STATE OF MISSOURI

AGED AND DISABLED WAIVER MANUAL
SECTION 1 - PARTICIPANT CONDITIONS OF PARTICIPATION

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

1.1.A(1) MO HealthNet
1.1.A(2) MO HealthNet for Kids
1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP)
1.1.A(4) Voluntary Placement Agreement for Children
1.1.A(5) State Funded MO HealthNet
1.1.A(6) MO Rx
1.1.A(7) Women’s Health Services
1.1.A(8) ME Codes Not in Use

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

1.2.A FORMAT OF MO HEALTHNET ID CARD
1.2.B ACCESS TO ELIGIBILITY INFORMATION
1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

General Manual

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Section 1 - Client Conditions of Participation

1.4.B NEWBORN ADOPTION ........................................................................................................ 17
1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT ....... 17

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS ........................................... 18
1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE .......... 18
1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN ............................................................. 19
1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS ............................................ 20
   1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program ............ 21
1.5.D HOSPICE BENEFICIARIES ......................................................................................... 22
1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB) .................................................... 23
1.5.F CHILDREN'S HEALTH INSURANCE PROGRAM/MO HEALTHNET FOR KIDS .... 24
1.5.G WOMEN’S HEALTH SERVICES PROGRAM (ME CODES 80 AND 89) ................. 24
1.5.H TEMP PARTICIPANTS ................................................................................................ 25
   1.5.H(1) TEMP ID Card ................................................................................................... 25
   1.5.H(2) TEMP Service Restrictions .............................................................................. 26
   1.5.H(3) Full MO HealthNet Eligibility After TEMP ...................................................... 26
1.5.I PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) ................. 27
1.5.J MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT .... 27
   1.5.J(1) Eligibility Criteria ............................................................................................... 28
   1.5.J(2) Presumptive Eligibility ...................................................................................... 28
   1.5.J(3) Regular BCCT MO HealthNet .......................................................................... 28
   1.5.J(4) Termination of Coverage .................................................................................. 29
1.5.K TICKET TO WORK HEALTH ASSURANCE PROGRAM ......................................... 29
   1.5.K(1) Disability .......................................................................................................... 29
   1.5.K(2) Employment ..................................................................................................... 30
   1.5.K(3) Premium Payment and Collection Process ....................................................... 30
   1.5.K(4) Termination of Coverage .................................................................................. 31
1.5.L PRESUMPTIVE ELIGIBILITY FOR CHILDREN ........................................................... 31
   1.5.L(1) Eligibility Determination ................................................................................... 31
   1.5.L(2) MO HealthNet for Kids Coverage .................................................................. 32
1.5.M MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION .... 32
1.5.M(1) MO HealthNet Coverage Not Available .................................................................33
1.5.M(2) MO HealthNet Benefits ...........................................................................................34
1.5.N VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES .............................................................................................................................34
1.5.N(1) Duration of Voluntary Placement Agreement ..........................................................35
1.5.N(2) Covered Treatment and Medical Services ................................................................35
1.5.N(3) Medical Planning for Out-of-Home Care .................................................................35

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS.................................36
1.6.A DAY SPECIFIC ELIGIBILITY ..........................................................................................37
1.6.B SPENDDOWN ..................................................................................................................38
1.6.B(1) Notification of Spenddown Amount .........................................................................38
1.6.B(2) Notification of Spenddown on New Approvals .......................................................39
1.6.B(3) Meeting Spenddown with Incurred Expenses .........................................................39
1.6.B(4) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown ............40
1.6.B(5) Spenddown Pay-In Option .......................................................................................40
1.6.B(6) Prior Quarter Coverage ..........................................................................................41
1.6.B(7) MO HealthNet Coverage End Dates .....................................................................41
1.6.C PRIOR QUARTER COVERAGE ......................................................................................42
1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS ..................................42

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE .............43
1.7.A NEW APPROVAL LETTER ...........................................................................................43
1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals .....................................44
1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter ...........................................44
1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice ................................44
1.7.B REPLACEMENT LETTER ..............................................................................................44
1.7.C NOTICE OF CASE ACTION ..........................................................................................45
1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS .............................45
1.7.E PRIOR AUTHORIZATION REQUEST DENIAL ............................................................45
1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER ................46

1.8 TRANSPLANT PROGRAM .................................................................................................46
Section 1 - Client Conditions of Participation

1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS ..............46
1.8.B PATIENT SELECTION CRITERIA .................................................................47
1.8.C CORNEAL TRANSPLANTS ...........................................................................47
1.8.D ELIGIBILITY REQUIREMENTS .................................................................47
1.8.E MANAGED CARE PARTICIPANTS .........................................................48
1.8.F MEDICARE COVERED TRANSPLANTS .................................................48
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 do not qualify for a public assistance program but who meet the Qualified Medicare Beneficiary (QMB) eligibility criteria.</td>
</tr>
<tr>
<td>18, 43, 44, 45, 61</td>
<td>Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.</td>
</tr>
<tr>
<td>10, 19, 21, 24, 26</td>
<td>Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.</td>
</tr>
</tbody>
</table>
23, 41  Children in a Nursing Facility/ICF/MR.

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

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

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

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

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

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

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

1.1.A(2)  MO HealthNet for Kids

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>05, 06</td>
<td>Eligible children under the age of 19 in MO HealthNet for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional MO HealthNet.</td>
</tr>
</tbody>
</table>
Section 1 - Client Conditions of Participation

60 Newborns (infants under age 1 born to a MO HealthNet or managed care participant).

40, 62 Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.

07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70 Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.

36, 56 Children who receive a federal adoption subsidy payment.

71, 72 Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)

73 Covers uninsured children under the age of 19 in families with gross income above 185% of the FPL. (Also known as MO HealthNet for Kids.)

74 Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL. (Also known as MO HealthNet for Kids.)

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

NOTE: Providers should encourage pregnant women with an ME code of 71, 72, 73, 80 or 89 to apply for regular MO HealthNet. The advantage to the woman is the elimination of the copay requirement (ME code 80 and 89) or receipt of more services including Non-Emergency Medical Transportation (NEMT). The advantage to the provider is that under regular MO HealthNet the provider does not collect copay, nor is copay deducted from the reimbursement amount of the claim.

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

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

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

1.1.A(4) Voluntary Placement Agreement for Children

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>Children seventeen (17) years of age or younger in need of mental health treatment</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Individuals who receive a Blind Pension check.</td>
</tr>
<tr>
<td>08</td>
<td>Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state funded foster care.</td>
</tr>
<tr>
<td>52</td>
<td>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.)</td>
</tr>
<tr>
<td>57</td>
<td>Children who receive a state only adoption subsidy payment.</td>
</tr>
<tr>
<td>64</td>
<td>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.</td>
</tr>
<tr>
<td>65</td>
<td>Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.</td>
</tr>
</tbody>
</table>

1.1.A(6) MO Rx

<table>
<thead>
<tr>
<th>ME CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>Participants only have pharmacy Medicare Part D wrap-around benefits through the MoRx.</td>
</tr>
</tbody>
</table>
Section 1 - Client Conditions of Participation

1.1.A(7)  Women’s Health Services

ME CODE  DESCRIPTION

80  Uninsured women, ages 18 through 55, who do not qualify for other benefits, and lose their MO HealthNet for Pregnant Women eligibility 60 days after the birth of their child, will continue to be eligible for family planning and limited testing and treatment of Sexually Transmitted Diseases if the family income is at or below 185 percent of the Federal poverty level (FPL), and assets total less than $250,000, and who are not otherwise eligible for Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.

89  Women’s Health Services Program provides family planning and limited testing and treatment of Sexually Transmitted Diseases to women, ages 18 through 55, who have family income at or below 185 percent of the Federal poverty level (FPL), and assets totaling less than $250,000, and who are not otherwise eligible for Medicaid, 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 caseworker’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 caseworker’s action under the following circumstances:

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

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

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

1.2.B  ACCESS TO ELIGIBILITY INFORMATION

Providers must verify eligibility via the Internet or by using the interactive voice response (IVR) system by calling (576) 751-2896 and keying in the participant ID number shown on the face of the card. All MO HealthNet enrolled providers receive the “Interactive Voice Response (IVR) System User Manual” which provides instructions for making eligibility inquiries, and explains the different options available and the different responses received. 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

1.2.C(2)  MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

• some adults and children who used to get a MO HealthNet ID card
• people eligible under the MO HealthNet for Kids (SCHIP) and the uninsured parent's program
• people enrolled in a MO HealthNet managed care health plan*
The following ME codes identify people who get a MO HealthNet Managed Care health insurance approval letter and MO HealthNet Managed Care ID Card

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

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

1.2.C(3) TEMP

A pregnant woman who has not applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits during pregnancy. The following ME codes identify people who have TEMP eligibility:

58, 59

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

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

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

1.2.C(5) Presumptive Eligibility for Children

Children in families with income below 225% 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 an 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.
Section 1 - Client Conditions of Participation

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) providers for benefits under the Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility (PE) Program receive a BCCT Temporary MO HealthNet Authorization letter which provides for limited MO HealthNet benefits while they wait for a formal eligibility determination by the FSD.

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

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

ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

When the MO HealthNet Division (MHD) has information that the participant has third party insurance coverage, the insurance coverage code, relationship code and the full name and address of the third party coverage are identified. 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 and deductible 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. 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. Participants with restrictions or limitations are identified on the Internet or on the IVR informational response.

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

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

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

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

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

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

Some MO HealthNet participants are restricted or locked-in to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. When the participant has an administrative lock-in provider, the provider’s name and telephone number are identified on the Internet, IVR, or point of service terminal 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 an attached Certificate of Medical Necessity and 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 necessary.
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 from Missouri Medicaid Audit and Compliance (MMAC) Provider Review, 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, IVR, or point of service terminal when verifying eligibility. The response received identifies the name and phone number of the participant’s selected managed care health plan. The response also includes the identity of the participant’s primary care provider in the managed care program areas. Participants who are eligible for MO HealthNet and who are enrolled with a managed care health plan must have their basic benefit services provided by or prior authorized by the managed care health plan.

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

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

The following information is provided to assist providers in determining those participants who are eligible for inclusion in MO HealthNet Managed Care Programs. The participants who are eligible for inclusion in the health plan are divided into five groups.* Refer to Section 11 for a listing of included counties and the managed care benefits package.
• Group 1 and 2 have been combined and are referred to as Group 1. Group 1 generally consists of the MO HealthNet for Families population (both the caretaker and child[ren]), the children up to age 19 of families with income under the applicable poverty standard, Refugee MO HealthNet participants and pregnant women. NOTE: Previous policy stated that participants over age 65 were exempt from inclusion in managed care. There are a few individuals age 65 and over who are caretakers or refugees and who do not receive Medicare benefits and are therefore included in managed care.

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

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

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

• Group 5 consists of uninsured children.

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

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

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

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

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

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

1.5.D HOSPICE BENEFICIARIES

MO HealthNet or 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 and coinsurance 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. 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 amounts for QMB-only covered services.
1.5.F CHILDREN'S HEALTH INSURANCE PROGRAM/ MO HEALTHNET FOR KIDS

Title XXI, of the Social Security Act, established the Children's Health Insurance Program (CHIP), to assist state efforts to provide health care coverage to uninsured, low-income children. This program is known as MO HealthNet for Kids regardless of whether services are provided through a managed care health plan or on a fee-for-service basis. Some families are required to pay a premium for coverage.

The uninsured low-income children eligible for health coverage under Title XXI ME codes 71 and 72 receive all services. ME codes 73, 74 and 75 receive all services, except Non-Emergency Medical Transportation (NEMT). All limits and prior authorization requirements of all programs and services apply when providing services.

Refer to information in specific provider manuals regarding copay requirements.

1.5.G 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 range of V25 through V25.9.
1.5.H 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 Office. 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.H(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.H(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.H(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.
1.5.1 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 24 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.J 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.J(1) Eligibility Criteria

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

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

1.5.J(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.J(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.J(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.K 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.K(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.K(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.K(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 premium paid 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.K(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.L 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.L(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 make 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.L(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.M 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...
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.M(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.M(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.N 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.N(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.N(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.N(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. 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. Participants with an ME code 75 are not subject to the provisions of Day Specific Eligibility. 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.
Section 1 - Client Conditions of Participation

For those participants who reside in an 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 be 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 or 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 in 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 either of the following options:

- submitting incurred medical expenses to their Family Support Division (FSD) caseworker; or
- paying the monthly spenddown amount to the MO HealthNet Division (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 caseworker. For those months that the individual does not pay-in or submit bills, no coverage is available.

1.6.B(1) Notification of Spenddown Amount

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

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

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

On new approvals, the FSD caseworker 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 caseworker 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 caseworker.

1.6.B(3) Meeting Spenddown with Incurred Expenses

If the participant chooses to meet spenddown for a month using incurred medical expenses, MO HealthNet coverage begins on the date the incurred 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 caseworker counts the full amount of the valid medical expenses the participant incurred to establish eligibility for spenddown coverage. The caseworker does not try to estimate amounts, or deduct estimated amounts, to be paid by the participant's insurance from the amount of an incurred expenses. The QMB Program provides MO HealthNet payment of the Medicare premium, and coinsurance and deductibles for all Medicare covered services. Therefore, the cost of Medicare covered services cannot be used to meet spenddown for participants approved for QMB.

Upon receipt of verification that spenddown has been met with incurred expenses for a month, FSD sends a Notification of Spenddown Coverage letter to inform the participant spenddown was met with the incurred 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)  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 client 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(5)  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(6) 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 caseworker receives bills to meet spenddown for a prior quarter month, eligibility is met.

1.6.B(7) 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:

After sudden onset, the medical condition (including emergency labor and delivery)
manifests itself by acute symptoms of sufficient severity (including severe pain) that the
absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient’s health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

NOTE: All labor and delivery is considered an emergency for purposes of this eligibility
provision.

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 quarter 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.

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
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

- Liver
- Lung
- Small Bowel
- Multiple organ transplants involving a covered transplant
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 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 pretransplant 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, postsurgery 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. Barnes-Jewish Hospital and St. Louis University are also Medicare-certified liver transplant facilities. Barnes-Jewish Hospital is a Medicare approved lung transplant facility. Potential heart, lung and liver transplant candidates who have Medicare coverage or who will be eligible for Medicare coverage within six months from the date of imminent need for the transplant should be referred to one of the approved Medicare transplant facilities. MO HealthNet only considers authorization of a Medicare-covered transplant in a non-Medicare transplant facility if the Medicare beneficiary is too ill to be moved to the Medicare transplant facility.
SECTION 2 - PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

2.1.A QMB-ONLY PROVIDERS

2.1.B NON-BILLING MO HEALTHNET PROVIDER

2.1.C PROVIDER ENROLLMENT ADDRESS

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

2.2 NOTIFICATION OF CHANGES

2.3 RETENTION OF RECORDS

2.3.A ADEQUATE DOCUMENTATION

2.4 NONDISCRIMINATION POLICY STATEMENT

2.5 STATE’S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

2.6 FRAUD AND ABUSE

2.7 OVERPAYMENTS

2.8 POSTPAYMENT REVIEW

2.9 PREPAYMENT REVIEW
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. Refer to Section 13, Benefits and Limitations, 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.

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

2.1.C PROVIDER ENROLLMENT ADDRESS

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

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit
P. O. Box 6500
Jefferson City, Missouri 65102
mmac.providerenrollment@dss.mo.gov
2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

A provider wishing to submit claims or attachments electronically or access the Internet website, 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 or the Provider Enrollment Unit at: mmacproviderenrollment@dss.mo.gov.

Providers wishing to access the Internet website, 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.

2.2 NOTIFICATION OF CHANGES

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

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

2.3 RETENTION OF RECORDS

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

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

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

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

2.4 NONDISCRIMINATION POLICY STATEMENT

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

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

2.5 STATE’S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

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

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

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

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

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

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

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

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

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

2.7 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.

END OF SECTION

TOP OF PAGE
SECTION 3 - PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES ................................................................. 2
   3.1.A WIPRO INFOCROSSING HELP DESK .................................................. 2

3.2 PROVIDER ENROLLMENT UNIT ..................................................... 2

3.3 PROVIDER RELATIONS COMMUNICATION UNIT ......................... 2
   3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM .............................. 3
      3.3.A(1) Using the Telephone Key Pad .................................................. 6
   3.3.B MO HEALTHNET SPECIALIST ..................................................... 6
   3.3.C INTERNET ............................................................................. 6
   3.3.D WRITTEN INQUIRIES .............................................................. 7

3.4 PROVIDER EDUCATION UNIT ...................................................... 8

3.5 PARTICIPANT SERVICES ............................................................. 8

3.6 FORMS .................................................................................... 9
   3.6.A RISK APPRAISAL FORM ........................................................... 9

3.7 CLAIM FILING METHODS ........................................................ 9

3.8 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET ............... 9
SECTION 3 - PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES

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

3.1.A WIPRO INFOCROSSING HELP DESK

Wipro Infocrossing provides a help desk for use by fee-for-service providers, electronic billers and managed health care plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

- front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission as well as assistance in the use and maintenance of billing software developed by the MO HealthNet Division.
- front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- front-line assistance to managed health care plans in establishing required electronic formats, network communications and ongoing operations.
- front-line assistance to providers in submitting claim attachments via the Internet.

3.2 PROVIDER ENROLLMENT UNIT

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

3.3 PROVIDER RELATIONS COMMUNICATION UNIT

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

A copy of a lost Remittance Advice can be obtained by contacting the Provider Relations Communication Unit’s number (573) 751-2896. A minimal copy fee is required prior to release of the replacement. An old or lost RA can be requested at the billing web site at www.emomed.com. In the section "File Management" you can request and print a current RA by clicking on "Printable
Remittance Advice". To retrieve an older RA click on "Request Aged RA's", fill out the required information and submit. The RA will be under "Printable Aged RA's" the next day. The requested RA will remain in the system for 5 days.

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

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

The interactive voice response (IVR) system at (573) 751-2896 allows an active MO HealthNet provider five inquiry options:

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

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

Option 1. Participant Eligibility

The caller is prompted to supply the following information:

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

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may not exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may not inquire on dates that exceed one year prior to the current date. The caller is limited to ten inquiries per call.
The caller is given standard MO HealthNet eligibility coverage information including ME code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits. The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under QMB or the Presumptive Eligibility (TEMP) Program. Please reference the provider manual for a description of these services. Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Refer to Section 1 for more detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a sub-menu. The sub-menu options include:

1. Managed care enrollment and health plan name and telephone number
2. Eye exam and eyeglass information
3. Third party liability information
4. Medicare Part A, Part B and/or QMB coverage
5. MO HealthNet ID, participant name, spelling of participant name and repeat of eligibility information
6. Repeat of confirmation number
7. Inquiry on another participant
8. Return to the main menu
9. End the call
0. Transfer to a MO HealthNet hotline specialist

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

**Option 2. Last Two Check Amounts**

The caller is prompted to supply their NPI number.

The caller is given the last two remittance advice (RA) dates, RA numbers and check amounts. Check amount inquiries are limited to ten provider numbers per call. The caller is told if the provider for which the inquiry being made is eligible to bill their claims electronically.
Option 3. Claim Status

The caller is prompted to supply the following:

- Provider’s NPI number
- Participant ID
- First date of service (mm/dd/yy)
- Claim type (optional), valid values are:
  - zero (0) - any claim type
  - One (1) - medical
  - Two (2) - inpatient
  - Three (3) - outpatient
  - Four (4) - dental
  - Five (5) - home health
  - Six (6) - drug
  - Seven (7) - nursing home
  - Eight (8) - Medicare crossover

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

Option 5. MO HealthNet Informational Message

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

The caller is given the option to select from a list of informational messages. The IVR tells the caller to which MO HealthNet Program or topic each informational message pertains. When a particular message option is selected, a detailed message is read to the caller by the IVR. The informational messages available through this option may include, but are not limited to, changes or additions to the MO HealthNet Program, areas of interest for specific provider types, changes to the managed care program, and special instructions for receiving additional information. The messages are similar to the types of informational messages occasionally appearing on the cover page of provider remittance advices. If no informational messages are currently available on the message area, callers are not able to select option 5 from the main menu.
3.3.A(1) Using the Telephone Key Pad

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

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

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

3.3.B MO HEALTHNET SPECIALIST

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

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

3.3.C INTERNET

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://manuals.momed.com/Application.html and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.
The current inquiry options available through the interactive voice response (IVR) system is offered, with the exception of procedure code inquiry. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security Number and date of birth, claim status and check inquiry. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

Providers also have the capability to receive and download their Remittance Advice from the Internet. Access to this information is restricted to users with authorization. In addition to the Remittance Advice, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this web site include: claim submission; claim attachment submission; inquiries on claim status, attachment status, and check amounts; and credit adjustment(s).

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

3.3.D WRITTEN INQUIRIES

Letters directed to the Provider Relations Communication Unit are answered by trained MO HealthNet specialists. Written or telephone responses are provided to all inquiries.

A provider who encounters a complex billing problem; numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage; or wishes to lodge a complaint should submit the inquiry or complaint in writing to:

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

A written inquiry should state the problem as clearly as possible and should include the provider's name, NPI number, address, and telephone number. Written inquiries should also include the MO HealthNet participant's full name, MO HealthNet identification number, and birthdate. A copy of all pertinent information, such as Remittance Advice forms, invoices, participant information, form letters, and timely filing documentation must be included with the written inquiry.
3.4 PROVIDER EDUCATION UNIT

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

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

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

3.5 PARTICIPANT SERVICES

Providers may direct participants to the MO HealthNet Participant Services Unit for questions regarding such things as MO HealthNet-covered services, the denial or payment of claims filed with the MO HealthNet Program, and the location of participating providers in their areas of the state. This unit can be helpful, for example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

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

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

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

3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is not received within 60 days, providers may resubmit a new claim to the fiscal agent. However, providers should not
resubmit a claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of claim. Refer to Section 17 for further discussion of the RA and Suspended Claims.

