STATE OF MISSOURI

TRANSPLANT MANUAL

SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

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

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

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

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

1.1.A(1) MO HealthNet

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

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

1.1.A(2) MO HealthNet for Kids

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

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

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

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

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

1.1.A(4) Voluntary Placement Agreement for Children

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

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

1.1.A(5) State Funded MO HealthNet

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

1.1.A(6) MO Rx

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

1.1.A(7) Women's Health Services

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

1.1.A(8) ME Codes Not in Use

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

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

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

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

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

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

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

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

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

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

1.2.A FORMAT OF MO HEALTHNET ID CARD

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

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

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

1.2.B ACCESS TO ELIGIBILITY INFORMATION

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

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

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

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

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

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

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

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

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

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

1.2.C(3) TEMP

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

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

58, 59

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

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

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

1.2.C(5) Presumptive Eligibility for Children

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

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

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

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

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

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

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

ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

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

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

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

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

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

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

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

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

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

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

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

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

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

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

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

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

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

1.4.A NEWBORN INELIGIBILITY

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

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

1.4.B NEWBORN ADOPTION

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

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

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

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

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

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

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

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

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

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

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

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

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

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

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

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

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

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

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

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

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

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

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

- Group 5 consists of uninsured children.

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

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

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

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

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

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

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

1.5.D HOSPICE BENEFICIARIES

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

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

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

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

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

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

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

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

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

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

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

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

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

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

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

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

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

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

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

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

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

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

1.5.G TEMP PARTICIPANTS

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

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

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

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

1.5.G(1) TEMP ID Card

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

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

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

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

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

1.5.G(2) TEMP Service Restrictions

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

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

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

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

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

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

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

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

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

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

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

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

1.5.I(1) Eligibility Criteria

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

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

1.5.I(2) Presumptive Eligibility

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

1.5.I(3) Regular BCCT MO HealthNet

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

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

1.5.I(4) Termination of Coverage

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

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

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

1.5.J(1) Disability

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

1.5.J(2) Employment

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

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

1.5.J(3) Premium Payment and Collection Process

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

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

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

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

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

1.5.J(4) Termination of Coverage

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

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

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

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

1.5.K(1) Eligibility Determination

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

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

1.5.K(2) MO HealthNet for Kids Coverage

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

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

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

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

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

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

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

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

1.5.L(1) MO HealthNet Coverage Not Available

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

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

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

1.5.L(2) MO HealthNet Benefits

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

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

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

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

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

1.5.M(1) Duration of Voluntary Placement Agreement

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

1.5.M(2) Covered Treatment and Medical Services

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

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

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

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

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

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

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

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

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

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

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

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

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

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

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

1.6.A DAY SPECIFIC ELIGIBILITY

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

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

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

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

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

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

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

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

1.6.B SPENDDOWN

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

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

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

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

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

1.6.B(1) Notification of Spenddown Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6.B(6) Spenddown Pay-In Option

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

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

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

1.6.B(7) Prior Quarter Coverage

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

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

1.6.B(8) MO HealthNet Coverage End Dates

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

1.6.C PRIOR QUARTER COVERAGE

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

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

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

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

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

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

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

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

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

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

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

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

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

1.7.A NEW APPROVAL LETTER

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

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

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

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

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

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

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

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

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

1.7.B REPLACEMENT LETTER

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

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

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

1.7.C NOTICE OF CASE ACTION

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

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

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

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

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

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

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

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

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

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

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

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

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

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

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

1.8 TRANSPLANT PROGRAM

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

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

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

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

1.8.B PATIENT SELECTION CRITERIA

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

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

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

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

1.8.C CORNEAL TRANSPLANTS

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

1.8.D ELIGIBILITY REQUIREMENTS

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

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

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

1.8.E MANAGED CARE PARTICIPANTS

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

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

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

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

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

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

1.8.F MEDICARE COVERED TRANSPLANTS

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

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

END OF SECTION

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

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

2.1.A QMB-ONLY PROVIDERS

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

2.1.B NON-BILLING MO HEALTHNET PROVIDER

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

2.1.C PROVIDER ENROLLMENT ADDRESS

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

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

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

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

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

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

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

2.2 NOTIFICATION OF CHANGES

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

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

- Change of direct deposit information.

2.3 RETENTION OF RECORDS

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

2.3.A ADEQUATE DOCUMENTATION

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

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

2.4 NONDISCRIMINATION POLICY STATEMENT

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

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

2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

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

2.6 FRAUD AND ABUSE

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

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

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

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

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

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

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

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

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

2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

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

2.7 OVERPAYMENTS

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

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

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

2.8 POSTPAYMENT REVIEW

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

2.9 PREPAYMENT REVIEW

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

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

2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

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

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

Missouri Medicaid Audit and Compliance (MMAC)

Provider Enrollment Unit

P.O. Box 6500

Jefferson City, MO 65102

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

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

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

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

All payments are direct deposited.

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

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

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

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

END OF SECTION

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SECTION 3 - PROVIDER AND PARTICIPANT SERVICES

3.1 PROVIDER SERVICES

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

3.1.A WIPRO INFOCROSSING HELP DESK

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

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

3.2 PROVIDER ENROLLMENT UNIT

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

3.3 PROVIDER RELATIONS COMMUNICATION UNIT

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

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

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

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

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

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

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

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

Option 1. Participant Eligibility

The caller is prompted to supply the following information:

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

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

The caller is given standard MO HealthNet eligibility coverage information including ME code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits. The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under QMB or the Presumptive Eligibility (TEMP) Program. Please reference the provider manual for a description of these services. Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Refer to Section 1 for more detailed information on participant eligibility.

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

1 Managed care enrollment and health plan name and telephone number

2 Eye exam and eyeglass information

3 Third party liability information

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

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

6 Repeat of confirmation number

7 Inquiry on another participant

8 Return to the main menu

9 End the call

0 Transfer to a MO HealthNet hotline specialist

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

Option 2. Last Two Check Amounts

The caller is prompted to supply their NPI number.

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

Option 3. Claim Status

The caller is prompted to supply the following:

- Provider's NPI number

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

  zero (0) - any claim type

  One (1) - medical

  Two (2) - inpatient

  Three (3) - outpatient

  Four (4) - dental

  Five (5) - home health

  Six (6) - drug

  Seven (7) - nursing home

  Eight (8) - Medicare crossover

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

Option 5. MO HealthNet Informational Message

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

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

3.3.A(1) Using the Telephone Key Pad

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

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

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

3.3.B MO HEALTHNET SPECIALIST

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

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

3.3.C INTERNET

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

The internet inquiry options include the same inquiry options available through the interactive voice response (IVR) system. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security Number and date of birth, claim status and check inquiry. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-

time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

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

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

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

3.3.D WRITTEN INQUIRIES

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

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

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

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

3.4 PROVIDER EDUCATION UNIT

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

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

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

3.5 PARTICIPANT SERVICES

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

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

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

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

3.6 PENDING CLAIMS

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

3.7 FORMS

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

3.7.A RISK APPRAISAL FORM

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

3.8 CLAIM FILING METHODS

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

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

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

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SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

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

4.1.B MEDICARE/MO HEALTHNET CLAIMS

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

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

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

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

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

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

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

4.2.A CLAIMS FILED AND DENIED

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

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

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

4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

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

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT REQUEST FORM

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

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

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

4.5 DEFINITIONS

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

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

Nursing Homes: The last date of service for the billing period indicated on the participant's detail record. Nursing Homes *must* bill electronically, unless attachments are required.

Pharmacy: The date dispensed.

Outpatient Hospital: The ending date of service for each individual line item on the claim form.

Professional Services: The ending date of service for each individual line item on the claim form.

Dental: The date service was performed for each individual line item on the claim form.

Inpatient Hospital: The through date of service in the area indicating the period of service.

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

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

Internal Control Number (ICN): The 13-digit number printed by the fiscal agent on each document that processes through the claims processing system. The first two digits indicate the type of claim. The year of receipt is indicated by the 3rd and 4th digits, and the Julian date appears as the 5th, 6th, and 7th digits. For example, in the number 4912193510194, “49” is an internet/emomed claim, “12” is the year 2012, and “193” is the Julian date for July 11.

Julian Date: The number of a day of the year when the days of the year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 2012, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2012.

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

Twelve-Month Time Limit Unit: 366 days.

Six-Month Time Limit: 181 days.

Twenty-four-Month Time Limit: 731 days.

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SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

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

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

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

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

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

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

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

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

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

5.1.B THIRD PARTY LIABILITY FOR MANAGED HEALTH CARE ENROLLEES

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

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

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

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

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

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

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

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

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

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

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

5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR

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

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

5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

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

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

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

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

5.2 HEALTH INSURANCE IDENTIFICATION

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

5.2.A TPL INFORMATION

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

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

5.2.B SOLICITATION OF TPR INFORMATION

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

A few of the more common health insurance resources are:

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

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

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

5.3 INSURANCE COVERAGE CODES

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

AC Accident

AM Ambulance

CA Cancer

CC Nursing Home Custodial Care

DE Dental

DM Durable Medical Equipment

HH Home Health

HI Inpatient Hospital

HO Outpatient Hospital—includes outpatient and other diagnostic services

HP Hospice

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

MA Medicare Supplement Part A

MB Medicare Supplement Part B

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

MH Medicare Replacement HMO

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

professional

RX Pharmacy

SC Nursing Home Skilled Care

SU Surgical

VI Vision

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

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

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

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

5.5 MEDICAL SUPPORT

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

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

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

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

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

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

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

5.6.A EXCEPTION TO TIMELY FILING LIMIT

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

5.6.B TPR CLAIM PAYMENT DENIAL

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

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

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

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

5.7 THIRD PARTY LIABILITY BYPASS

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

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

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

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

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

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

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

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

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

5.9 LIABILITY AND CASUALTY INSURANCE

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

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

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

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

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

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

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

5.9.A TPL RECOVERY ACTION

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

5.9.B LIENS

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

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

5.9.C TIMELY FILING LIMITS

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

5.9.D ACCIDENTS WITHOUT TPL

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

Examples are:

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

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

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

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

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

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

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

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

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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

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

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END OF SECTION

TOP OF SECTION

SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

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

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

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

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

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

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

6.2.B ADJUSTING CLAIMS ONLINE

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

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

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

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

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

6.2.B(1)(i) Void

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

6.2.B(1)(ii) Replacement

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

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

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

6.2.B(2)(i) Timely Filing

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

6.2.B(2)(ii) Copy Claim – Original

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

6.2.B(2)(iii) Copy Claim – Advanced

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

6.2.C CLAIM STATUS CODES

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

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

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

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

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

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

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

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

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

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

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

1. An adjustment that credits the original payment and then repays the claim based on the adjusted information appears on the Remittance Advice as a two-step transaction consisting of two ICN's.
    - An ICN that credits (recoups) the original paid amount and
    - An ICN that repays the claim with the corrected payment amount.
2. An adjustment that credits or recoups the original payment but does not repay the claim (resulting in zero payment) appears on the Remittance Advice with one ICN that credits (recoups) the original paid amount.

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

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

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

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

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

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

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

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

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

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

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

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

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

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

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

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

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

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

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

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

8.2 PRIOR AUTHORIZATION GUIDELINES

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

The following general guidelines pertain to all prior authorized services:

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

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

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

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

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

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

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

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

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

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

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

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

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Initiate the start of services that require prior authorization.

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

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

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

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

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

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

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

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

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

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

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

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

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

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

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

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

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

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

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

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

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

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

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

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

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

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

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

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

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

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

The written request *must* include:

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

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

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

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

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

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

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

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

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

9.2 PLACE OF SERVICE (POS)

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

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

9.3 DIAGNOSIS CODE

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

9.4 INTERPERIODIC SCREENS

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

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

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

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

9.5 FULL HCY/EPSDT SCREEN

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

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

A full HCY/EPSDT screen includes the following:

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

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

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

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

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

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

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

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

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

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

9.5.A QUALIFIED PROVIDERS

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

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

9.6 PARTIAL HCY/EPSDT SCREENS

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

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

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

9.6.A DEVELOPMENTAL ASSESSMENT

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

This screen includes the following:

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

9.6.A(1) Qualified Providers

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

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

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

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

PROCEDURE CODE	DESCRIPTION	MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT

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

The HCY unclothed physical and history includes the following:

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

9.6.B(1) Qualified Providers

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

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

9.6.C VISION SCREENING

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

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

9.6.C(1) Qualified Providers

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

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

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

9.6.D HEARING SCREEN

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

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

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

9.6.D(1) Qualified Providers

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

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

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

9.6.E DENTAL SCREEN

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

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

Children may receive age-appropriate dental screens and treatment services until they become 21 years old. *A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems*

such as nursing caries, and educate parents in the prevention of dental disease in their child. It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated.

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

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

9.6.E(1) Qualified Providers

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

9.6.F ALL PARTIAL SCREENERS

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)

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

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

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

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

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

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

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

SIGNS AND SYMPTOMS

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

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

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

EXPOSURE PATHWAYS

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

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

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

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

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

9.7.B LEAD RISK ASSESSMENT

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

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

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

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

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

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

9.7.C(1) Risk Assessment

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

9.7.C(2) Determining Risk

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

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

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

9.7.C(3) Screening Blood Tests

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

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

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

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

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

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

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

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

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

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

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

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

(Capillary specimen or venous blood samples.)

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

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

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

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

Recommended Interventions:

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

9.7.E(2) Blood Lead Level 10-19 µg/dL

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

Recommended Interventions:

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

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

9.7.E(3) Blood Lead Level 20-44 µg/dL

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

Recommended Interventions:

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

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

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

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

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

Recommended Interventions:

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

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

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

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

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

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

Recommended Interventions:

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

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

9.7.F COORDINATION WITH OTHER AGENCIES

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

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

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

9.7.G(1) Environmental Lead Investigation

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

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

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

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

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

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

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

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

9.7.H ABATEMENT

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

9.7.I LEAD CASE MANAGEMENT

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

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

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

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

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

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

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

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

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

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

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

Quest Diagnostics
11636 Administration
St. Louis, MO 63146

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

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

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

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

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

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

Arup Laboratories

500 Chipeta Way

Salt Lake City, UT 84108

Esa

22 Alpha Rd.

Chelmsford, MA 01824

Iowa Hygenic Lab

Wallace State Office Building

Des Moines, IA 50307

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

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

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

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Tamarac Medical

7800 Broadway Ste. 2C

Centennial, Co 80122

Specialty Laboratories
2211 Michigan Ave.
Santa Monica, CA 90404

9.8 HCY CASE MANAGEMENT

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

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

9.9 IMMUNIZATIONS

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

9.9.A VACCINE FOR CHILDREN (VFC)

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

9.10 ASSIGNMENT OF SCREENING TIMES

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

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

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

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

the patient's medical record that indicates the medical necessity of the additional full medical screening service.

