdrawal process and restoring the individual to a previously effective dose. In collaboration with the individual served, the physician shall determine if an additional period of maintenance is necessary before further medically supervised withdrawal is attempted.

Regardless of whether medically supervised withdrawal is conducted with or against medical advice (AMA), careful review of the risks and benefits of withdrawal from maintenance treatment must be provided to the individual and informed written consent obtained from those who choose to initiate medically supervised withdrawal.


Individuals who request voluntary medically supervised withdrawal from medication treatment AMA of the physician or program staff, may receive it. Individuals have the right to leave treatment when they choose to do so. The same services that are available to individuals engaged in voluntary medically supervised withdrawal shall be offered to individuals choosing medically supervised withdrawal AMA.

The program must fully document the issue(s) that caused the individual to seek discharge, steps taken to avoid discharge, and the circumstances of readmission, as applicable. In the case of a woman who is pregnant, the program must keep the physician or agency providing prenatal care informed, consistent with the privacy standards of 42 CFR section 2.


Any deviation from the OTP regulations requires prior approval from the State Opioid Treatment Authority (SOTA)/designee and/or SAMHSA. Requests must be submitted on the Exception Request and Record of Justification form (SMA-168), SAMHSA, 5600 Fishers Ln., Rockville, MD 20857, (240) 276-2710.

OTPs shall follow department requirements for submitting form SMA-168 to the SOTA/designee and or/SAMHSA. Failure to submit the completed form and
obtain prior approval from the SOTA/designee and/or SAMHSA constitutes a regulatory violation which may jeopardize the OTP’s accreditation and certification status.

SAMHSA and the SOTA/designee must be notified of any change to the OTP sponsor or medical director within three (3) weeks of the change by submitting SAMHSA form SMA-162 in accordance with established procedures.


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The unit of service is one (1) opioid (methadone) administration/service per day. Refer to the CSTAR procedure codes in Section 19 for other billable services.

13.14.P Adolescent Treatment Support


Assist, promote and support children in a therapeutic supervised substance- and alcohol-free setting to take personal responsibility for their daily interactions with peers, and to encourage implementation of the coping mechanisms they are developing, to restore them to their full functionality, without the influence of substances and alcohol. Adolescent treatment support would be available to children under 21 years of age determined to need SUD treatment and for whom this service is clinically appropriate. Children under age 21 years determined to have medically necessary needs that cannot be met with adolescent treatment support will be referred for additional Medicaid covered services appropriate for their age and clinical need.

Adolescent treatment support is a per diem unit of service.


In order to fully participate in and benefit from the intensive set of services offered in adolescent treatment support, an individual must meet the following admission and eligibility criteria:

1. Is age twelve (12) through seventeen (17) years;
2. Does not demonstrate symptoms of intoxication, impairment or withdrawal that hinders or prohibits full participation in treatment services;
3. Needs an alternative, supervised living environment to ensure safety and protection from harm;
4. Meets the general treatment eligibility requirement of a current diagnosis of SUD (excluding tobacco use disorder) and, in addition, demonstrates one or more of the following:
   A. Recent patterns of extensive or severe substance use;
   B. Inability to establish a period of sobriety without continuous supervision and structure;
   C. Presence of significant resistance or denial of an identified SUD;
   or
   D. Limited recovery skills and/or support system.

An individual may qualify for transfer from outpatient to a treatment support setting if the person—

   1. Has been unable to establish a period of substance-free behavior despite active participation in the most intensive set of services available on an outpatient basis; or,
   2. Presents imminent risk of serious consequences associated with substance use.


Adolescent treatment support is the provision of structured and safe monitoring and oversight in a therapeutic, supervised substance- and alcohol-free setting.


1. Remind and assist adolescents to utilize their self-management strategies as they interact with peers during daily living activities;
2. Support the practical aspect of treatment such as assuring adolescents are adhering to daily domicile rules (e.g. showering, meals, attending educational activities, etc.);
3. Assist with communication and conflict resolution as adolescents interact with peers during structured activities; and
4. Monitor the pattern of behaviors exhibited by each adolescent throughout the day for signs of risky behaviors, changes in mood, or changes in physical appearance.


Services shall be responsive to the needs of individuals served. There shall be a current schedule of program activities that offers a minimum of fifty (50) hours of structured, therapeutic activity per week.

1. Therapeutic activities shall be provided seven (7) days per week;
2. Group rehabilitative support and group counseling *must* constitute at least twenty (20) of the required hours of therapeutic activity per week; and

3. At least one (1) hour of individual counseling per week shall be available to each individual. Additional individual counseling shall be available in accordance with the individual's needs.

The program *must* provide or arrange for a history and physical examination performed by a physician.


Counseling, education, medication services, community support, and medication services support *must* be provided by qualified staff of the Adolescent Treatment Team specified in Section 13.11.A of this manual.

Service delivery staff shall—

1. Have training and demonstrate expertise regarding the treatment of both SUDs and other disorders related to adolescents; and,
2. Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.

Staffing Patterns. The following minimum individual-to-staff ratios shall be maintained at all times adolescents are present in a treatment support program:

1. At a program with six (6) individuals or less, one (1) staff member *must* be providing supervision of individuals during program hours and also during designated individual sleeping hours;
2. At a program with seven (7) to twelve (12) residents, two (2) staff members *must* be providing supervision of individuals during program hours and also during designated individual sleeping hours;
3. At a program with thirteen (13) to sixteen (16) individuals, three (3) staff members *must* be providing supervision of individuals during program hours, with a required ration of two (2) staff during designated individual sleeping hours; and
4. In co-ed programs, the staffing pattern shall include at least one (1) female and at least one (1) male staff member any time individuals are present. If treatment support is provided for females only, a female staff member *must* be present at all times. If treatment support is provided for males only, a male staff member *must* be present at all times.