### 3.6 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MO HealthNet web site at [www.dss.mo.gov/mhd/providers/index.htm](http://www.dss.mo.gov/mhd/providers/index.htm). Choose the “MO HealthNet forms” link in the right column.

#### 3.6.A RISK APPRAISAL FORM


### 3.7 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MO HealthNet billing site at [www.emomed.com](http://www.emomed.com). Most claims that require attachments may also be submitted at this site. Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in Section 15.

### 3.8 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include: (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of Restricted Participant (PI-118) and Certificate of Medical Necessity (for Durable Medical Equipment providers only). These attachments may not be submitted via the Internet when additional documentation is required. The web site address for these submissions is [www.emomed.com](http://www.emomed.com).
SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

4.1.B MEDICARE/MO HEALTHNET CLAIMS

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

4.2.A CLAIMS FILED AND DENIED

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

4.2.C SECOND RESUBMISSIONS

4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT REQUEST FORM

4.5 DEFINITIONS
Section 4 - Timely Filing

SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

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

4.1.B MEDICARE/MO HEALTHNET CLAIMS

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

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

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

Claims for participants who have other insurance must first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim must still meet the MO HealthNet timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does not serve to extend the filing requirement.) If the provider has not had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait no longer than 6 months after the date of service before contacting the TPL Unit. If the MO HealthNet Division waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the MO HealthNet timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.
Section 4 - Timely Filing

The 12 month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the 12 months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the MO HealthNet Division. Under this set of circumstances, the provider may file a claim with the MO HealthNet Division later than 12 months from the date of service. The provider must submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MO HealthNet Division may accept and pay this specific type of claim without regard to the 12 month timely filing rule; however, all claims must be filed for MO HealthNet reimbursement within 24 months from the date of service in order to be paid.

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

Claims that originally were submitted and received within 12 months from the date of service and that 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

A copy of a Remittance Advice must be attached to a claim that was previously denied and is being resubmitted more than 12 months after the date of service. The Remittance Advice indicate that the claim had originally been filed timely. The Julian date within the internal control number (ICN) on the attached Remittance Advice and on the claim is the determinant for timely filing.

Providers may enter the ICN number of the denied claim that was filed timely instead of attaching a copy of the Remittance Advice for the following claim types:

- CMS-1500—enter the ICN in Field #22
- UB-04—enter the ICN in Field #64
- Dental Claim—enter the ICN in Remarks Field #35
- Pharmacy Claim—enter the ICN in Remarks Field #19

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

Some 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.

4.2.C SECOND RESUBMISSIONS

Claims may be resubmitted more than once. 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 (reference Section 4.2.A). 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.

4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

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

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT REQUEST FORM

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

When overpayments are discovered, it is always the provider’s responsibility to notify the state agency. When Individual Adjustment Request forms for overpayments are submitted 24 months after the date of the Remittance Advice on which payment was made, the provider is notified by letter that a recoupment will be made by deducting the amount of the overpayment from the next check written to him or her.
Occasionally the claims-processing system is not able to process an Individual Adjustment Request form in the usual manner. In that situation, the provider is informed by letter that a recoupment of the paid claim will be made and that a new, corrected claim must be resubmitted. The timely filing limit for resubmitting the new, corrected claim is no more than 90 days from the date of the Remittance Advice indicating the recoupment or 12 months from the date of service, whichever is longer. A copy of the Remittance Advice indicating the recoupment must be attached to the new claim.

4.5 DEFINITIONS

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

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

- Nursing Homes: The last date of service for the billing period indicated on the participant's detail record. Nursing Homes must bill electronically, unless attachments are required.
- Pharmacy: The date dispensed for each line item for each individual participant listed on the paper claim form, or on electronically submitted claims through point of service (POS) or the Internet.
- 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 409516652006, “40” is a tape claim, “95” is the year 1995, and “166” is the Julian date for June 15.

**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 1992, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 1992.

**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 .................................................................2
  5.1.A  MO HEALTHNET IS PAYER OF LAST RESORT .........................2
  5.1.B  THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES ........3
  5.1.C  PARTICIPANTS LIABILITY WHEN THERE IS A TPR .........................4
  5.1.D  PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL ........5

5.2  HEALTH INSURANCE IDENTIFICATION ............................................5
  5.2.A  TPL INFORMATION ...............................................................6
  5.2.B  SOLICITATION OF TPR INFORMATION .................................6

5.3  INSURANCE COVERAGE CODES ........................................................7

5.4  COMMERCIAL MANAGED HEALTH CARE PLANS .................................8

5.5  MEDICAL SUPPORT ................................................................................8

5.6  PROVIDER CLAIM DOCUMENTATION REQUIREMENTS ......................9
  5.6.A  EXCEPTION TO TIMELY FILING LIMIT ........................................9
  5.6.B  TPR CLAIM PAYMENT DENIAL ...........................................10

5.7  THIRD PARTY LIABILITY BYPASS ..................................................10

5.8  MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4) ..................11

5.9  LIABILITY AND CASUALTY INSURANCE .........................................12
  5.9.A  TPL RECOVERY ACTION ................................................12
  5.9.B  LIENS ...............................................................................13
  5.9.C  TIMELY FILING LIMITS ........................................................13
  5.9.D  ACCIDENTS WITHOUT TPL .............................................13

5.10  RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION ..........14

5.11  OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE .....14

5.12  THE HEALTH INSURANCE PREMIUM PAYMENT (HIPPP) PROGRAM ....14

5.13  DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY .........15
SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

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

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

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

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

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

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

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

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

5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES

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

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

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

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

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

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

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

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

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

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

**5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR**

The provider may not bill the participant for any unpaid balance of the total MO HealthNet covered charge when the other resource represents all or a portion of the MO HealthNet maximum allowable amount. The provider is not entitled to any recovery from the participant except for services/items which are not covered by the MO HealthNet Program or services/items established by a written agreement between the MO HealthNet participant and provider indicating MO HealthNet is not the intended payer for the specific service/item but rather the participant accepts the status and liability of a private pay patient.
Missouri regulation does allow the provider to bill participants for MO HealthNet covered services if, due to the participant's action or inaction, the provider is not reimbursed by the MO HealthNet Program. It is the provider’s responsibility to document the facts of the case. Otherwise, the MO HealthNet agency rules in favor of the participant.

5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

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

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

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

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

5.2 HEALTH INSURANCE IDENTIFICATION

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

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

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

5.2.B  SOLICITATION OF TPR INFORMATION

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

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse’s employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.
- CHAMPUS/CHAMPVA or veteran’s benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the “Improved Pension Program,” effective in 1979.
- If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency
requirement for aliens or refugees) and the Part B premium be paid. Individuals who have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)

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

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

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

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

5.3 INSURANCE COVERAGE CODES

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

AC Accident
AM Ambulance
CA Cancer
CC Nursing Home Custodial Care
DE Dental
DM Durable Medical Equipment
HH Home Health
HI Inpatient Hospital
HO Outpatient Hospital—includes outpatient and other diagnostic services
HP Hospice
IN Hospital Indemnity—refers to those policies where benefits cannot be assigned and it is not an income replacement policy
MA Medicare Supplement Part A
MB Medicare Supplement Part B
MD Physician—coverage includes services provided and billed by a health care professional
MH Medicare Replacement HMO
Section 5 - Third Party Liability

PS Psychiatric—physician coverage includes services provided and billed by a health care professional
RX Pharmacy
SC Nursing Home Skilled Care
SU Surgical
VI Vision

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

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

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

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

5.5 MEDICAL SUPPORT

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

At the time the provider obtains MO HealthNet and third party resource information from the child’s caretaker, the provider should ask whether this type of resource exists. Medical support is a primary resource. There are new rules regarding specific situations for which the provider can require the MO HealthNet agency to collect from the medical support resource. Refer to Section 5.7 for details.
Section 5 - Third Party Liability

It must be stressed that if the provider opts not to collect from the third party resource in these situations, recovery is limited to the MO HealthNet payment amount. By accepting MO HealthNet reimbursement, the provider gives up the right to collect any additional amounts due from the insurance resource. Federal regulation requires any excess amounts collected by the MO HealthNet agency be distributed to the participant/policyholder.

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

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

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

5.6.A EXCEPTION TO TIMELY FILING LIMIT

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

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

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

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

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

5.7 THIRD PARTY LIABILITY BYPASS

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

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

- The claim is for personal care or homemaker/chore services.
Section 5 - Third Party Liability

- The claim is for adult day health care.
- The claim is for mentally retarded/developmentally disabled (MRDD) waiver services.
- The claim is for a child who is covered by a noncustodial parent’s medical support order.
- The claim is related to preventative pediatric care for those participants under age 21 and has one of the following PRIMARY diagnosis codes:
  
  V01-V07.9  V72.0-V72.3  V78.2-V78.3  V82.3-V82.4  
  V20-V20.2  V73-V75.9  V79.2-V79.3  EPS  
  V70.0  V77.0-V77.7  V79.8

- The claim relates to prenatal care for pregnant women and has one of the following:
  
  A. PRIMARY diagnosis codes:
     
     V22-V23.9  **640-648.9  **673-673.8  
     V28-V28.9  **651-658.9  **675-676.9  
      *671-671.9

     ** Diagnosis codes require fourth and fifth digits. Claim is exempt from TPL denial only if the fifth digit is 3.

  OR

  B. Procedure Codes:
     
     59400 -------------- Global Delivery—Vaginal  
     59425, 59426 Global Prenatal  
     59510 -------------- Global Cesarean

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

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

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

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

5.9 LIABILITY AND CASUALTY INSURANCE

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

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

The state monitors possible accident-related claims to determine if another party may be liable; therefore, information given on the claim form is very important in assisting the state in researching accident cases. 13 CSR 4.030 and 13 CSR 4.040 requires the provider to report the contingent liability to the MO HealthNet Division.

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

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

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

5.9.A TPL RECOVERY ACTION

Accident-related claims are processed for payment by MO HealthNet. The Third Party Liability Unit seeks recovery from the potentially liable third party on a postpayment basis. Once MO HealthNet is billed, the MO HealthNet payment precludes any further recovery
Section 5 - Third Party Liability

action by the provider. The MO HealthNet provider may not then bill the participant or his/her attorney.

5.9.B LIENS

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

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

5.9.C TIMELY FILING LIMITS

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

5.9.D ACCIDENTS WITHOUT TPL

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

Examples are:

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

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

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

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

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

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

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

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

The Health Insurance Premium Payment (HIPP) Program is a MO HealthNet Program that pays for the cost of health insurance premiums for certain MO HealthNet participants. The program purchases health insurance for MO HealthNet-eligible participants when it is determined cost effective. Cost effective means that it costs less to buy the health insurance to cover medical care than to pay for the same services with MO HealthNet funds. The HIPP Program cannot find health insurance policies for MO HealthNet participants, rather it purchases policies already available to participants through employers, former employers, labor unions, credit unions, church affiliations,
Section 5 - Third Party Liability

other organizations, or individual policies. Certain participants may have to participate in this program as a condition of their continued MO HealthNet eligibility. Other participants may voluntarily enroll in the program. Questions about the program can be directed to:

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

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

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

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

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

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

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

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

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

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

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

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

A modified form of self-insurance, called minimum premium, allows the insurance company to charge only a minimum premium that includes a specified percentage of projected annual premiums, plus administrative and legal costs (retention) and a designated percentage of the annual premium. The employer usually holds the claim reserves and earns the interest paid on these funds.
Claims administration may be done by the old insurance carrier, which virtually guarantees replication of the former insurance program’s administration. Or the self-insurance program can be serviced through the employer’s own benefits office, an option commonly employed by very large companies of 10,000 or more employees. The final option is to hire an outside third-party administrator (TPA) to process claims.

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

6.1 GENERAL REQUIREMENTS

6.2 INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL ADJUSTMENT REQUEST FORM

6.2.A INSTRUCTIONS FOR COMPLETION OF INDIVIDUAL ADJUSTMENTS VIA THE INTERNET

6.3 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS
SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

Providers who are paid incorrectly for a claim may use the most current Individual Adjustment Request form to request an adjustment. Providers may submit paper individual adjustment requests however MO HealthNet’s preferred method is via the Internet. Medicare crossover claims must be adjusted (voided/replaced) via the internet. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply. Medicare crossover claims must be done via the internet, reference Bulletin dated 07/01/05. For crossover claims past MO HealthNet’s timely filing guidelines, see Section 4 for requirements for adjustments and claim resubmissions.

In some instances, more than one change may be necessary on a claim. ALL the changes to the claim must be addressed on the same Individual Adjustment Request form. Specify all the changes required, addressing each change separately. Field #15 of the form may be used to provide additional information.

More than one claim cannot be processed per Individual Adjustment Request form. Each adjustment request addresses one particular claim. A separate Individual Adjustment Request form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

Providers submitting adjustment requests for change of procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

When providers submit paper adjustments that do not have the required fields completed, the adjustment will be recouped and providers are required to resubmit the claim for payment.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original Individual Adjustment Request and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word TRACER. Submitting another request without indicating it as a TRACER can further delay processing. Adjustments for claim credits submitted via the Internet get an immediate adjudication. Reference Claim Management after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.
If a claim has been adjusted but the payment is still incorrect, another adjustment may be requested. The Internal Control Number (ICN) from the most recent payment must be used on the Individual Adjustment Request (the ICN begins with a 50 or 55).

See Section 4 for timely filing requirements for adjustments and claim resubmissions.

Individual Adjustment Requests are to be submitted to the address shown on the form:

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

Individual Adjustment Requests are not accepted by telephone.

Individual adjustments may be done via the Internet. The web site address is www.emomed.com. Providers wishing to access the Internet web site, www.emomed.com, must complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.missouri.gov/mhd/ 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. NOTE: Providers must be enrolled as an electronic billing provider. See Section 2.1.D.

6.2 INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL ADJUSTMENT REQUEST FORM

Fields with an asterisk (*) are required information and must be completed.

Check the appropriate box at the top of the form indicating whether the adjustment is to correct an overpayment or underpayment.

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Claim Copy</td>
<td>A copy of the original claim may be attached to the adjustment to assist in processing.</td>
</tr>
<tr>
<td>2. Remittance Advice Copy</td>
<td>A copy of that Remittance Advice page must be attached to the Individual Adjustment Request form.</td>
</tr>
<tr>
<td>*3. Internal Control Number (ICN)</td>
<td>Enter the 13-digit ICN from the Remittance Advice for the claim in question.</td>
</tr>
<tr>
<td>*4. Participant MO HealthNet Number</td>
<td>Enter the eight-digit MO HealthNet ID number as printed on the Remittance.</td>
</tr>
</tbody>
</table>
Section 6 - Adjustments

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Provider Label Place the provider label in this space. If a provider does not use the label, they must enter their provider number, name, and address in this space. Use of the provider label saves time and helps eliminate errors.</td>
</tr>
<tr>
<td>6.</td>
<td>Participant Name Enter the participant’s name as shown on the ID card.</td>
</tr>
<tr>
<td>7.</td>
<td>Remittance Advice Date Enter the Remittance Advice date.</td>
</tr>
<tr>
<td></td>
<td>R.A. Page Number Enter the page number from the upper right corner of the Remittance Advice that pertains to the claim in question.</td>
</tr>
<tr>
<td>8.</td>
<td>Qty/Units Under “Information on Remittance Advice” enter the incorrect quantity or units as shown on the Remittance Advice. Under “Corrected Information” enter the corrected quantity or units.</td>
</tr>
<tr>
<td>9.</td>
<td>NDC/Procedure Code Under “Information on Remittance Advice” enter incorrect national drug code (NDC) or procedure code shown on the Remittance Advice. Under “Corrected Information” enter the corrected NDC or procedure code.</td>
</tr>
<tr>
<td>10.</td>
<td>Service Date(s) Under “Information on Remittance Advice” enter the service date as it appears on the Remittance Advice. Under “Corrected Information” enter the corrected date of service.</td>
</tr>
<tr>
<td>11.</td>
<td>Billed Amount Under “Information on Remittance Advice” enter the billed amount as it appears on the Remittance Advice. Do not put the payment amount in this location. Under “Corrected Information” enter the corrected billed amount.</td>
</tr>
<tr>
<td>12.</td>
<td>Paid Amount Under “Information on Remittance Advice” enter the paid amount as it appears on the Remittance Advice. Under “Corrected Information” enter the corrected paid amount.</td>
</tr>
</tbody>
</table>
### Section 6 - Adjustments

Information,” the correct payment amount may be entered.

<table>
<thead>
<tr>
<th><strong>13. Patient Surplus (Nursing Home, Mental Health Facilities, and Hospice)</strong></th>
<th>For correction of patient surplus (participant liability) amount, enter the patient surplus shown on the Remittance Advice under “Information on Remittance Advice.” Enter the corrected patient surplus under “Corrected Information.”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14. Other Resources (TPL) (Identify Source)</strong></td>
<td>For other resource payment, enter the amount paid by the other resource under “Corrected Information” and give the name of the source.</td>
</tr>
<tr>
<td><strong>15. Other/Remarks</strong></td>
<td>Enter the specific reason for this request, if not specified elsewhere, and any other information pertinent to this claim. This field may be used to provide additional information for any of the previous lines, or additional pages may be attached. Do not use a second Individual Adjustment Request as the second page.</td>
</tr>
<tr>
<td><strong>16. Provider’s Signature</strong></td>
<td>The signature of the provider or other authorized party is entered on this line.</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>The date the request is completed is entered on this line.</td>
</tr>
</tbody>
</table>

*Required field.*

### 6.2.A INSTRUCTIONS FOR COMPLETION OF INDIVIDUAL ADJUSTMENTS VIA THE INTERNET

When a provider bills electronically it is expected that the adjustments or voids will be done electronically. To do these on line the provider logs onto the MO HealthNet billing site at www.emomed.com. The provider enters the participant DCN and DOS in the search box and clicks on the highlighted ICN of the claim to be adjusted. The provider then clicks on Void to delete a paid claim or Replacement if corrections/additions need to be made to a paid claim. If the provider is still billing paper claims they may still send in paper adjustment forms. Electronic claims over two years old may not be adjusted on line.
6.3 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.

NOTE: If a provider submits an on-line adjustment, the provider should not send in a check and paper adjustment for the same adjustment.
SECTION 7 - MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY .........................................................................................................................................................2
7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS .........................................................................................................................3
7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY ..............................................................................................................................................3
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 for 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 that are 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

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

7.2  INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

<table>
<thead>
<tr>
<th>FIELD NUMBER &amp; NAME</th>
<th>INSTRUCTIONS FOR COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Name</td>
<td>Enter last name, first name and middle initial as shown on the ID card.</td>
</tr>
<tr>
<td>2. MO HealthNet ID Number</td>
<td>Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant’s ID card or letter of eligibility.</td>
</tr>
<tr>
<td>3. Procedure/Revenue Codes</td>
<td>Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).</td>
</tr>
<tr>
<td>4. Description of Item/Service</td>
<td>For each procedure/revenue code listed, describe in detail the service or item being provided.</td>
</tr>
<tr>
<td>5. Reason for Service</td>
<td>For each procedure/revenue code listed, state clearly the medical necessity for this service/item.</td>
</tr>
<tr>
<td>Section 7 - Medical Necessity</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>6. Months Item Needed</td>
<td>For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).</td>
</tr>
<tr>
<td>(DME only)</td>
<td></td>
</tr>
<tr>
<td>7. Name and Signature of</td>
<td>The prescriber's signature, when required, <em>must</em> be an original signature. A stamp, facsimile, or the signature of a prescriber's employee is <em>not</em> acceptable. A signature is <em>not</em> required here if the prescriber is the provider (Fields #12 thru #14).</td>
</tr>
<tr>
<td>Prescriber</td>
<td></td>
</tr>
<tr>
<td>8. Prescriber's MO HealthNet</td>
<td>Enter the NPI number if the prescriber participates in the MO HealthNet Program.</td>
</tr>
<tr>
<td>Provider Identifier</td>
<td></td>
</tr>
<tr>
<td>9. Date Prescribed</td>
<td>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 <em>must</em> be prior to or equal to the date of service.</td>
</tr>
<tr>
<td>10. Diagnosis</td>
<td>Enter the appropriate ICD-9 code(s) that prompted the request for this service or item, if required by program.</td>
</tr>
<tr>
<td>11. Prognosis</td>
<td>Enter the participant's prognosis and the anticipated results of the requested service or item.</td>
</tr>
<tr>
<td>12. Provider Name and Address</td>
<td>Enter provider's name, address, and telephone number or use provider label.</td>
</tr>
<tr>
<td>13. MO HealthNet Provider</td>
<td>Enter provider's NPI number.</td>
</tr>
<tr>
<td>Identifier</td>
<td></td>
</tr>
<tr>
<td>14. Provider Signature</td>
<td>The provider <em>must</em> sign here with an original signature. This certifies that the information given on the form is true, accurate and complete.</td>
</tr>
</tbody>
</table>

END OF SECTION
TOP OF PAGE
SECTION 8 - PRIOR AUTHORIZATION

8.1 BASIS ...............................................................................................................................................2
8.2 PRIOR AUTHORIZATION GUIDELINES ...........................................................................................2
8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION ..............................................................3
8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT ....................................................4
8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM .....................5
8.6 PRIOR AUTHORIZATION (PA) REQUEST .......................................................................................6
  8.6.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST .............................................6
8.7 MO HEALTHNET AUTHORIZATION DETERMINATION ...............................................................7
  8.7.A A DENIAL OF PRIOR AUTHORIZATION REQUESTS ..............................................................8
  8.7.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION ................................8
8.8 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST .........................9
  8.8.A WHEN TO SUBMIT A REQUEST FOR CHANGE (RFC) .............................................................9
8.9 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS) .....................................................10
8.10 OUT-OF-STATE, NON-EMERGENCY SERVICES .........................................................................11
  8.10.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS ................11
SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

Under the MO HealthNet Program, certain covered services and equipment require approval from the Department of Social Services, MO HealthNet Division, 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.