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

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

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

9.11.A DENTAL SCREENING SCHEDULE

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

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

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

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

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

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

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

9.13 PARTICIPANT NONLIABILITY

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

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

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

9.15 STATE-ONLY FUNDED PARTICIPANTS

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

9.16 MO HEALTHNET MANAGED CARE

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

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

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

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

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

a) A comprehensive unclothed physical examination

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

c) Health education (including anticipatory guidance)

d) Appropriate immunizations according to age

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

f) Lead screen according to established guidelines

g) Hearing screen

h) Vision screen

i) Dental screen

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

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

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

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

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

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

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

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

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

END OF SECTION

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SECTION 10 - FAMILY PLANNING

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

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

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

END OF SECTION

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SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

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

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

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

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

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

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

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

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

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

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

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

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

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

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

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

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

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

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

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

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

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

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

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

Managed Care Health Plan members fall into four groups:

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

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

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

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

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

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

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

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

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

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

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

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

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

to receive these extra benefits.

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

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

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

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

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

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

11.8 QUALITY OF CARE

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

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

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

provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

MO HealthNet Managed Care health plans may also issue their own individual Managed Care health plan ID cards. The individual *must* be eligible for the Managed Care Program and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

11.9.A NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access eMOMED or the Interactive Voice Response (IVR) only if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued an atypical provider identifier that permits access to eMOMED or the IVR; however, it is *not* valid for billing MO HealthNet on a Fee-For-Service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at mmac.providerenrollment@dss.mo.gov.

11.10 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition for MO HealthNet Managed Care health plan members means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or; (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Post stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

11.11.A ELIGIBILITY FOR PACE

Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive service delivery system and finance model for the frail elderly. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the participant. All medical services that the participant requires, while enrolled in the program, are the financial responsibility of the PACE provider. Enrollment in a PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is the entry point for referrals to the PACE provider and assessments for PACE program eligibility. Referrals for the program may be made to DSDS by completing the PACE Referral/Assessment form and faxing to the DSDS Call Center at 314/877-2292 or by calling toll free at 866/835-3505. The PACE Referral/Assessment form can be located at http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the

Intellectually Disabled (ICF/ID);

- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. All services are provided solely through the PACE provider. Lock-in information is available to providers through eMOMED and the IVR at (573) 751-2896. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the Fee-For-Service system at any time.

11.11.D PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:

- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;
- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
- In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- Pharmaceutical services, prescribed drugs, and over the counter medications;
- Medical and surgical specialty and consultation services;

- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;
- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through Fee-For-Service.

END OF SECTION

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SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

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.

12.1 A DETERMINING A FEE

Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established.

In determining what this fee should be, MO HealthNet Division (MHD) 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.

MO HealthNet Division then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

12.2 TRANSPLANT SERVICES

Reimbursement for transplant services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by MO HealthNet 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.

12.2.A TRANSPLANT MAXIMUMS

MO HealthNet Division reimburses authorized transplant services at the following established rates for "reasonable charges" *not* to exceed:

- $100,000 for heart, lung (double or single), liver, small bowel, and stem cell transplants, including bone marrow, peripheral blood stem cell and cord blood.
- $39,000 for kidney and pancreas transplants.
- for multiple organ transplants involving a covered transplant(s), the maximum allowable amount of the highest coverage for the highest single transplant (e.g., heart/lung $100,000 cap or kidney/pancreas $39,000 cap).

Authorization for transplant services is made on a case-by-case basis and reimbursed up to the maximums established.

12.2.B CHARGES EXCEEDING REIMBURSEMENT MAXIMUMS

The transplant facility and other providers by virtue of their participation as a MO HealthNet provider agree to accept MO HealthNet's reimbursement as reimbursement of services in full. Reimbursement is made as claims are received and processed. If any claims within the established maximum reimbursement cap are received after the cap has been reached, the claim(s) are denied for payment. No collection for MO HealthNet covered services in connection with the transplant and related services can be made from the participant/patient, the participant's spouse, parent or guardian, relative or anyone else receiving public assistance.

12.2.C SECOND/THIRD TRANSPLANTS

Reimbursement of a second/third *organ* transplant due to failure of engraftment or rejection is authorized on a case-by-case basis. Each transplant is treated as a new authorization and subject

to the same reimbursement policies as those of the initial transplant. When the second/third transplant is performed during the same course of stay as the initial transplant, the date of the second/third surgery begins a new authorization/reimbursement period subject to the same reimbursement limitations as for the initial transplant. Refer to Section 15 for inpatient billing instructions.

Reimbursement of a second/third *stem cell* transplant is considered on a case-by-case basis as outlined in Section 13. Second/third stem cell transplants are treated as new authorizations and each is individually reviewed as such. Tandem stem cell transplants are considered on a case-by-case basis and reimbursed within the initial prior authorization and the maximum $100,000 approved.

12.2.D OUT-OF-STATE HOSPITAL REIMBURSEMENT RATES—BOTH BORDERING AND NONBORDERING STATES

Reimbursement of inpatient services provided in an out-of-state hospital for participants 21 years of age and older is the lower of the hospital's billed charge or the Missouri Title XIX per diem rate times the applicable number of days. Refer to Hospital Manual for further information.

12.3 SERVICES INCLUDED IN MAXIMUM TRANSPLANT REIMBURSEMENT

The following description of services is provided in order to distinguish those charges that are considered by MHD to be a part of the transplant maximum reimbursement.

12.3.A INPATIENT TRANSPLANT SERVICES

Reimbursement of inpatient transplant services is limited to "reasonable charges" and MO HealthNet covered services for the inpatient transplant stay, including; anti-rejection medications and other pharmacy products, and all procurement services. The transplant stay begins with the date of the transplant surgery and follows through the date of discharge, or significant change in diagnosis *not* related to the transplant.

The amount billed to MO HealthNet for the inpatient services may be cut back for non-covered services or services *not* considered "reasonable" by MHD and the maximum reimbursement reduced by such services, not considered "reasonable" or covered.

12.3.B ORGAN PROCUREMENT SERVICES

The established maximum reimbursement rate for the transplant procedure includes coverage of the procurement costs associated with all approved bone marrow/stem cell, heart, lung, liver, kidney, pancreas, small bowel and multiple organ transplants. The associated costs invoiced from the organ procurement agency or marrow donor program are included on the inpatient

claim for the transplant stay, as well as any costs associated with the organ/marrow transport after retrieval. Procurement services include the below and are reimbursed as follows,

12.3.B(1) Solid Organ

The excision for cadaveric transplants are manually priced and reimbursed directly by MO HealthNet *only if* the services are *not* included on the inpatient bill as part of the organ procurement charge billed on the organ procurement organization's statement of charges or by an invoice submitted to the transplant facility by the excision surgeon. Excision services for living kidney, lung or liver donors are reimbursed on a fee-for-service basis, billed to the facility and included on the hospital claim as an invoiced amount or billed on a separate itemized UB-04 (CMS-1450) claim form. Outpatient claims for lab services will be paid according to the lab fee schedule on file with MHD.

12.3.B(2) Bone Marrow/Stem Cell Harvest

Reimbursement of the bone marrow/stem cell harvest (autologous or allogeneic) is reimbursed on a fee-for-service basis, billed to the facility and included on the hospital claim as an invoiced amount or billed on a separate itemized UB-04 (CMS-1450) claim form. Outpatient claims for lab services will be paid according to the lab fee schedule on file with MHD.

12.3.B(3) Donor Anesthesia Services

Reimbursement of anesthesia services for the bone marrow/stem cell or living related solid organ donor is based on minutes of use, the anesthesia relative value, and the base rate for the anesthesiologist or CRNA.

12.3.B(4) T-Cell Depletion/Marrow Purging

The cost of t-cell depletion or marrow purging of bone marrow/stem cell for transplantation *may* be billed as a separate service. A copy of the treatment process record showing the purging process used (chemo or magnetic antibody) and the number of units processed must be sent with the claim.

12.3.B(5) Cryopreservation

The cost of autologous stem cell cryopreservation *may* be billed as a separate service. In the event an autologous transplant is performed, the transplant facility may show the cost of cryopreservation on the inpatient bill associated with the stem cell transplant or the service may be billed separately when performed on an outpatient basis.

12.3.B(6) Donor Search (Match)

The DR and MLC lab studies (search) for the individual who is finally determined to be a suitable donor (Match) are covered for adults and children and may be submitted to MHD for consideration of reimbursement. MO HealthNet does *not* reimburse the costs associated with locating a non-related donor for a transplant candidate who is 21 years of age or older. Non-related is considered any relation beyond; parent, sibling, spouse, child (by adoption, marriage or birth), grandparent and grandchild.

12.3.B(7) Donor Search (Non-Match)

The search for a non-matched donor is *not* part of procurement and, therefore, does not apply to the maximum allowable for the transplant. Refer to Section 12 for reimbursement guidelines on this service.

12.4 SERVICES NOT INCLUDED IN MAXIMUM TRANSPLANT REIMBURSEMENT

The services of the transplant surgeon(s) are reimbursed to the surgeon(s) on a fee-for-service basis. The surgeon(s) *must* enroll with the MO HealthNet Division in order to receive reimbursement. Refer to the Physician Manual for enrollment criteria and reimbursement guidelines for surgeons, co-surgeons and surgical teams.

12.4.A DONOR SEARCH (MATCH)

The DR and MLC lab studies (search) for the individual who is finally determined to be a suitable donor (Match) are covered for adults and children and may be submitted to MHD for consideration of reimbursement. MO HealthNet does *not* reimburse the costs associated with locating a non-related donor for a transplant candidate who is 21 years of age or older.

12.4.B PRE-TRANSPLANT INPATIENT DAYS

Reimbursement of the pre-transplant stay is limited to the hospital's per diem rate subject to the length of stay limitation determined by the final discharge diagnosis. The current out-of-state facility rate is applied to out-of-state transplant facilities for the pre-transplant date(s) of service.

12.4.B(1) MO HealthNet Managed Care Participants

Reimbursement for any necessary pre-transplant inpatient services provided to MO HealthNet Managed Care participants is the responsibility of the patient's health plan. This care *must* be coordinated with and billed to the participant's specific chosen or assigned health plan.

12.4.C PRE-SURGERY ASSESSMENT

Inpatient, outpatient, and physician services for the pre-surgery assessment and evaluation of the transplant candidate should be billed according to the service performed. Pre-surgery assessment services are reimbursed according to general policies at regular MO HealthNet rates.

12.4.C(1) MO HealthNet Managed Care Participants

Reimbursement for any necessary pre-surgery assessment services provided to MO HealthNet Managed Care participants is the responsibility of the patient's health plan. This care *must* be coordinated with and billed to the participant's specific chosen or assigned health plan.

12.4.D FOLLOW-UP CARE

Reimbursement for any necessary medical services provided after the discharge or significant change in diagnosis not related to the transplant surgery, for the inpatient transplant stay is made using the general policies, reimbursement guidelines and rates established for all MO HealthNet providers, as outlined in the MO HealthNet Program Manuals.

12.4.D(1) MO HealthNet Managed Care Participants

Reimbursement for any necessary medical services provided to MO HealthNet Managed Care participants after the discharge or significant change in diagnosis not related to the transplant surgery, for the inpatient transplant stay is the responsibility of the patient's health plan. This care *must* be coordinated with and billed to the participant's specific chosen or assigned health plan.

12.5 PHARMACY SERVICES

The cost of pharmacy services while the transplant patient is admitted to the hospital (both during the stay for the transplant procedure and during any subsequent admissions) is included in the hospital's reimbursement for the hospital stay.

12.5.A MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants must use MO HealthNet enrolled pharmacy providers for coverage of pharmacy via fee-for-service. The MO HealthNet Managed Care health plan is not responsible for these services.12.6 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.

12.6.A MEDICARE COVERED TRANSPLANTS

Medicare covered transplants are reimbursed by the Medicare carrier or intermediary for applicable services up to Medicare's maximum allowed amount. The provider may bill MO HealthNet for the deductible and co-insurance amounts. Please refer to Section 16.

12.6.B NON-MEDICARE COVERED TRANSPLANTS

Transplant services *not* covered by Medicare but which are covered by MO HealthNet are reimbursed in accordance with the limits defined for MO HealthNet covered transplants. The transplant service *must* be prior authorized and the provider *must* submit evidence that the service is *not* a Medicare covered service before MO HealthNet can reimburse any claims.

12.7 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay. The inpatient transplant stay is subject to a copay amount.

12.8 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

The MO HealthNet Program utilizes the managed care delivery system for certain included eligibles. Refer to Section 1 and Section 11 for a detailed description.

12.8.A HEALTH PLAN TRANSPLANT RESPONSIBILITIES

Claims for the pre-transplant assessment and care are the responsibility of the plan and *must* be authorized by the health care plan. Unless the patient has been disenrolled from the plan or becomes eligible under another type of assistance after the transplant, the plan is responsible for outpatient follow-up care after the transplant patient's discharge or significant change in diagnosis not related to the transplant surgery for the transplant stay. Services *must* be authorized by the health care plan. Reimbursement of those authorized services is made by the plan.

MO HealthNet Division is responsible for reimbursement of those charges directly related to the transplant including the organ/stem cell procurement costs, actual inpatient transplant surgery costs (date of transplant through the date of discharge or significant change in diagnosis not related to the transplant surgery) and physician's charges during the transplant stay.

Refer to Section 11 for additional information regarding MO HealthNet managed health care enrollees.

12.10 DONATED FUNDS

MO HealthNet Division acknowledges that many transplant candidates are the subject of community fund raisers to help with the cost of transplant related services. The "trust" agreements established to administer those funds are reviewed by MHD to determine if the funds are subject to any contractual or legal requirement for payment of MO HealthNet *covered* services.

If it is determined that the donated funds are legally or contractually available to the MO HealthNet transplant candidate, the candidates spouse or the candidates parent, the donated funds are treated as a primary source of payment. Subsequently, any amount to be paid by MO HealthNet for *covered* services is the amount remaining up to maximum reimbursement allowable after the donated funds have been exhausted.

If the transplant facility receives donated funds that assist in the reimbursement of the cost of the transplant procedure and are *not* from a contractual or legally binding source, the funds are *not* applied to reduce the MO HealthNet Program's commitment.

In addition to the MO HealthNet maximum allowable amount established for the transplant procedure, providers may accept donated funds for reimbursement of non-covered MO HealthNet services and/or for costs over the maximum amount allowed for the transplant. However, under no circumstances, may the provider bill the transplant patient, the patient's spouse or parent or anyone else receiving public assistance, nor may the provider accept both MO HealthNet reimbursement and donated funds for reimbursement of the same charges.