Individuals shall be supervised at all times by a staff member with current certification in First Aid and cardiopulmonary resuscitation.

Each individual's length of stay in an adolescent treatment support setting shall be individualized, based on the individual’s needs and progress in achieving treatment goals. To qualify for successful completion and discharge, the individual shall—

1. Demonstrate recognition and understanding of a SUD and its consequences;
2. Achieve an initial period of substance-free behavior and accept the need for continued treatment;
3. Develop a plan for continuing substance-free behavior and recovery/resiliency; and
4. Take initial steps to mobilize supports in the community for continuing recovery/resiliency.

An individual may be discharged before accomplishing these goals if maximum benefit has been achieved and—

1. No further progress is imminent or likely to occur;
2. Clinically appropriate therapeutic efforts have been made by staff; and
3. Commitment to abstinence and recovery is not demonstrated by the individual.


This service is limited to one unit per day.


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Peer and family support services are coordinated within the context of a comprehensive, individualized treatment plan that includes specific individualized goals. Peer and family support services are person-centered and promote individual ownership of the treatment plan.

This service may be provided to the individual’s family members/natural supports when such services are for the direct benefit of the individual, in accordance with
the individual’s needs and treatment goals identified in the individual’s treatment plan, and for assisting in the individual’s recovery.

Key components for peer and family support include:

1. Person-centered planning to promote the development of self-advocacy;
2. Empowering the individual to take a proactive role in the development, updating, and implementation of their person-centered plan;
3. Crisis support;
4. Assisting the individual and families in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the person-centered plan so that the individual remains in the least restrictive settings; achieves recovery and resiliency goals; self-advocates for quality physical and behavioral health services; and has access to strength-based behavioral health services and medical services in the community;
5. Assisting individuals/families in identifying strengths and personal/family resources to aid recovery/promoting resilience, and to recognize their capacity for recovery/resilience. Serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health of an adolescent with substance use or co-occurring disorders; and
6. Providing information and support to parents/caregivers of adolescents with substance use disorders so they have a better understanding of the individual’s needs, the importance of their voice in the development and implementation of the individualized treatment plan, the roles of the various providers, and the importance of the “team” approach; and assisting in the exploration of options to be considered as part of treatment.

13.14.Q(2) Qualified Providers of Peer and Family Support

The service is provided by a Certified Peer Specialist or Family Support Provider.


The unit of service is fifteen (15) minute increments.


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13.14.R Communicable Disease Counseling

Communicable disease counseling assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and to restore them to their best possible functional level. Communicable disease counseling topics can include, but are not limited to, human immunodeficiency virus (HIV), hepatitis, sexually transmitted infections (STI), tuberculosis (TB) status, and/or disclosure of substance use to family members/natural supports, addressing stigma in accessing services; maximizing healthcare service interactions; reducing substance use and avoiding overdose, and addressing anxiety, anger, and depressive episodes.

The provider shall have a working relationship with a local health department, physician, or other qualified healthcare practitioner to provide individuals with necessary testing for HIV, TB, STIs, and hepatitis.

Prior to an individual being tested for HIV, counseling must be provided by staff who are knowledgeable about communicable diseases including HIV, TB and STIs through training and/or previous employment experience. Post-test counseling may be provided for those testing positive for either HIV or TB. Staff providing these services shall also be competent to therapeutically assist individuals to understand and appropriately respond to test results.

13.14.R(1) HIV Pre-Test Counseling

Individuals with an SUD diagnosis may receive counseling for the purpose of assessing their risk of exposure to HIV. Included in the HIV pre-test are an HIV risk assessment interview, HIV pre-test counseling session and appropriate documentation of the pre-test counseling session.

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13.14.R(2) HIV Post-Test Counseling

Individuals with an SUD diagnosis testing positive for HIV may receive counseling following the test. This service includes HIV post-test counseling and the appropriate documentation and medical, social, and psychological referrals as needed or requested by the individual.

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13.14.R(3) TB Post-Test Counseling

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<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Individuals testing positive for TB may receive a counseling session that includes the test results and documentation. If appropriate, referrals may be made to local TB clinics.

**PROCEDURE CODE  DESCRIPTION**

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0047 TS</td>
<td>TB Post-Test Counseling</td>
</tr>
</tbody>
</table>

**13.14.R(4) Qualified Providers of Communicable Disease Counseling**

This service shall be provided by LMHPs, QMHPs, QAPs, and associate substance use counselors who are knowledgeable about communicable diseases, including HIV, TB, and STIs through training and/or previous employment experience. Knowledge shall include, but is not limited to, awareness of risks, disease management/treatment and resources for care, confidentiality requirements, and therapeutically assisting individuals in understanding and appropriately responding to test results.

Post-test counseling may be provided for those testing positive for either HIV or TB. Post-test counseling for HIV or TB must also be knowledgeable about services and care coordination available through the DHSS.


These services are limited to one (1) fifteen (15) minute unit of each per episode of care.

HIV pre-test counseling and TB/HIV post-test counseling must be used with one (1) of the following diagnosis codes: Z20.1 or Z20.6.