Please refer to Sections 13 and 14 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 manual, mail requests to:
  
  Infocrossing Healthcare Services  
  P.O. Box 5700  
  Jefferson City, MO 65102

A PA Request form can be printed and completed by hand or the form can 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 finished, print the PA Request and send to the address listed above.

- The provider performing the service must submit the Prior Authorization 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.
Section 8 - Prior Authorization

• Do not request prior authorization for services to be provided to an ineligible person. (see Sections 1 and 13).
• 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 Prior Authorization Request form or after the authorization deadline.
• For services to continue after the expiration date of an existing Prior Authorization Request, a new Prior Authorization Request must be completed and mailed.

8.3  PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

Complete the Prior Authorization 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 Prior Authorization Request is not returned. Providers should retain a copy of the original Prior Authorization Request and any supporting documentation submitted for processing. Instructions for completing the Prior Authorization Request form are on the back of the form. Unless otherwise stated in Section 13 or 14 of the provider manual, mail the Prior Authorization Request form and any required attachments to:

Infocrossing Healthcare Services
P.O. Box 5700
Jefferson City, Missouri 65102

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
Section 8 - Prior Authorization

assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible participants are not reimbursed.

If the request for authorization of services is denied, the provider receives a MO HealthNet Authorization Determination (Reference Section 8.7). The participant is notified by letter each time a request for prior authorization is denied. (Reference Section 1 for a sample Prior Authorization Request Denial.)

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. Emergency services are services required when there is a sudden or unforeseen situation or occurrence, or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
  1. Placing the patient’s health in serious jeopardy; or
  2. Serious impairment to bodily functions; or
  3. Serious dysfunction of any bodily organ or part.

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 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 retrospective 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 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.

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:

<table>
<thead>
<tr>
<th>Service 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>RP</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>

- **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. Check the provider manual for additional instructions.

The provider receives a MO HealthNet Authorization Determination (Refer to Section 8.7) indicating if the request has been approved or denied. Any comments made by the MO HealthNet/Mc+ consultant may be found in the comments section of the MO HealthNet Authorization Determination. The provider does not receive the Prior Authorization Request or a copy of the Prior Authorization 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.*

8.6 PRIOR AUTHORIZATION (PA) REQUEST

Providers are encouraged to follow the steps outlined on the back of the form to assure proper completion of an initial submission for prior authorization.

- Complete Section I.
- Complete Section II if the participant is under the age of 21 and the services requested are expanded Healthy Children and Youth services.
- Complete Section III.

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 Prior Authorization Request for documentation.

- Place a provider label in Section IV or complete each field in that section. See Sections 13 and 14 of the provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.
- Section V is only required for certain programs. Refer to the program requirements in Sections 13 and 14 of the provider manual.

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

Providers may submit a 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 procedure for the services requested \textit{cannot} overlap dates that are already approved and \textit{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 requesting 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 \textit{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 \textit{must} be explained in detail in Field #24 of Section III.

4. Mark the PA Request “\textit{Special Handle}” at the top of the form.

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

1. When requesting a PA Request due to a change of provider \textit{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” \textit{must} be the date the new provider begins services and field 20 “THROUGH” \textit{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 \textit{must} be explained in Field #24 of Section III.

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

\textbf{8.7 MO HEALTHNET AUTHORIZATION DETERMINATION}

The MO HealthNet Authorization Determination is sent to the provider who submitted the Prior Authorization 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 provider number, 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 Prior Authorization 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.
8.7.A A DENIAL OF PRIOR AUTHORIZATION 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 either denial status, "D" or "I", a new Prior Authorization Request form must be submitted for the request to be reconsidered.

8.7.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 PA Request was received by the fiscal agent</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Authorized provider number, name and address</td>
</tr>
<tr>
<td>Participant</td>
<td>Participant's DCN, name, date of birth and sex</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>The procedure code</td>
</tr>
<tr>
<td>Modifier</td>
<td>The modifier(s)</td>
</tr>
<tr>
<td>Authorization Dates</td>
<td>The authorized from and thru dates</td>
</tr>
<tr>
<td>Units</td>
<td>The units requested, units authorized (if approved), units used</td>
</tr>
<tr>
<td>Dollars</td>
<td>The dollar amount requested, dollar amount authorized (if approved), dollar amount used</td>
</tr>
<tr>
<td>Status</td>
<td>The status codes of the PA Request</td>
</tr>
<tr>
<td></td>
<td>The status codes are:</td>
</tr>
<tr>
<td></td>
<td>A—Approved</td>
</tr>
<tr>
<td></td>
<td>C—Closed</td>
</tr>
<tr>
<td></td>
<td>D—Denied</td>
</tr>
<tr>
<td></td>
<td>I—Incomplete</td>
</tr>
<tr>
<td>Reason</td>
<td>The applicable Explanation of Benefit (EOB) reason(s)</td>
</tr>
<tr>
<td>Comments</td>
<td>Comments by the consultant which may explain denials or</td>
</tr>
</tbody>
</table>
make notations referencing specific procedure code(s)

Physician/Provider Signature  Signature of provider when submitting a Request for Change (RFC)

Date  Date of provider’s signature when submitting a RFC

Reason Code Description  Reason code description(s) listed in Reason field

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

To request a change to an approved 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 an RFC. Providers must submit a new PA Request form for reconsideration of denied detail lines.

When an RFC is approved, a MO HealthNet Authorization Determination incorporating the requested changes is sent to the provider. When an 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 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 provider manual, PA Request forms and RFCs should be mailed to:

Infocrossing Healthcare Services
P. O. Box 5700
Jefferson City, MO 65102

8.8.A WHEN TO SUBMIT A REQUEST FOR CHANGE (RFC)

Providers may submit a RFC 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 provider number. The provider number can only be corrected if both of the following conditions are met:
  • The number on the original request is in error;
  • The provider was not reimbursed for any units on the initial Prior Authorization Request.
• Discontinue services for a participant.

8.9 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

PA Requests and RFCs for the Personal Care and Home Health Programs' services for children under the age of 21 must be submitted to DHSS, Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN submits the request to Infocrossing Healthcare Services. The BSHCN staff continues to complete and submit PA Requests and RFCs for Private Duty Nursing and Physical Disabilities Waiver Programs' 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, Section of STD/HIV contract case management staff.

Personal Care and Aged and Disabled Waiver Programs' services continue to be authorized by DHSS, Division of Senior Services and Regulation staff through the Long Term Alternative Care Services (LTACS) system. The LTACS system has been upgraded to allow 12 detail lines of service information.

Please reference the provider manual for further information.
8.10 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 nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

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

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

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

The written request must include:

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

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

8.10.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

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

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

3. Emergency ambulance services

4. Independent laboratory services

END OF SECTION
TOP OF PAGE
SECTION 9 - HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION .................................................................................................................................4
9.2 PLACE OF SERVICE ........................................................................................................................................4
9.3 TYPE OF SERVICE (TEXT DEL. 9/04) ................................................................................................................5
9.4 DIAGNOSIS CODE ...........................................................................................................................................5
9.5 INTERPERIODIC SCREENS ..............................................................................................................................5
9.6 FULL HCY/EPSDT SCREEN ............................................................................................................................6
  9.6.A QUALIFIED PROVIDERS ............................................................................................................................7
9.7 PARTIAL HCY/EPSDT SCREENS ....................................................................................................................7
  9.7.A DEVELOPMENTAL ASSESSMENT ................................................................................................................8
  9.7.A(1) Qualified Providers ..................................................................................................................................8
  9.7.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN ..............................................................................................................................9
  9.7.B(1) Qualified Providers ..................................................................................................................................9
  9.7.C VISION SCREENING ......................................................................................................................................9
  9.7.C(1) Qualified Providers ..................................................................................................................................10
  9.7.D HEARING SCREEN ......................................................................................................................................10
  9.7.D(1) Qualified Providers ..................................................................................................................................10
  9.7.E DENTAL SCREEN .........................................................................................................................................11
  9.7.E(1) Qualified Providers ..................................................................................................................................11
  9.7.F ALL PARTIAL SCREENERS ..........................................................................................................................11
9.8 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY) ........................................................................................................................................12
  9.8.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS ......................................................................................12
  9.8.B LEAD RISK ASSESSMENT ..........................................................................................................................15
  9.8.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING ....................................................................15
  9.8.C(1) Risk Assessment ......................................................................................................................................15
  9.8.C(2) Determining Risk ......................................................................................................................................15
  9.8.C(3) Screening Blood Tests ............................................................................................................................16
9.8.C(4) MO HealthNet Managed Care Health Plans

9.8.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

9.8.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.8.E(1) Blood Lead Level <10 µg/dL

9.8.E(2) Blood Lead Level 10-19 µg/dL

9.8.E(3) Blood Lead Level 20-44 µg/dL

9.8.E(4) Blood Lead Level 45-69 µg/dL

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

9.8.F COORDINATION WITH OTHER AGENCIES

9.8.G ENVIRONMENTAL LEAD INVESTIGATION

9.8.G(1) Environmental Lead Investigation

9.8.H ABATEMENT

9.8.I LEAD CASE MANAGEMENT

9.8.J POISON CONTROL HOTLINE TELEPHONE NUMBER

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

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

9.9 HCY CASE MANAGEMENT

9.10 IMMUNIZATIONS

9.10.A VACCINE FOR CHILDREN (VFC)

9.11 ASSIGNMENT OF SCREENING TIMES

9.12 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

9.12.A DENTAL SCREENING SCHEDULE

9.12.B VISION SCREENING SCHEDULE

9.12.C HEARING SCREENING SCHEDULE

9.13 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

9.13.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES)
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.14</td>
<td>PARTICIPANT NONLIABILITY</td>
<td>27</td>
</tr>
<tr>
<td>9.15</td>
<td>EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS</td>
<td>27</td>
</tr>
<tr>
<td>9.16</td>
<td>STATE-ONLY FUNDED PARTICIPANTS</td>
<td>27</td>
</tr>
<tr>
<td>9.17</td>
<td>MO HEALTHNET MANAGED CARE</td>
<td>27</td>
</tr>
<tr>
<td>9.18</td>
<td>ORDERING HEALTHY CHILDREN AND YOUTH SCREENING AND HCY LEAD SCREENING GUIDE</td>
<td>29</td>
</tr>
</tbody>
</table>
SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

9.2 PLACE OF SERVICE

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

- 03 School
- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 25 Birthing Center
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 99 Other
9.3 TYPE OF SERVICE (text del. 9/04)

9.4 DIAGNOSIS CODE

The Early Periodic Screening (V20.2 for children over 28 days old, V20.31 for a newborn fewer than 8 days old, and V20.32 for a newborn 8 to 28 days old) 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.

9.5 INTERPERIODIC SCREENS

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

The interperiodic screen does not eliminate the need for full HCY screening services at established intervals based on the child’s age.
If all components of the full or unclothed physical are not met, the Reduced Preventative Screening codes must be billed.

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET</th>
<th>MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 - 99385</td>
<td>Preventative Screen; new patient</td>
<td>$23.00</td>
<td></td>
</tr>
<tr>
<td>99391 - 99395</td>
<td>Preventative Screen; established patient</td>
<td>$15.00</td>
<td></td>
</tr>
</tbody>
</table>
A full HCY/EPSDT screen includes the following:

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

It is not always possible to complete all components of the full medical HCY screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow their child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian with regard to the importance of these services. If the parent/guardian continues to refuse the service the child’s medical record must document the reason the service was not provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work was refused. By fully documenting in the child’s medical record the reason for not providing these services, the provider may bill a full medical HCY screening service even though all components of the full medical HCY screening service was not provided.
It is mandatory that the Healthy Children and Youth Screening guide be retained in the patient’s medical record as documentation of the service that was provided. The Healthy Children and Youth Screening guide is not all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. The screener must sign and date the guide and retain it in the patient’s medical record.

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they make them available to appropriate state and federal officials on request. The Healthy Children and Youth Screening guide may be photocopied or obtained at no charge from the MO Health Net Division. Providers must have this form in the medical record if billing the screening.

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

Office visits and 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 and a Certificate of Medical Necessity form is attached to the claim when submitting for payment.

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

9.6.A QUALIFIED PROVIDERS

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

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

9.7 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 refer the child for the remaining components of a full screening service.
Office visits and screenings that occur on the same day by the same provider are not covered unless the medical necessity is clearly documented in the participant’s record.

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

9.7.A DEVELOPMENTAL ASSESSMENT

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>9942959</td>
<td>Developmental/Mental Health partial screen</td>
<td>$15.00</td>
</tr>
<tr>
<td>9942959UC</td>
<td>Developmental/Mental Health partial screen with Referral</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

This screen includes the following:

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

9.7.A(1) Qualified Providers

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

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

* only infants age 0-2 months; and females age 15-20 years
9.7.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET</th>
<th>MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>9938152EP-9938552EP</td>
<td>HCY Unclothed Physical and History</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>9939152EP-9939552EP</td>
<td>HCY Unclothed Physical and History</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>9938152EPUC-9938552EPUC</td>
<td>HCY Unclothed Physical and History with Referral</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>9938552EPUC-9939152EPUC</td>
<td>HCY Unclothed Physical and History with Referral</td>
<td>$20.00</td>
<td></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.

9.7.B(1) Qualified Providers

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

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

9.7.C VISION SCREENING

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET</th>
<th>MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>9942952</td>
<td>Vision Screening</td>
<td>$5.00</td>
<td></td>
</tr>
</tbody>
</table>
9942952UC ---------------
Vision Screening with Referral -------------- $5.00

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

9.7.C(1) Qualified Providers

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

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

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

9.7.D HEARING SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429EP---------</td>
<td>HCY Hearing Screen ----------------------- $5.00</td>
<td></td>
</tr>
<tr>
<td>99429EPUC ------</td>
<td>HCY Hearing Screen with Referral---------- $5.00</td>
<td></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.

9.7.D(1) Qualified Providers

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

- Physician, nurse practitioner or nurse midwife*;
- Audiologist or hearing aid dealer/fitter; or
- Speech pathologist.
* Reimbursement for immunizations and laboratory procedures is not included in the screening fee and may be billed separately.

### 9.7.E DENTAL SCREEN

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET</th>
<th>MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>99429</td>
<td>HCY Dental Screen</td>
<td></td>
<td>$20.00</td>
</tr>
<tr>
<td>99429UC</td>
<td>HCY Dental Screen with Referral</td>
<td></td>
<td>$20.00</td>
</tr>
</tbody>
</table>

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

### 9.7.E(1) Qualified Providers

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

### 9.7.F ALL PARTIAL SCREENERS
The provider of a partial medical screen must have a referral source to send the participants for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

9.8 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 refer to 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.

9.8.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.

<table>
<thead>
<tr>
<th>SIGNS AND SYMPTOMS</th>
<th>MILD TOXICITY</th>
<th>SEVERE TOXICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myalgia or paresthesia</td>
<td>Mild fatigue</td>
<td>Paresis or paralysis</td>
</tr>
<tr>
<td>Mild fatigue</td>
<td></td>
<td>Encephalopathy—may abruptly lead to</td>
</tr>
</tbody>
</table>

General Manual

Production - 04/30/2012
Irritability, seizures, changes in level of consciousness, coma and death
Lethargy
Occasional abdominal discomfort
Lead line (blue-black) on gingival tissue
Colic (intermittent, severe abdominal cramps)

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

EXPOSURE PATHWAYS

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

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

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.
Section 9 - Healthy Children and Youth Program

9.8.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 providers’ 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.

9.8.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.

9.8.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.

9.8.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 recategorized as high risk.

9.8.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.
Section 9 - Healthy Children and Youth Program

9.8.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.

9.8.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</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>83655</td>
<td>Lead, quantitative blood</td>
<td>$15.00</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 Missouri Code of State Regulations 19 CSR 20-20.
9.8.E  BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.8.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.

9.8.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.

9.8.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.

9.8.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.

9.8.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.

9.8.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.
9.8.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.

9.8.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.

9.8.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.

9.8.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 Manual.

9.8.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.

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

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

Kneibert Clinic, LLC PO Box
PO Box 220
Poplar Bluff, MO 63902

Hannibal Clinic Lab
711 Grand Avenue
Hannibal, MO 63401

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

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

Physicians Reference Laboratory
7800 W. 110 St.
Overland, MO 66210
## Section 9 - Healthy Children and Youth Program

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

Quest Diagnostics  
11636 administration  
St. Louis, MO 63146  

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

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

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

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

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

### 9.8.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>
<th>City, State Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arup Laboratories</td>
<td>500 Chipeta Way, Salt Lake City, UT 84108</td>
<td>Chelmsford, MA 01824</td>
</tr>
<tr>
<td>Iowa Hygienic Lab</td>
<td>Wallace State Office Building, Des Moines, IA 50307</td>
<td>Iowa Methodist Medical Center, 1200 Pleasant St, Des Moines, IA 50309</td>
</tr>
<tr>
<td>Kansas Department of Health</td>
<td>619 Anne Ave, Kansas City, KS 66101</td>
<td>Mayo Medical Laboratories, 2050 Superior Dr. NW, Rochester, MN 55901</td>
</tr>
<tr>
<td>Leadcare, Inc.</td>
<td>52 Court Ave, Stewart Manor, NY 11530</td>
<td>Physician’s Reference Laboratory, 7800 W. 110th St, Overland Park, KS 66210</td>
</tr>
<tr>
<td>Quincy Medical Group</td>
<td>1025 Main St, Quincy, IL 62301</td>
<td>Tamarac Medical, 7800 Broadway Ste. 2C, Centennial, Co 80122</td>
</tr>
<tr>
<td>Specialty Laboratories</td>
<td>2211 Michigan Ave, Santa Monica, CA 90404</td>
<td></td>
</tr>
</tbody>
</table>
9.9 HCY CASE MANAGEMENT

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1016EP</td>
<td>HCY Case Management</td>
<td>$12.50</td>
</tr>
<tr>
<td>T1016TSEP</td>
<td>HCY Case Management; Follow-up</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

For more information regarding HCY Case Management, refer to Section 13.66.D of the Physician's Manual.
9.10 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.

9.10.A VACCINE FOR CHILDREN (VFC)

For information on the Vaccine for Children (VFC) program, reference Section 13.13.A of the Physician Program.

9.11 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.

9.12 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

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

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

The HCY Program makes available to MO HealthNet participants under the age of 21 a full HCY screening examination during each of the age categories in the following periodicity schedule:
9.12.A DENTAL SCREENING SCHEDULE
   • Twice a year from age 6 months to 21 years.

9.12.B VISION SCREENING SCHEDULE
   • Once a year from age 3 to 21 years.

9.12.C HEARING SCREENING SCHEDULE
   • Once a year from age 3 to 21 years.

9.13 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.
9.13. PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES 
(EXPANDED HCY SERVICES)

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

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

9.14 PARTICIPANT NONLIABILITY

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

9.15 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.16 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.

9.17 MO HEALTHNET MANAGED CARE

MO HealthNet Managed Care health plans are responsible for insuring that Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.
The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or mental illness, or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid state plan. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose and may only be limited by medical necessity. According to the MO HealthNet Managed Care contracts, the MO HealthNet Managed Care health plans are responsible for providing all EPSDT/HCY services for their enrollees.

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

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

- A comprehensive unclothed physical examination
- A comprehensive health and developmental history including assessment of both physical and mental 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 screen according to established guidelines
- Hearing screen
- Vision screen
- 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 have 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 V20.2, V20.31, or V20.32 when reporting encounter data to the MO HealthNet Division on Full and Partial EPSDT/HCY Screens:
Section 9 - Healthy Children and Youth Program

Unclothed Physical and History 99381 through 99385 and 99391 through 99395
Developmental/Mental Health 9942959 9942959UC
Hearing Screen 99429EP 99429EPUC
Vision Screen 9942952 9942952UC
Dental Screen 99429 99429UC

The history and exam of a normal newborn infant and initiation of diagnostic and treatment programs may be reported by the plans with procedure code 99431. Normal newborn care in other than a hospital or birthing room setting may be reported by the plans with procedure code 99432. 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-4 code. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and an 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.

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

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

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

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

- Adult Day Health Care
- Aged and Disabled Waiver
- AIDS Waiver
- Ambulance
- Comprehensive Day Rehabilitation
- Dental
- Durable Medical Equipment
- Environmental Lead Assessment
- Hearing Aid
- Hospice
- Nursing Home
- Optical
- Personal Care
- Private Duty Nursing
- Psychology/Counseling
- Rehabilitation Centers
- Therapy
SECTION 11 - MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM

11.1 MO HEALTHNET 'S MANAGED CARE PROGRAM .................................................................2
   11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE
       HEALTH PLANS ...............................................................................................................2
   11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE
       HEALTH PLANS ...........................................................................................................2
11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT ......................3
11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS.....4
11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS ....4
11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS..............................................5
11.6 STANDARD BENEFITS UNDER MO HEALTHNET MANAGED CARE PROGRAM ....6
   11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF
       ASSISTANCE FOR PREGNANT WOMEN .......................................................................8
11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE
       PROGRAM ......................................................................................................................9
11.8 QUALITY OF CARE .......................................................................................................10
11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS ..........11
   11.9.A NON-BILLING MO HEALTHNET PROVIDER ......................................................11
11.10 EMERGENCY SERVICES ..............................................................................................11
11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) ..............12
   11.11.A PACE PROVIDER AND SERVICE AREA ..............................................................12
   11.11.B ELIGIBILITY FOR PACE .....................................................................................13
   11.11.C INDIVIDUALS NOT ELIGIBLE FOR PACE .......................................................13
   11.11.D LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS ......................................13
   11.11.E PACE COVERED SERVICES ...............................................................................14
SECTION 11 - MO HEALTHNET MANAGED HEALTH CARE 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 in three regions of the state: Eastern (St. Louis area), Central 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.

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, 5 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).

A listing of the health plans providing services for the Eastern region Managed Care Program can be found on the MHD website at [http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm](http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm).

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).
A listing of the health plans providing services for the Central region Managed Care Program can be found on the MHD website at http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm.