12.11 THIRD PARTY LIABILITY PAYMENTS

Participants must exhaust any third liability benefits regarding the transplant prior to MO HealthNet making payment(s) on claim(s). A remittance advice from the third party insurance company must accompany transplant claims with either the denial or payment amount for the service. Remaining payment from MHD will not exceed established maximum reimbursement for the type of transplant.

END OF SECTION

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SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

The Department of Social Services, MO HealthNet Division provides limited coverage for the transplantation of human organs or bone marrow/stem cell and the medical services related to the transplant, including, but *not* necessarily limited to, evaluation, treatment and necessary post-operative care, for the specific procedures defined herein and further defined by the MO HealthNet Division provider manuals for specific program areas (hospital, physicians, etc.).

13.1.A TRANSPLANT SERVICES

Hospital, physician and other related medical services are covered for the following types of transplants when performed in a MO HealthNet approved transplant facility, for patients who meet the patient selection criteria, and have been prior authorized by the MO HealthNet Division.

- Stem Cell from cord blood, peripheral blood or bone marrow
- Heart
- Lung
- Liver
- Kidney
- Small Bowel
- Pancreas in combination with kidney or following a kidney transplant
- Multiple Organ (*must* include an organ transplant listed above)

13.1.B PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.2 REQUIREMENTS FOR PROVIDER PARTICIPATION

To participate in the MO HealthNet Transplant Program, transplant providers *must* satisfy the following requirements:

- The transplant facility is an enrolled MO HealthNet hospital provider;
- The transplant facility is an approved MO HealthNet transplant facility;
- The transplant surgeon is an enrolled MO HealthNet provider; and
- Any physician who is a member of the transplant team or who is a consultant or otherwise involved in treating the transplant patient, in which reimbursement is expected, is an enrolled MO HealthNet provider. The MO HealthNet Division does *not* have provisions to provide payment to a provider other than the physician performing the service.

Additional information on provider conditions of participation can be found in Section 2 of this provider manual.

13.2.A TRANSPLANT FACILITY PARTICIPATION REQUIREMENTS

The MO HealthNet Transplant Program requires covered transplants to be performed in a facility approved by the MO HealthNet Division (MHD) as a MO HealthNet transplant facility. To be considered for approval as a MO HealthNet transplant facility, the facility *must* be an enrolled MO HealthNet hospital provider. To enroll as a MO HealthNet provider, providers may contact Provider Enrollment.

A facility may apply for approval to perform any or all of the transplant services. In order to qualify for approval in the MO HealthNet Transplant Program, a facility *must* meet all criteria specific to the transplant service (heart, lung, liver, kidney, pancreas, small bowel, multiple organ or bone marrow/stem cell). Transplant facility participation requirements were developed by MHD with the assistance of its Transplant Advisory Committee.

The facility *must* submit documentation which substantiates that the facility complies with the appropriate criteria to:

MO HealthNet Division
Pharmacy and Clinical Services
Transplant Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

The MO HealthNet Division advises the facility in writing as to whether the application to provide specific transplant types is approved or denied. A facility *must* be approved by MHD for each type of bone marrow/stem cell or organ transplant to be performed.

13.2.B ORGAN TRANSPLANT FACILITY CRITERIA

1. The transplant facility *must* qualify for membership in the national transplantation network and *must* provide a copy of a current effective certification from the United Network for Organ Sharing (UNOS) granting approval to perform specific transplant(s). The certification from UNOS is considered appropriate verification and documentation for organ transplant facility approval.

2. Each type of MO HealthNet covered organ transplant is subject to separate UNOS certification.

3. When the period for initial UNOS certification expires, the transplant facility *must* provide evidence that continued approval from UNOS allowing participation to perform the transplant(s) has been granted.

4. The transplant facility *must* provide the C.V. of all members of the transplant team at the time of application and *must* notify MHD of each new primary transplant surgeon who becomes a member of the transplant team. The primary transplant surgeons *must* be enrolled as MO HealthNet participating providers. Other physicians who wish to receive reimbursement for services *must* also be enrolled as MO HealthNet participating providers.

5. The transplant facility *must* provide the name of the Organ Procurement Organization (OPO) presently utilized by the facility. The transplant facility *must* also furnish a copy of the notification from Centers for Medicare & Medicaid Services (CMS) which designates the facility's OPO as an acceptable organ procurement source.

6. The facility *must* submit a copy of its "Protocol for Transplantation Cases" and "Patient Selection Criteria" for the type(s) of transplant(s) for which it is requesting transplant facility approval.

13.2.B(1) Kidney Transplant Facility

A facility seeking certification as an approved MO HealthNet kidney transplant center *must* furnish a copy of its current Medicare certification indicating active participation in the "Medicare Renal Transplant Program."

The Medicare certification *must* be submitted in addition to the organ transplant facility participation criteria items 1 through 6.

13.2.B(2) Organ Transplant Facility Application Process

A facility may contact the MO HealthNet Division—Pharmacy and Clinical Services Transplant Unit (573) 751-6963 for further information regarding the organ transplant facility application process.

13.2.C BONE MARROW/STEM CELL TRANSPLANT FACILITY CRITERIA

The initial provisional approval for a bone marrow/stem cell transplant center is for a period of one to three years. The ASC/ASCO criteria are used for final approval.

MHD advises the facility in writing whether the application is approved or denied.

An autologous only transplant center *must* meet criteria 1 through 10 of the following. An allogeneic transplant center *must* meet all 14 criteria listed below.

Autologous/Allogeneic Criteria

1. Physician(s) with expertise in pediatric and/or adult bone marrow/stem cell transplantation, hematology and oncology. (List staff members and qualifications);
2. Identified nursing unit with facility defined protective isolation unit for bone marrow/stem cell transplantation;
3. Blood bank with pheresis capability and the capability to supply required blood products, or association with a qualified blood bank;
4. Physicians with expertise in infectious disease, immunology, pathology and pulmonary medicine. (List staff members and qualifications);
5. Capability of providing cardiac/respiratory intensive care and renal dialysis;
6. Performed at least 13 bone marrow/stem cell transplants a year or demonstrated an ability to care for prolonged marrow failure by treating 20 adult or 10 pediatric marrow failure patients per year.
7. Capability for marrow cryopreservation and purging techniques, if appropriate, or affiliation with a facility with these capabilities;
8. Capability to provide psycho-social support to patients and their families;
9. Close affiliation with academically based institutions to ensure that all components of comprehensive care for patients undergoing bone marrow/stem cell transplantation are present in the facility. The mere presence or availability of components 1 through 8 is *not* adequate. The facility *must* demonstrate that a coordinated bone marrow/stem cell transplantation program is in place and directed

by a physician trained in an institution with a well established bone marrow/stem cell transplantation program.

10. Submit a copy of its "Protocol for Transplantation Cases" and "Patient Selection Criteria" for the type of bone marrow/stem cell transplants to be performed at the facility. Once approved as a facility, each new type of bone marrow/stem cell transplant or diagnosis added for treatment by the facility *must* be documented by submitting the new protocol and patient selection criteria;

Additional Allogeneic Criteria

11. Physicians with expertise in infectious disease, immunology, pathology (of Graft vs. Host Disease), and pulmonary medicine. (List staff members and qualifications);

12. Tissue typing laboratory with capability to perform typing for HLA, A, B, C, DR, and MLC;

13. Cytogenetic laboratory; and

14. Adequate laboratory facility to assay drug levels including Cyclosporin A.

13.2.C(1) Bone Marrow/Stem Cell Transplant Facility Application

The MO HealthNet Division has compiled a Bone Marrow Facility Application which addresses all criteria and protocols required for approval as a bone marrow/stem cell transplant facility.

An application may be requested by writing:

MO HealthNet Division
Pharmacy and Clinical Services
Transplant Unit
P.O. Box 6500
Jefferson City, Missouri 65102-6500

or by calling the MO HealthNet Division, Pharmacy and Clinical Services at (573) 751-6963.

13.2.D APPROVED MO HEALTHNET TRANSPLANT FACILITIES

Below is a complete listing of facilities, located in the State of MO or bordering the state, approved by MO HealthNet to perform transplants for MO HealthNet or MO HealthNet Managed Care participants. Note that facilities are listed by the type of transplant for which they have requested approval. Some facilities are approved for several types of transplants. Some facilities may be certified as a Medicare transplant facility.

Requests for transplants involving out-of-state transplant facilities (facilities not located in Missouri or a state physically bordering Missouri; i.e. Kansas, Tennessee, etc.) may require the referring physician to submit a statement to the MO HealthNet Division indicating why the transplant patient must have the procedure performed at an out-of-state facility.

Medicare-Certified Transplant Facility

BONE MARROW/STEM CELL

Barnes-Jewish Hospital (Adult)—St. Louis, MO
Cardinal Glennon Children's Hospital—St. Louis, MO
Children's Mercy Hospital of K.C.—Kansas City, MO
Kansas University Medical Center—Kansas City, KS
St. Jude Children's Research Hospital—Memphis, TN
St. Louis Children's Hospital—St. Louis, MO
St. Louis University—St. Louis, MO
St. Lukes Cancer Institute of Kansas City—Kansas City, MO
University of Nebraska—Omaha, NE

HEART

Barnes-Jewish Hospital*—St. Louis, MO
Cardinal Glennon Children's Hospital*—St. Louis, MO
Children's Mercy Hospital of K.C.—Kansas City, MO
St. Louis Children's Hospital*—St. Louis, MO
St. Louis University—St. Louis, MO
St. Lukes Hospital of K.C.*—Kansas City, MO
University of Nebraska*-Omaha, NE

KIDNEY

Barnes-Jewish Hospital*—St. Louis, MO
Cardinal Glennon Children's Hospital*—St. Louis, MO

Children's Mercy Hospital of K.C.*—Kansas City, MO
Kansas University Medical Center*—Kansas City, KS
St. Louis Children's Hospital*—St. Louis, MO
St. Louis University*—St. Louis, MO
St. Lukes Hospital of K.C.*—Kansas City, MO
University of Missouri-Columbia*—Columbia, MO
University of Nebraska*—Omaha, NE

KIDNEY/PANCREAS

Barnes-Jewish Hospital*-St. Louis, MO
Kansas University Medical Center*-Kansas City, KS
St. Louis University*-St. Louis, MO
University of Nebraska*-Omaha, NE

LIVER

Barnes-Jewish Hospital*—St. Louis, MO
Cardinal Glennon Children's Hospital*—St. Louis, MO
Children's Mercy Hospital of K.C.—Kansas City, MO
Kansas University Medical Center*—Kansas City, KS
St. Louis Children's Hospital*—St. Louis, MO
St. Louis University*—St. Louis, MO
University of Nebraska*—Omaha, NE

LUNG

Barnes-Jewish Hospital*—St. Louis, MO
St. Louis Children's Hospital*—St. Louis, MO

HEART/LUNG

Barnes-Jewish Hospital*-St. Louis, MO
St. Louis Children's Hospital*—St. Louis, MO

NOTE: Providers may contact the MO HealthNet Division—Transplant Unit at (573) 751-6963 for additional questions concerning the transplant facility listing.

13.3 REQUIREMENTS FOR PARTICIPANT PARTICIPATION IN THE MO HEALTHNET TRANSPLANT PROGRAM

In order for MO HealthNet to prior authorize and reimburse a covered transplant the individual *must* have been determined eligible for MO HealthNet by the Family Support Division (FSD):

- Some participants are determined eligible on a spenddown basis. Refer to Section 1 for information on spenddown.
- Refer to Section 1 for a list of ME codes that identify participants of state only funded Medical Assistance programs who are *not* eligible for transplant services unless they are under the age of 21 years. Individuals under the age of 21 can receive a transplant under the EPSDT provisions which allow all medically necessary treatment services for both state and federally matched types of assistance. All state only eligible individuals, regardless of age, should apply for a federally matched assistance program. Individuals age 21 and over *must* be determined eligible for a federally matched assistance program in order to be eligible for authorization of transplant services. Individuals whose type of assistance does *not* cover transplants should be referred to their local Family Support Division office to request application under a type of assistance that covers transplants. In this instance the MO HealthNet Division Transplant Unit should be advised immediately.
- For the transplant facility or related service providers to be reimbursed by MO HealthNet Division, the transplant patient *must* be eligible for MO HealthNet assistance on each date of service. A participant *must* have a valid ID card or eligibility letter to receive MO HealthNet benefits.

  Refer to regarding Managed Health Care Participants.

13.3.A GENERAL MO HEALTHNET TRANSPLANT ELIGIBILITY

- Each facility must have previous approval on file with MHD for each specific transplant type (excluding combined transplants as long as the component types are approved);
- An eligible participant *must* be determined to be a suitable transplant candidate:
- The participant *must* be evaluated according to the facility's protocol for transplantation, a copy of which *must* be on file at MHD;
- The transplant evaluation *must* indicate that the participant is a suitable candidate for the surgery, from a medical and psychosocial standpoint, having met the facility's patient selection criteria, a copy of which *must* be on file at MHD;
- In addition to meeting the facility's patient selection criteria, a bone marrow/stem cell harvest or transplant candidate *must* be approved by the State Medical Consultant or, when deemed necessary, the Bone Marrow Transplant Advisory Group;

- Each request for coverage is handled on a case-by-case basis:
- A request for prior authorization *must* be submitted for each participant;
- A request for prior authorization *must* be submitted for each subsequent transplant for participants previously authorized and transplanted;
- Participants previously authorized but then removed from the waiting list for any reason, *must* be re-evaluated and have their requests for transplant coverage prior authorized again in order to be eligible for MO HealthNet transplant coverage;
- A financial agreement is executed between MHD and the transplant facility for each participant for each authorized transplant;
- The agreement outlines the terms of coverage;
- **The agreement is *not* valid without an original signature from both an authorized representative of the transplant facility and MHD representative, then returned to the MO HealthNet Division**;
- The agreement is in effect from the date of the agreement until the participant is transplanted or removed from the transplant list;
- The facility *must* notify the MO HealthNet Transplant Coordinator if the participant is removed from the list of transplant candidates; and
- The participant *must* be eligible for MO HealthNet on each date that service is rendered.

13.4 GUIDELINES AND INFORMATION SPECIFIC TO BONE MARROW /STEM CELL TRANSPLANTS

The following medical guidelines have been established by the MO HealthNet Division as criteria for consideration of requests for coverage of bone marrow/stem cell transplants for MO HealthNet patients.

- Bone marrow/stem cell transplantation is considered an acceptable alternative form of therapy when there is a potential of at least a 20% two year disease free survival after transplant.
- The patient should *not* present evidence of severe cardiac, pulmonary, renal, hepatic, metabolic disease, or poor performance status.