**13.15 Non-Covered Services**

**13.15.A Laboratory Services**

Laboratory services are not covered by MO HealthNet through the CSTAR Program. Laboratory services may be reimbursable to other appropriate MO HealthNet enrolled provider types subject to program limitations.

**13.15.B Prescriptions**

The MO HealthNet Pharmacy Program covers all drug products, except for Drug Efficacy Study Implementation (DESI) drugs, made by manufacturers that have entered into a rebate with the Federal Government. CSTAR services for MO HealthNet participants do not include the coverage of drug products.
13.16 MO HealthNet Managed Health Care Program

CSTAR services are available to MO HealthNet Managed Health Care enrollees, but it is not a plan benefit.

13.17 Administrative Lock-In

Some MO HealthNet participants are restricted or “locked in” to authorized MO HealthNet providers of certain services to aid the participant in proper utilization of the MO HealthNet Program. Refer to Section 1, Participant Conditions of Participation, for additional information about the program.

13.18 State Funded Assistance Participants

CSTAR services are not reimbursable by MO HealthNet for participants under state funded categories of assistance. These participants may have their needs met if they receive services from a provider who has a purchase of service CSTAR contract administered by the DMH, DBH. See Section 1 for a listing of state funded ME codes.

13.19 Quality Assurance

All CSTAR providers are monitored to assure compliance and quality of care by the DMH.

END OF SECTION

TOP OF PAGE
SECTION 14-Special Documentation Requirements

Program limits may require prior authorization or medical necessity. This program has unique documentation requirements beyond those outlined in Section 7, Medical Necessity, or 8, Prior Authorization. For the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program, authorization of services is required through the Department of Mental Health (DMH) CSTAR Customer Information Management, Outcomes and Reporting (CIMOR) system.

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

END OF SECTION
TOP OF PAGE
SECTION 15-Billing Instructions

15.1 Internet Electronic Claim Submission
For all Comprehensive Substance Treatment and Rehabilitation (CSTAR) services, the provider submits all billing to the Missouri Department of Mental Health (DMH) through the web based Customer Information Management Outcomes and Reporting system (CIMOR). The DMH in turn submits eligible claims to the MO HealthNet Division (MHD).

The DMH submits services for the provider electronically using the most current required X12N version.

Providers may submit services electronically to CIMOR via a HIPAA 837 or through keying services directly online to CIMOR. Providers who wish to submit services electronically should refer to the “HIPAA 837 Companion Guide”, the “835 Companion Guide”, “Batch Test Steps and Checklist”, and the “Batch Submission Contacts List” available at the DMH website. Providers submitting CSTAR services electronically to CIMOR will receive a remittance advice from the DMH.

Medicaid eligibility and claims submitted to MHD may be viewed in CIMOR. Providers may also use eMOMED to view eligibility. Providers are required to complete the online Application for MO HealthNet Internet Access Account. Please reference the MHD Information for Providers page for further information. Providers are unable to access eMOMED without proper authorization. An authorization is required for each individual user.

15.2 CMS-1500 Claim Form
For all CSTAR services, the provider submits all billing information to the DMH, who in turn bills this information to MHD. This includes all adjustments.

The DMH bills all CSTAR services for the CSTAR provider electronically.

15.3 Resubmission of Claims
Providers may view their claims in CIMOR or may use the Remittance Advice if services were submitted to CIMOR electronically on a HIPAA 837.

Services that resulted in zero payment on a claim can be resubmitted if the claim denied due to a correctable error. The error that caused the claim to deny should be corrected before resubmitting it to MHD through CIMOR. The provider may use the Replace button on the service in CIMOR to resubmit a claim to MHD.

15.4 Inquiries
Providers may inquire about CSTAR services by emailing the Division of Behavioral Health (DBH) Support Center. Select the “Help Ticket” link from the menu on the left section of the secure portal, and select “DBH Support Center” on the subject line.
15.5 CSTAR Invoices

The DMH generates CSTAR invoices through CIMOR. CSTAR Medicaid invoices are generated after the remittance advice (835) is received from MHD. CIMOR invoices are available to providers, and can be viewed on-line or printed.

15.6 Payments

After the MO HealthNet payments are generated, DMH accounting will generate invoice payments through CIMOR.

15.7 Insurance Coverage Codes

While providers are verifying the participant’s eligibility, they can obtain the Third Party Liability (TPL) information in CIMOR. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on TPL resources. The provider may also use eMOMED to verify eligibility and inquire on TPL resources. Reference Sections 1 and 3 for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by CIMOR, the IVR, or Internet. It is the provider’s responsibility to obtain from the participant the name and address of the insurance company, the policy number, and the type of coverage. Reference Section 5 of this manual, Cost Recovery/Third Party Liability.

15.8 CSTAR Rebill Instructions

If a service on a claim was incorrect because the service was billed with incorrect information, units are too high for instance, the provider should use the Replace button on the claim to adjust the service in CIMOR and the claim will be resubmitted by the DMH.

If a health insurance payment is received after the invoice has been paid, the amount collected must be credited back through CIMOR. The provider should utilize the Replace button on the claim to make the adjustment in CIMOR and the claim will be resubmitted by the DMH.

15.9 Special Billing Issues

For other special billing issues concerning CSTAR services, email the DBH Support Center. Select the “Help Ticket” link from the menu on the left section of the secure portal, and select “DBH Support Center” on the subject line.