11.1.C 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).

A listing of the health plans providing services for the Western region Managed Care Program can be found on the MHD website at http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm.

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.

Participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program 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/point of service/Internet 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 status for each date of service that a MO HealthNet Managed Care health plan is not listed for the participant.

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the MO HealthNet 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 foster care assistance or adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the MO HealthNet Managed Care Program. The option is entirely up to the participant, parent or guardian.
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 3 groups:

- Individuals with the following ME codes fall into Group 1: 05, 06, 10, 18, 19, 21, 24, 26, 40, 43, 44, 45, 60, 61 and 62.
- Individuals with the following ME codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70 and 88.
- Individuals with the following ME codes fall into Group 5: 71, 72, 73, 74 and 75;

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.

- Individuals who are eligible for both Medicare and MO HealthNet
- Individuals who are residents of a domiciliary, residential care facility or nursing home
- Individuals who are receiving MO HealthNet as a permanently and totally disabled individual
- Pregnant Women who are presumptively eligible under the Temporary Eligibility During Pregnancy (TEMP) program
- Individuals eligible for Blind Pension or Aid to the Blind
- Individuals in a state mental institution or institutional care facility
- AIDS Waiver Participants
- Missouri Children with Developmental Disabilities Waiver (ME Codes 33 and 34)
- 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.
• Terminated Temporary Assistance for Needy Families (TANF) individuals who have had their medical eligibility temporarily reinstated. (ME code 81)
• Presumptive Eligibility for Children. (ME code 87)
• Voluntary Placement (ME Code 88)
• Children placed in foster homes or residential care by the Department of Mental Health (ME Codes 28, 49 and 67).
• Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary - QMB).
• Children placed in residential care by their parents if eligible for MO HealthNet on the date of placement (ME code 65).
• Women eligible under ME Codes 83 and 84 (Breast and Cervical Cancer Treatment).
• Individuals eligible under ME Code 82 (MoRx).

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
Section 11 - MO HealthNet Managed Health Care Delivery System

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 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 room services
- Ambulatory surgical center, birthing center
- 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.
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services
- 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. Dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.
- Personal care/advanced personal care
- Adult day health 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), and one pair of eyeglasses every two years (during any 24 month period of time).

- 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 and substance abuse services. Covered for children (except Group 4) and adults in all Managed Care regions without limits. 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, provisional licensed clinical social worker, licensed professional counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or state certified behavioral health or substance abuse program
  - 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 and substance abuse services that are court ordered, 96 hour detentions, and for involuntary commitments.

• Behavioral health and substance abuse services to transition the Managed Care member who received behavioral health and substance abuse 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. 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 twenty-one (21) years of age. For some members the age limit may be less than nineteen (19) years of age. Some services need prior approval before getting them. Women must be in a MO HealthNet category of assistance for pregnant women to get these extra benefits.
• Comprehensive day rehabilitation, services to help you recover 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 per year, and, for children under age twenty-one (21), HCY/EPSDT optical screen and services;
• Podiatry, medical services for your feet;
• Services that are included in the comprehensive benefit package, medically necessary, and identified in the IFSP or IEP (except for physical, occupational, and speech therapy services).
• Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

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

• Abortion services (subject to MO HealthNet Program benefits and limitations)
• Physical, occupational and speech therapy services for children included in:
  • the Individual Education Plan (IEP); or
  • the Individual Family Service Plan (IFSP)
• Environmental lead assessments for children with elevated blood lead levels
• Community Psychiatric Rehabilitation program services
• Comprehensive substance treatment and rehabilitation (CSTAR) services
• Lab tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
• SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
• MRDD waiver services for MRDD waiver participants included in all Managed Care regions.
• Bone marrow/stem cell and solid organ transplant services (corneal tissue transplants are covered as an outpatient benefit under the MO HealthNet Managed Care health plan). Services include the hospital stay from the date of transplant through the date of discharge, procurement, and physician services related to the transplant and procurement procedures. Pre-transplant and post-transplant follow-up care after the inpatient transplant discharge are the responsibility of the MO HealthNet Managed Care health plan.
• 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:
    • comprehensive substance treatment and rehabilitation (CSTAR) provider
    • 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
    • Missouri certified substance abuse counselor
    • a qualified behavioral health professional in the following settings:
      • federally qualified health center (FQHC)
      • 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 the Internet or interactive voice response (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). Providers who need to contact the PCP, 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 managed health care 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 the Internet or 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 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.

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 lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

General Manual

Production - 04/30/2012
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 PACE PROVIDER AND SERVICE AREA

Missouri and CMS have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St Louis. Services are provided to eligible individuals who reside in areas with the following zip codes:

63005 63011 63017 63021 63025 63026 63031 63033
63034 63038 63040 63042 63043 63044 63049 63069
11.11.B ELIGIBILITY FOR PACE
The PACE program is one more option along the continuum of long-term care services available under the Department of Health and Senior Services' (DHSS) "Missouri Care Options" (MCO) program, which offers a variety of home and community-based services to prevent or delay entry into a nursing facility. PACE targets individuals who require services above and beyond the standard package of in-home services available through MCO. The DHSS is the entry point for assessment for PACE program eligibility and referral to the PACE provider. Referrals for the program may be made to the DHSS office in St. Louis by calling (314) 340-7300.

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.C 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 Mentally Retarded (ICF/MR);
- persons enrolled in the Managed Care program;
- persons currently enrolled with a MO HealthNet hospice provider;

11.11.D 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. Lock-in information is available to providers through the Internet and Interactive Voice Response (IVR) at (573) 635-8908. A PACE Lock-In Provider is recognized by an "89" provider number. 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.E 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;
• 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 ..................................................2
12.2 AGED AND DISABLED WAIVER SERVICES ......................................................................2
12.3 DETERMINING A FEE ........................................................................................................2
12.3.A ON-LINE FEE SCHEDULE ............................................................................................3
12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS) ....................3
12.5 PARTICIPANT COST SHARING AND COPAY .................................................................3
12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT .........................................................................................................................4
12.7 PRIOR CONTENTS NO LONGER APPLICABLE .................................................................4
12.8 DIRECT DEPOSIT OPTION .............................................................................................4
SECTION 12 - REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

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

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

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

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

12.2 AGED AND DISABLED WAIVER SERVICES

Reimbursement for aged and disabled waiver services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Division to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider’s actual billed charge (should be the provider’s usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

12.3 DETERMINING A FEE

Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established.
Section 12 - Reimbursement Methodology

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

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

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

12.3.A ON-LINE FEE SCHEDULE

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

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

Refer to Section 13 for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

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

12.5 PARTICIPANT COST SHARING AND COPAY

Certain MO HealthNet services are subject to participant cost sharing or copay. The cost sharing amount is paid by the participant at the time services are rendered. Services of the Aged and Disabled Waiver Program described in this manual are not subject to a cost sharing or copay amount.
12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

Aged and disabled waiver services are not included as a plan benefit in MO HealthNet's Managed Care program.

12.7 PRIOR CONTENTS NO LONGER APPLICABLE

12.8 DIRECT DEPOSIT OPTION

The MO HealthNet Program offers providers the option of having their MO HealthNet checks automatically deposited into their checking or savings accounts. This option is much quicker than receiving payment through the mail and eliminates the possibility of lost checks.

Providers electing to participate in direct deposit must complete the Application for Provider Direct Deposit form. Direct deposit begins following a submission of a properly completed application form to the MO HealthNet Division, the successful processing of a test transaction through the banking system and the authorization of the Division to make payment using the direct deposit option. 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 Application for Provider Direct Deposit form provides instructions for completing the form on the reverse side. This form must also be used if providers wish to change an account number or cancel their election to participate. Exact copies of the form may be used. One form must be completed for each provider number. Providers may obtain additional forms by contacting the Provider Enrollment Unit of the MO HealthNet Division at P.O. Box 6500, 615 Howerton Court, Jefferson City, MO 65102-6500 or by e-mail at providerenrollment@dss.mo.gov. The provider may also download these forms from the website at www.emomed.com. Please read the form and instructions carefully; Section C contains statements regarding legal obligations.

The MO HealthNet Division 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 or mailed. Providers and their representatives are not permitted to accept delivery of MO HealthNet checks in person.
The MO HealthNet Remittance Advice is mailed separately or may be downloaded from the billing website at www.emomed.com.
SECTION 13 - BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION .................................................................................................................. 4

13.1.A SERVICE DEFINITIONS .................................................................................................................. 4

13.1.A(1) Homemaker Services .................................................................................................................. 4

13.1.A(2) Chore Services ............................................................................................................................ 5

13.1.A(3) Respite Care Services .................................................................................................................. 6

13.1.A(4) Institutional Respite Services ..................................................................................................... 7

13.1.A(5) Advanced Respite Care ............................................................................................................. 7

13.1.A(6) Required Nurse Visits ............................................................................................................... 8

13.1.A(7) Nurse Respite Care .................................................................................................................... 8

13.1.A(8) Home Delivered Meals .............................................................................................................. 9

13.1.A(9) Adult Day Care-Basic Services .................................................................................................. 9

13.1.B SERVICE LIMITATIONS ............................................................................................................... 10

13.1.B(1) Place of Service ......................................................................................................................... 10

13.1.C PROVIDER PARTICIPATION ........................................................................................................... 10

13.1.C(1) Homemaker, Chore and In-Home Respite ................................................................................. 10

13.1.C(2) Home Delivered Meals ............................................................................................................. 10

13.1.C(3) Adult Day Care-Basic Services ................................................................................................ 11

13.1.D RECIPIENT ELIGIBILITY .................................................................................................................. 11

13.1.E AUTHORIZATION OF SERVICES .................................................................................................. 12

13.2 ADMINISTRATION AND EMPLOYEE RESPONSIBILITY ................................................................. 12

13.2.A RECIPIENT RIGHTS ......................................................................................................................... 13

13.2.B ELDERLY ABUSE, NEGLECT, EXPLOITATION ............................................................................. 14

13.2.C NONDISCRIMINATION .................................................................................................................... 14
Section 13 - Benefits and Limitations

13.2.D PRIOR CONTENTS NO LONGER APPLICABLE ............................................................. 14
13.2.E RECIPIENT NONLIABILITY .................................................................................. 14
13.2.F DISCHARGE POLICIES AND PROCEDURES ......................................................... 14
13.2.G PROVIDER COMPLIANCE .................................................................................. 15

13.3 PERSONNEL REQUIREMENTS .................................................................................. 16
13.3.A SUPERVISORY STAFF OF IN-HOME SERVICES .................................................. 16
13.3.B IN-HOME SERVICES WORKER REQUIREMENTS ................................................ 16

13.4 SUPERVISION OF IN-HOME SERVICES ................................................................ 17

13.5 TRAINING FOR IN-HOME SERVICES ...................................................................... 18
13.5.A ORIENTATION AND BASIC TRAINING ................................................................. 18
13.5.B DOCUMENTATION OF BASIC AND IN-SERVICE TRAINING FOR IN-HOME
SERVICES WORKERS .................................................................................................. 19
13.5.B(1) Basic Training for In-home Services Workers .................................................... 19
13.5.B(2) Code Of Ethics .................................................................................................. 20
13.5.C WAIVER OF BASIC TRAINING FOR IN-HOME SERVICES WORKERS ............... 20
13.5.C(1) Experience or Aide Certification ....................................................................... 20
13.5.C(2) Licensed Nurse/Certified Nurse Aide (CNA) ...................................................... 21
13.5.C(3) Provider Verification ........................................................................................ 21
13.5.D ADVANCED RESPITE WORKER TRAINING ........................................................ 21
13.5.E IN-SERVICE TRAINING FOR IN-HOME SERVICES WORKERS .......................... 21

13.6 RECORDS .................................................................................................................. 22
13.6.A RECIPIENT CASE RECORD .................................................................................. 22
13.6.B PERSONNEL RECORD ....................................................................................... 23
13.6.C RETENTION OF RECORDS .................................................................................. 24
13.6.D ADEQUATE DOCUMENTATION ....................................................................... 24
13.6.D(1) Required Documentation .................................................................................. 24
13.6.D(2) Unit of Service .................................................................................................. 26
13.6.D(3)  Accrued Units—Homemaker, Chore and Respite (15-Minute Unit Services) .......... 27
13.6.D(4)  Prior Contents No Longer Applicable ................................................................. 27
13.6.D(5)  Billing Services by the Month—Home Delivered Meals ..................................... 27
13.6.D(6)  Billing Services by the Month—Adult Day Care-Basic ........................................ 28

13.7  QUALITY ASSURANCE .................................................................................................. 28

13.8  AUTHORIZED SERVICES FOR HOSPICE .................................................................. 28

13.9  MANAGED HEALTH CARE PROGRAM ..................................................................... 29

13.10  RECIPIENT COST SHARING AND COPAY .............................................................. 29
SECTION 13—BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

Aged and disabled waiver services are included in the Missouri Medicaid Program under the authority of a Home and Community-Based Waiver granted by the Centers for Medicare & Medicaid Services (CMS). Under a waiver, certain services that could not otherwise be reimbursed under Title XIX may be provided to a select group of recipients, in order to provide an alternative to institutional care. CMS approval of a waiver is subject to strict conditions of eligibility, case management, accountability and cost containment. Missouri’s Home and Community-Based Waiver for the Aged and Disabled currently has been approved until April 2008. Services provided through the Aged and Disabled Waiver include homemaker services, chore services, basic and advanced respite care, institutional respite, nurse respite care, home delivered meals and adult day care - basic services.

13.1.A SERVICE DEFINITIONS

13.1.A(1) Homemaker Services

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

- Planning and preparing meals, including special diet menus, and cleaning-up meals;
- Tidying and dusting the home;
- Cleaning kitchen counters, cupboards, and appliances, including oven, surface burners and inside refrigerator;
- Cleaning bathroom fixtures;
- Laundering clothes and linens;
- Making beds and changing sheets;
- Ironing and mending clothes;
- Washing dishes, pots, pans and utensils;
Section 13 - Benefits and Limitations

• Washing inside windows and cleaning venetian blinds, which are within reach without climbing;
• Sweeping and/or vacuuming, and mopping floors;
• Bagging trash inside the home and putting it out for pick-up;
• Shopping for essential items (e.g., groceries, cleaning supplies, etc.);
• Performing essential errands (e.g., picking up medication, posting mail, etc.); and
• Instructing the client in ways to become self sufficient in performing household tasks.

13.1.A(2) Chore Services

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

• Washing walls and woodwork;
• Cleaning closets, basements, and attics;
• Shampooing rugs;
• Airing mattresses and bedding;
• Spraying for insects within the home using over-the-counter supplies;
• Providing pest control within the home (e.g., setting traps and putting out over-the-counter poisons);
• Mowing lawns;
• Removing snow;
• Installing windows and screens;
• Washing inside windows and/or cleaning blinds, which require climbing;
• Washing outside windows and screens, which require climbing;
• Bagging outside trash;
• Performing minor carpentry repair;
• Performing minor electrical repair;
• Performing simple handyman activities;
Section 13 - Benefits and Limitations

- Washing and/or changing curtains and drapes; and
- Performing essential errands (e.g., picking up medications, posting mail, etc.)

13.1.A(3) Respite Care Services

Respite care is the provision of required care to a frail elderly individual in order to provide temporary relief to the usual caregiver(s). In-home respite care is the delivery of the respite services within the confines of the client’s normal living situation. The cost of respite care, in any given month, combined with the cost of all other waivered services provided in that month, may not exceed the average statewide cost per resident per month of nursing home care. Services are oriented toward maintenance and supervision and include meal preparation, minor chores, minor personal care and companion sitting. Respite services provided by members of the recipient’s household or immediate family are not covered by Medicaid.

A unit of basic block respite care is from 9 to 12 consecutive hours of service to one individual. Two units per day may be authorized. Basic respite care may also be authorized in units of 15 minutes.

Basic respite care (S5150) is intended to offer short-term periods of caregiver relief.
- Basic respite authorization shall not exceed 32 units (8 hours) in any one 24-hour period.
- Additional in-home services—other than respite—may be authorized in conjunction with hourly respite care.

Basic block respite care (S5151) is intended to offer caregiver relief during long periods of recipient dependency.
- A unit of basic block respite is 9-12 consecutive hours.
- Two consecutive units of basic block respite may be authorized during any one visit, intending to cover up to a 24 hour period.
- Additional services may not be delivered in the same day as basic block respite.
- Basic block respite care can only be funded through Medicaid.

In-home respite care must include the provision of the following services as appropriate to the needs of the recipient, authorized by the Missouri Division of Senior Services and Regulation, and specified in a plan of care developed by the provider.
- Supervision—the respite care worker must provide supervision of the recipient for the duration of the service period although sleeping is permitted when the recipient is asleep. The worker must be in proximity to the recipient during sleep periods, although not necessarily in the same room.
• Companionship—the worker must provide companionship during the recipient’s waking hours and attempt to make the recipient as comfortable as possible.

• Direct Client Assistance—The worker provides direct client assistance as needed to meet the needs usually provided by the regular caregiver.

13.1.A(4) Institutional Respite Services

Institutional respite services (H0045) are intended to offer caregiver relief through placement of an eligible adult in a Medicaid certified nursing facility. Institutional respite care shall include basic room, board, skilled nursing services and protective oversight.

Institutional respite services allow an eligible Medicaid recipient admission to a nursing facility for periods covering up to a maximum of six weeks in any calendar year for any individual. The cost of respite care in any given month, combined with the cost of all other waivered services provided in that month, must not exceed the average statewide cost per resident per month of nursing facility care.

13.1.A(5) Advanced Respite Care

Advanced respite care services are maintenance services provided to a client with special needs in that individual's residence for the purpose of temporary relief to a caregiver who lives with the client. Clients appropriate for this service include persons with special needs approved by the Division of Senior Services and Regulation. This includes, but is not limited to clients who:

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

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

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

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

• have special monitoring and assistance needs due to swallowing problems; and

• have care needs similar to clients for whom basic respite is appropriately authorized but with a higher level of oversight required.

Advanced respite care (S5150TF) may be delivered for up to 20 consecutive 15-minute units (5 hours).

Advanced block respite (S515152TF) may be delivered to cover a six to eight hour period of time. Two units may be authorized during any continuous period of time when the client is in need of fourteen to sixteen hours of advanced respite care.
Advanced daily respite care (S5151TF) may be delivered for a continuous seventeen to twenty-four hour period. No other in-home services may be delivered during the same twenty-four hour period as advanced daily respite care.

Advanced respite care includes all personal care and advanced personal care services. Additional in-home services are not to be delivered until the whole unit has been delivered. Example: advanced respite care (block), one unit is six to eight hours, additional in-home services are not to be delivered by the provider until all eight hours have been delivered.

Advanced respite care provided by members of the recipient's household or immediate family are not covered by Medicaid.

13.1.A(6) Required Nurse Visits

Nurse visits shall be provided to advanced respite recipients as follows:

1. An initial on-site evaluation of the client's condition and identification of special training needs for the advanced respite care worker shall be made by the provider RN prior to initiation of service.

2. A monthly nurse visit is authorized for each advanced respite care client for each month advanced respite care is authorized. This visit evaluates the adequacy of the authorized services to meet the needs and condition of the client. However, the visit does not need to be authorized if there is a previously authorized nurse visit from the same agency.

3. For clients receiving ongoing advanced respite care and nurse respite care services, it is required that on-site visits by a RN be conducted at six (6) month intervals. During these visits, the RN shall conduct an evaluation of the client's condition and the adequacy of the care plan.

13.1.A(7) Nurse Respite Care

Nurse respite care is provided in accordance with licensure requirements by an RN or by an LPN under the supervision of an RN to a recipient with skilled nursing needs that are normally performed by a live-in caregiver. Clients appropriate for this service include, but are not limited to those who are in need of:

- tracheostomy care requiring removal, cleaning and replacing of the tube;
- ventilator care;
- administration of tube feeding;
- suctioning;
- administration of medication requiring skilled care;
Section 13 - Benefits and Limitations

- diabetic monitoring (including client on sliding insulin scale);
- treatment of pressure sores;
- sterile dressing changes;
- colostomy irrigation; and/or
- catheter changes or catheterizations.

Nurse respite care may be delivered for a minimum of 16 15-minutes units (four hour block). Up to 96 units may be authorized for any continuous 24-hour period of time.

Nurse respite care includes all personal care and advanced personal care services. Additional in-home services are not to be delivered until 16 15-minutes units (four hour block) have been delivered.

Nurse respite care provided by members of the recipient's household or immediate family are not covered by Medicaid.

13.1.A(8) Home Delivered Meals

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

A reimbursable unit of service is one meal delivered to the home of the recipient, and individuals must reside in their home or the home of a caregiver.

The maximum units of service are two meals per day.

13.1.A(9) Adult Day Care-Basic Services

Adult Day Care-Basic (S510252) is a service to provide the continuous care and supervision of aged and disabled individuals in an adult day care setting. Assistance with activities of daily living, planned group activities, food services and client observation are required services. Planned group activities may include socialization, recreation and cultural activities that stimulate the individual and help the client maintain optimal functioning. The provider must arrange or provide transportation to the adult day care facility at no cost to the recipient regardless of the location of a recipient. As this service includes one meal per day which must meet at least one-third of the minimum daily nutritional requirements, prior authorization for the home delivered meals service under the waiver are limited to one meal per day for any individual receiving adult day care-basic services.
13.1.B SERVICE LIMITATIONS

13.1.B(1) Place of Service

An aged and disabled waiver provider may provide care in the following places of service:

12—Home; for homemaker, chore, in-home respite care, and home delivered meals.

32—Nursing Facility; for institutional respite care only.

99—Other Place of Service; for adult day care-basic services.

13.1.C PROVIDER PARTICIPATION

The provider of aged and disabled waiver services must have a valid participation agreement in effect with the Department of Social Services (DSS), Division of Medical Services (DMS).