13.4.A DONOR TYPES

The following donor types are currently determined appropriate for bone marrow/stem cell transplants:

Allogeneic (Syngeneic)

- *Related Donor:* The donor is HLA A, B, and DR genotypically identical; an MLC study is *not* necessary for sibling donors provided a family study has been completed. A one-antigen mismatch family member is considered appropriate.
- *Non-Related Donor:* The donor is an unrelated HLA computer matched A and B donor or molecular typing of DR region. Requests for coverage of a matched unrelated donor bone marrow/stem cell transplant are considered on a case-by-case basis:
- *Haplo-Identical Donor:* Haplo-identical donors are only considered for immunodeficiency syndromes.
- *Cord Blood:* Requests are reviewed on a case-by-case basis

Autologous

- Intensive chemo-radiation therapy followed by infusion of the patient's own marrow or peripheral blood previously harvested and cryopreserved, is considered appropriate for certain malignancies. Peripheral blood stem cell recruitment for autologous transplantation is also considered appropriate for certain conditions. The physician *must* state that peripheral blood stem cell recruitment is included as part of the treatment plan.
- The requesting physician *must*, in addition to the diagnosis, treatment and current status of malignancy, document that the bone marrow or stem cell source is free of the disease and, that the facility has the capability of in-vitro marrow purging, if appropriate.
- Because of the changing role of bone marrow/stem cell transplantation in various leukemias, lymphomas, and solid tumors, each request for malignancies *not* listed in the patient selection criteria is reviewed on a case-by-case basis.

13.4.B DIAGNOSIS CRITERIA

The MO HealthNet Division is aware of the ever changing role of bone marrow/stem cell transplantation, therefore requests for bone marrow/stem cell transplantation for diagnoses *not* listed in this section are considered on a case-by-case basis. The requesting physician *must* present the physician's best evidence (journal articles) that bone marrow/stem cell transplant provides the potential of at least a 20% two year disease free survival after transplant.

The following diagnoses criteria are currently considered appropriate for bone marrow/stem cell transplant authorization requests:

Allogeneic

For the treatment of leukemia, leukemia in remission or aplastic anemia when it is reasonable and necessary;

For the treatment of severe combined immunodeficiency disease (SCID) and for the treatment of Wiskott-Aldrich syndrome;

For the treatment of myelodysplastic syndromes (MDS) pursuant to coverage with evidence development (CED) in the context of a Medicare-approved, prospective clinical study; and

Other medical diagnoses will be reviewed on a case by case basis.

Autologous

Acute leukemia in remission, lymphoid, myeloid, monocytic, acute erythremia and erythroleukemia and patients who have a high probability of relapse and who have no human leukocyte antigens (HLA)-matched;

Resistant to non-Hodgkins lymphomas or those presenting with poor prognostic features following an initial response;

Recurrent or refractory neuroblastoma; or

Advanced Hodgkin's disease patients who have failed conventional therapy and have no HLA-matched donor.

Multiple myeloma for beneficiaries less than age 78, who have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma and adequate cardiac, renal, pulmonary and hepatic functioning.

Multiple rounds of autologous stem cell transplantation (tandem) will only be reviewed on a case by case basis; and

Primary amyloidosis for participants under the age of 64 or any age if they have amyloid deposition in two or fewer organs and cardiac left ventricular ejection fraction (EF) greater than 45 percent.

Other medical diagnosis will be reviewed on a case by case basis.

13.4.C BONE MARROW/STEM CELL RELATED SERVICES

The following unique services are covered for bone marrow/stem cell transplant patients. Services may be billed separately when performed on an outpatient basis. When provided on

an inpatient basis, they should be identified as a separate item on the UB-04 (CMS-1450) claim form. Claims for these specialized services *must* be billed to

MO HealthNet Division
Pharmacy and Clinical Services Unit—Transplant Program
P.O. Box 6500
Jefferson City, MO 65102-6500.

13.4.C(1) T-Cell Depletion/Marrow Purging

T-Cell depletion or marrow purging of bone marrow/stem cell for transplantation may be billed using procedure codes 38210-38215, in addition to the appropriate blood related revenue code; 39X.

A copy of treatment process record showing the purging process used (chemo or magnetic antibody) and the number of units processed *must* be sent with the claim.

** These codes are considered outpatient codes only and should be billed appropriately.*

13.4.C(2) Processing and Storage of Stem Cells

Procedure codes 38207, 38208, or 38209 may be billed by the facility for the processing and storage/cryopreservation of stem cells that have been harvested , in addition to the appropriate blood related revenue code; 39X.

** These codes are considered outpatient codes only and should be billed appropriately.*

13.4.C(3) Stem Cell Recruitment/Harvest

The *professional* component related to the bone marrow/peripheral stem cell recruitment/harvest may be billed on the CMS-1500 using procedure code 38230, 38232, 38205 or 38206.

NOTE: A copy of the peripheral stem cell collection record should be attached to any claims billing peripheral stem cell collection procedures.

13.5 SECOND/THIRD REQUESTS AND MULTIPLE LISTINGS

13.5.A SECOND/THIRD BONE MARROW/STEM CELL TRANSPLANT REQUESTS

Allogeneic

Allogeneic transplant patients who have survived 12 months or more after first transplant and who are in good status but relapse or a patient who has had primary graft failure which is substantiated by documentation can be considered on an individual basis. Other patient selection criteria established for first transplant should then be applied.

Autologous

Criteria for second autologous transplantation is the same as allogeneic transplantation except in the following situations:

- For patients who relapse following autologous transplantation, and have a matched sibling, an allogeneic transplant may be considered.
- When a tandem autologous transplant is the plan of treatment from the onset, approval is given for a maximum authorization amount of $100,000. Any procurement cost (peripheral stem cells harvested and stored) and transplant costs (stem cells infused) associated with the tandem transplant (each inpatient stay) is covered under the single cap amount.
- When a tandem transplant is not the plan, however the plan is to secure additional stem cells post-transplant for future use, the facility may submit a claim for the additional harvest providing a cap amount remains from the transplant.

13.5.B SECOND/THIRD ORGAN TRANSPLANT REQUESTS

Organ transplant patients who experience organ failure or rejection may be considered for a second/third transplant. The patient *must* be reevaluated and found to be a suitable candidate according to the facility's patient selection criteria. A new authorization *must* be requested from MHD following the same prior authorization process as for the initial transplant. If graft failure is due to non-compliance with the facility's transplant protocol, documentation addressing the situation must be attached to the new request.

13.5.C MULTIPLE FACILITY LISTINGS FOR SOLID ORGANS

A participant may be on multiple waiting lists for solid organs. The multiple waiting lists are defined as concurrent listings with two or more transplant centers that are not associated with the same organ procurement organization or regional OPO. Transplant centers must follow the United Network for Organ Sharing's (UNOS) policy regarding multiple listings.

Once the transplant takes place, the facility that did not perform the transplant will be notified that their agreement is to be voided.

13.6 NON-EXPERIMENTAL/MEDICALLY NECESSARY TRANSPLANT REQUESTS

Non-experimental, medically necessary, organ and bone marrow/stem cell transplants which are *not* covered by the MO HealthNet Transplant Program may be considered for coverage under the expanded Healthy Children and Youth (HCY) Program for persons under 21 years of age. The need for the transplant *must* have been identified as the result of an HCY/EPSDT screening and *must* be prior authorized by the MO HealthNet Division. Refer to Section 9 for more information on the HCY Program.

Providers may request coverage under the HCY Program for noncovered, non-experimental transplants by completing the transplant prior authorization process.

The maximum allowed amount for any such transplant does *not* exceed established limitations and is reimbursed in accordance with the limitations and procedures established for covered transplants.

13.7 MEDICARE/MO HEALTHNET TRANSPLANTS

Patients who are eligible for both Medicare and MO HealthNet have services primarily covered by Medicare and secondarily by MO HealthNet. Transplant services covered by Medicare are subject to the limitations or criteria imposed by Medicare.

Medicare patients who do *not* meet the criteria for coverage under Medicare guidelines but who are eligible for MO HealthNet may be eligible for transplant coverage under MO HealthNet. The provider *must* contact the MO HealthNet Division to request prior authorization of the transplant.

13.7.A MEDICARE LIMITATIONS

Medicare transplant limitations should be verified to determine Medicare coverage limits prior to the time of transplant. Providers may request a MO HealthNet prior authorization for participants who have Medicare coverage. When an individual is eligible for both Medicare MO HealthNet, a claim *must* be filed with Medicare first. Providers must know their Medicare carriers policy when billing drugs and services.

Qualified Medicare Beneficiary (QMB) only participants (ME code 55) are only eligible for coverage of their Medicare premiums, deductibles and coinsurance amounts. MO HealthNet covers the deductible and coinsurance amounts for Medicare covered transplants when billed directly for a Medicare covered transplant. If the QMB participant is in need of a non-Medicare covered transplant, the participant *must* qualify for MO HealthNet coverage under a federally matched assistance program, in order to receive prior authorization from MHD for the transplant.

13.7.B MEDICARE TRANSPLANT FACILITIES

Kidney, pancreas, heart, limited bone marrow/stem cell, liver, intestinal, and lung transplant coverage is available to persons who have Medicare benefits. If the participant 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 coinsurance and deductible amounts without an agreement in place. For transplants not covered by Medicare policy MO HealthNet's regular transplant policy applies.

Medicare restricts coverage of heart, lung and liver transplants to Medicare-approved facilities. Refer to the Approved Transplant Facility Listing for those facilities that are MHD and Medicare approved. Missouri Medicare/MO HealthNet participants should be referred for evaluation to Missouri Medicare approved facilities prior to referral to Medicare approved facilities in other states.

Potential heart, lung and liver transplant patients who have Medicare coverage or who will be eligible for Medicare coverage within 6 months from the date of eminent need for transplant should be referred to one of the approved Medicare transplant facilities for evaluation.

If the Medicare/MO HealthNet participant is too ill to be referred to an approved Medicare transplant facility, MO HealthNet may issue a temporary authorization for transplant services at a non Medicare approved facility until the patient can be stabilized. Refer to Section 14 regarding prior authorization procedures for Medicare/MO HealthNet participants.

13.8 TRANSPLANT PRIOR AUTHORIZATION AND APPROVAL PROCESS

Refer to Section 14 of the Transplant Manual.

13.9 INPATIENT HOSPITAL ADMISSION CERTIFICATION REVIEW

All transplant stays for MO HealthNet eligible participants are subject to inpatient hospital admission certification review. Transplant prior authorization does *not* exempt the facility from the admission certification review process.

Approval for inpatient hospital admission should *not* be confused with the transplant prior authorization. The transplant facility *must* have prior authorization to perform the transplant and receive approval for admission by the MO HealthNet Division's medical review agent at the time of the actual transplant. All inpatient admissions for the transplant patient related to the pre-transplant evaluation, the stay for the transplant surgery (which includes pre-transplant days), the stay for the bone marrow/stem cell harvest (autologous marrow patients) and follow-up admissions *must* be certified in accordance with the criteria established by the MO HealthNet Division. Refer to the MO HealthNet Hospital Manual Section 13 for a complete description of the inpatient hospital admission certification review.

Inpatient services for the bone marrow/stem cell donor (allogeneic/non-related) or the living related kidney or liver donor are considered organ procurement services and are *not* subject to the admission certification review process.

13.9.A REVIEW AUTHORITY

- The authorized medical review agent *must* be contacted by physician office staff or hospital staff to provide patient/provider identifying information regarding the patient's condition and planned services. The patient should be identified as a transplant patient and the authorized medical review agent should be notified that MHD transplant prior authorization has been granted.
- The authorized medical review agent can be contacted to request certification at the toll-free telephone number (in-state or out-of-state), (800) 766-0686, OR by submitting the Mail/Fax Preadmission Certification Request form to (573) 634-4262 OR by mailing the form to:

Conduent
P. O. Box 105110
Jefferson City, MO 65110-5110

13.9.B MEDICAL REVIEW AGENT LETTER OF APPROVAL

After the medical review agent approves an admission they send a letter to both the hospital and the attending physician. It is important to verify the information in the approval letter is complete and accurate. The medical review agent *must* be contacted to correct any discrepancies or be notified of changes to the patient's planned services subsequent to the initial request.

The medical review agent contacts the MO HealthNet Division Transplant Unit to verify MHD prior authorization has been approved by transplant type and facility.

13.10 COVERED AND NONCOVERED SERVICES FOR TRANSPLANT

Certain services and procedures are commonly billed for transplant patients. The following covered and noncovered services are identified for provider information. More detailed information is available in this section and other sections of the Transplant Manual, or in the specific MO HealthNet Program Manuals.

13.10.A COVERED SERVICES

The following services are covered for the transplant when there is a signed agreement between the transplant facility and MHD:

- Date of transplant through date of discharge or significant change in diagnosis not related to the transplant surgery;
- Inpatient donor services for the bone marrow/stem cell harvest, kidney nephrectomy (living donor), liver lobectomy (living donor), or pneumectomy (living donor);
- Outpatient and physician donor (actual donor) services directly related to the bone marrow/stem cell transplant (including cell procurement, labs, etc.)
    - Matched donor (actual donor) and nonmtached donor search and testing services must be billed separately;
- Physician's services related to the transplant procurement, including the services of the excision surgeon, the bone marrow/stem cell harvest and other procurement procedures;
- Bone marrow/stem cell cryopreservation;
- Bone marrow/stem cell purging;
- Peripheral stem cell recruitment;
- T-cell depletion;
- Laboratory studies to determine a suitable kidney or bone marrow/stem cell donor; *(related for adults and children, unrelated for children under 21 years of age)*; and
- Physician's services related to the transplant: the transplant surgeon, co-surgeon, assistant surgeon, infusion surgeon, anesthesiologist, or consulting physician for the transplant participant.

The services identified below are covered services, however when a participant is a member of a MO HealthNet Managed Care plan, the plan is responsible for the services. The health plan may *not* determine the need for an evaluation or establish criteria of coverage for transplants based on their own internal protocols.

- Dental evaluation and services required to ensure the patient does *not* have any major cavities and/or infections prior to transplant (under age 21);
- Follow-up services, including evaluations and assessments provided to the successfully transplanted patient;
- Home pulse oximeter following lung transplant;
- Human Hyperimmune CMV Globulin (IVG-CMV);
- Inpatient services, including pre-transplant days and follow-up stays;

- Medically necessary services required to assess a patient's suitability for transplantation are covered, whether or not the patient is ultimately accepted as a candidate;
- Medically necessary inpatient services following the discharge for the transplant stay which are required to manage complications of the transplant including late infection or rejection episodes;
- Physician services, pre-transplant critical care and other post hospital follow-up services; and
- Transportation for the patient who does *not* have access to free transportation. Refer to Section 22 for more information on Non-Emergency Medical Transportation (NEMT).