15.9.A Units of Service Provided Over Daily Limit

CIMOR uses business rules to hold services to maximum limits where applicable. If providers wish to exceed service limits, providers must submit an Individualized Package request for the participant, with adequate clinical justification, and await approval from DMH Utilization Review staff before limits can be exceeded.
15.9.B Participant Direct Pay Portion

When a participant, as a result of the Standard Means Test (SMT) must pay an amount for CSTAR services provided, the provider must add the monthly SMT amount to CIMOR. CIMOR will deduct the SMT amounts from invoice payments.
SECTION 16 - MEDICARE/MEDICAID CROSSOVER CLAIMS

For participants having both Medicare and Medicaid eligibility, MO HealthNet pays the amounts indicated by Medicare to be deductible and/or coinsurance due on the Medicare allowed amount. These payments are referred to as “Crossovers.”

Section 16, Medicare/Medicaid Crossover Claims, is not applicable to the following manuals:

- Adult Day Care Wavier
- Adult Day Health Care (Note: the Adult Day Health Care Program ends June 30, 2013)
- Aged and Disabled Waiver
- AIDS Waiver
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Environmental Lead Assessment
- Hospice
- Independent Living Waiver
- Medically Fragile Adult Waiver
- MRDD Waiver
- Personal Care
- Private Duty Nursing

The following programs contain a modified Section 16, Medicare/Medicaid Crossover Claims

- Dental
- Durable Medical Equipment
- Home Health
- Hospital
- Nursing Home
- Pharmacy
SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim cannot pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.
17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization must be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user must obtain a user ID and password. Internet access user IDs and passwords cannot be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form must be submitted as corrections cannot be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

- Crossovers
- Inpatient
- Outpatient (Includes Rural Health Clinic and Hospice)
- Medical
- Nursing Home
- Home Health
- Dental
- Drug
- Capitation
- Credits
Claims in each category are listed alphabetically by participant’s last name. Each category starts on a separate RA page. If providers do not have claims in a category, they do not receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>FIELD DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAGE</td>
<td>The remittance advice page number.</td>
</tr>
<tr>
<td>CLAIM TYPE</td>
<td>The type of claim(s) processed.</td>
</tr>
<tr>
<td>RUN DATE</td>
<td>The financial cycle date.</td>
</tr>
<tr>
<td>PROVIDER IDENTIFIER</td>
<td>The provider’s NPI number.</td>
</tr>
<tr>
<td>RA #</td>
<td>The remittance advice number.</td>
</tr>
<tr>
<td>PROVIDER NAME</td>
<td>The name of the provider.</td>
</tr>
<tr>
<td>PROVIDER ADDR</td>
<td>The provider’s address.</td>
</tr>
<tr>
<td>PARTICIPANT NAME</td>
<td>The participant’s last name and first name.</td>
</tr>
<tr>
<td>NOTE: If the participant’s name and identification number are not on file, only the first two letters of the last name and the first letter of the first name appear.</td>
<td></td>
</tr>
<tr>
<td>MO HEALTHNET ID</td>
<td>The participant’s current 8-digit MO HealthNet identification number.</td>
</tr>
<tr>
<td>ICN</td>
<td>The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:</td>
</tr>
<tr>
<td></td>
<td>11— Paper Drug</td>
</tr>
<tr>
<td></td>
<td>13— Inpatient</td>
</tr>
<tr>
<td></td>
<td>14— Dental</td>
</tr>
<tr>
<td></td>
<td>15— Paper Medical</td>
</tr>
<tr>
<td></td>
<td>16— Outpatient</td>
</tr>
<tr>
<td></td>
<td>17— Part A Crossover</td>
</tr>
<tr>
<td></td>
<td>18— Paper Medicare/MO HealthNet Part B Crossover Claim</td>
</tr>
<tr>
<td></td>
<td>21— Nursing Home</td>
</tr>
<tr>
<td></td>
<td>40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.</td>
</tr>
<tr>
<td></td>
<td>41— Direct Electronic MO HealthNet Information (DEMI)</td>
</tr>
<tr>
<td></td>
<td>43— MTB/DEMI</td>
</tr>
<tr>
<td></td>
<td>44— Direct Electronic File Transfer (DEFT)</td>
</tr>
<tr>
<td></td>
<td>45— Accelerated Submission and Processing (ASAP)</td>
</tr>
<tr>
<td></td>
<td>46— Adjudicated Point of Service (POS)</td>
</tr>
<tr>
<td></td>
<td>47— Captured Point of Service (POS)</td>
</tr>
</tbody>
</table>