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

To enroll in homemaker, chore and in-home respite, the applicant must be an approved Department of Health and Senior Services, Division of Senior Services and Regulation Title XX Social Services Block Grant (SSBG) provider. Providers must maintain their approval to participate as a Title XX provider, whether or not they actually service Title XX eligible clients, in order to remain qualified to participate in the Title XIX (Medicaid) Aged and Disabled Waiver Program.

The provider of institutional respite services must have a valid participation agreement in effect with the Department of Social Services (DSS), Division of Medical Services (DMS). To enroll, an applicant must:

- be currently licensed and certified by the Division of Senior Services and Regulation as an intermediate care or skilled nursing facility.

13.1.C(2) Home Delivered Meals

The home delivered meals provider must be enrolled as an Aged and Disabled Waiver Program provider with a home delivered meals specialty and must maintain qualification as a nutrition service provider with the Division of Senior Services and Regulation meeting the requirements set forth in RSMo 660.099, 19 CSR 15-7.060 and 19 CSR 15-7.010.

The provider shall have the capability to provide the number of meals prior authorized regardless of the location of a recipient within the designated service area. Designated service areas are determined by the Division of Senior Services and Regulation.
To request enrollment criteria, potential providers may contact the Division of Senior Services and Regulation at (573) 751-3082.

All aged and disabled waiver providers shall immediately notify the Division of Senior Services and Regulation's central office and the Division of Medical Services’ Provider Enrollment Unit of any changes in location, telephone number, administrative or corporate status.

The provider shall notify the Division of Senior Services and Regulation and the Division of Medical Services at least 30 days prior to the termination of the provider agreement.

13.1.C(3)  Adult Day Care-Basic Services

Medicaid providers of adult day care-basic services are required to be licensed by the Department of Health and Senior Services, Division of Senior Services and Regulation, meeting the requirements of 19 CSR 30-90.010-080, before applying for enrollment with Medicaid. The license issued by the Division of Senior Services and Regulation must be for the social type of program with the adult day care program. Providers must maintain their license in order to remain qualified to participate in the Title XIX (Medicaid) Aged and Disabled Waiver Program.

13.1.D  RECIPIENT ELIGIBILITY

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

- be 63 years of age or older;
- be assessed by the Division of Senior Services and Regulation to have certain impairments and unmet needs, such that the recipient requires admission to a hospital or a nursing facility if aged and disabled waiver services are not provided; and
- be willing to receive comprehensive assessment and case management services from the Division of Senior Services and Regulation.

Recipients in State only medical eligibility categories and uninsured working parents who meet the above criteria are not eligible to receive aged and disabled waiver services reimbursed through the Medicaid Program. Reference Section 1.

The recipient must be Medicaid eligible and meet the criteria for aged and disabled waiver services on the day the service is delivered. This is a requirement even when the service has been prior authorized by the Division of Senior Services and Regulation. It is the responsibility of the provider to verify the recipient’s Medicaid eligibility on the day the service is provided by contacting the interactive voice response (IVR) system at (573) 635-8908 or through a point of service (POS) terminal. Reference Section 3.3 for further information.
13.1.E AUTHORIZATION OF SERVICES

All units of Title XIX aged and disabled waiver services must be authorized by a case manager with the Missouri Division of Senior Services and Regulation before services can be delivered. Following development of a care plan by the case manager and its review by the recipient’s physician, a set of documents is sent to the provider. These include the following:

- Alternative Services Intake/Screening (DA-1);
- Service Plan (DA-3);
- Service Plan Supplement (DA-3a); and
- LCDE (LTACS Client Data Entry).

The DA-13/LCDE shows how many units of service are authorized and specifies the period covered by the authorization. Services may be prior authorized for up to 12 months and must be reauthorized by the Division of Senior Services and Regulation for subsequent periods of service.

The DA-3a Service Plan Supplement is a checklist that shows the specific service activities that must be performed, at a minimum, by the in-home services worker. Additional service activities may be performed as long as the time spent does not exceed the time (units) authorized.

More information about documentation is contained in Section 14 of this Manual.

13.2 ADMINISTRATION AND EMPLOYEE RESPONSIBILITY

For each worker, the provider shall maintain documentation of at least two employment or personal references contacted within 30 calendar days before or after the date of employment. References shall be former employers or other reputable persons, excluding relatives of the worker.

For in-home services workers, the provider shall establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with clients when the employee has a communicable condition, including colds or flu. The provider shall ensure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out. The provider shall ensure that no in-home services worker is a member of the immediate family of the client being served by that worker. A family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

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

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

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

The provider shall make essential supplies available to the in-home services worker to perform tasks for the initial visit. It is the recipient’s responsibility to provide supplies thereafter as necessary.

The provider must ensure all subcontractors comply with all standards.

The provider must have an established grievance system through which a recipient may present grievances concerning the operation of the Aged and Disabled Waiver Program. The provider must document the recipient's receipt of information regarding the grievance procedures.

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

The provider must have the capability to provide services outside of regular business hours, on weekends, and on holidays in accordance with the Service Plan for each client. Services must be provided by qualified persons on the provider’s staff.

The provider must deliver the aged and disabled waiver service within seven calendar days of receipt of the Service Plan or on the beginning date specified by the authorization whichever is later, and on a regular basis thereafter in accordance with the Service Plan. The date of receipt must be recorded on each service authorization by the provider. If service is not initiated within the required time period, detailed written justification must be maintained in the recipient’s file and sent to the Division of Senior Services and Regulation case manager.

13.2.A RECIPIENT RIGHTS

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

- be treated with respect and dignity;
- have all personal and medical information kept confidential;
- have direction over the services provided, to the degree possible, within the Service Plan;
Section 13 - Benefits and Limitations

- know the provider’s established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;
- receive service without regard to race, creed, color, age, sex or national origin; and
- receive a copy of the code of ethics under which services are provided.

13.2.B ELDERLY ABUSE, NEGLECT, EXPLOITATION

- The aged and disabled waiver provider must report all instances of potential abuse, neglect and/or exploitation of a recipient to the Division of Senior Services and Regulation Elderly Abuse and Neglect Hotline, (800) 392-0120, including all instances that may involve an employee of the provider agency.
- The provider shall agree to not accept donations, contributions, gifts or payments from any recipient of aged and disabled waiver services.
- The provider must monitor a current copy of the Division of Senior Services and Regulation's Employee Disqualification List to ensure that no current or prospective employee’s name appears on the list and take the appropriate action once it is discovered by the provider that the employee is on the Employee Disqualification List.

13.2.C NONDISCRIMINATION

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

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

13.2.D PRIOR CONTENTS NO LONGER APPLICABLE

13.2.E RECIPIENT NONLIABILITY

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

13.2.F DISCHARGE POLICIES AND PROCEDURES

Services for a client shall be discontinued by a provider agency under the following circumstances:
- When the client’s case is closed by the state agency;
Section 13 - Benefits and Limitations

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

- When the client is noncompliant with the agreed upon plan of care. Noncompliance requires persistent actions by the client or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider shall notify the state agency case manager in writing of the noncompliant acts and request that the client’s services be discontinued;

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

- When a provider is unable to continue to meet the maintenance needs of a client. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client’s services be discontinued; or

- When a provider is unable to continue to meet the maintenance needs of a client whose plan of care requires advanced respite care services. In these circumstances the provider shall provide written notice of discharge to the client or client’s family and the state agency case manager at least 21 days prior to the date of discharge. During this 21 day period, the state agency case manager shall assist in making appropriate arrangements with the client for transfer to another agency, institutional placement or other appropriate care. Regardless of circumstances, the provider must continue to provide care in accordance with the plan of care for these 21 days or until alternate arrangements can be made by the case manager, whichever comes first.

Discontinuing services for a client still in need of assistance shall occur only after appropriate conferences with the state agency case manager, client and client’s family.

13.2.G PROVIDER COMPLIANCE

The Departments of Social Services and Health and Senior Services or their designee conducts both program and fiscal monitoring of the Aged and Disabled Waiver Program. Monitoring visits may be announced or unannounced. The providers must agree to comply with any evaluation conducted by the Departments of Social Services and Health and Senior Services'. The Division of Senior Services and Regulation may, in accordance with the protective service mandate (RSMo Chapter 660), take action to protect clients from providers who are found to be out of compliance with the requirements of its regulations and of any other regulations applicable to the Aged and Disabled Waiver Program, when such noncompliance is determined by the Division of Senior Services and Regulation to create a risk of injury or harm to clients. Evidence of such risk may include: unreliable or inadequate provider documentation of services or training due to
falsification or fraud, the provider’s failure to deliver services in a reliable and dependable manner; or use of in-home services workers who do not meet the minimum training standards of this regulation. Immediate action by the Division of Senior Services and Regulation may include, but is not limited to:

- Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance, after which any informed choice is honored by the Division of Senior Services and Regulation; or
- Informing current clients served by the provider of the provider’s noncompliance and that the Division of Senior Services and Regulation has determined the provider unable to deliver safe care. Such clients are allowed to choose a different provider from the list maintained by the Division of Senior Services and Regulation, which is then immediately authorized to provide service to them.

### 13.3 PERSONNEL REQUIREMENTS

#### 13.3.A SUPERVISORY STAFF OF IN-HOME SERVICES

An in-home services care supervisor shall be designated by the provider ownership or administrative management to supervise the day to day delivery for direct waiver services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.

The designated supervisor shall be at least 21 years of age. In addition, the supervisor must meet at least one of the following criteria before performing the supervisory duties required by these standards. The supervisor must:

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

#### 13.3.B IN-HOME SERVICES WORKER REQUIREMENTS

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

- be at least eighteen years of age;
- be able to read, write and follow directions; and
• have at least six months paid work experience as an agency homemaker or respite nurse aide, housekeeper or household worker, or at least one year experience in caring for children or for sick or aged individuals. Successful completion of formal training in nursing arts or as a nursing aide or home health aide, can substitute for the qualifying experience.

All chore workers employed by the provider must:
• be at least eighteen years of age; and
• be able to read, write, and follow directions.

13.4 SUPERVISION OF IN-HOME SERVICES

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

• Monitor the provision of services by the in-home services worker to ensure that services are delivered in accordance with the services authorized by the Division of Senior Services and Regulation and the recipient’s physician. This shall include routine review and comparison of the workers’ record of provided services with the Service Plan for each recipient, the units of service authorized (on the Service Plan), the tasks specified (on the LCDE (LTACS Client Data Entry), and the authorized frequency of delivered services. A written explanation of any discrepancies and description of corrective action taken must be signed and dated by the supervisor and be readily available for monitoring or inspection. The written explanation must be completed monthly. One explanation for each county served shall be sent to the Alternative Service Regional Manager(s) whose region includes the counties served. It is due by the thirtieth day of each month immediately following the month of the explanation. A copy of each explanation document shall be kept by the provider and be available for monitoring as necessary.

• Complete a written evaluation of each in-home services worker’s performance at least annually. The evaluation should be based in part on at least two on-site visits, unannounced to the worker beforehand. The worker must be present during the visits. The written report of the evaluation should document the visits, contain the recipients’ names and addresses, the date and time of the visits, the worker's name, and the supervisor's observations and notes from the visits. The on-site visits should also include an evaluation of the adequacy of the service plan, including review of the plan of care with the recipients.

In addition to information from the on-site visits, the written evaluation should contain sufficient other data on the worker’s performance to demonstrate that the evaluation was based on qualified observation. The written evaluation should show what support, supervision, and other intervention is planned as a result of the evaluation. The evaluation must be signed and dated by the supervisor who prepared it and by the worker. The written record of the evaluation shall be maintained in the personnel file of the worker. If the required evaluation is not performed or not documented, the in-home services worker's qualification to provide the
service may be presumed inadequate and all payments made for services by that worker may be recouped. Unless, medically, the recipient's condition supports a visit or all recipients have been visited, a service recipient shall not receive more than one combined on-site supervisory visit and on-site RN visit per state fiscal year.

- Designate a trainer(s) to perform the two on-the-job training sessions required as part of the basic training of the in-home services worker. The designated trainer(s) may be the supervisor or a worker who has been employed by the provider agency at least half-time for a period of six months. Exceptions to the required six month period of employment may be made on a case-by-case basis through the central offices of the Division of Senior Services and Regulation and Division of Medical Services. A list of designated trainers and documentation of any exceptions waiving the required length of employment must be available for monitoring.

- Communicate, in writing with the Division of Senior Services and Regulation case manager regarding changes in any client’s condition and recommended changes in scope or frequency of service delivery.

- Be available for regular case conferences with the appropriate state agency case manager.

### 13.5 TRAINING FOR IN-HOME SERVICES

The following information provides guidelines for the minimum training for in-home services.

#### 13.5.A ORIENTATION AND BASIC TRAINING

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

- Organization, purpose and philosophy of the aged and disabled waiver provider;
- Relationship of the provider to the Division of Senior Services and Regulation and the Division of Medical Services;
- Code of ethics;
- Activities that shall and shall not be performed under the standards for services;
- Basic first aid and procedures to be followed in an emergency; and
- Information about record-keeping and report forms required by the standards.

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

- Techniques in basic aged and disabled waiver activities;
- Techniques in food preparation, nutritional requirements, and basic sanitation practices;
- Household management and home maintenance skills;
- Safety precautions and recognition of job hazards; and
- Information about the availability of other community resources.
13.5.B DOCUMENTATION OF BASIC AND IN-SERVICE TRAINING FOR IN-HOME SERVICES WORKERS

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

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

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

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

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

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

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

- All basic training must be completed within 30 days of first day of recipient contact.
- 8 hours of classroom training must be completed prior to first recipient contact.
- 2 hours of basic training must include orientation to the provider agency and the agency’s protocols for handling emergencies.
• 4 hours of basic training must include supervised on-the-job training under the direction of the designated trainer.
• Reading materials shall constitute no more than 2 of the total 20 hours.

13.5.B(2) Code Of Ethics

As part of basic training, the provider shall distribute to all in-home services workers a code of ethics. The code of ethics shall forbid, at a minimum, the following actions:
• Using the recipient’s car;
• Consuming the recipient’s food or drink (except water);
• Using the recipient’s telephone for personal calls;
• Discussing own or others' personal problems or religious or political beliefs with the recipient;
• Accepting gifts or tips;
• Bringing other persons to the recipient’s home;
• Consuming alcoholic beverages, or using medicine or drugs for any purpose, other than medical, in the recipient’s home or prior to service delivery;
• Smoking in the recipient’s home;
• Accepting money or goods for personal gain from the recipient;
• Breaching the recipient’s privacy and confidentiality of information and records;
• Purchasing any item from the recipient even at fair market value;
• Assuming control of the financial and/or personal affairs of the recipient or the recipient’s estate including power of attorney, conservatorship, guardianship;
• Residing with the recipient in either the recipient’s or worker’s residence;
• Taking anything from the recipient’s home; and
• Committing any act of abuse, neglect, or exploitation.

13.5.C WAIVER OF BASIC TRAINING FOR IN-HOME SERVICES WORKERS

13.5.C(1) Experience or Aide Certification

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

13.5.C(2) Licensed Nurse/Certified Nurse Aide (CNA)

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

13.5.C(3) Provider Verification

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

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

13.5.D ADVANCED RESPITE WORKER TRAINING

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

13.5.E IN-SERVICE TRAINING FOR IN-HOME SERVICES WORKERS

All in-home services workers shall receive a total of ten hours of in-service training annually after the first twelve months of employment. In-service training sessions shall be conducted at least every six months.

At least six hours of the required ten hours shall be classroom instruction. The additional four hours may use any appropriate training method.
The provider may waive the required annual in-service training hours, and require only two hours of refresher training annually, when the worker has been employed for 3 years and has completed 30 hours of in-service training that meets the standards set forth in this section. This waiver shall be adequately documented and noted in the employee’s records.

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

- Process and effects of aging;
- Problems identification and procedures for making appropriate referrals;
- Meal preparation for special diets;
- Home management and budgeting;
- Comparison shopping techniques;
- Problems common to the aged and handicapped;
- AIDS education;
- Death and dying; and
- Recognizing and reporting abuse or neglect.

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

13.6 RECORDS

The aged and disabled waiver provider shall document implementation of requirements for the following, as applicable:

- Coordination with other providers;
- Non-discrimination on basis of handicap; and
- Administrative policies and procedures.

13.6.A RECIPIENT CASE RECORD

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

- The Service Plan (DA-3) and the LCDE (LTACS Client Data Entry), which document authorization for all units of service provided;
• Copies of any written communications transmitted to the Division of Senior Services and Regulation case manager;

• Each provider agency may design its own services log sheet, but all paid units of services must be documented. If these documents are not maintained in the recipient’s case record, they must be readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services or any other state or federal agency acting on these department's behalf. If the services delivered differ from the services specified in the Plan of Care, the discrepancy must be explained in writing by the supervisor;

• For in-home services, the recipient’s service log sheets must contain the in-home services worker’s name, the recipient’s name, dates of service delivery, time spent and activities performed on each date, and the recipient’s signature for each date of service. If the recipient cannot write, the recipient’s mark (X) shall be witnessed by at least one person who may be the worker.

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

• Any other pertinent documentation regarding the recipient.

13.6.B PERSONNEL RECORD

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

• Employment application with the employee's signature showing the date of birth, education, work experience, and the date employed and terminated by the service provider;

• For RNs and LPNs, a copy of their current Missouri license;

• Documentation of at least two references contacted;

• Documentation of basic and in-service training received (individual training report, reference Section 13.5.A and for in-home services workers, also reference Section 13.5.B);

• Documentation for any waiver of employment or training requirements (reference Section 13.5.C);

• Annual performance evaluation which includes observations from two on-site visits for in-home services workers;

• For supervisory staff, documentation that they have been provided with and have read Section 13 of this provider manual;
• Signed statement(s) verifying that the worker received the code of ethics and that the provider policy regarding confidentiality of recipient information was explained prior to service delivery;

• Returned ID card for a terminated in-home services worker, or documentation of why it is not available; and

• Copies of the written explanation that document discrepancies between authorized and delivered services, and describing the corrective action taken. These copies must be maintained in a central location and available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.

The provider must also maintain the written plans for basic training and in-service training.

13.6.C RETENTION OF RECORDS

Medicaid providers must retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the Medicaid Agency, and must furnish or make the records available for inspection or audit by the Departments of Social Services and Health and Senior Services or their representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the Medicaid Program may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider’s participation in the Medicaid Program. This policy continues to apply in the event of the provider’s discontinuance as an actively participating Medicaid provider through change of ownership or any other circumstance.

13.6.D ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (1)(A) defines “adequate documentation” and “adequate medical records” as follows:

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

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

13.6.D(1) Required Documentation

The following are the requirements for the documentation of services rendered.
1. The date of the service.

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

3. A description of the service (specific tasks).

4. The name of the worker who provided the in-home services.

5. The recipient’s name and Medicaid number.

6. For each date of in-home services: the signature of the recipient, or the mark of the recipient witnessed by at least one person, or the signature of another responsible person present in the recipient’s home at the time of service. A responsible person may include the aged and disabled waiver worker's supervisor, if the supervisor is present in the home at the time of service delivery. The worker may only sign on behalf of the recipient when the recipient is unable to sign and there is no other responsible person present. The entire signature of the recipient or witness to the mark or the responsible party must be present in the record for each date of service billed to Medicaid. Initials are not acceptable in lieu of the entire signature. The recipient’s Medicaid number is not required on the time sheet.

The provider should not submit claims solely on the basis of the prior authorization, but must base claims upon documentation of actual services rendered. The recipient may have been in the hospital or nursing home during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were not necessary or could not be delivered. The prior authorization merely establishes the maximum number of hours and types of
services which may be given to a recipient during a time period. All units billed to Medicaid must be supported by the documentation of delivery as described in this section.

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

For adult day care-basic services, appropriate documentation must be maintained at the facility. Appropriate documentation shall meet the requirements set forth in 19 CSR 30-90.060(2).

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

A unit of aged and disabled waiver service is defined as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>ONE UNIT EQUALS</th>
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<tbody>
<tr>
<td>Homemaker</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Chore</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Basic Respite</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Basic Block Respite</td>
<td>9-12 hours</td>
</tr>
<tr>
<td>Institutional Respite</td>
<td>1 day</td>
</tr>
<tr>
<td>Advanced Respite</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Advanced Block Respite</td>
<td>6-8 hours</td>
</tr>
<tr>
<td>Advanced Daily Respite</td>
<td>17-24 hours</td>
</tr>
<tr>
<td>Nurse Respite Block</td>
<td>15 minutes (minimum of 96 units or 4 hours)</td>
</tr>
<tr>
<td>Home Delivered Meal</td>
<td>1 meal</td>
</tr>
<tr>
<td>Adult Day Care-Basic</td>
<td>1 day (4 or more hours)</td>
</tr>
</tbody>
</table>

A unit of service includes time spent completing work vouchers and obtaining service recipient signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall not be included.

Providers shall not bill Medicaid recipients for any services reimbursed by the Division of Medical Services or for any services that would have been reimbursed by the Division of Medical Services if the provider had followed proper policies and procedures for obtaining payment.
NOTE: A unit of service for home delivered meals is defined as a "delivered unit of service" which is a meal delivered to the senior in the senior's home or home of their caregiver. The maximum units of service are two meals per day.

13.6.D(3) Accrued Units—Homemaker, Chore and Respite (15-Minute Unit Services)

Aged and disabled waiver providers may bill up to one full calendar month of service on one detail line of a claim when billing for homemaker, chore or respite services (15-minute services). It is permissible to accrue partial units (of homemaker, chore or respite) of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month, as long as care delivery is consistent with the written plan of care.

The following instructions apply to billing accrued units on separate detail lines of a claim:

• When billing each date of service, partial units may be accrued and billed on the first date a whole unit is accrued. For example, a provider delivers care from 10:00 to 11:40 on June 1, then provides care from 10:00 to 12:10 on June 4. Six units of service are billed for June 1, and nine units of service are billed on June 4.

• When billing multiple dates of service on one detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do not round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of service to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15=41.33 units. Bill for 41 whole units (15-minutes) of service.