13.10.B NONCOVERED SERVICES

The following services are *not* covered by MO HealthNet:

- Pancreas only transplants, which do *not* follow or coincide with a kidney transplant;
- Bone marrow/stem cell transplant services performed as part of a study or protocol for which there is no clear cut evidence that the transplant provides a reasonable chance for cure;
- Services and supplies for which the beneficiary has no legal obligation to pay. For example, MO HealthNet does *not* reimburse expenses that are waived by the transplant center or for which research funds are available;
- Out-of-hospital living expenses or other non-medical expenses (NOTE: NEMT may assist or cover some out of hospital living expenses. Refer to Section 22 for more information;
- Maintenance services after an individual has been declared deceased are part of the procurement charge billed by the Organ Procurement Agency. Maintenance services may *not* be billed to MO HealthNet as the cadaveric donor's own charges when the cadaveric donor is a MO HealthNet participant;
- A beeper/pager for a patient on a waiting list. It is also *not* a covered service through the MO HealthNet exceptions process;
- The costs associated with the search for a non-related bone marrow/stem cell donor (for a participant 21 years of age or older), except for the laboratory services for the donor who is determined to be a match. *(Non-related is considered any relation*

beyond; parent, sibling, spouse, child (by adoption, marriage or birth), grandparent and grandchild.);

- Psychological battery tests or assessment instrument procedures (BSI, HAP, LES, MBHI, MMSE, SSI, SDMT, TMT, etc.) used to help assess adult patients (age 21 and older) for clinical purposes, as part of the transplant evaluation, when provided to adults by a psychologist; however, they are covered when provided by a psychiatrist;
- Nurse Clinician Assistant services for the bone marrow/stem cell harvest or any other type of transplant service—*may not* be billed by a physician or included as part of a revenue code/charges shown on the UB-04 (CMS-1450) claim form;
- Services of a transplant coordinator as part of the facility's organ procurement costs. They may *not* be included as a pass through charge between the organ procurement agency and transplant facility. The services of the transplant coordinator may *not* be billed by a physician and *cannot* be incorporated into an inpatient revenue code;
- Drawing fees (CPT procedure code 36415), whether billed inpatient, outpatient, by a physician or laboratory under any ancillary, as charges, supply, revenue code or "99" (unlisted) CPT procedure code;
- "Stat" charges;
- Portable x-ray/echography surcharges;
- Educational supplies (books, pamphlets, tapes);
- Analysis of information data stored in computers (e.g., ECG's, blood pressure, hematologic data);
- Certain services performed in a hospital by specific departments are considered to be part of the hospital's accommodation rate (room charge) and should *not* be billed separately. Refer to Section 13 of the Hospital Manual;
- Autopsy/Necropsy (post-mortem examination);
- Claim filing fees or preparation of special reports;
- Experimental medical procedures and experimental drugs;
- Handling charges for specimens referred to an independent laboratory for interpretation;
- Charges for incidental surgical procedures performed through the *same* incision;

- Occupational Therapy services provided on an outpatient basis for adults;
- Non-care and personal comfort items such as telephone, television, newspapers, cots, and the services of a beautician, barber, manicurist, and private duty nurse;
- Partial hospitalization or day treatment;
- Non-invasive ear or pulse oximetry for oxygen saturation (procedure codes 94760, 94761 and 94762) are *not* covered by MO HealthNet;
- Mark-up for organ procurement, transportation or excision (these charges must provide an invoice to be considered for payment);
- Special dietary items and guest trays; and
- Take home drugs, supplies and equipment (Drugs, supplies, and equipment which meet program limitations can be reimbursed through the Pharmacy or DME Program).
- Fee for 'formal search' to initiate search for anonymous donor (any age transplant participant). *Invoice will not be reimbursed as this service is not considered procurement.*

13.11 INPATIENT HOSPITAL SERVICES

Pre-transplant inpatient services and follow-up services (inpatient services provided after discharge of the transplant patient) are subject to the limitations of the MO HealthNet Hospital Program which are further described in the MO HealthNet Hospital Manual, Section 13. MO HealthNet Managed Care participants receive pre-transplant inpatient services and follow-up services from the MO HealthNet Managed Care health plan.

13.11.A PARTICIPANT LIABILITY FOR INPATIENT DAYS

Refer to Section 13 of the Hospital Program Manual for further information regarding participant liability for inpatient services.

13.11.B PRE-TRANSPLANT STAY

Fee-for-service patients who are hospitalized prior to the date of transplant are entitled to coverage of inpatient services for the pre-transplant stay (for billing purposes, this is the day(s) prior to the date of transplant) subject to the following benefits and limitations:

- The inpatient stay *must* be pre-certified by the medical review agent;

and

- Reimbursement of the pre-transplant stay is limited to the facility's per diem rate and subject to the medical review agent's certification.

Patients who are enrolled in a managed health care plan receive the pre-transplant coverage through the health plan.

13.11.C DATE OF TRANSPLANT

The date of transplant is defined as the day the transplant is performed. This date usually coincides with the date of organ procurement for organ transplants and is the date of marrow infusion for bone marrow/stem cell transplants.

13.11.D TRANSPLANT STAY

Inpatient services from the date of transplant through date of discharge or significant change in diagnosis not related to the transplant surgery, are covered for each day the patient is MO HealthNet eligible. Reimbursement is provided by MO HealthNet for "reasonable charges" up to the maximum allowable for the type of transplant being performed.

Leave of absence from an inpatient facility is *not* covered by MO HealthNet.

The duration of the inpatient stay is only approved for the transplant and directly related treatment (excluding complications). The patient's stay may be extended due to a condition unrelated to the transplant or complications of the transplant. If this occurs, the facility *must* contact the medical review agent for certification of days beginning with the date of onset of the change in diagnosis. Reference Section 13 of the Hospital Manual for further information regarding hospital admission certification.

13.11.D(1) "Reasonable Charges"

Charges *must* be substantiated by the itemized bill submitted with the claim for the transplant.

The "reasonable charges" *must* be listed under the appropriate revenue code on the UB-04 (CMS-1450) claim form.

The claim for the date of transplant through date of discharge or significant change in diagnosis ot related to the transplant surgery may include all "reasonable charges" for:

- Accommodations (services which are charged to every patient for each patient day are to be included in the routine accommodation charge and *cannot* be billed as ancillary charges);
- Intensive care;

- Coronary care (when appropriate use the heart transplant revenue code);
- Pharmacy (may *not* include charges for take home drugs or experimental drugs);
- IV therapy;
- Medical/surgical supplies (may *not* include charges for take home supplies; prosthetic devices; and take home oxygen.) Items of a non-durable nature (syringes, needles, latex gloves, face masks, oxygen tubing, etc.) may be included on the itemized bill if it is the routine practice of the facility to include such items on the itemized bill for non-MO HealthNet patients;
- Oncology;
- Laboratory (may *not* include charges for renal patient [home]);
- Laboratory—pathological;
- Radiology—diagnostic;
- Radiology—therapeutic;
- Nuclear Medicine;
- CT scan;
- Other imaging services;
- Operating room (OR) services (specific OR revenue codes for the transplant surgery should be used to show charges related to the transplant. General OR revenue codes should be used for all other OR charges occurring during the transplant stay);
- Anesthesia (excluding acupuncture);
- Blood;
- Blood storage and processing;
- Respiratory services;
- Physical, occupational and speech therapy;
- Pulmonary function;
- Cardiology services (heart catheterization, coronary angiography, etc.);
- Recovery room;

- EKG/ECG (electrocardiogram);
- EEG (electroencephalogram);
- Gastro intestinal (endoscopic procedures *not* performed in an operating room);
- Inpatient renal dialysis;
- Organ acquisition or other donor bank. These charges must be accompanied by an invoice to justify charges and will not be reimbursed above the invoiced charges to the facility. (This includes all services related to organ procurement or bone marrow/stem cell acquisition – Refer to Section 14); and
- Other diagnostic/therapeutic services.

13.12 PHARMACY SERVICES

Pharmacy services are covered for MO HealthNet participants on a fee-for-service basis.

- Pharmacy services, provided while the MO HealthNet participant is a patient in the hospital, are covered and reimbursement is included in the reimbursement for the inpatient stay (both during the stay for the transplant procedure and during any subsequent admission);
- The provider and patient should be aware that MO HealthNet can make reimbursement only to a participating MO HealthNet pharmacy provider. Out of state hospitals may wish to have the hospital's pharmacy or a nearby independent pharmacy enroll as a MO HealthNet provider so that patients can have their prescriptions filled upon discharge. Pharmacies may enroll as a MO HealthNet provider by contacting Provider Enrollment at http://mmac.mo.gov/providers/provider-enrollment.

13.13 VENTRICULAR ASSIST DEVICES

A ventricular assist device (VAD) used to assist a damaged or weakened heart is only covered when used as a bridge to transplant. The VAD is *not* covered as an artificial heart. The device *must* be used with FDA labeling instructions. The VAD services can only be reimbursed if the patient has an existing, approved, prior authorization for heart transplant. The service is reimbursed through the MO HealthNet Hospital Program as part of the per diem and *not* reimbursed as part of the heart transplant prior authorized dollars through the Transplant Program.

13.14 DENTAL SERVICES

The MO HealthNet Division assures coverage of medically necessary dental services for MO HealthNet transplant candidates. This assurance is given to eliminate any risk-factors posed to the transplant candidate that may result from poor dental health that would jeopardize the transplant candidate's health or impede an opportunity for transplant if the services were *not* provided.
The dentist providing services for transplant patients *must* be an enrolled MO HealthNet provider and is reimbursed in accordance with the benefits and limitations outlined in the Dental Manual. Refer to the Dental Manual for dental services for MO HealthNet Managed Care enrollees.

13.14.A DENTAL PANOREX

When a transplant patient is *not* referred to the patient's own dentist for evaluation, the oral surgeon and/or hospital may bill procedure code 70355 (Orthopantogram) to bill for a full mouth dental survey.

13.15 PHYSICIAN SERVICES

Billed services for a given diagnosis should *not* exceed the level of service defined for new or established patients. Definitions are described in the introduction section of the Physicians' Current Procedural Terminology (CPT) procedure code book under Definitions and Items of Commonality. Please refer to the definitions when determining the level of service to be billed for each patient.

Refer to the MO HealthNet Physician Manual for a complete listing of benefits and limitations. The following information is provided as a quick reference of services most often provided by transplant surgeons and attending physicians.

13.15.A TRANSPLANT SURGEON

The transplant surgeon's services should be billed using the appropriate procedure code. The fee is payable either 100% of the maximum allowable amount or the billed amount, if less, for the major surgical procedure (transplant). Routine surgical follow-up care (wound check, etc.) provided by the surgeon is subject to the 30 day post-operative policy.

The transplant surgeon, assistant surgeon or other physician in attendance may bill for critical care or inpatient follow-up care when *not* related to routine surgical follow-up care.

13.15.B ASSISTANT SURGEON

Only one assistant surgeon is paid for those procedures that warrant an assistant. Refer to Section 13 of the Physician's Manual for more information.

13.15.C CO-SURGEON'S SERVICES (TWO SURGEONS)

"Co-surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Refer to Section 13 of the Physician Manual for more information.

13.15.C(1) Bone Marrow/Stem Cell Harvest—Co-Surgeon

MO HealthNet allows the reimbursement of a co-surgeon for bone marrow/stem cell harvest when necessary. Documentation of medical necessity is *not* required; however, a copy of the operative report *must* be submitted with the claim form.

13.15.D SURGICAL TEAM (THREE OR MORE SURGEONS)

When a surgical team (three or more surgeons) is used to perform a transplant, each surgeon is reimbursed at the base rate divided by the number of surgeons listed on the operative report for the procedure code divided by the number of surgeons on the team, according to the operative report.

When billing for the surgical team, all surgeons *must* file separate claims, each using their own individual MO HealthNet provider number. The surgical procedure code with modifier 66 (surgical team) should be shown on each claim. A copy of operative report *must* be submitted with each claim.

13.15.E TRANSPLANT SURGERY CODES

The transplant procedure and appropriate modifier should be used when billing the services of the surgeon, co-surgeon, assistant surgeon, team surgeons, and anesthesiologist.

Surgeon fees associated with the procurement of an organ harvested for transplant *must* be submitted with the invoice submitted to the transplant facility by the Organ Procurement Organization (OPO).

When billing for an authorized kidney/pancreas transplant use the appropriate kidney transplant procedure code and the appropriate pancreas transplant procedure code. The pancreas transplant is reimbursed as a second surgery on the same date in accordance with policy for reimbursement of multiple surgeries. On a case by case basis, MO HealthNet may provide reimbursement for isolated pancreas transplant when there has *not* been a previous kidney transplant.

13.15.F POST-OPERATIVE CARE

Post-operative care includes 30 days of *routine* follow-up care (wound check, etc.) for those surgical or diagnosis procedures having a MO HealthNet reimbursement amount of $75.00 or more. For counting purposes, the date of transplant surgery is the first day.

- Post-operative care by a physician other than the transplant surgeon is payable if:

- the diagnosis treated is *not* related to the surgery.
- the illness would have required hospitalization in its own right.
- the surgeon would *not* be expected to handle the condition.

- When a surgeon provides the surgical procedure and the post-operative care, 100% of the maximum allowable amount for the procedure is allowed.
- When a surgeon performed the surgical procedure(s) only, 80% of the maximum allowable amount for the surgical procedure is allowed.
- When a physician provides post-operative care only, 20% of the maximum allowable amount for the surgical procedure is allowed.

13.15.G CRITICAL CARE

Critical care services provided by the transplant surgeon, assistant surgeon and co-surgeon are *not* subject to post-op limitation policies.

13.16 OUTPATIENT HOSPITAL SERVICES

13.16.A OUTPATIENT STEM CELL TRANSPLANTS

Although the MO HealthNet Division recognizes stem cell transplants performed on an outpatient basis are a standard treatment method in some facilities, the Division does *not* currently authorize stem cell transplants that will be performed on an outpatient basis.

The Division does *not* allow infusion of stem cells for clinical purposes other than those outlined in the Physician Manual, Section 13 (Therapeutic apheresis).

Inpatient admissions directly following a stem cell infusion (apheresis) performed on an outpatient basis are reviewed carefully to assure that an unauthorized transplant has *not* occurred. Claims from any provider for unauthorized stem cell transplants and related services may be recouped.

13.17 DONOR LEUKOCYTE INFUSION (DLI)

MO HealthNet does not consider donor leukocyte infusions (DLI) to be traditional transplants. However, a request must be made and approved through the Transplant Program for a DLI to take place.

13.17.A PHYSICIAN CLAIM

The physician performing the DLI uses CPT code 38242 on the date the infusion(s) are performed.