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The third and fourth digits indicate the year the claim was received.
The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from “001” (January 1) to “365” (December 31) (“366” in a leap year).
The last digits of an ICN are for internal processing.
For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE DATES FROM</td>
<td>The initial date of service in MMDDYY format for the claim.</td>
</tr>
<tr>
<td>SERVICE DATES TO</td>
<td>The final date of service in MMDDYY format for the claim.</td>
</tr>
<tr>
<td>PAT ACCT</td>
<td>The provider’s own patient account name or number. On drug claims this field is populated with the prescription number.</td>
</tr>
<tr>
<td>CLAIM: ST</td>
<td>This field reflects the status of the claim. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>1 — Processed as Primary</td>
</tr>
<tr>
<td></td>
<td>3 — Processed as Tertiary</td>
</tr>
<tr>
<td></td>
<td>4 — Denied</td>
</tr>
<tr>
<td></td>
<td>22 — Reversal of Previous Payment</td>
</tr>
<tr>
<td>TOT BILLED</td>
<td>The total claim amount submitted.</td>
</tr>
<tr>
<td>TOT PAID</td>
<td>The total amount MO HealthNet paid on the claim.</td>
</tr>
<tr>
<td>TOT OTHER</td>
<td>The combined totals for patient liability (surplus), participant copay and spenddown total withheld.</td>
</tr>
<tr>
<td>LN</td>
<td>The line number of the billed service.</td>
</tr>
<tr>
<td>SERVICE DATES</td>
<td>The date of service(s) for the specific detail line in MMDDYY.</td>
</tr>
<tr>
<td>REV/PROC/NDC</td>
<td>The submitted procedure code, NDC, or revenue code for the specific detail line.</td>
</tr>
<tr>
<td></td>
<td>NOTE: The revenue code only appears in this field if a procedure code is <em>not</em> present.</td>
</tr>
<tr>
<td>MOD</td>
<td>The submitted modifier(s) for the specific detail line.</td>
</tr>
<tr>
<td>REV CODE</td>
<td>The submitted revenue code for the specific detail line.</td>
</tr>
<tr>
<td></td>
<td>NOTE: The revenue code only appears in this field if a procedure code has also been submitted.</td>
</tr>
</tbody>
</table>

PRODUCTION : 09/08/2022
QTY The units of service submitted.
BILLED AMOUNT The submitted billed amount for the specific detail line.
ALLOWED AMOUNT The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT The amount MO HealthNet paid on the claim.
PERF PROV The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL The submitted line item control number.
GROUP CODE The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are:
  - CO—Contractual Obligation
  - CR—Correction and Reversals
  - OA—Other Adjustment
  - PI—Payer Initiated Reductions
  - PR—Patient Responsibility
RSN The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT The dollar amount adjusted for the corresponding reason code.
QTY The adjustment to the submitted units of service. This field is not printed if the value is zero.
REMARK CODES The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are:
  - HE—Claim Payment Remark Codes
  - RX—National Council for Prescription Drug Programs Reject/Payment Codes
The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.
CHECK AMOUNT The total check amount for the provider.
EARNINGS REPORT

PROVIDER IDENTIFIER  The provider’s NPI number.

RA #  The remittance advice number.

EARNINGS DATA

NO. OF CLAIMS PROCESSED  The total number of claims processed for the provider.

DOLLAR AMOUNT PROCESSED  The total dollar amount processed for the provider.

CHECK AMOUNT  The total check amount for the provider.

17.5  CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A  FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

<table>
<thead>
<tr>
<th>Claim Payment Reduction/Cutback</th>
<th>Claim Group Code</th>
<th>Description</th>
<th>Claim Adjustment Reason Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment reimbursed at the maximum allowed</td>
<td>CO</td>
<td>Contractual Obligation</td>
<td>45</td>
<td>Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.</td>
</tr>
<tr>
<td>Payment reduced by other insurance amount</td>
<td>OA</td>
<td>Other Adjustment</td>
<td>23</td>
<td>Payment adjusted because charges have been paid by another payer</td>
</tr>
</tbody>
</table>

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Medicare Part A Repricing OA Other Adjustment 45 Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.

Payment cut back to federal percentage (IEP therapy services) OA Other Adjustment A2 Contractual adjustment

Payment reduced by co-payment amount PR Patient Responsibility 3 Co-Payment amount

Payment reduced by patient spenddown amount PR Patient Responsibility 178 Payment adjusted because patient has not met the required spenddown

Payment reduced by patient liability amount PR Patient Responsibility 142 Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should not have been made at all, there will not be a corrected payment ICN.
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.
17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.
SECTION 18—Diagnosis Codes

18.1 General Information

The diagnosis code is a required field and the accuracy of the code that describes the participant’s condition is important.

This section contains a listing of the most commonly used diagnosis codes.

18.2 Diagnosis Code Listing

The diagnosis code is a required field on the claim. The following list contains the Diagnostic and Statistical Manual (DSM-5-TR) diagnoses and the corresponding International Classification of Diseases (ICD)-10 Clinical Modification (CM) codes.

NOTE: Providers should use the available DSM-5-TR diagnoses when admitting a CSTAR participant in the Department of Mental Health’s Customer Information Management Outcomes and Reporting (CIMOR) system. CSTAR claims are submitted electronically to MHD from the CIMOR system. The DSM-5-TR code description is mapped to the appropriate ICD-10 code in CIMOR, and the ICD-10 code is submitted on the electronic HIPAA 837 from the DMH.