• When billing multiple dates of service on one detail line of a claim, dates during which the client is in a hospital, in a nursing home, visiting relatives or is ineligible should not be included in the range of dates.

• When billing multiple dates of service on one detail line of a claim, do not bill for dates of service falling in two separate calendar months.

13.6.D(4) Prior Contents No Longer Applicable

13.6.D(5) Billing Services by the Month—Home Delivered Meals

Home delivered meal providers may bill up to one full calendar month of service on one detail line of a claim.

The following instructions apply to billing accrued units on one detail line of a claim:

• The "from" and "to" format must be utilized for dates of service.
• The provider must not bill for dates falling in two separate calendar months on the same detail line.
• The provider must only bill for the total delivered units of service, not the total units authorized for any given month.
• When billing for multiple dates of service on one detail line of a claim, the range of dates should not include dates that a client is in a hospital, in a nursing home, visiting relatives or ineligible.

13.6.D(6) Billing Services by the Month—Adult Day Care-Basic

Aged and disabled waiver providers may bill up to one full calendar month of service on one detail line of a claim when billing for adult day care-basic services.

The following instructions apply to billing accrued units on one detail line of a claim:
• The "from" and "to" format must be utilized for dates of service.
• The provider must not bill for dates falling in two separate calendar months on the same detail line.
• The provider must only bill for the total delivered units of service, not the total units authorized for any given month.
• When billing for multiple dates of service on one detail line of claim, the range of dates should not include dates that a client is in a hospital, in a nursing home, visiting relatives or ineligible.

13.7 QUALITY ASSURANCE

All providers are subject to survey by the Missouri Department of Social Services (DSS) or any entity that DSS authorizes to conduct such surveys to ensure compliance and quality of care.

13.8 AUTHORIZED SERVICES FOR HOSPICE

When electing the hospice benefit, a Medicaid recipient does not automatically forfeit his or her right to receive medical services such as home and community-based waiver services. When a Medicaid recipient is authorized with an agency to receive personal care services or home and community-based waiver services for the aged and disabled and then elects hospice, the Division of Senior Services and Regulation case manager must develop a care plan in collaboration with the hospice provider to ensure that services are not duplicative.

The hospice may provide short-term inpatient respite care. Aged and disabled waiver respite services are provided in the home or in a nursing facility. The waiver respite service cannot be authorized during times when inpatient respite care under the hospice benefit is used. Respite care is appropriate for the hospice recipient who has a caregiver (other than the hospice provider) who needs to be away from the
home for periods of time (2- to 12-hour periods or for up to several days at a time). The Division of Senior Services and Regulation case manager authorizes respite, when necessary, to augment hospice services.

13.9 MANAGED HEALTH CARE PROGRAM

Aged and disabled waiver services are not included as a plan benefit for either the managed care program or the State of Missouri’s MC+ Programs.

13.10 RECIPIENT COST SHARING AND COPAY

Recipients eligible to receive certain Missouri Medicaid services are required to pay a small portion of the cost of the services. Services of the Aged and Disabled Waiver Program described in this manual are not subject to a cost sharing or copay amount.
SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>DA-13/LCDE (LTACS CLIENT DATA ENTRY)</td>
<td>2</td>
</tr>
<tr>
<td>14.2</td>
<td>DA-1—HOME AND COMMUNITY SERVICES INTAKE/SCREENING</td>
<td>3</td>
</tr>
<tr>
<td>14.3</td>
<td>DA-3—CARE PLAN</td>
<td>3</td>
</tr>
<tr>
<td>14.4</td>
<td>DA-3A—CARE PLAN SUPPLEMENT</td>
<td>3</td>
</tr>
<tr>
<td>14.5</td>
<td>PRIOR CONTENTS NO LONGER APPLICABLE</td>
<td>4</td>
</tr>
<tr>
<td>14.6</td>
<td>PRIOR CONTENTS NO LONGER APPLICABLE</td>
<td>4</td>
</tr>
<tr>
<td>14.7</td>
<td>HOME AND COMMUNITY SERVICES MAP</td>
<td>4</td>
</tr>
<tr>
<td>14.8</td>
<td>PRIOR CONTENTS NO LONGER APPLICABLE</td>
<td>4</td>
</tr>
</tbody>
</table>
SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

All services covered by the Title XIX (MO HealthNet) Aged and Disabled Waiver Program must be prior authorized by the Missouri Division of Senior and Disability Services (DSDS). The form used by the DSDS to authorize aged and disabled waiver services is the DA-13/LCDE (LTACS Client Data Entry). This form shows which services are authorized and specifies the period of time covered by the authorization. A copy of this form is sent to the provider.

DSDS may authorize up to 12 months of service on one DA-13/LCDE. Each DA-13/LCDE, whether an initial or re-authorization, has a corresponding computer file established by the fiscal agent.

The provider should be aware that if a participant loses MO HealthNet eligibility during an authorized period of time, services are not reimbursed for the ineligible dates, the prior authorization notwithstanding. Providers are referred to Section 1 of the manual for details about participant eligibility.

Providers should make sure that the participant's name and identification number on the DA-13/LCDE match the participant's ID card, and that the DA-13/LCDE contains the provider's correct name and provider number for the service to be provided. If any of these items on the DA-13/LCDE are incorrect, the provider should immediately contact DSDS to initiate a correction. The DA-13/LCDE (LTACS Client Data Entry) form can be found at: http://manuals.momed.com/manuals/presentation/forms.jsp

In addition to the DA-13/LCDE (LTACS Client Data Entry), the provider receives:

- Form DA-3, Care Plan; and
- Form DA-3a, Care Plan Supplement.

All of the forms above become a part of the fiscal and medical records that must be retained to document services billed to MO HealthNet. These records must be retained for five years and be open to inspection as specified in Section 13 of this manual.

14.1 DA-13/LCDE (LTACS CLIENT DATA ENTRY)

The LCDE (LTACS Client Data Entry) is the screen used to enter demographic and assessment information and to authorize services for all participants. It functions to begin, correct, update or close the delivery of all services. The DA-13/LCDE screen for the initial authorization must be signed and dated by the DSDS. The print-out serves as the provider’s authorization for services.
14.2 DA-1—HOME AND COMMUNITY SERVICES INTAKE/SCREENING

This form can be used to make referrals for home and community based services to DSDS. The Home and Community Services Intake/Screening (DA-1), is designed to provide information about probable service needs, participant functional condition, preliminary Level of Care and other persons significant to the participant's situation.

14.3 DA-3—CARE PLAN

The Care Plan (DA-3) allows documentation of the participant’s involvement in determining the plan of care by including the participant’s acknowledgment of his/her:

- participation in the development of the care plan;
- right to choose and receive home and community based services rather than nursing facility care;
- right to refuse home and community based services;
- right to choose the home and community based services or either agency;
- right to choose the home and community based provider;
- discriminatory behavior regarding service delivery;
- participant's expectations and responsibilities;
- need for notifying HCS of any problems concerning service delivery as well as changes in health, informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment.

The DA-3 is completed by DSDS upon initial assessment. DSDS reviews the subjects covered on the form with the participant and ensures the participant’s understanding of the subject. The original copy is retained in the forms section of the participant’s case record. A copy is left with the participant. A copy is forwarded to the in-home service provider(s), including any subsequent changes in provider agencies.

14.4 DA-3A—CARE PLAN SUPPLEMENT

The Care Plan Supplement (DA-3a) is designed to provide information to the participant and provider identifying the specific services that are to be provided.

The DA-3a is completed by DSDS along with the original DA-13/LCDE or as necessary, with a DA-13/LCDE revision.
One copy is sent to the provider and one is retained in the local office DDS. A copy is sent to the physician and a copy is sent to the participant.

14.5 PRIOR CONTENTS NO LONGER APPLICABLE

14.6 PRIOR CONTENTS NO LONGER APPLICABLE

14.7 HOME AND COMMUNITY SERVICES MAP
A copy of the Section for Adult Protective and Community Services - Bureau of Home & Community Services map may be found at: http://www.dhss.mo.gov/HomeComServices/RegionalMap.html

14.8 PRIOR CONTENTS NO LONGER APPLICABLE
SECTION 15 - BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE .................................................................2
15.2 INTERNET ELECTRONIC CLAIM SUBMISSION ............................................2
15.3 CMS-1500 CLAIM FORM .............................................................................3
15.4 PROVIDER RELATIONS COMMUNICATION UNIT .......................................3
15.5 RESUBMISSION OF CLAIMS .......................................................................3
15.6 CMS-1500 CLAIM FILING INSTRUCTIONS ..................................................3
15.7 PLACE OF SERVICE CODES .......................................................................10
15.8 INSURANCE COVERAGE CODES .................................................................11
SECTION 15-BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at www.wpc-edi.com. For Missouri specific information, including connection methods, the biller’s responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12N Version 4010A1 and NCPDP Telecommunication V.5.1 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.missouri.gov/mhd/ 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.

For full functionality of the Internet application, either the Internet Explorer 5.0 or higher web browser or the Netscape 4.7 or higher web browser is recommended. The features of the Internet application include claim submissions, claim credits and eligibility verification.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 1999, Version 2000), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.
15.3 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for aged and disabled waiver services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

15.4 PROVIDER RELATIONS COMMUNICATION UNIT

It is the responsibility of the Provider Relations Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider may resubmit electronically or on a CMS-1500 claim form. An example of a correctable error is the use of an invalid procedure code.

If a line item on a claim paid but the payment was incorrect do not resubmit that line item. For instance, if a provider bills the incorrect amount for a service, the claim cannot be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider must submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.6 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

   Infocrossing Healthcare Services
   P.O. Box 5600
   Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.
### Section 15 - Billing Instructions

**FIELD NUMBER & NAME**

1. **Type of Health Insurance Coverage**

Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box; if a MO HealthNet claim is being filed, check the Medicaid box and if the patient has both Medicare and MO HealthNet, check both boxes.

*1a. Insured’s I.D. Number*

Enter the patient’s eight-digit MO HealthNet ID number (DCN) as shown on the patient’s ID card.

*2. Patient’s Name*

Enter last name, first name, middle initial in that order as it appears on the ID card.

3. **Patient’s Birth Date**

   **Sex**

Enter month, day, and year of birth. Mark appropriate box.

**4. Insured’s Name**

If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13. If no private insurance is involved, leave blank.

5. **Patient’s Address**

Enter address and telephone number if available.

**6. Patient’s Relationship to Insured**

Mark appropriate box if there is other insurance.

**7. Insured’s Address**

Enter the primary policyholder’s address; enter policyholder’s telephone number, if available. If no private insurance is involved, leave blank.

8. **Patient Status**

Not used.

**9. Other Insured’s Name**

If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder’s name. (See Note)

**9a. Other Insured’s Policy or Group Number**

Enter the secondary policyholder’s insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. (See Note)

**9b. Other Insured’s Date of Birth**

Enter the secondary policyholder’s date of birth, and mark the appropriate box for sex. (See Note)
**Section 15 - Billing Instructions**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9c.</strong> Employer’s Name</td>
<td>Enter the secondary policyholder’s employer name. (See Note) (1)</td>
</tr>
<tr>
<td><strong>9d.</strong> Insurance Plan Name or Program Name</td>
<td>Enter the secondary policyholder’s insurance plan or program name.  If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. (See Note) (1)</td>
</tr>
<tr>
<td><strong>10a-10c.</strong> Is Condition Related to:</td>
<td>If services on the claim are related to patient’s employment, auto accident, or other accident, mark the appropriate box. If the services are not related to an accident, leave blank.</td>
</tr>
<tr>
<td>10d. Reserved for Local Use</td>
<td>May be used for comments/descriptions.</td>
</tr>
<tr>
<td><strong>11.</strong> Insured’s Policy or Group Number</td>
<td>Enter the primary policyholder’s insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. (See Note) (1)</td>
</tr>
<tr>
<td><strong>11a.</strong> Insured’s Date of Birth, Sex</td>
<td>Enter primary policyholder’s date of birth and mark the appropriate box reflecting the sex of the primary policyholder. (See Note) (1)</td>
</tr>
<tr>
<td><strong>11b.</strong> Employer’s Name</td>
<td>Enter the primary policyholder’s employer name. (See Note) (1)</td>
</tr>
<tr>
<td><strong>11c.</strong> Insurance Plan Name</td>
<td>Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. (See Note) (1)</td>
</tr>
<tr>
<td><strong>11d.</strong> Other Health Plan</td>
<td>Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. (See Note) (1)</td>
</tr>
<tr>
<td>12. Patient’s Signature</td>
<td>Leave blank.</td>
</tr>
<tr>
<td><strong>13.</strong> Insured’s Signature</td>
<td>This field should be completed only when the patient has another health insurance policy. Obtain the policyholder’s or authorized person’s signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any</td>
</tr>
</tbody>
</table>
Section 15 - Billing Instructions

14. Date of Current Illness, Injury, or Pregnancy
   Leave blank.

15. Date Same/Similar Illness
   Leave blank.

16. Dates Patient Unable to Work
   Leave blank.

**17. Name of Referring Provider or Other Source**

Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order:

1. Referring provider
2. Ordering Provider
3. Supervising Provider

**17a. Other ID #**

Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field 17B.

**17b. NPI**

Enter the NPI number of referring, ordering, or supervising provider.

18. Hospitalization Dates
   Leave blank.

19. Reserved for Local Use
   Leave blank.

20. Lab Work Performed Outside Office
   Leave blank.

*21. Diagnosis*

Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.

NOTE: A diagnosis code is not required when billing home delivered meals services on paper claims. Fields #21 and #24e of the CMS-1500 claim form should be left blank. However, a diagnosis code is required for billing home delivered meals services electronically.
Section 15 - Billing Instructions

Electronically filed claims must have the diagnosis code V69.1 (Inappropriate Diet and Eating Habits) in the appropriate field.

NOTE: A diagnosis code is not required when billing adult day care-basic services on paper claims. Fields #21 and #24e of the CMS-1500 claim form should be left blank. However, a diagnosis code is required for billing adult day care-basic services electronically. Electronically filed claims must have the diagnosis code of V60.4 (No other household member able to render care) in the appropriate field.

**22. Medicaid Resubmission**

For timely filing purposes; if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.

23. Prior Authorization Number

*24a. Date of Service

Enter the date of service under “from” in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a from date. Refer to Section 13.6.D(3). For home delivered meals, refer to Section 13.6.D(5). The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

*24b. Place of Service

Enter the appropriate place of service code in the unshaded area of the field. For homemaker/chore, in-home respite, and home delivered meals this is 12, “Home.” For institutional respite, this is 32, “Nursing Facility.”

**24c. EMG-Emergency**

Leave blank.
Section 15 - Billing Instructions

*24d. Procedure Code
Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. See Section 19 of this manual for applicable procedure codes. (Field #19 may be used for remarks or descriptions.)

*24e. Diagnosis Pointer
Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21 in the unshaded area of the field.

NOTE: A diagnosis code is not required when billing home delivered meals services on paper claims. Fields #21 and #24e of the CMS-1500 claim form should be left blank. However, a diagnosis code is required for billing home delivered meals services electronically. Electronically filed claims must have the diagnosis code, V69.1 (Inappropriate Diet and Eating Habits), in the appropriate field.

*24f. Charges
Enter the provider’s usual and customary charge for each line item in the unshaded area of each field. This should be the total charge for multiple days or units.

*24g. Days or Units
Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a “1” if the field is left blank.

24h. EPSDT/Family Planning
Leave blank.

**24i. ID Qualifier
Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet.

A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.

**24j. Rendering Provider ID
If the Provider Taxonomy qualifier was reported in 24i; enter the 10 digit Provider Taxonomy Code in the shaded area.
Section 15 - Billing Instructions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.</td>
<td>SS #/Fed. Tax ID</td>
</tr>
<tr>
<td></td>
<td>Enter the 10-digit NPI number of the individual rendering the service in the unshaded area. Leave blank.</td>
</tr>
<tr>
<td>26.</td>
<td>Patient Account Number</td>
</tr>
<tr>
<td></td>
<td>For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.</td>
</tr>
<tr>
<td>27.</td>
<td>Assignment</td>
</tr>
<tr>
<td></td>
<td>Not required on MO HealthNet claims.</td>
</tr>
<tr>
<td><strong>28.</strong></td>
<td>Total Charge</td>
</tr>
<tr>
<td></td>
<td>Enter the sum of the line item charges.</td>
</tr>
<tr>
<td>29.</td>
<td>Amount Paid</td>
</tr>
<tr>
<td></td>
<td>Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field.</td>
</tr>
<tr>
<td>30.</td>
<td>Balance Due</td>
</tr>
<tr>
<td></td>
<td>Enter the difference between the total charge (Field #28) and the amount paid (Field #29).</td>
</tr>
<tr>
<td>31.</td>
<td>Provider Signature</td>
</tr>
<tr>
<td></td>
<td>Leave Blank</td>
</tr>
<tr>
<td><strong>32.</strong></td>
<td>Name and Address of Facility</td>
</tr>
<tr>
<td></td>
<td>If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.</td>
</tr>
<tr>
<td><strong>32a.</strong></td>
<td>NPI#</td>
</tr>
<tr>
<td></td>
<td>Enter the 10-digit NPI number of the service facility location in Field #32.</td>
</tr>
<tr>
<td><strong>32b.</strong></td>
<td>Other ID#</td>
</tr>
<tr>
<td></td>
<td>Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code. A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.</td>
</tr>
<tr>
<td><strong>33.</strong></td>
<td>Provider Name/Number/Address</td>
</tr>
<tr>
<td></td>
<td>Affix the provider label or write or type the information exactly as it appears on the label.</td>
</tr>
</tbody>
</table>
Section 15 - Billing Instructions

**33a. NPI #**

Enter the NPI number of the billing provider in Field #33.

**33b. Other ID #**

Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field 33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.

MO HealthNet reimburses the lower of the provider's billed charge or the MO HealthNet maximum allowed amount for the unit of service billed. Providers may not bill MO HealthNet at a higher rate than they charge their private service clients. Providers must bill MO HealthNet their usual and customary rate. Providers must maintain appropriate documentation.

* These fields are mandatory on all CMS-1500 claim forms.
** These fields are mandatory only in specific situations, as described.
(1) NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

### 15.7 PLACE OF SERVICE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Home</td>
<td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
</tr>
<tr>
<td>32 Nursing Facility (institutional respite only)</td>
<td>A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis health-related care services above the level of custodial care to other than mentally retarded individuals.</td>
</tr>
</tbody>
</table>
15.8 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on the interactive voice response (IVR) system, a point of service (POS) terminal, or eligibility files accessed via the Internet are listed in Section 5, Third Party Liability.

While providers are verifying the patient’s eligibility, they can obtain the TPL information contained on the MO HealthNet Division’s participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 635-8908, which allows the provider to inquire on third party resources. The provider may also use a point of service (POS) terminal or the Internet at www.emomed.com to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by the IVR, POS terminal or Internet. IT IS THE PROVIDER’S RESPONSIBILITY TO OBTAIN FROM THE PATIENT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.
SECTION 16 - MEDICARE/MEDICAID CROSSOVER CLAIMS

For recipients having both Medicare and Medicaid eligibility, the state Medicaid Program 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 Health Care
- Aged and Disabled Waiver
- AIDS Waiver
- Community Psychiatric Rehabilitation
- Comprehensive Day Rehabilitation
- CSTAR
- Environmental Lead Assessment
- Hospice
- MRDD Waiver
- Personal Care
- Private Duty Nursing

The following programs contain a modified Section 16, Medicare/Medicaid Crossover Claims

- Dental
- Durable Medical Equipment
- Home Health
- Hospital
- Nursing Home
- Pharmacy

END OF SECTION

TOP OF PAGE
SECTION 17 - CLAIMS DISPOSITION

17.1 ACCESS TO REMITTANCE ADVICES .................................................................2
17.2 INTERNET AUTHORIZATION .........................................................................3
17.3 ON-LINE HELP ..............................................................................................3
17.4 REMITTANCE ADVICE ..................................................................................3
17.5 CLAIM STATUS MESSAGE CODES .................................................................7
  17.5A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS .........................7
17.6 SPLIT CLAIM ..................................................................................................8
17.7 ADJUSTED CLAIMS .......................................................................................8
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED) .........................9
17.9 CLAIM ATTACHMENT STATUS ...............................................................9
17.10 PRIOR AUTHORIZATION STATUS .............................................................10
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.
Section 17 - Claims Disposition

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.
Section 17 - Claims Disposition

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

<table>
<thead>
<tr>
<th>FIELD NAME</th>
<th>FIELD DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAGE</td>
<td>The remittance advice page number.</td>
</tr>
<tr>
<td>CLAIM TYPE</td>
<td>The type of claim(s) processed.</td>
</tr>
<tr>
<td>RUN DATE</td>
<td>The financial cycle date.</td>
</tr>
<tr>
<td>PROVIDER IDENTIFIER</td>
<td>The provider’s NPI number.</td>
</tr>
<tr>
<td>RA #</td>
<td>The remittance advice number.</td>
</tr>
<tr>
<td>PROVIDER NAME</td>
<td>The name of the provider.</td>
</tr>
<tr>
<td>PROVIDER ADDR</td>
<td>The provider’s address.</td>
</tr>
<tr>
<td>PARTICIPANT NAME</td>
<td>The participant’s last name and first name.</td>
</tr>
</tbody>
</table>

NOTE: If the participant’s name and identification number are not on file, only the first two letters of the last name and the first letter of the first name appear.

<table>
<thead>
<tr>
<th>MO HEALTHNET ID</th>
<th>The participant’s current 8-digit MO HealthNet identification number.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICN</td>
<td>The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:</td>
</tr>
</tbody>
</table>

11 — Paper Drug
13 — Inpatient
14 — Dental
15 — Paper Medical
16 — Outpatient
17 — Part A Crossover
18 — Paper Medicare/MO HealthNet Part B Crossover Claim
21 — Nursing Home
40 — Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries.
41 — Direct Electronic MO HealthNet Information (DEMI)
43 — MTB/DEMI
44 — Direct Electronic File Transfer (DEFT)
45 — Accelerated Submission and Processing (ASAP)
46 — Adjudicated Point of Service (POS)
47 — Captured Point of Service (POS)
49 — Internet
50 — Individual Adjustment Request
55—Mass Adjustment

The third and fourth digits indicate the year the claim was received.
The fifth, sixth and seventh digits indicate the Julian date. In a Julian system,
the days of a year are numbered consecutively from “001” (January 1) to “365”
(December 31) (“366” in a leap year).