13.17.B OUTPATIENT CLAIM

The facility can perform infusions on an outpatient basis and these claims are not paid through the Transplant Program. The claims must be submitted fee-for-service and paid on the outpatient rate and/or lab fee schedule.

13.17.B(1) DLI Procurement

If additional procurement is necessary for a DLI to take place the facility will request approval for an additional harvest. If approved, the facility will receive a maximum reimbursement of $1,150 for the additional harvest/procurement. The facility should bill the procurement/harvest on a separate outpatient claim to the Transplant Unit, accompanied by an invoice from the procurement organization. If the participant is enrolled in a MO HealthNet Managed Care program the MO HealthNet Managed Care plan is responsible for the reimbursement of all fees in connection with the DLI with the exception of the procurement.

END OF SECTION

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SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

Special documentation is required for approval and reimbursement of transplant services. The following information is provided to aid the provider in identifying the procedures and documents required by the Transplant Program. Prior authorization means approval before the service is rendered. MO HealthNet requires prior authorization of transplants and bone marrow/stem cell harvest services. Each transplant for which MO HealthNet coverage is requested *must* meet all transplant prior authorization procedures and protocols specific to the transplant as defined by the Department of Social Services/MO HealthNet Division (DSS/MHD).

Patients whose medical history indicates a planned transplant or bone marrow/stem cell harvest for more than 30 days prior to the date of the transplant or harvest should *not* need to request emergency authorization. Only in very rare circumstances is an emergency prior authorization needed. Providers *must* request authorization for transplant or bone marrow/stem cell harvest as soon as the patient is identified as a transplant or bone marrow/stem cell harvest candidate.

Providers who perform bone marrow/stem cell harvests and transplants are reminded that a physician consultant reviews the request prior to approval, therefore, sufficient time for review by the consultant should be allowed when planning the course of treatment.

The "Transplant Prior Authorization" requirement should *not* be confused with the standard prior authorization outlined in Section 8 of the provider manual or with the "Inpatient Hospital Admission Certification Review". All inpatient hospital admissions for MO HealthNet participants *must* be certified as medically necessary and appropriate for inpatient services before payment is made. Refer to Section 13 for inpatient admission certification procedures as they apply to transplant participants. A MO HealthNet Prior Authorization Request Form is *not* required for transplant requests and should *not* be sent to Wipro Infocrossing.

All transplant and bone marrow/stem cell harvest prior authorization requests should be directed to the MO HealthNet Division (MHD) by writing to:

Transplant Coordinator
MO HealthNet Division
P.O. Box 6500
Jefferson City, Missouri 65102-6500
or by calling (573) 751-6963.

- Prior authorization *must* be obtained from the MO HealthNet Division for each MO HealthNet participant who is a potential candidate for transplant. A written transplant or bone marrow/stem cell harvest agreement is developed and issued on a case-by-case basis for those patients for whom authorization is granted. Patients who require a second/third transplant *must* have the second/third transplant prior authorized.

- The transplant agreement *must* be signed by a representative of the transplant facility and returned to the MO HealthNet Division. The agreement is effective from the date of the verbal approval or date of the agreement until the transplant is performed. It is only valid during periods of the participant's MO HealthNet eligibility, and it is the responsibility of the transplant facility to verify eligibility prior to treatment. The facility *must* notify the MHD Transplant Coordinator if the patient is removed from the list of transplant candidates.

14.1 EMERGENCY OR CONDITIONAL AUTHORIZATION

14.1.A Facility Approval Pending

In a medical emergency, a facility *not* currently approved as a MO HealthNet transplant facility may be given conditional authorization to perform a transplant or bone marrow/stem cell harvest. Submission of the required facility documentation may be waived for a period of 90 days. During that period, the facility *must* submit the appropriate documentation required for facility selection approval. Prior authorization procedures *must* still be followed and authorization may be granted pending final facility approval.

Facilities shall be financially "at risk" regarding state approval for any transplant related services rendered prior to the approval of their application for transplant facility status.

14.1.B MO HealthNet Eligibility Pending

Conditional verbal and/or written authorization may be given to the transplant facility when a MO HealthNet eligibility determination is pending, provided the necessary medical information has been received documenting the need for the transplant or bone marrow/stem cell harvest. The conditional authorization does *not* constitute MO HealthNet liability for any transplant or bone marrow/stem cell harvest performed on a date when the participant is *not* MO HealthNet eligible. If the participant is eligible for only a portion of the hospital transplant stay, the services rendered on the eligible days are covered by MO HealthNet.

The facility shall be financially "at risk" for reimbursement of services performed on dates when the participant is *not* MO HealthNet eligible.

14.1.C Emergency Prior Authorization Process

MHD may grant verbal authorization for organ transplants pending receipt of required documentation, for emergency requests received by telephone call or fax. A written agreement is sent after all required documentation has been received and all the criteria for authorization have been met. Only in acute onset of illness is an emergency prior

authorization request needed because providers should request the prior authorization as soon as a MO HealthNet applicant or participant is identified as a transplant candidate.

14.2 PROCESS FOR TRANSPLANT REQUEST, PRIOR AUTHORIZATION AND ROLES OF STAFF

Procedures have been developed to assist the physician and/or transplant facility in obtaining the required prior authorization for candidates of MO HealthNet covered transplants.

Immediately after identifying a potential MO HealthNet transplant candidate, the physician, social worker or transplant coordinator of the transplant hospital should notify the MO HealthNet Division, Pharmacy and Clinical Services Unit-Transplant Program by:

calling (573) 751-6963.

or by faxing the appropriate information/documentation to the MO HealthNet Division, Pharmacy and Clinical Services Unit, (573) 526-4650.

14.2.A TRANSPLANT STAFF ROLES

14.2.A(1) Patient's Referring Physician

- Identifies transplant candidate.
- Refers patient to transplant surgeon/facility and requests a transplant evaluation.

14.2.A(2) Transplant Surgeon

- Notifies the transplant social worker or transplant coordinator of potential candidate.
- Assesses patient's status as a transplant candidate.
- Writes a letter to the MO HealthNet Division requesting consideration for coverage by MO HealthNet.

14.2.A(3) Transplant Facility Coordinator/Social Worker

- Evaluates patient's need and qualifications for public assistance/Social Security disability benefits.
- Refers patient to local Family Support Division (FSD) and Social Security Administration (SSA) offices to apply for assistance, if applicable.

- Assures that the transplant surgeon has written a letter to the MO HealthNet Division and requests appropriate medical records to be forwarded to the MO HealthNet Division.
- Notifies the facility's patient accounts department of impending MO HealthNet covered transplant.
- Notifies the MO HealthNet Division Transplant Unit of an impending request.
- Identifies patient name, date of birth, MO HealthNet identification number, Social Security number, address, type of transplant, current medical status, Medicare status, and available insurance or trust funds.

14.2.A(4) MO HealthNet Division Staff

- Assists facilities through the facility approval process.
- Establishes case file for each request.
- Assists transplant coordinator/social worker with questions regarding MO HealthNet eligibility and prior authorization process.
- Verifies MO HealthNet eligibility.
- Receives transplant surgeon's letter and medical records and reviews for completeness.
- Routes appropriate material to Medical Consultant for medical review.
- If transplant is approved, initiates agreement to the facility.
- Assures investigation of Third Party Liability (TPL) and other payment resources by the Cost Recovery Unit.
- Follows patient's status.
- Processes transplant claims.
- Verifies continued facility approval.
- Ability to track transplant costs and survival statistics.

14.2.A(5) Transplant Facility (Patient Accounts)

- Reviews agreement issued by MO HealthNet Division.
- Signs and returns agreement to MO HealthNet Division.

- Provides copy of signed agreement to physician providers.
- Contacts MO HealthNet's Medical Review Agent for pre-admission certification.
- Submits claim for hospital related services.

14.2.B DOCUMENTATION REQUIREMENTS

The pretransplant evaluation information and the letter from the transplant surgeon *must* be received before the MO HealthNet Division will review any documentation for transplant request. The transplant surgeon *must* submit a letter to the MO HealthNet Division requesting authorization for coverage of the transplant. MO HealthNet does *not* consider a form letter that merely states the patient needs a transplant and meets the facility's patient selection criteria an appropriate request for authorization. MO HealthNet requires the request letter to contain the transplant surgeon's signature; signature stamps are *not* acceptable.

1. Patient's full name;
2. Patient's date of birth;
3. MO HealthNet identification number and/or Social Security number;
4. Synopsis of alternative treatments performed and results;
5. Diagnosis (including disease staging) and prognosis; and
6. Specific transplant type being requested;

Medical records *must* be submitted in conjunction with the transplant surgeon's letter which substantiates:

- the patient's diagnosis;
- results of the transplant evaluation upon completion;
- that the patient has been evaluated according to and meets the facility's "Patient Selection Protocols";
- patient has been determined to be a suitable transplant candidate, from a psychosocial and medical standpoint; and transplant treatment has been specifically discussed with patient/guardians.

The following information documentation must be included in the fax:

1. Permanent residence;

2. Pertinent medical history;

3. Availability of Medicare coverage and Medicare claim number;

4. Policy name and number of other potential health insurance;

5. Correspondence from referring physicians (when applicable);

6. Consultation reports/letters (when applicable);

7. In cases involving out-of-state facilities, a statement from the patient's referring physician may be required to explain why the transplant should be performed at an out-of-state facility;

8. Transplant evaluation forms (required forall transplant requests) refer to Section 14.3.B(2);

9. Medical records and laboratory reports showing HIV status and donor compatibility for stem cell transplants (HIV notes should be within 6 months of MHD request);

10. Psychiatric/social service evaluations (should be within 6 months of MHD request) to get most accurate psychosocial assessment or impression of patient's ability to be an adequate candidate for transplant;

11. Identify the donor for living related kidney, liver or allogeneic related bone marrow/stem cell transplants (when information is available);

12. Allogeneic bone marrow/stem cell transplant requests *must* include the lab reports documenting the patient's and donor's antigen and compatibility studies.

i. For bone marrow/stem cell transplants and harvests, the type of bone marrow/stem cell transplant planned (syngeneic, allogeneic, haplo-identical, non-related, autologous, peripheral stem cell, or cord blood) should be identified and a statement regarding current status of malignancy. Allogeneic types of transplant should identify the donor (related, unrelated, anonymous). MO HealthNet also requires a copy of the results of the HLA and MLC antigen match studies of both the patient and the potential donor for allogeneic bone marrow/stem cell transplant requests.

1. Autologous marrow harvest and transplant requests *must* contain a statement that the marrow is free of the disease.

ii. The request for stem cell transplant or harvest should contain a brief historical background, including the initial diagnosis, complete staging, the initial treatment and response. If there has been a recurrence, the date and its nature should be clearly outlined and response to treatment should be documented. Include a comment about status and organ function. The use of stem cell transplantation should be clearly justified based on current results. When transplantation is clearly the standard therapy, a lengthy justification is *not* necessary. However for less clear indications, the requesting physician *must* provided the best evidence to support the transplant as the best treatment approach. This should be supported with references.

iii. All bone marrow/stem cell transplant requests must include the original consult letter providing the decision and rationale for the transplant.

iv. In addition to the specific test results used to evaluate the need for a bone marrow/stem cell transplant, the allogeneic or autologous bone marrow/stem cell transplant candidate's most recent bone marrow/stem cell test results may be requested at the discretion of the Bone Marrow Physician Consultant or Bone Marrow Transplant Advisory Group.

v. Bone marrow/stem cell harvest only request letters and medical records are reviewed by the state's Bone Marrow Transplant Physician Consultant. At the Consultant's discretion, additional documentation may be requested attesting to the acceptability of the patient as a transplant candidate. In some instances, the request for coverage may be reviewed by the Bone Marrow Transplant Advisory Group prior to a final decision.

13. Requests for a pancreas transplant following a kidney transplant *must* include documentation or medical history of the prior kidney transplant.

If MHD approves coverage of the transplant, and the patient is MO HealthNet eligible, an agreement is issued to the transplant facility authorizing coverage of the transplant or bone marrow/stem cell harvest.

In order for the transplant facility or any other provider to receive reimbursement from MO HealthNet, the patient *must* be MO HealthNet eligible on each date of service. In order to assure that a spenddown patient is eligible on the date of transplant and/or subsequent days, providers are reminded that the patient *must* make application at the patient's local Family Support Division office at the beginning of each new spenddown quarter.

NOTE: MO HealthNet is the last payer, therefore any other available insurance *must* be utilized prior to MO HealthNet payment. It is important to note that many private insurance companies now require pre-certification/prior authorization of transplant surgeries.

The patient must meet MO HealthNet's special restrictions applicable to the type of transplant as outline in Section 13.

14.3.B TRANSPLANT EVALUATION FORMS

Some transplant facilities have developed a transplant evaluation form or check list for use by the facility's transplant team that briefly documents the findings of the transplant team members. If the facility uses their own transplant evaluation form or check list, a copy of the transplant candidate's completed form must accompany the transplant surgeon's letter. The Stem Cell Request form (or the facilities equivalent) is required for all bone marrow/stem cell transplant requests. The Solid Organ Transplant Request Form (or the facilities equivalent) is required for all other transplant requests. MHD can provide the Stem Cell Request form and Solid Organ Transplant Request form if the facility does not have its own.

14.4 MEDICARE/MO HEALTHNET PATIENTS

MO HealthNet participants with Medicare Part A Benefit coverage are exempt from the transplant prior authorization process under the following circumstances:

- The transplant is a Medicare covered service and Medicare requirements for coverage have been met. Currently kidney, heart, liver, lung, pancreas and certain bone marrow/stem cell transplants are eligible for Medicare coverage. Providers are required to verify Medicare's policy for coverage of transplants at the time of the transplant.

  Currently, heart, lung and liver transplants can be performed for Medicare patients only in approved Medicare heart, lung and liver transplant facilities. **EXCEPTION:** MO HealthNet may issue a short term (90 day) agreement for Medicare/MO HealthNet participants if transport to an approved Medicare facility would jeopardize the patient's life. The temporary authorization *must* follow MO HealthNet's established prior authorization process. The surgeon's letter of request *must* identify the patient's critical condition and state that transport would place the patient in a life threatening position. Medicare/Medicaid heart, lung and liver patients whose medical condition stabilizes should be referred to an approved Medicare facility.

- The transplant facility and physician(s) *must* accept the Medicare/ MO HealthNet reimbursement as payment in full. MO HealthNet processes the applicable deductible and coinsurance amounts.