18.2.A Admission to CSTAR Services

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Description</th>
<th>DSM 5 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.10</td>
<td>Alcohol abuse, uncomplicated</td>
<td>Alcohol use disorder, Mild</td>
</tr>
<tr>
<td>F10.11</td>
<td>Alcohol abuse, in remission</td>
<td>Alcohol use disorder, Mild, in early or sustained remission</td>
</tr>
<tr>
<td>F10.20</td>
<td>Alcohol dependence, uncomplicated</td>
<td>Alcohol use disorder Moderate</td>
</tr>
<tr>
<td>F10.21</td>
<td>Alcohol dependence, in remission</td>
<td>Alcohol use disorder Moderate, in early or sustained remission</td>
</tr>
<tr>
<td>F10.13</td>
<td>Alcohol abuse, with withdrawal</td>
<td></td>
</tr>
<tr>
<td>F10.130</td>
<td>Alcohol abuse with withdrawal, uncomplicated</td>
<td></td>
</tr>
<tr>
<td>F10.131</td>
<td>Alcohol abuse with withdrawal delirium</td>
<td></td>
</tr>
<tr>
<td>F10.132</td>
<td>Alcohol abuse with withdrawal with perceptual disturbance</td>
<td></td>
</tr>
<tr>
<td>F10.139</td>
<td>Alcohol abuse with withdrawal, unspecified</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Severity</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>F10.93</td>
<td>Alcohol use, unspecified with withdrawal</td>
<td></td>
</tr>
<tr>
<td>F10.930</td>
<td>Alcohol use, unspecified with withdrawal, uncomplicated</td>
<td></td>
</tr>
<tr>
<td>F10.931</td>
<td>Alcohol use, unspecified with withdrawal delirium</td>
<td></td>
</tr>
<tr>
<td>F10.932</td>
<td>Alcohol use, unspecified with withdrawal with perceptual disturbance</td>
<td></td>
</tr>
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**18.2.B Collateral Dependent**

The following diagnosis code qualifies a family member for CSTAR collateral dependent services.
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SECTION 19-Procedure Codes

Procedure codes used by the MO HealthNet Division are identified as HCPCS codes (Health Care Procedure Coding System). The HCPCS is divided into three subsystems, referred to as level I, level II and level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes. Level III codes have been developed by Medicaid State agencies for use in specific programs.

19.1 Procedure Codes for CSTAR

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<td>Evaluation/Management-Resident/established patient, Telemedicine</td>
</tr>
<tr>
<td>99202 SA</td>
<td>Evaluation/Management-APN/new patient</td>
</tr>
<tr>
<td>99203 SA</td>
<td>Evaluation/Management-APN/new patient</td>
</tr>
<tr>
<td>99204 SA</td>
<td>Evaluation/Management-APN/new patient</td>
</tr>
<tr>
<td>99205 SA</td>
<td>Evaluation/Management-APN/new patient</td>
</tr>
<tr>
<td>99212 SA</td>
<td>Evaluation/Management-APN/established patient</td>
</tr>
<tr>
<td>99213 SA</td>
<td>Evaluation/Management-APN/established patient</td>
</tr>
<tr>
<td>99214 SA</td>
<td>Evaluation/Management-APN/established patient</td>
</tr>
<tr>
<td>99215 SA</td>
<td>Evaluation/Management-APN/established patient</td>
</tr>
<tr>
<td>99202 SA GT</td>
<td>Evaluation/Management-APN/new patient, Telemedicine</td>
</tr>
<tr>
<td>99203 SA GT</td>
<td>Evaluation/Management-APN/new patient, Telemedicine</td>
</tr>
<tr>
<td>99204 SA GT</td>
<td>Evaluation/Management-APN/new patient, Telemedicine</td>
</tr>
<tr>
<td>99205 SA GT</td>
<td>Evaluation/Management-APN/new patient, Telemedicine</td>
</tr>
<tr>
<td>99212 SA GT</td>
<td>Evaluation/Management-APN/established patient, Telemedicine</td>
</tr>
<tr>
<td>99213 SA GT</td>
<td>Evaluation/Management-APN/established patient, Telemedicine</td>
</tr>
<tr>
<td>99214 SA GT</td>
<td>Evaluation/Management-APN/established patient, Telemedicine</td>
</tr>
<tr>
<td>99215 SA GT</td>
<td>Evaluation/Management-APN/established patient, Telemedicine</td>
</tr>
</tbody>
</table>
*HIV pre-test counseling (code H0047) and HIV and TB post-test counseling (code H0047 TS) must be used with one of the following diagnosis codes: Z20.1 or Z20.6, in order to allow the claim to pay.

19.2 Place of Service Codes

The place of service code must be one of the following:
02 – Telemedicine
03 - School
11 - Office
12 - Home
99 - Other Unlisted Facility
SECTION 20 - EXCEPTION PROCESS

The Exception Process is a formal process under which the MO HealthNet Division may grant an exception and authorize an essential medical service or item of equipment that otherwise exceeds the benefits and limitations set in policy.

Section 20, Exception Process, is not applicable to the following manuals, because services cannot be approved in accordance with the exception process regulation.

- Adult Day Health Care
- Aged and Disabled Waiver
- AIDS Waiver
- Ambulance
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Environmental Lead Assessment
- Hearing Aid
- Hospice
- MRDD Waiver
- Nurse Midwife
- Optical
- Personal Care
- Private Duty Nursing
- Psychology/Counseling
- Therapy

END OF SECTION

TOP OF PAGE
SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is not applicable to the following manuals:

- Adult Day Health Care
- Aged and Disabled Waiver
- Ambulance
- Ambulatory Surgical Centers
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- MRDD Waiver
- Nurse Midwife
- Optical
- Pharmacy
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy
SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation’s (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do not have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>The denial, termination, suspension, or reduction of an NEMT service.</td>
</tr>
<tr>
<td>Ancillary</td>
<td>Meals and lodging are part of the transportation package for participants,</td>
</tr>
<tr>
<td>Services</td>
<td>when the participant requires a particular medical service which is only</td>
</tr>
<tr>
<td></td>
<td>available in another city, county, or state and the distance and travel time</td>
</tr>
<tr>
<td></td>
<td>warrants staying in that place overnight. For children under the age of 21,</td>
</tr>
<tr>
<td></td>
<td>ancillary services may include an attendant and/or one parent/guardian to</td>
</tr>
<tr>
<td></td>
<td>accompany the child.</td>
</tr>
<tr>
<td>Appeal</td>
<td>The mechanism which allows the right to appeal actions of the broker to a</td>
</tr>
<tr>
<td></td>
<td>transportation provider who as (1) has a claim for reimbursement or request</td>
</tr>
<tr>
<td></td>
<td>for authorization of service delivery denied or not acted upon with</td>
</tr>
<tr>
<td></td>
<td>reasonable promptness; or (2) is aggrieved by an rule or policy or procedure</td>
</tr>
<tr>
<td></td>
<td>or decision by the broker.</td>
</tr>
<tr>
<td>Attendant</td>
<td>An individual who goes with a participant under the age of 21 to the MO</td>
</tr>
<tr>
<td></td>
<td>HealthNet covered service to assist the participant because the participant</td>
</tr>
</tbody>
</table>
cannot travel alone or cannot travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.

### Basic/Urban/Rural Counties

As defined in 20 CSR, the following counties are categorized as:

- **Urban** – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
- **Basic** – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
- **Rural** – All other counties.

### Broker

Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.

### Call Abandonment

Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.

### Call Wait Time

Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.

### Clean Claim

A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.

### Complaint

A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.

### DCN

Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.

### Denial Reason

The category utilized to report the reason a participant is not authorized for transportation. The denial categories are:

- Non-covered Service
- Lack of Day’s Notice
• Participant Ineligible
• Exceeds Travel Standards
• Urgency Not Verified by Medical Provider
• Participant has Other Coverage
• No Vehicle Available
• Access to Vehicle
• Not Closest Provider
• MHD Denied: Over Trip Leg Limit
• Access to Free Transportation
• Not Medicaid Enrolled Provider
• Incomplete Information
• Refused Appropriate Mode
• Minor Without Accompaniment
• Participant Outside Service Area

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

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

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

Fraud
Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.
Free Transportation

Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.

Grievance (Participant)

A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker’s personnel, or failure to respect the participant’s rights.

Grievance (Transportation Provider)

A written request for further review of a transportation provider’s complaint that remains unresolved after completion of the complaint process.

Inquiry

A request from a transportation provider regarding information that would clarify broker’s policies and procedures, or any aspect of broker function that may be in question.

Most Appropriate

The mode of transportation that accommodates the participant’s physical, mental, or medical condition.

MO HealthNet Covered Services

Covered services under the MO HealthNet program.

Medically Necessary

Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the participant’s condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Medical Service Provider

An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans Administration or Shriners Hospital.
NEMT Services  Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.

No Vehicle Available  Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All “no vehicle available” trips shall be reported as denials in the category of no vehicle available.

Participant  A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.

Pick-up Time  The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.

Public Entity  State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.

Transportation Leg  From pick up point to destination.

Transportation Provider  Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.

Urgent  A serious, but not life threatening illness/injury. Examples include, but are not limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant’s medical provider.

Will Call  An unscheduled pick-up time when the participant calls the broker or
transportation provider directly for a return trip. Transportation shall
pick-up participant within 60 minutes of the participants call requesting
return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services
for participants to MO HealthNet covered services for the Department of Social Services, MO
HealthNet Division. The broker must ensure that NEMT services are available 24 hours per day, 7
days per week, when medically necessary. To provide adequate time for NEMT services to be
arranged, a participant should call at least two (2) business days in advance when they live within an
urban county and at least three (3) business days advance notice if they live in the a rural or basic
county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days’ notice if they are of an urgent
nature. Urgent calls are defined as a serious, but not life threatening illness/injury. Urgent trips may
be requested by the participant or participant’s medical provider. The number for scheduling
transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-
urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do not include
transportation. In addition, the broker must arrange NEMT services for one parent/guardian to
accompany children under the age of 21, if requested. The broker must also arrange NEMT services
for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under
the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least
expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are not available at no charge to the
   participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO
HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant’s
   parent/guardian, AND
2. Hospital is more than 120 miles from the participant’s residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to
non-bordering states.
If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant must be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are not eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are not related to the participant’s terminal illness.
6. Participants in a MO HealthNet managed care health plan.
   a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall not be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant must request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards
are based on the participant’s county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. **Urban**-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. **Basic**-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. **Rural**-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

### TRAVEL STANDARDS: MAXIMUM MILEAGE

<table>
<thead>
<tr>
<th>Provider/Service Type</th>
<th>Urban Access County</th>
<th>Basic Access County</th>
<th>Rural Access County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>PCPs</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Neurology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Dermatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Physical Medicine/Rehab</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Vision Care/Primary Eye Care</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Allergy</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Cardiology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nephrology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Specialty</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Urology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>General surgery</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Psychiatrist-Adult/General</td>
<td>15</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>Psychiatrist-Child/Ageont Adolescent</td>
<td>22</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>Psychologists/Other Therapists</td>
<td>10</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
</tbody>
</table>

**Hospitals**

<table>
<thead>
<tr>
<th>Type</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Hospital</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Secondary Hospital</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

**Tertiary Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I or Level II trauma unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Neonatal intensive care unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Perinatology services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cancer services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Comprehensive cardiac services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric subspecialty care</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Mental Health Facilities**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health treatment facility</td>
<td>25</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Ambulatory mental health treatment providers</td>
<td>15</td>
<td>25</td>
<td>45</td>
</tr>
</tbody>
</table>
Residential mental health treatment providers 20 30 50

Ancillary Services

<table>
<thead>
<tr>
<th>Service</th>
<th>30</th>
<th>30</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Audiology</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

The broker must transport the participant when the participant has chosen a qualified, enrolled medical service provider who is not within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is not a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the Family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
   • Participant eligibility; and
   • MO HealthNet covered service.
22.7 COPAYMENTS

The MO HealthNet Division (MHD) does not require copayments for any services at this time. Providers will be notified when copayments are reinstated.