The last digits of an ICN are for internal processing.

For a drug claim, the last digit of the ICN indicates the line number from the
Pharmacy Claim form.

SERVICE DATES FROM
The initial date of service in MMDDYY format for the claim.

SERVICE DATES TO
The final date of service in MMDDYY format for the claim.

PAT ACCT
The provider’s own patient account name or number. On drug claims this field
is populated with the prescription number.

CLAIM: ST
This field reflects the status of the claim. Valid values are:

1 — Processed as Primary
3 — Processed as Tertiary
4 — Denied
22 — Reversal of Previous Payment

TOT BILLED
The total claim amount submitted.

TOT PAID
The total amount MO HealthNet paid on the claim.

TOT OTHER
The combined totals for patient liability (surplus), participant copay and
spenddown total withheld.

LN
The line number of the billed service.

SERVICE DATES
The date of service(s) for the specific detail line in MMDDYY.

REV/PROC/NDC
The submitted procedure code, NDC, or revenue code for the specific detail
line.

NOTE: The revenue code only appears in this field if a procedure code is not
present.

MOD
The submitted modifier(s) for the specific detail line.

REV CODE
The submitted revenue code for the specific detail line.

NOTE: The revenue code only appears in this field if a procedure code has also
been submitted.

QTY
The units of service submitted.
### Section 17 - Claims Disposition

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLED AMOUNT</td>
<td>The submitted billed amount for the specific detail line.</td>
</tr>
<tr>
<td>ALLOWED AMOUNT</td>
<td>The MO HealthNet maximum allowed amount for the procedure/service.</td>
</tr>
<tr>
<td>PAID AMOUNT</td>
<td>The amount MO HealthNet paid on the claim.</td>
</tr>
<tr>
<td>PERF PROV</td>
<td>The NPI number for the performing provider submitted at the detail.</td>
</tr>
<tr>
<td>SUBMITTER LN ITM CNTL</td>
<td>The submitted line item control number.</td>
</tr>
<tr>
<td>GROUP CODE</td>
<td>The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>CO—Contractual Obligation</td>
</tr>
<tr>
<td></td>
<td>CR—Correction and Reversals</td>
</tr>
<tr>
<td></td>
<td>OA—Other Adjustment</td>
</tr>
<tr>
<td></td>
<td>PI—Payer Initiated Reductions</td>
</tr>
<tr>
<td></td>
<td>PR—Patient Responsibility</td>
</tr>
<tr>
<td>RSN</td>
<td>The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at <a href="http://www.wpc-edi.com/codes/claimadjustment">http://www.wpc-edi.com/codes/claimadjustment</a>.</td>
</tr>
<tr>
<td>AMT</td>
<td>The dollar amount adjusted for the corresponding reason code.</td>
</tr>
<tr>
<td>QTY</td>
<td>The adjustment to the submitted units of service. This field is not printed if the value is zero.</td>
</tr>
<tr>
<td>REMARK CODES</td>
<td>The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>HE—Claim Payment Remark Codes</td>
</tr>
<tr>
<td></td>
<td>RX—National Council for Prescription Drug Programs Reject/Payment Codes</td>
</tr>
<tr>
<td>CATEGORY TOTALS</td>
<td>Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.</td>
</tr>
<tr>
<td>CHECK AMOUNT</td>
<td>The total check amount for the provider.</td>
</tr>
</tbody>
</table>

General Manual
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>

General Manual
Section 17 - Claims Disposition

<table>
<thead>
<tr>
<th>Medicare Part A Repricing</th>
<th>OA</th>
<th>Other Adjustment</th>
<th>45</th>
<th>Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment cut back to federal percentage (IEP therapy services)</td>
<td>OA</td>
<td>Other Adjustment</td>
<td>A2</td>
<td>Contractual adjustment</td>
</tr>
<tr>
<td>Payment reduced by co-payment amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>3</td>
<td>Co-Payment amount</td>
</tr>
<tr>
<td>Payment reduced by patient spenddown amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>178</td>
<td>Payment adjusted because patient has not met the required spenddown</td>
</tr>
<tr>
<td>Payment reduced by patient liability amount</td>
<td>PR</td>
<td>Patient Responsibility</td>
<td>142</td>
<td>Claim adjusted by monthly MO HealthNet patient liability amount</td>
</tr>
</tbody>
</table>

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should not have been made at all, there will not be a corrected payment ICN.
17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are not listed on the Remittance Advice (RA). To inquire on the status of a submitted claim not appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.
17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

END OF SECTION
TOP OF PAGE
SECTION 18 - DIAGNOSIS CODES

18.1 GENERAL INFORMATION
SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field and the accuracy of the code that describes the patient’s condition is important.

The diagnosis code must be entered on the claim exactly as it appears in the ICD-9-CM. Note that the appropriate code(s) may be three, four or five digits, depending upon the patient’s diagnosis. The fourth and fifth digits give greater detail or specificity, and must be used as applicable to the patient’s diagnosis(es) when available.

Diagnosis codes are not included in this section. Claims may be denied if a three digit code is used. The ICD-9-CM may require a fourth or fifth digit. The ICD-9-CM (Volume I) should be used as a guide in the selection of the appropriate three, four or five digit diagnosis code. The ICD-9-CM may be purchased in softbound or binder. The binder contains all three volumes, which are:

- Volume 1: Diseases: Tabular List
- Volume 2: Diseases: Alphabetic Index
- Volume 3: Procedures: Tabular List and Alphabetic Index

Additional information regarding the ICD-9 CM may be found at www.cdc.gov/nchs/icd9.htm.
### SECTION 19 - PROCEDURE CODES

19.1 PROCEDURE CODES .................................................................................................................................................2

| 19.1.A | HOMEMAKER ..................................................................................................................................................................................2 |
| 19.1.B | CHORE ..........................................................................................................................................................................................3 |
| 19.1.C | BLOCK BASIC RESPITE ......................................................................................................................................................................3 |
| 19.1.D | BASIC RESPITE ..................................................................................................................................................................................3 |
| 19.1.E | INSTITUTIONAL RESPITE ......................................................................................................................................................................3 |
| 19.1.F | ADVANCED RESPITE ............................................................................................................................................................................4 |
| 19.1.G | ADVANCED BLOCK RESPITE .................................................................................................................................................................4 |
| 19.1.H | ADVANCED DAILY RESPITE .................................................................................................................................................................4 |
| 19.1.I | ADVANCED NURSE RESPITE .................................................................................................................................................................4 |
| 19.1.J | HOME DELIVERED MEALS .................................................................................................................................................................5 |
| 19.1.K | ADULT DAY CARE BASIC *(TEXT DEL. 02/09)* ..................................................................................................................................................5 |
SECTION 19 - PROCEDURE CODES

Procedure codes used by MO HealthNet 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. NOTE: Replacement of level III codes is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should reference bulletins for code replacement information.

Reference materials regarding the HealthCare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) may be obtained through the American Medical Association at:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
Telephone Number: (800) 621-8335
AMA Members (800) 262-3211
Fax Orders: (312) 464-5600
https://catalog.ama-assn.org/Catalog/home.jsp

19.1 PROCEDURE CODES

All homemaker, chore, respite and home delivered meals are authorized by the Department of Health and Senior Services (DHSS)/Division of Senior and Disability Services (DSDS). Participants must be 63 or older to be authorized for these services.

19.1.A HOMEMAKER

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5130</td>
<td>Homemaker service</td>
<td>$4.24/15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.
19.1.B  CHORE

PROC  CODE  DESCRIPTION  MO HEALTHNET MAXIMUM
      S5120  ...  Chore service  ................................................. $4.24/15 min. unit

Place of service code is 12-home.

19.1.C  BLOCK BASIC RESPITE

PROC  CODE  DESCRIPTION  MO HEALTHNET MAXIMUM
      S515152  .....  Basic Block Respite  ....................................... $76.92/9-12 hours

Place of service code is 12-home.

A full unit of block basic respite care is 9 to 12 consecutive hours, of which no more than 4 entail direct client care.

When care is needed for at least 2 consecutive 12 hour periods, the maximum quantity per calendar date is 2.

19.1.D  BASIC RESPITE

PROC  CODE  DESCRIPTION  MO HEALTHNET MAXIMUM
      S5150  .......  Basic Respite  ................................................. $3.78/15 min. unit

Place of service code is 12-home

Maximum quantity per calendar date is 32 units (8 hours).

19.1.E  INSTITUTIONAL RESPITE

PROC  CODE  DESCRIPTION  MO HEALTHNET MAXIMUM
      H0045  .......  Institutional Respite  ....................................... $55.98/day

(24 hours)

Place of service code is 32-nursing facility.

Maximum quantity per calendar date is 1.
### 19.1.F Advanced Respite

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5150TF</td>
<td>Advanced Respite</td>
<td>$4.53/15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

Maximum quantity per calendar date is 20 units (5 hours).

### 19.1.G Advanced Block Respite

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S515152TF</td>
<td>Advanced Block Respite</td>
<td>$101.20/6-8 hours</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

A full unit of advanced block respite is 6 to 8 consecutive hours. The maximum quantity per calendar date is 2.

### 19.1.H Advanced Daily Respite

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5151TF</td>
<td>Advanced Daily Respite</td>
<td>$250.32/17-24 hrs</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

A full unit of advanced daily respite care is 17 to 24 continuous hours.

No other in-home services may be delivered during the same 24 hour period as advanced daily respite care.

### 19.1.I Advanced Nurse Respite

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1005</td>
<td>Nurse Respite</td>
<td>$5.66/15 min. unit</td>
</tr>
</tbody>
</table>

Place of service code is 12-home.

Advanced nurse respite is authorized in blocks of 16 units (4 hours).

Authorization shall *not* exceed 96 units or six 4-hour blocks per day.
19.1.J HOME DELIVERED MEALS

PROC CODE DESCRIPTION MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT

S5170 ........ Home Delivered Meal .......................... $5.45 per delivered unit

Maximum of 2 meals per day.

19.1.K ADULT DAY CARE BASIC (text del. 02/09)
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
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...........................................................................................................................3
22.2 DEFINITIONS................................................................................................................................3
22.3 COVERED SERVICES..................................................................................................................7
22.4 PARTICIPANT ELIGIBILITY .......................................................................................................8
22.5 NON-COVERED PARTICIPANTS .............................................................................................8
22.6 TRAVEL STANDARDS .............................................................................................................9
22.7 COPAYMENTS..........................................................................................................................12
22.8 MODES OF TRANSPORTATION.............................................................................................13
22.9 ARRANGING TRANSPORTATION ..........................................................................................14
22.10 NON-COVERED SERVICES ..................................................................................................14
22.11 PUBLIC ENTITY REQUIREMENTS......................................................................................15
22.12 PROVIDER REQUIREMENTS...............................................................................................16
22.13 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS ............17
22.14 PARTICIPANT RIGHTS .........................................................................................................17
22.15 DENIALS...............................................................................................................................18
22.16 PARTICIPANT GRIEVANCE PROCESS ..............................................................................18
22.17 MTM SERVICES AVAILABLE FOR FACILITY SUPPORT .............................................18
   22.17.A. CARE MANAGEMENT (CM) ......................................................................................19
   22.17.B. QUALITY MANAGEMENT DEPARTMENT (QM) ..................................................19
   22.17.C. CUSTOMER SERVICE CENTER (CSC) ..............................................................20
   22.17.D. WHAT IS CARE MANAGEMENT (CM)? ...............................................................20
   22.17.E. CARE MANAGEMENT OUTREACH ........................................................................21
   22.17.F. WHAT IS QUALITY MANAGEMENT (QM)? ..........................................................22
   22.17.G. WHAT IS THE CUSTOMER SERVICE CENTER (CSC)? ........................................22
   22.17.H. ARRANGING TRANSPORTATION FOR FACILITIES ........................................23
   22.17.I. HOW DOES A FACILITY REQUEST TRANSPORTATION? ................................24
   22.17.J. FORMS COMPLETED BY FACILITIES .................................................................24
   22.17.K. SCHEDULING URGENT TRIPS ............................................................................25

General Manual
Section 22 - Non-Emergency Medical Transportation (NEMT)

22.17.L. SCHEDULING A HOSPITAL DISCHARGE .................................................................25
22.17.M. TRANSPORTATION RESTRICTIONS .................................................................25
22.17.N. AMERICAN WITH DISABILITIES ACT (ADA) CERTIFICATION ......................26
22.17.O. PARTICIPANT ASSISTANCE DURING TRANSPORT .......................................26
22.17.P. WHAT MTM WILL DO IF A CAREGIVER IS NOT AVAILABLE .........................26
22.17.Q. FILING A GRIEVANCE ........................................................................................27
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.

Effective October 1, 2010, the NEMT broker for Missouri is:

Medical Transportation Management, Inc.
16 Hawk Ridge Drive
Lake St. Louis, MO 63367
(866) 269-5927

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 Services</td>
<td>Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.</td>
</tr>
</tbody>
</table>
### Appeal
The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by a rule or policy or procedure or decision by the broker.

### Attendant
An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant cannot travel alone or cannot travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.

### 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.

### 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.

### Emergency
A medical or mental 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 could reasonably be expected to result in placing the participant’s physical or mental health (or, with respect to a pregnant woman, the health of the woman or...
her unborn child) in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or others due to an alcohol or drug abuse emergency, injury to self or bodily harm to others, or 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 child.

**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.

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.

Participant
A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.

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.
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. Urgent care is determined by the participant’s medical care provider. An appointment shall be considered urgent if the medical service provider grants an appointment within five (5) days of the participant’s request.

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 five (5) calendar days in advance. NEMT services may be scheduled with less than five (5) calendar days notice if they are of an urgent nature. Urgent calls are defined as a serious, but not life threatening illness/injury. Urgent care is determined by the participant's medical care provider. An appointment shall be considered urgent if the medical service provider grants an appointment within five (5) calendar days of the participant's request. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week.

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.

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
Section 22 - Non-Emergency Medical Transportation (NEMT)

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.

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 and 89.

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 and PACE programs are arranged by those programs for services included in the benefit package. The broker shall not be responsible for arranging NEMT services for those programs.

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, St. Francois;
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.

<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>Obstetrics/Gynecology</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Neurology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Dermatology</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Physical Medicine/Rehab</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Vision Care/Primary Eye Care</td>
<td>15</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Allergy</td>
<td>25</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Specialty</td>
<td>Max</td>
<td>Mid</td>
<td>Min</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</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>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/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>Max</th>
<th>Mid</th>
<th>Min</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>Type</th>
<th>Max</th>
<th>Mid</th>
<th>Min</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>
</tbody>
</table>

General Manual
Section 22 - Non-Emergency Medical Transportation (NEMT)

Perinatology services 100 100 100
Comprehensive cancer services 100 100 100
Comprehensive cardiac services 100 100 100
Pediatric subspecialty care 100 100 100

**Mental Health Facilities**

Inpatient mental health treatment facility 25 40 75
Ambulatory mental health treatment providers 15 25 45
Residential mental health treatment providers 20 30 50

**Ancillary Services**

Physical Therapy 30 30 30
Occupational Therapy 30 30 30
Speech Therapy 50 50 50
Audiology 50 50 50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.

3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care. The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:
   - Participant eligibility; and
   - MO HealthNet covered service.

22.7 COPAYMENTS

The participant is required to pay a $2.00 copayment for transportation services. The $2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker cannot deny transportation services because a participant is unable to pay the copay. The copay does not apply for public transportation or bus tokens, or for participant’s receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;

2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind;
   - 03, Aid to the blind;
   - 12, MO HealthNet-Aid to the blind; and
   - 15, Supplemental Nursing Care-Aid to the blind;
   - 18, MO HealthNet for pregnant women;
   - 43, Pregnant women-60 day assistance;
   - 44, Pregnant women-60 day assistance-poverty;
   - 45, Pregnant women-poverty; and
   - 61, MO HealthNet for pregnant women-Health Initiative Fund.

3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital; and

4. Foster Care participants.
A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant’s liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a reasonable opportunity to pay an uncollected co-payment. If a transportation provider is not willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider must give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

22.8 MODES OF TRANSPORTATION

The broker must arrange the least expensive and most appropriate mode of transportation based on the participant’s medical needs. The modes of transportation that may be utilized by the broker include, but are not limited to:

1. Public transit/bus tokens;
2. Gas reimbursement
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the State agency.

The broker must not utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy,
2. Pregnancy after the eighth month,
3. High risk cardiac conditions,
4. Severe breathing problems,
5. More than three block walk to the bus stop,
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 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.
- For facilities arranging transportation for your dialysis participants, please refer to the Section 22.17.

22.10 NON-COVERED SERVICES

The following services are not eligible for NEMT:

1. The broker shall not provide NEMT services to a pharmacy.
2. Transportation to services included in the Mentally Retarded Developmental Disabilities (MRDD) Waiver Program, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Adult Day Health Care Program are arranged by those programs. Community psychiatric rehabilitation services only provide transportation to attend the psychosocial rehabilitation program and to receive medication services. The broker shall not be responsible for arranging NEMT services.
services for these programs. 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.

### 22.11 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children’s Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.

2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child’s Individual Education Plan (IEP). Eligible children are identified by the school district.

3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals must complete an application and be approved to participate in the program.

4. **Missouri Kidney Program (MOKP)** MOKP provides reimbursement for transportation expenses for dialysis patients who do not have access to transportation for dialysis treatment. Dialysis patients who need assistance with transportation to dialysis services should contact the dialysis center.

5. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.

General Manual

Production - 04/30/2012
6. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.

7. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.

8. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.

9. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

### 22.12 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.

**22.13 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:

Medical Transportation Management, Inc
16 Hawk Ridge Drive
Lake St. Louis, MO 63367
Attn: Grievance and Appeals Committee
(866) 436-0457

**22.14 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.

22.15 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.

22.16 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) 436-0457. Written grievances can be sent to:

Medical Transportation Management, Inc
16 Hawk Ridge Drive
Lake St. Louis, MO  63367
Attn:  Grievance and Appeals

22.17 MTM SERVICES AVAILABLE FOR FACILITY SUPPORT

MTM carries out its processes in the following customer service departments:

1. Care Management (CM)
2. Quality Management (QM)
3. Customer Service Center (CSC)
22.17.A. CARE MANAGEMENT (CM)

- MTM Care Management Coordinators (CMCs) are the single point of contact for facility staff.
- Each CMC is educated on the policies and procedures specific to MO HealthNet or the health plan to which they are assigned.
- Care Management specializes in working with participants needing such services as dialysis, cancer treatments, high-risk obstetrics, behavioral health, transplants, hospital discharges, and other specialized services.
- CMCs can set transportation for normal appointment requests with five (5) calendar days notice.
- CMCs will help arrange transportation for urgent trip requests.
- CMCs provide trip coordination for recurring appointments.
- MTM shall authorize out-of-state travel based on state approval. CMCs will work with referring physicians to ensure the correct documentation is received. The CMC will then complete the necessary travel arrangements.
- CMCs will assist in the prior-authorization process for long distance trip requests.
- CMCs will coordinate with participants and dialysis facilities, as well as the Missouri Kidney Program (MoKP), to ensure transportation to critical care dialysis treatment.
- CMCs will assist the participant in arranging meals and lodging when specific criteria are met.
- CMCs will assist the participant with the Americans with Disabilities Act (ADA) application process if they are a candidate for these services.

22.17.B. QUALITY MANAGEMENT DEPARTMENT (QM)

- MTM Quality Service Coordinators (QSCs) field and document incoming grievances and issues regarding MTM staff and transportation providers.
- Grievances are forwarded to the appropriate transportation provider and/or department within MTM.
- A grievance response shall be submitted to QM by the transportation provider and/or appropriate MTM department within 72 hours.
- The QSC will document the response and provide education so the issue will not repeat.
- All grievances are forwarded to MO HealthNet per contract requirements.
- QM monitors all transportation providers to keep the grievance rate below 3% monthly.
- If the 3% threshold is met or exceeded, QM will place the transportation provider on a corrective action plan.
- If the grievance is associated with staff at MTM, a performance improvement plan will be executed as indicated.
22.17.C. CUSTOMER SERVICE CENTER (CSC)

- Participants and facility staff may contact the Customer Service Center to schedule transportation 24 hours a day, 7 days a week, including all holidays.
- The CSC is open 24 hours a day, 7 days a week, to handle urgent same or next day appointment scheduling and hospital discharges.
- Customer Service Representatives (CSRs) can answer questions regarding which services are covered.

22.17.D. WHAT IS CARE MANAGEMENT (CM)?

The Care Management Department provides medical facilities, social workers, and case managers with a single point of contact at MTM for the transportation coordination of all participants under their care. This type of direct contact ensures special transportation services are booked in a timely and appropriate manner, improving client satisfaction. Care Management Coordinators (CMCs) establish relationships with social workers and hospital staff. Special transportation includes coordination of services for dialysis patients, drug and alcohol programs, psychiatric outpatient treatment programs, reimbursement for mileage, meals, and lodging, and out of state travel.

If a participant has a recurring appointment at a facility, Care Management can program the NET Management System to automatically generate transportation requests for up to 90 days at a time, with the exception of dialysis appointments which can be set for six (6) months at a time. This reduces the time facilities spend requesting transportation on a weekly basis. When the recurring request is made, the facility will be advised of the end date, and either the facility or the participant, will be responsible for contacting MTM to request an extension if needed. The facility must contact MTM when the participant is discharged from a program, becomes ineligible for MO HealthNet services, or has a schedule change. Notifying MTM of cancellations or adjustments to recurring appointments helps MTM keep resources available for all MO HealthNet participants.