For MO HealthNet to provide reimbursement as the primary payor for a covered transplant, Medicare/MO HealthNet participants who do *not* meet the Medicare criteria for transplant

coverage *must* have the transplant prior authorized by the MO HealthNet. Medicare/MO HealthNet participants *must* have prior authorization requested under the following circumstances:

- *Liver transplants:* Patients who do *not* meet the Medicare patient selection criteria for liver transplant coverage but who are suitable candidates according to the transplant facility's patient selection criteria may request MO HealthNet authorization.
- *Pancreas transplants:* Medicare may provide coverage for a pancreas transplant under limited guidelines. In circumstances where a pancreas transplant does not meet the Medicare criteria, MO HealthNet Division will only authorize coverage of the pancreas transplant if the pancreas is done in conjunction with or following a kidney transplant.
- *Lung transplants:* Patients who do *not* meet the Medicare patient selection criteria for lung transplant coverage but who are suitable candidates according to the transplant facility's patient selection criteria may request MO HealthNet authorization.
- *Bone Marrow/stem cell transplants:* Patients who do *not* meet the Medicare criteria for bone marrow/stem cell transplant coverage but who may meet the MO HealthNet coverage criteria may request MO HealthNet authorization.

Patients whose Medicare Part A benefits have been exhausted or the transplant does not meet Medicare's coverage guidelines *must* have the transplant prior authorized by the MO HealthNet Division in order to receive MO HealthNet reimbursement on facility or physician claims.

Patients who have Medicare Part A **only** coverage *must* apply for QMB or Buy-In in order to get Part B benefits to cover physician services. If a participant does not get Part B benefits along with Part A coverage, only the facility service will be covered by MHD.

Patients who have Medicare Part B **only** coverage *must* have the transplant prior authorized by the MO HealthNet Division in order to receive MO HealthNet reimbursement of inpatient (Part A) facility charges.

Patients who may be determined eligible for Medicare coverage as a result of a kidney transplant but who are *not* yet Medicare eligible should have the kidney transplant prior authorized by the MO HealthNet Division to ensure reimbursement should the patient *not* be determined Medicare eligible. Patients who may be determined eligible for Medicare coverage as a result of a kidney transplant but who are *not* yet Medicare eligible should have the kidney transplant prior authorized by the MO HealthNet Division to ensure reimbursement should the patient *not* be determined Medicare eligible.

14.5 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM TRANSPLANT REQUESTS

When a non-covered transplant is requested for coverage for a child under 21 years who qualifies under the Healthy Children and Youth Program, the provider *must* include a copy of the health assessment form and a plan of care which includes a recommendation for the transplant procedure. The provider *must* also include any journal articles that support the provider's claim that the requested transplant procedure is *not* experimental and is considered an acceptable therapeutic procedure for the patient's diagnosis.

14.6 DOCUMENTATION REQUIREMENTS FOR REIMBURSEMENT

The MO HealthNet Division requires specific documentation be submitted in connection with the claims for the transplant. The following information is provided to clarify MO HealthNet's definition of procurement services, transportation charges, and excision surgeon fees.

14.6.A PROCUREMENT SERVICES

14.6.A(1) Organ Procurement Organizations

Section 1138(b) of the Federal Social Security Act stipulates Organ Procurement Agencies *must* be designated by the Centers for Medicare & Medicaid Services (CMS) as an approved Organ Procurement Organization (OPO) for the Medicare and Medicaid Programs. To be so designated, an OPO *must* meet and maintain the criteria and conditions of the Organ Procurement and Transplantation Network established under Section 372 of the Public Health Services Act.

14.6.A(2) Organ Procurement Charge

The transplant facility *must* submit a copy of the OPO's invoice when billing the organ procurement charge. Components that make up the organ procurement charge of the OPO may *not* be billed separately. Listed below are the components that are generally included in the organ procurement charge submitted to the transplant facility by the OPO.

- Salaries (organ procurement coordinators & education coordinator);
- Medical director;
- Contract labor;
- Excision hospital costs (paid to hospitals for donor expenses, physician billing services for lab work, anesthesia, radiology);

- Excision surgeon for cadaveric donor organs must have an invoice submitted to the transplant facility by the excision surgeon.
- Excision surgeon for live donor organs must be submitted fee-for-service.
- Computer registry (listing participants on national registries);
- Donor evaluation (physician charges to evaluate the donor and provide medical maintenance);
- Organ preservation (medical supplies);
- Donor tissue typing;
- Imported organ costs (from another OPO or hospital);
- Other lab costs (miscellaneous lab charges related to HTLV-III, HAA, ABO rechecks *not* performed at donor hospital, etc.);
- Automotive (van maintenance, gas, etc.);
- Professional education (expenses for awareness programs, donor card brochures, slide shows, films, etc. specifically to inform the general public of organ donation and transplantation);
- Miscellaneous organ acquisition costs;
- All administrative and general costs of the OPO.

14.6.A(3) Bone Marrow/Stem Cell, Living Related Kidney or Liver Procurement Services

Procurement services in connection with a bone marrow/stem cell transplant or living related kidney or liver transplant should be billed separately. Listed below are the services that are generally provided to determine a suitable donor and the services related to obtaining the marrow or organ. Services *must* be billed on the appropriate claim form.

- Donor tissue typing (including all living related potential donor(s) lab services);
- Other miscellaneous lab tests performed for the donor;
- Physician's consultation services, office visits, hospital visits, bone marrow/stem cell harvest, or kidney or liver excision provided on behalf of the donor;
- All outpatient evaluation or transplant services provided on behalf of the donor;
- X-ray services when required;

- Inpatient bone marrow/stem cell harvest services;
- Marrow purging;
- Peripheral stem cell recruitment;
- T-cell depletion;
- Cryopreservation;
- Inpatient living related kidney or liver donor services.

The following items *must* be included on the UB-04 (CMS-1450) claim form for the submitted transplant, accompanied by an invoice to support the charges:

- Non-related bone marrow/stem cell donor services billed as a lump sum by an outside source for matched donor (including search and testing);
- Transportation of the non-related donor marrow.

14.6.A(4) Organ Transportation Charges

The OPO may include in their acquisition charge the charges for the transportation of the transplant team to a donor facility and their return with donor organ(s). Transportation charges may include the cost for ground transportation, commercial air courier service, or chartered air transportation.

If the organ transportation charge is included as part of the lump sum acquisition charge, the facility should indicate that transportation charges are included in the organ acquisition charge.

If the transportation charge(s) are received as a separate invoice or item, the charge(s) should be included on the inpatient transplant claim under revenue code 811 (Living Donor) or 812 (Cadaver Donor). A copy of the transportation invoice *must* be attached to the UB-04 (CMS-1450) transplant claim form.

NOTE: Transportation charges incurred by the transplant patient to go to the transplant facility for the transplant procedure are *not* covered as organ procurement charges.

14.6.A(5) Excision Surgeon Fees

The services of the surgeon who performs the donor organ excision are considered by MHD to be part of the organ procurement. Excision surgeon fees may or may not be included as part of the organ procurement charge submitted by the OPO.
When included as a portion of the organ procurement charge, the excision surgeon's fee should be specified as a separate statement on the invoice from the OPO, listing the surgeon's name and total amount of the charge. In this case, the

excision surgeon's fee may be included on the inpatient transplant claim under revenue code 811 (Living Donor) or 812 (Cadaver Donor). A copy of the organ procurement invoice *must* be submitted with the UB-04 (CMS-1450) transplant claim form.

14.6.B INPATIENT CLAIMS

Inpatient claims for the transplant surgery *must* have certain documents attached. In the following list of documents, the items with the asterisks (*) are required for all transplants. If the attachments are *not* present, the MO HealthNet Division *cannot* process the claim but returns it to the provider.

* UB-04 (CMS-1450) claim form. A separate UB-04 (CMS-1450) claim form is required for each defined stay as listed below.

1. Date of admission through day prior to transplant.

2. Date of transplant through date of discharge. A single UB-04 (CMS-1450) is required if the date of admission equals the date of transplant.

* A separate UB-04 (CMS-1450) claim form *must* be submitted for each additional transplant performed in the same hospital stay beginning with the date of transplant.

* If a bone marrow/stem cell harvest is performed during the pre-transplant period, the day of the harvest *must* be submitted on a separate UB-04 (CMS-1450) claim form.

* An itemized hospital bill from the date of *transplant* through the date of discharge or significant change in diagnosis not related to the transplant surgery.

* The invoice submitted to the transplant facility from the Organ Procurement Organization verifying the organ procurement charge.

* The invoice submitted to the transplant facility from transport company(s) verifying transport of the transplant team and/or donor organ.

* The invoice submitted to the facility verifying services of the excision surgeon.

* Medicare RA/EOMB or service denial notification.

* Third Party EOB showing the amount billed and payment received or the service denial notification.

* For non-related bone marrow/stem cell transplant services, the invoice or other identifying documentation that substantiates the charges of bone marrow/stem cell

harvest, transport of the marrow, and inpatient/outpatient services for the unrelated donor which are being included as a bone marrow/stem cell acquisition charge on the UB-04 (CMS-1450) claim form.

* The peripheral stem cell collection record for each date of service performed.

* Required for all transplants, if applicable.

END OF SECTION

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SECTION 15-BILLING INSTRUCTIONS

15.1 PROVIDER RELATIONS COMMUNICATION UNIT

It is the responsibility of the Provider Communications Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896.

15.2 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.

If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, the incorrect number of inpatient days was paid. That claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request or submit an adjustment online through a replacement or voided claim. Section 6 of this manual explains the adjustment request process.

15.3 BILLING PROCEDURES FOR MEDICARE/MO HEALTHNET

When a participant has both Medicare Part B and MO HealthNet coverage, a claim *must* be filed with Medicare first if the service is covered by Medicare. If the patient has Medicare Part B but the service is *not* covered or the limits of coverage have been reached previously, an electronic or paper claim *must* be submitted to MO HealthNet. Refer to Section 16.3 of this manual for filing instructions.

If the provider has indicated MO HealthNet coverage on a claim sent to Medicare and no disposition is received from MO HealthNet after 60 days (a reasonable period for transmission and MO HealthNet processing), reference Section 16 of this manual for billing instructions.

15.4 INPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS

THE FOLLOWING INSTRUCTIONS HAVE BEEN DEVELOPED FOR USE IN BILLING INPATIENT HOSPITAL CLAIMS FOR TRANSPLANT PARTICIPANTS.

Refer to Section 14 of this manual for any special documentation requirements.

The UB-04 (CMS-1450) claim form should be typed or legibly printed. It may be duplicated if the copy is legible. All claims related to the transplant stay including all claims for donor services, harvest, cryopreservation and processing and storage *must* be mailed to the attention of:

Transplant Coordinator
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

Providers should follow the instructions provided by the participant's health plan when billing for pre-transplant and follow-up services for managed care enrollees. Pre-transplant assessment and follow-up service claims for participants who are *not* enrolled in a managed health care plan should be submitted 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/providers/index.htm 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.

Information about ordering claim forms and provider labels is in Section 3 of this manual.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
*1. Provider Name, Address, Telephone Number	Enter the provider's name, address and telephone number.
2. Unlabeled Field	Leave blank.
3a. Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
3b. Med Rec #	Leave blank.
*4. Type of Bill	The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The allowed values for each of the digits found in the type of bill are listed below: Type of Facility: 1st digit:

(1) Hospital

Bill Classification: 2nd digit:

(1) Inpatient (Including Medicare Part A)
(2) Inpatient (Medicare Part B only)

Frequency: 3rd digit

(1) Admit thru Discharge Claim

(2) Interim Bill - First Claim

(3) Interim Bill - Continuing Claim

(4) Interim Bill - Last Claim

5. Federal Tax Number — Enter the provider's federal tax number.

*6. Statement Covers Period (from and through dates) — Indicate the beginning and ending dates being billed on this claim form in MMDDYY numeric format. This field should include days in excess of length of stay limitations.

Transplant Stay:

The statement covered period begins with the date of the transplant surgery and continues through the date of discharge. (Refer to Section 13 for a brief description of date of surgery.)

Donor:

Enter the date of admission for the donor through the donor's date of discharge.

Subsequent Transplant(s) (same stay):

A second/third prior authorization agreement *must* be negotiated if a second/third transplant procedure is required during the same stay as the transplant. The date of the second/third transplant begins a new billing period.

Days a participant is not MO HealthNet eligible must not be included in this field.

7. Unlabeled Field — Leave blank.

8a. Patient's Name - ID	Enter the participant's 8-digit MO HealthNet DCN or MO HealthNet Managed Care identification number. NOTE: The MO HealthNet DCN or MO HealthNet Managed Care identification number is *required* in Field #60.
*8b. Patient Name	Enter the transplant participant's last name, first name, middle initial. If the claim is for a donor or potential donor, the donor's last name, first name and middle initial would be used in this field. If the donor is an anonymous/National Marrow Donor Program (NMDP) donor, an anonymous/NMDP Assigned identification number *must* be entered here (e.g., NMDP 010101010 or Anonymous 010101010). If the claim is for the donor or potential donor, the relationship to the participant *must* be supplied in Field #80 (Remarks).
9. Patient Address	Enter the street, city, state and zip code of the participant or donor.
10. Patient Birth Date	Enter the participant's or donor's month, day and year of birth. If only the month and year are known, enter month and year.
11. Patient Sex	Enter the patient's sex, "M" (male) or "F" (female).
*12. Admission Date	Enter in MMDDYY format the date that the patient was admitted for inpatient care. This should be the actual date of admission regardless of the patient's eligibility status on that date or MO HealthNet's medical review agent certification/denial of the admission date. When billing for date of transplant through date of discharge or significant change in diagnosis not related to the transplant surgery, the actual admission date for

	inpatient care should be used.
13. Admission Hour	Leave blank.
*14. Admission Type	Enter the appropriate type of admission; the allowed values are: 1—Emergency 2—Urgent 3—Elective (Do *not* use for transplant patients.) 4—Newborn (Do *not* use for transplant patients.)
**15. Source of Admission (SRC)	If this is a transfer admission, complete this field. The allowed values are: 4—Transfer from a hospital 5—Transfer from a skilled nursing facility 6—Transfer from another health care facility 7—Emergency Room 8—Court/Law 9—Information not available A—Transfer from a Critical Access Hospital D—Transfer from Hospital Inpatient in the same facility, resulting in a separate claim to payer.
16. Discharge Hour	Leave blank.
*17. Patient Status	Enter the 2-digit patient status code that best describes the patient's discharge status Common values are: 01—Discharged to home or self-care 02—Discharged/transferred to another short-term general hospital for inpatient care 03—Discharged/transferred to skilled nursing facility

04—Discharged/transferred to an intermediate care facility

05—Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution

06—Discharged/transferred to home under care of organized home health service

07—Left against medical advice, or discontinued care

08—Discharged/transferred to home under care of Home IV provider

20—Expired

30—Still a patient

63—Discharged/transferred to a Medicare certified long-term care hospital (LTCH)

*18-24. Condition Codes

Enter the appropriate two-character condition code(s). The values applicable to MO HealthNet are:

C1—Approved as billed

Indicates the facility's Utilization Review authority has certified all days billed.