22.8 MODES OF TRANSPORTATION

The broker must arrange the least expensive and most appropriate mode of transportation based on the participant’s medical needs. The modes of transportation that may be utilized by the broker include, but are not limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi or rideshare service;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker must not utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant’s trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.
The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

### 22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that ModivCare (formerly LogistiCare) provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. **Ambulatory** includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. **Wheelchair** those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. **Stretcher Service** those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. **Non-emergency Ambulance** participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist ModivCare (formerly LogistiCare) by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

### 22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller must provide the following information:

- The patient/participant’s name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.
22.11 NON-COVERED SERVICES

The following services are not eligible for NEMT:

1. The broker shall not provide NEMT services to a pharmacy except when a participant has an appointment to receive a vaccination.

2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall not be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.

3. School districts must supply a ride to services covered in a child’s Individual Education Plan (IEP).

4. The broker shall not arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall not provide delivery of DME products in lieu of transporting the participant.

5. The broker shall not provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.

6. The broker shall not provide NEMT services for discharges from a nursing home.

7. The broker shall not authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children’s Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.

2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child’s Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **KCATA/RideKC Connection** KCATA provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.

4. **Bi-State Development Agency DBA Metro Transit** Metro Transit provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.

5. **City Utilities of Springfield, Transit** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.

6. **City of Jefferson/Jefftran** Jefftran is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Jefftran is provided to all eligible individuals with disability without priority given for trip purpose. Jefftran is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.

7. **Nevada City Hospital** Nevada City Hospital transports individuals who live within a 20 mile radius of Nevada.

8. **Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

### 22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker’s network, for as long as the broker is unable to
provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers’ non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a “hit” on any list maintained and checked by the registry.

**22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS**

All transportation provider inquiries, complaints, grievances and appeals as defined under ‘Definition’, *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite210
Maryland Heights, MO  63043
866-269-5944

**22.15 PARTICIPANT RIGHTS**

Participants *must* be given the rights listed below:
1. **General rule.** The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker’s personnel and transportation providers take those rights into account when furnishing services to participants.

2. **Dignity and privacy.** Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

3. **Copy of transportation records.** Each participant is guaranteed the right to request and receive a copy of his or her transportation records.

4. **Free exercise of rights.** Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker’s transportation providers or the state agency treat the participant.

### 22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant’s right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant’s estate.

### 22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

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ModivCare (formerly LogistiCare)  
13690 Riverport Drive  
Suite 210  
Maryland Heights, MO  63043
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22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a ModivCare (formerly LogistiCare) facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:

2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the ModivCare (formerly LogistiCare) facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.

3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.

4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, ModivCare (formerly LogistiCare) will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to ModivCare (formerly LogistiCare).

5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform ModivCare (formerly LogistiCare) of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.

6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to ModivCare (formerly LogistiCare) so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an
overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and

2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the ModivCare (formerly LogistiCare) Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.

2. A ModivCare (formerly LogistiCare) Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, ModivCare (formerly LogistiCare) will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by ModivCare (formerly LogistiCare).

3. ModivCare (formerly LogistiCare) will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.

4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice ModivCare (formerly LogistiCare) along with a copy of the ModivCare (formerly LogistiCare) Authorized Ancillary Services Form.
for the meals to ModivCare (formerly LogistiCare) MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.

5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the ModivCare (formerly LogistiCare) Facility Department, 13690 Riverport Drive, Suite 210, Maryland Heights, MO 63043. They must reference the job number and date of service on the receipt for reimbursement. The job number or confirmation number is found on the authorization form faxed to the requesting facility.

6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.

7. The confirmation number (job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944. Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The ModivCare (formerly LogistiCare) staff determines where the driver is and ensures the participant is transported.

2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.

3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.

4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.
22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. ModivCare’s (formerly LogistiCare) QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any ModivCare (formerly LogistiCare) representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.

2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call ModivCare (formerly LogistiCare) at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All ModivCare (formerly LogistiCare) approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, ModivCare’s (formerly LogistiCare)'s Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for ModivCare (formerly LogistiCare).

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.
C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a ModivCare (formerly LogistiCare) Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a ModivCare (formerly LogistiCare) window decal is applied to the vehicle. This provides for a quick visual identification of a ModivCare (formerly LogistiCare) approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to ModivCare (formerly LogistiCare) through the WMR line referenced above. For reoccurring issues, the ModivCare (formerly LogistiCare) Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. ModivCare (formerly LogistiCare) will attempt to schedule transport with the preferred provider; however ModivCare (formerly LogistiCare) is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. ModivCare (formerly LogistiCare) will investigate any incident causing such a request.
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Certificate of Medical Necessity (only for the Durable Medical Equipment Program)

These attachments should not be submitted with a claim form. These attachments should be mailed separately to:

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

These attachments may also be submitted to Wipro Infocrossing via the Internet when additional documentation is not required. The web site address for these submissions is www.emomed.com.

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do not need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is not found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment must be submitted incorporating the new procedure code.
23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.