Transportation to MO HealthNet services is verified by MTM. When participants schedule transportation to a facility for MO HealthNet covered services, MTM is contractually bound to verify the participant did attend their appointment. If MTM is unable to verify that the participant attended, MTM will cancel the trip request. Each morning before the facility opens for business, MTM’s computer system will automatically send a fax to the facility for all participants scheduled for that day. The facility can indicate “scheduled,” “scheduled but did not attend,” or “not scheduled” and return the fax to MTM at the end of each day.

MTM staff is cross trained to assist other members of the Care Management Department. If the designated CMC is out of the office, backup staff will monitor the faxes, voice messages, and emails to ensure that all urgent requests are responded to in a timely manner. Facilities will receive a response to a request within one (1) business day.
22.17.E. CARE MANAGEMENT OUTREACH

MTM provides outreach and education to facilities and advocacy groups on NEMT programs and MTM’s program management. MTM can meet with facility staff before start-up of operations and provide on-going support as needed or requested to ensure service satisfaction.

In-service training on the following topics is available as requested or needed:
- Department Programs
- Dialysis Transportation
- Urgent Transportation
- Arranging Transportation for MO HealthNet participants

Care Management Coordinators also provide education and training on MTM’s services to facility staff, case managers, and social workers. Care Management disseminates educational materials and has in-service training available for any facility, staff, or social service department that requests education on MO HealthNet services, rights, and responsibilities.

The Care Management Department has a dedicated toll-free number, as well as a local telephone number, for the medical community to access the department directly.

**MTM Care Management Coordinators**

**Local Phone Number:** (636) 695-5720  
**Dedicated Toll Free Number:** (888) 561-8747 ext. 5720

**MTM Care Management Manager**  
Sherry Moore  
Email: smoore@mtm-inc.net  
Toll Free: (888) 561-8747 Ext. 5641  
Dedicated Fax: (877) 406-0658

Contact: Melissa Whitmore  
Email: mwhitmore@mtm-inc.net  
Toll Free: (888) 561-8747 Ext. 5720  
Dedicated Fax: (877) 406-0658

Contact: Mellissa Workman  
Email: mworkman@mtm-inc.net  
Toll Free: (888) 561-8747 Ext. 5730  
Dedicated Fax: (877) 406-0658

Contact: Ana Underwood  
Email: aunderwood@mtm-inc.net  
Toll Free: (888) 561-8747 Ext. 5793  
Dedicated Fax: (877) 406-0658
MTM Education, Training & Outreach Manager
Anna Lee
Email: alee@mtm-inc.net
Toll Free: (888) 561-8747 Ext 5532
Cell: (636) 614-6135
Dedicated Fax: (877) 406-0658

22.17.F. WHAT IS QUALITY MANAGEMENT (QM)?

MTM’s Quality Management Department monitors all aspects of MTM’s operational departments (Care Management, Call Center, Quality Management, and Network Management) and executes MTM’s formal Quality Management Program, Work Plan, and Compliance Program.

The scope of the QM Program includes:
- Credentialing transportation providers
- Audits and site reviews to ensure transportation provider compliance
- Management of complaints and grievances
- Fraud and abuse investigation and reporting
- Incident and accident monitoring, reporting, and prevention
- Systematic oversight of Customer Service Centers

MTM’s Quality Management Department must ensure that participants are treated with respect and that any issues, concerns, or grievances about service provided by MTM staff or a contracted transportation provider are properly resolved.

A facility can file a grievance, or address any issues regarding service by contacting:

MTM, Inc.
Quality Management Department
Toll Free: (866) 436-0457
Fax: (866) 343-0998
Mail: 16 Hawk Ridge Dr., Lake St. Louis, MO 63367

MTM After Hours Contact
Customer Service Center
Toll Free: (866) 269-5927

22.17.G. WHAT IS THE CUSTOMER SERVICE CENTER (CSC)?

MO HealthNet participants have a toll-free number to reach the Customer Service Center (CSC):

Customer Service Center
Toll Free: (866) 269-5927
Customer Service Representatives (CSR’s) help the participant schedule his or her appointment.

MTM CSRs field calls from participants and facilities and assist with transportation requests for standard and urgent appointment requests. CSRs also provide information regarding which services are covered. If facility staff is unable to reach a designated Care Management Coordinator, the Customer Service Center is available to handle the requests.

22.17.H. ARRANGING TRANSPORTATION FOR FACILITIES

- The facility MAY call to schedule transportation to medical appointments and must provide the following information:
  1) MO HealthNet ID #
  2) Pick up address
  3) Telephone number
  4) Date of birth
  5) Date and time of appointment(s)
  6) Type of appointment(s)
  7) Doctor’s name
  8) Facility name
  9) Complete doctor/facility address
  10) Doctor/facility telephone number

- Request for transportation services for a routine medical appointment must be at least five (5) calendar days in advance of the appointment. Urgent trips, follow-up appointments, and discharges can be set up with less than five days notice. If a facility calls for urgent/same day trips, MTM will confirm that it is an urgent trip and then set the trip up according to guidelines.

- The participant must use the closest appropriate medical facility/provider unless a health care provider has referred the participant outside of the immediate community.

- Out-of-state trip requests to non-bordering states require prior authorization from MO HealthNet. Care Management will coordinate the approval effort. Trip requests to bordering states must fall within the travel standards and will follow the same policies as in state requests.

- Meals and lodging requests require prior authorization from Care Management.

- Participant must provide all devices/tools necessary for travel (i.e. wheelchairs).
22.17.I. HOW DOES A FACILITY REQUEST TRANSPORTATION?

A facility can schedule transportation one of four ways:

**By phone:** Call the MO HealthNet Care Management Coordinator, Mellissa Whitmore, at (888) 561-8747 ext 5720 or the Customer Service Center at (866) 269-5927 to set up transportation via telephone.

**By fax:** MTM has facility forms available upon request that can be completed and faxed to (877) 406-0658. The forms go to a confidential fax and a Care Management Coordinator will follow up with the facility when transportation has been arranged. A Care Management Coordinator will respond via phone or fax within 24 business hours to confirm a request has been received and processed.

**By e-mail:** Facilities may e-mail a Care Management Coordinator listed in Section 22.17.E. All email containing PHI must be sent using encrypted email systems.

**Online Trip Management:** A facility may be able to use the MTM Online Trip Management (OTM) program to set transportation up via the internet. A Care Management Coordinator can assist facilities on the OTM system and provide facility staff training on its use.

22.17.J. FORMS COMPLETED BY FACILITIES

**Transportation Request Form**

The information provided on this form will allow THE CMC to enter all trip information into MTM’s system and schedule transportation. This form can be faxed directly to a CMC for any trip that is more than five (5) calendar days out. A facility scheduling urgent transportation should call a CMC directly to ensure the request is received.

**Approved Distance Authorization Form**

For all trip requests outside of the set travel standards, the Approved Distance Authorization Form must be completed by the referring medical provider and returned to MTM Care Management for approval. The form can be obtained from MTM.

**Meals and Lodging (Ancillary Services)**

When a participant has an appointment that meets criteria in Section 22.3, MTM may authorize meal and lodging requests. MTM will provide prior authorization for all requests for these services.

**Daily Attendance Verification Form**

Facilities will receive a Daily Attendance Verification Form. This form will list the participant scheduled for appointments for the day. All MO HealthNet services must be
verified. Facilities will need to verify each participant’s attendance status (i.e. arrived, did not arrive, was not scheduled) and fax the completed form to MTM at (888) 240-6579. Although trip requests for recurring units will be authorized for periods of 90 days (or six (6) months for dialysis), these trips still require verification.

22.17.K. SCHEDULING URGENT TRIPS

A facility may call MTM’s CMC, Mellissa Whitmore at (888) 561-8747 ext 5720 or the Customer Service Center at (866) 269-5927 to schedule transportation via the phone for urgent trips.

22.17.L. SCHEDULING A HOSPITAL DISCHARGE

The MTM Customer Service Center is open 24 hours a day, seven (7) days a week for urgent trips and hospital discharges. Contact a Customer Service Representative at (866) 269-5927 to arrange discharge transportation.

22.17.M. TRANSPORTATION RESTRICTIONS

- **Public Transit**

  A participant can be excluded from public transit for:
  - Pregnancy after the 8th month
  - High risk pregnancy
  - High risk cardiac condition
  - Severe breathing problems
  - Living more than three (3) blocks from a bus stop
  - Medical provider location is more than 3 blocks from a bus stop
  - Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

  If a participant states he/she cannot ride the bus, the trip information is escalated to the Care Management department for review. If it is determined that further information is necessary, the Care Management department will contact the participant and/or medical provider.

- **Ambulatory** (sedan/cab, van/mini-bus, etc.)
  - Includes wheelchair transfer when a participant can transfer from wheelchair to a vehicle seat, with the wheelchair collapsed and placed in the trunk.

- **Wheelchair Lift Equipped Vehicle**
  - For participants who are unable to transfer to a vehicle seat or whose wheelchair does not collapse.

- **Stretcher**

General Manual

Production - 04/30/2012
Stretcher transportation is available for participants who are bed-bound and must travel in a prone or supine position. Unlike ambulance transportation, stretcher transportation providers do not provide any medical care or monitoring during the transport. Participants who can use a wheelchair are not eligible for stretcher transportation.

- **Non-Emergency Ambulance**
  - Non-emergency ambulance transportation is available for participants who are bed-bound, must travel in a prone or supine position and require life sustaining medical care or monitoring as needed during the transport. Participants who can use a wheelchair are not eligible for ambulance transportation.

### 22.17.N. AMERICAN WITH DISABILITIES ACT (ADA) CERTIFICATION

All participants that are certified for ADA transportation shall continue to utilize the available ADA transportation. In situations where the ADA provider is unable to transport, MTM will provide transportation to eligible services.

If a participant qualifies for ADA certification, MTM will assist the participant in the ADA application process. MTM will be able to direct the participant to the appropriate certification facility and shall transport the participant during the application process.

### 22.17.O. PARTICIPANT ASSISTANCE DURING TRANSPORT

A participant may bring someone as an escort at no cost in the following situations:
- Participants under the age of 17 must be accompanied by a parent/guardian, relative or other adult.
- Participants under 21 years old may be accompanied by a parent/guardian, relative, or other adult.
- Participants that cannot travel independently or need assistance due to age, illness, or a physical or mental disability may provide a parent/guardian, relative, or other adult. MTM may require verification from the medical provider.
- If the participant does not speak English, someone to interpret.

### 22.17.P. WHAT MTM WILL DO IF A CAREGIVER IS NOT AVAILABLE

If a transportation provider notifies MTM that no one is home when they attempt to return an adult with impairments who is able to transport without an escort or attendant, but is unable to be alone at home for long periods of time, the MTM employee will:
- Attempt to contact a family member using the main phone number and the alternate phone number listed in the participant’s file.
- Instruct the transportation provider to take participant to the closest police department if the facility is closed.
- Document the circumstances, actions taken, and outcomes.
- Immediately notify MTM management on duty.
• Inform the Manager of Quality Management of the situation the next business day for a complete follow-up. The Manager of Quality Management will determine any necessary action to be taken, including notification of MO HealthNet.

22.17.Q. FILING A GRIEVANCE

A grievance may be filed verbally or in writing by a participant, their representative, or facility by contacting:

**MTM, Inc.**  
Quality Management Department  
Toll Free: (866) 436-0457  
Fax: (866) 343-0998  
Mail: 16 Hawk Ridge Dr., Lake St. Louis, MO 63367
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

23.1 CLAIM ATTACHMENT SUBMISSIONS ........................................................................................................2
23.2 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ) .................................................................3
23.3 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY........................................................................................................................................3
23.4 ELECTRONIC PA REQUEST AND CLAIM ATTACHMENTS SUBMISSION VIA THE INTERNET .......................................................................................4
23.5 CLAIM ATTACHMENT REMITTANCE ADVICE .......................................................................................4
  23.5.A CERTIFICATE OF MEDICAL NECESSITY .........................................................................................4
  23.5.B SECOND SURGICAL OPINION FORM ...............................................................................................6
  23.5.C (STERILIZATION) CONSENT FORM ...............................................................................................7
  23.5.D ACKNOWLEDGMENT OF RECEIPT OF Hysterectomy INFORMATION ......................................7
  23.5.E MEDICAL REFERRAL FORM OF RESTRICTED PARTICIPANT (PI-118) .....................................8
  23.5.F OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ)8
SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments. This section also contains instructions for the Claim Attachment Remittance Advice, which is the document used to inform the provider of the status of each attachment.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Six claim attachments required for payment of certain services are separately processed from the claim form. The six attachments are:

- Second Surgical Opinion Form
- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form
- 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:

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

These attachments may also be submitted to Infocrossing Healthcare Services 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. The status of the attachment(s) is reflected on a Claim Attachment Remittance Advice (RA) (Refer to Section 23.5) similar to claim disposition.

Providers do not need to alter their claim submittal process or wait for an attachment to be finalized on an Claim Attachment Remittance Advice before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 60 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 60 days a match is not found, the claim denies for the missing attachment.
Example: Surgery that requires a Second Surgical Opinion Form is performed on a MO HealthNet participant, during an inpatient hospitalization, on December 5, 2001. The hospital submits a claim on December 21, 2001, without the Second Surgical Opinion Form. This claim does not deny based on the lack of the Second Surgical Opinion Form but suspends for up to 60 days. The system periodically checks to determine if an approved attachment can be located to link to the hospital’s claim.

The physician submits the Second Surgical Opinion Form on December 22, 2001 and a claim on December 24, 2001. The data from the attachment is entered into the system and subsequently finalized in the system on December 31, 2001. During the next cycle the hospital’s and the physician’s claims are linked to the attachment, and both claims continue through the adjudication process.

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 OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ)

The data from the OREMJ is entered into MMIS and processed for validity editing and MO HealthNet program requirements. Providers are required to include the correct modifier (NU, RR, RP) in the procedure code field with the corresponding procedure code.

Once an OREMJ has been submitted and approved for 12 months from the prescription date, providers are not required to submit the OREMJ with each claim submission or resubmission when the information on the claim matches the criteria on the OREMJ. The claims link up with the approved OREMJ and continue to process.

23.3 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, RP) in the procedure code field with the corresponding procedure code.

Once the Certificate of Medical Necessity has been submitted by a DME provider and 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 for payment, without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.
23.4 ELECTRONIC PA REQUEST AND CLAIM ATTACHMENTS SUBMISSION VIA THE INTERNET

Providers may submit PA Requests (Refer to Section 8.2) and certain claim attachments via the Internet. The claim attachments available for submission via the Internet include: Second Surgical Opinion Form; (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of Restricted Participant (PI-118), OREMJ and Certificate of Medical Necessity (for Durable Medical Equipment providers only) when additional documentation is not required. The web site address for these submissions is www.emomed.com.

23.5 CLAIM ATTACHMENT REMITTANCE ADVICE

The Claim Attachment Remittance Advice (RA) reflects the status of the attachment(s). When an attachment is approved, no EOB(s) or Exception(s) is reflected on the applicable line of the attachment status RA page. When an attachment is denied, the relevant EOB(s) and Exception(s) is indicated on the RA. Unless prohibited by the applicable program, the attachment can be corrected or additional information supplied on the attachment and resubmitted for consideration.

23.5.A CERTIFICATE OF MEDICAL NECESSITY

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. The following lists the fields found on the Certificate of Medical Necessity Claim Attachment Remittance Advice:

<table>
<thead>
<tr>
<th>FIELD REFERENCE &amp; NAME</th>
<th>EXPLANATION OF FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provider Identifier</td>
<td>The provider's 9-digit MO HealthNet number.</td>
</tr>
<tr>
<td>2. Attachment Name</td>
<td>The name of the attachment.</td>
</tr>
<tr>
<td>3. Remittance Advice Date</td>
<td>The financial cycle date.</td>
</tr>
<tr>
<td>4. Remittance Advice Number</td>
<td>The Claim Attachment Remittance Advice number.</td>
</tr>
<tr>
<td>5. Page</td>
<td>The Claim Attachment Remittance Advice page number.</td>
</tr>
<tr>
<td>6. Participant Name</td>
<td>The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.</td>
</tr>
</tbody>
</table>
### Section 23 - Claim Attachment Submission and Processing

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. MO HealthNet I.D.</td>
<td>The participant's 8-digit MO HealthNet identification number.</td>
</tr>
<tr>
<td>8. Attachment Internal Control Number (ICN)</td>
<td>The 13-digit number assigned to the attachment for identification purposes. The first two digits of an ICN indicate the type of attachment: 01—Second Surgical Opinion Form 02—Medical Referral Form of Restricted Participant (PI-118) 03—(Sterilization) Consent Form 07—Certificate of Medical Necessity 08—Oxygen and Respiratory Equipment Medical Justification Form (OREMJ) 09—Acknowledgment of Receipt of Hysterectomy Information</td>
</tr>
<tr>
<td>9. Service Date From</td>
<td>The initial date of service in MMDDYY format.</td>
</tr>
<tr>
<td>10. Service Date To (Thru)</td>
<td>The final date of service in MMDDYY format.</td>
</tr>
<tr>
<td>11. Proc Code/Mod1/Mod2</td>
<td>The procedure code, including any modifier(s).</td>
</tr>
<tr>
<td>12. Msg/Sys Inf</td>
<td>A message code(s) for the line. When an attachment is approved, no EOB(s) or Exceptions(s) are reflected on the line. For a description of the code, reference the last page of the Remittance Advice.</td>
</tr>
<tr>
<td>13. Edit Message Numbers (Nbrs)</td>
<td>A list of all the edits the attachment failed, if the reason(s) for denial cannot all be explained by the Message Code in field 12. If edit numbers are printed in this area, they indicate errors for which the attachment will fail again if resubmitted unchanged. For a description of the code, reference the last page of the Remittance Advice.</td>
</tr>
</tbody>
</table>
14. Category Totals

Each category (i.e., Second Surgical Opinion Form, Medical Referral Form of Restricted Participant (PI-118), (Sterilization) Consent Form, Certificate of Medical Necessity, Oxygen and Respiratory Equipment Medical Justification Form (OREMJ), Acknowledgment of Receipt of Hysterectomy Information) has separate totals for number of attachments. This total appears on the final page for that category.

15. Provider Totals

The grand total of all the Category Totals. This field appears after the Category Totals for whichever category is the final one for the Remittance Advice.

16-17.

Not applicable to the Certificate of Medical Necessity Claim Attachment Remittance Advice.

23.5.B SECOND SURGICAL OPINION FORM

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the Second Surgical Opinion Claim Attachment Remittance Advice:

**FIELD REFERENCE & NAME**  **EXPLANATION OF FIELD**

1-8. Reference Section 23.5.A.

9-10. Not applicable to the Second Surgical Opinion Claim Attachment Remittance Advice.

11. Proc Code1/Mod1/Mod2
   Proc Code2/Mod1/Mod2

Reference Section 23.5.A.

12-15.

Reference Section 23.5.A.

16. Date of Surgery

The date the surgical procedure was performed.
17. Not applicable to the Second Surgical Opinion Claim Attachment Remittance Advice

23.5.C  (STERILIZATION) CONSENT FORM

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the (Sterilization) Consent Form Claim Attachment Remittance Advice:

<table>
<thead>
<tr>
<th>FIELD REFERENCE &amp; NAME</th>
<th>EXPLANATION OF FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-8.</td>
<td>Reference Section 23.5.A.</td>
</tr>
<tr>
<td>9-11.</td>
<td>Not applicable to the (Sterilization) Consent Form Claim Attachment Remittance Advice.</td>
</tr>
<tr>
<td>12-15.</td>
<td>Reference Section 23.5.A.</td>
</tr>
<tr>
<td>16.</td>
<td>Reference Section 23.5.B.</td>
</tr>
<tr>
<td>17.</td>
<td>Not applicable to the (Sterilization) Consent Form Claim Attachment Remittance Advice.</td>
</tr>
</tbody>
</table>

23.5.D  ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice:

<table>
<thead>
<tr>
<th>FIELD REFERENCE &amp; NAME</th>
<th>EXPLANATION OF FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-8.</td>
<td>Reference Section 23.5.A.</td>
</tr>
<tr>
<td>9-11.</td>
<td>Not applicable to the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice.</td>
</tr>
</tbody>
</table>
12-15. Reference Section 23.5.A.

16. Not applicable to the Acknowledgment of Receipt of Hysterectomy Information Claim Attachment Remittance Advice.

17. Sign-Date Date of participant/participant's representative's signature in month/day/year format.

23.5.E MEDICAL REFERRAL FORM OF RESTRICTED PARTICIPANT (PI-118)

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for most of the fields on a Claim Attachment Remittance Advice. The following lists the field areas found on the PI-118 Claim Attachment Remittance Advice:

<table>
<thead>
<tr>
<th>FIELD REFERENCE &amp; NAME</th>
<th>EXPLANATION OF FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-8.</td>
<td>Reference Section 23.5.A.</td>
</tr>
<tr>
<td>9-11.</td>
<td>Not applicable to the PI-118 Claim Attachment Remittance Advice.</td>
</tr>
<tr>
<td>12-15.</td>
<td>Reference Section 23.5.A.</td>
</tr>
<tr>
<td>16.</td>
<td>Not applicable to the PI-118 Claim Attachment Remittance Advice.</td>
</tr>
<tr>
<td>17. Sign-Date</td>
<td>Date of authorized provider's signature in month/day/year format.</td>
</tr>
</tbody>
</table>

23.5.F OXYGEN AND RESPIRATORY EQUIPMENT MEDICAL JUSTIFICATION FORM (OREMJ)

The Claim Attachment Remittance Advice example references the field explanations by light italic bracketed numbers for the purpose of illustration. These numbers do not appear on the Claim Attachment Remittance Advice received by the provider. Section 23.5.A contains the explanation for the fields on the Oxygen and Respiratory Equipment Medical Justification Form Claim Attachment Remittance Advice.