C3—Partial Approval

The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. *If C3 is entered, Field #35 must be completed.*

NOTE: CODE C1 OR C3 IS REQUIRED.

A1—Healthy Children & Youth/EPSDT

If this hospital stay is a result of an HCY referral or is an HCY related stay,

		this condition code *must* be entered on the claim. A4—Family Planning If family planning services occurred during the inpatient stay, this condition code *must* be entered.
25-28.	Condition Codes	Leave blank.
29.	Accident State	Leave blank.
30.	Unlabeled field	Leave blank.
**31-34.	Occurrence Code and Date	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01—Auto Accident 02—No Fault Insurance 03—Accident/Tort Liability 04—Accident/Employment Related 05—Other Accident 06—Crime Victim
**35.	Occurrence Span Codes and Dates (from and through)	Required if C3 is entered in Fields #18-24. Enter code "MO" and the first and last days that were approved by Utilization Review.
36.	Occurrence Span Codes and Dates	Leave blank.
37.	Unlabeled field	Leave blank.
38.	Responsible Party Name and Address	When billing for the donor, show the name and address of the responsible party for the transplant participant.
*39-41.	Value Codes and Amounts	Enter the appropriate code(s) and unit amount(s) to identify the information necessary for the processing of the claim. 80—Covered Days Enter the number of days shown in field #6, minus the date of discharge. The discharge date is *not* a covered day and should *not* be included in the calculation of this field.

The through date of service in field #6 **is** included in the covered days, if the patient status code in Field #17 is equal to "30—still a patient."

NOTE: The units entered in this field *must* be equal to the number of days in "Statement Covers Period", less day of discharge. If patient status is "still a patient," units entered include through day.

81—Noncovered Days

If applicable, enter the number of noncovered days. Examples of noncovered days are those days for which the patient is ineligible.

NOTE: The total units entered in this field *must* be equal to the total accommodation units listed in field #46.

*42. Revenue Code

List appropriate accommodation codes first in chronological order.

Ancillary codes should be shown in numerical order.

Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to ICU to general.

A private room *must* be medically necessary and the medical need *must* be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge.

If the patient requested a private room, which is noncovered, multiply the private room rate by the number of days for the total charge in Field #47. Enter the difference between the private room total charge and the semiprivate room total charge in field

	#48, noncovered charges. NOTE: Organ acquisition charges or bone marrow/stem cell acquisition should *not* be included in any other revenue codes. Use revenue codes 811 (Living Donor) or 812 (Cadaver Donor) when billing organ procurement charges. After all revenue codes are shown, skip a line and list revenue code 001, which represents total charges.
43. Revenue Description	Not required, but beneficial to MHD for claims processing.
*44. HCPCS/Rates/HIPPS Code	Enter the daily room and board rate to coincide with accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use a separate line to report each rate.
45. Service Date	Leave blank.
*46. Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and noncovered days. NOTE: The number of units in Field #39-#41 *must* equal the number of units in this field. If two claims have been submitted to show pre-transplant days and transplant days, the days on the claim for the portion of the stay *not* being billed on that particular type of claim *should not* be shown as noncovered.
*47. Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 001. NOTE: The room rate multiplied by the number of units *must* equal the charge

	entered for room accommodation(s).
**48. Non-covered Charges	Enter any noncovered charges. This includes all charges incurred during those noncovered days entered in fields #39-#41. If Medicare Part B was billed, those Part B charges should be shown as noncovered. The difference in charges for private versus non-private room accommodations when the private room was *not* medically necessary should be shown as non-covered in this field. *Do not* show charges for the portion of stay *not* being billed, show only those noncovered charges that apply to the stay being billed. NOTE: When the admission for the transplant surgery(ies) necessitate more than one UB-04 claim form, the total of all charges shown on each claim, when added together, *must* equal the total amount of all charges shown on the itemized bill.
49. Unlabeled Field	Leave blank.
*50. Payer Name	The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer and "MO HealthNet" is listed last. If MO HealthNet is the primary payer, it is listed first. NOTE: If Medicare or insurance has denied the claim, an RA/EOMB or insurance letter *must* be attached to the claim form. If the patient has a trust fund from which the facility has received or expects to receive payment, list the trustee or fund name. See Section 5 for additional TPL information. Review the transplant agreement for possible insurance coverage and/or trust funds.
51. Health Plan ID	Leave blank.
52. Release of Information	Leave blank.

	Certification Indicator	
53.	Assignment of Benefits Certification of Indicator	Leave blank.
**54.	Prior Payments	Indicate the amount the hospital has received toward payment of this bill from the private insurance company or trust fund. Do *not* list payments received from Medicare, the patient, or amounts previously paid by MO HealthNet in this field. Payments *must* correspond with the appropriate payer entered in Field #50. (See Note)(1)
55.	Estimated Amount Due	Leave blank.
*56.	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCa.
57.	Other Provider ID	Leave blank.
**58.	Insured's Name	Complete if the insured's name is different from the patient's name. Show the MO HealthNet participant when billing for the bone marrow/stem cell and living related donor's services.(See Note)(1)
59.	Patient's Relationship to Insured	Leave blank.
*60.	Insured's Unique ID	Enter the transplant patient's (participant's) 8-digit MO HealthNet or MO HealthNet Managed Care identification number on all claims, including the donor's claims. If insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.
**61.	Insurance Group Name	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured. (See Note)(1)
**62.	Insurance Group Number	If insurance is shown in Field #50, state the number assigned by the insurance company

		to identify the group under which the individual is covered. (See Note)(1)
**63.	Treatment Authorization Codes	For claims requiring certification, enter the unique 7-digit certification number supplied by MO HealthNet's Medical Review Agent.
**64.	Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65.	Employer Name	If the patient is employed, the employer's name may be entered here.
66.	Diagnosis & Procedure Code Qualifier	Leave blank.
*67.	Principal Diagnosis Code	Enter the International Classification of Diseases (ICD) diagnosis code for the condition established after study to be chiefly responsible for the admission. The following diagnosis codes *must* be used when billing for donor services: Z52001—Stem Cell Donor Z52011 – Autologous Stem Cell Donor Z52091 – Other blood Stem Cell Donor Z523—Bone Marrow Donor Z524—Kidney Donor Z526—Liver Donor Z5289—Other Specified Organ or Tissue Z005—Potential Donor (Organ or Tissue) Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book.
**67. a-d	Other Diagnosis Codes	Enter any additional diagnosis codes that

		have an effect on the treatment received or the length of stay.
67. e-q	Other Diagnosis Codes	Leave blank.
68.	Unlabeled Field	Leave blank
69.	Admitting Diagnosis	Leave blank.
70.	Patient's Reason for Visit	Leave blank.
71.	Prospective Payment system (PPS) Code	Leave blank.
72.	External Cause of Injury Code (E Code)	Leave blank.
73.	Unlabeled Field	Leave blank.
**74.	Principal Procedure Code and Date	Enter the full ICD procedure code of the principal surgical procedure. The date on which the procedure was performed *must* be shown. Only month and day are required. The claim for the date of transplant through date of discharge or significant change in diagnosis not related to the transplant surgery *must* always list the transplant surgical procedure and the date of the transplant in this field.
**74. a-e	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed.
75.	Unlabeled field	Leave blank.
*76.	Attending Provider Name and Identifiers	Enter the attending provider's 10-digit NPI. Enter the attending physician's name, last name first. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCb.
**77.	Operating Provider Name and Identifiers	Physician's NPI is optional. Enter the operating physician's name, last name first. If applicable enter the corresponding 10-

		digit Provider Taxonomy code in Field 81CCc.
**78-79.	Other Provider Name and Identifiers	Physician's NPI is optional. Enter the physician's name, last name first. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCd.
**80.	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc. Donor Services: Name of donor or potential donor and the relationship to the participant *must* be entered here (e.g., John Doe, potential donor, brother to Jim Doe or Sarah Doe, actual donor, sister to Jim Doe or Anonymous 010101010 actual donor to Jim Doe). This information is necessary to process any donor claim.
**81CCa.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 56. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCb.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 76. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCc.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in

	Field # 77. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCd. Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 78-79. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.

* These fields are mandatory on *all* Inpatient UB-04 (CMS-1450) 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.

Attach a copy of the itemized bill for the inpatient hospital services provided for the day(s) being billed.

Organ transplant claims *must* include a copy of the invoice from the organ procurement agency showing the acquisition charges. Any other related costs submitted to the hospital from an outside source and passed through as a charge on the inpatient bill *must* also be documented by invoice.

If the claim for the deductible and/or coinsurance does *not* directly cross over from Medicare to MO HealthNet, refer to Section 16, Medicare/MO HealthNet Crossover Claims, for further information.

15.5 OUTPATIENT HOSPITAL CLAIM FILING INSTRUCTIONS

THE FOLLOWING INSTRUCTIONS HAVE BEEN DEVELOPED FOR USE IN BILLING OUTPATIENT HOSPITAL CLAIMS FOR TRANSPLANT PARTICIPANTS.

Refer to Section 14 of this manual for any special documentation requirements.

The UB-04 (CMS-1450) claim form should be typed or legibly printed. It may be duplicated if the copy is legible. All claims related to the transplant stay including all claims for donor services, harvest, cryopreservation and processing and storage *must* be mailed to the attention of:

Transplant Coordinator
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

Providers should follow the instructions provided by the participant's health plan when billing for pre-transplant and follow-up services for managed care enrollees. Pre-transplant assessment and follow-up service claims for participants who are *not* enrolled in a managed health care plan should be submitted 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/providers/index.htmand 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: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
*1. Provider Name, Address, Telephone Number	Enter the provider's name, address and telephone number.
2. Unlabeled Field	Leave blank.
3a. Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
3b. Med Rec #	Leave blank.
*4. Type of Bill	The required three digits in this code identify the following:

		1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency
		Outpatient Hospital:
		The *only* valid type of bill is "131".
5.	Federal Tax Number	Enter the provider's federal tax number.
*6.	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form in MMDDYY numeric format.
7.	Unlabeled Field	Leave blank.
8a.	Patient's Name - ID	Enter the participant's 8-digit MO HealthNet DCN or MO HealthNet Managed Care identification number. NOTE: The MO HealthNet DCN or MO HealthNet Managed Care identification number is *required* in Field #60.
*8b.	Patient Name	Enter the transplant participant's last name, first name, middle initial. If the claim is for a donor or potential donor, the donor's last name, first name and middle initial would be used in this field. If the donor is an anonymous/National Marrow Donor Program (NMDP) donor, an anonymous/NMDP Assigned identification number *must* be entered here (e.g., NMDP 010101010 or Anonymous 010101010). If the claim is for the donor or potential donor, the relationship to the participant *must* be supplied in Field #80 (Remarks).
9.	Patient Address	Enter the street, city, state and zip code of the participant or donor.
10.	Patient Birth Date	Enter the participant's or donor's month, day and year of birth. If only the month and year are known, enter month and year.
11.	Patient Sex	Enter the patient's sex, "M" (male) or "F"

	(female).
12. Admission Date	Leave blank.
13. Admission Hour	Leave blank.
**14. Admission Type	Leave blank unless claim is for an emergency room service. If so, enter Admission Type 1. Condition Code AJ also must be listed in field 24 to exempt the patient from the $3.00 copay for the service.
15. Source of Admission (SRC)	Leave blank.
16. Discharge Hour	Leave blank.
**17. Patient Status	Leave blank.
*18-24. Condition Codes	Enter the appropriate two-character condition code(s). The values applicable to MO HealthNet are: A1—Healthy Children & Youth/EPSDT If this service is the result of an HCY referral or is an HCY related visit, enter this condition code. If no applicable condition code then leave blank.
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled field	Leave blank.
**31-34. Occurrence Code and Date	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01—Auto Accident 02—No Fault Insurance 03—Accident/Tort Liability 04—Accident/Employment Related 05—Other Accident 06—Crime Victim
35-36. Occurrence Span Codes and	Leave blank.

	Dates	
37.	Unlabeled field	Leave blank.
38.	Responsible Party Name and Address	When billing for the donor, show the name and address of the responsible party for the transplant participant.
39-41.	Value Codes and Amounts	Leave blank.
**42.	Revenue Code	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s).
**43.	Revenue Description	Not required, but beneficial to MHD for claims processing.
*44.	HCPCS/Rates/HIPPS Code	Enter the CPT or HCPCS procedure code(s) and any applicable modifier.
*45.	Service Date	Enter the date of service on each line billed in MMDDYY format.
*46.	Service Units	Enter the number of units for each procedure, revenue code or supply items billed.
*47.	Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 0001.
48.	Non-covered Charges	Leave blank.
49.	Unlabeled Field	Leave blank.
*50.	Payer Name	The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer and "MO HealthNet" is listed last. If MO HealthNet is the primary payer, it is listed first. NOTE: If Medicare or insurance has denied the claim, an RA/EOMB or insurance letter *must* be attached to the claim form. If the transplant participant has a trust fund

		from which the facility has received or expects to receive payment, list the trustee or fund name. See Section 5 for additional TPL information. Review the transplant agreement for possible insurance coverage and/or trust funds.
51.	Health Plan ID	Leave blank.
52.	Release of Information Certification Indicator	Leave blank.
53.	Assignment of Benefits Certification of Indicator	Leave blank.
**54.	Prior Payments	Indicate the amount the hospital has received toward payment of this bill from the private insurance company or trust fund. Do *not* list payments received from Medicare, the patient, or amounts previously paid by MO HealthNet in this field. Payments *must* correspond with the appropriate payer entered in Field #50. (See Note)(1)
55.	Estimated Amount Due	Leave blank.
*56.	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCa.
57.	Other Provider ID	Leave blank.
**58.	Insured's Name	Complete if the insured's name is different from the patient's name. Show the MO HealthNet participant when billing for the bone marrow/stem cell and living related donor's services.(See Note)(1)
59.	Patient's Relationship to Insured	Leave blank.
*60.	Insured's Unique ID	Enter the transplant patient's (participant's) 8-digit MO HealthNet or MO HealthNet Managed Care identification number on all claims, including the donor's claims. If

		insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.
**61.	Insurance Group Name	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured. (See Note)(1)
**62.	Insurance Group Number	If insurance is shown in Field #50, state the number assigned by the insurance company to identify the group under which the individual is covered. (See Note)(1)
63.	Treatment Authorization Codes	Leave blank.
**64.	Document Control Number	If the current claim exceeds the timely filing limit of one year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one-year limit.
65.	Employer Name	If the patient is employed, the employer's name may be entered here.
66.	Diagnosis & Procedure Code Qualifier	Leave blank.
*67.	Principal Diagnosis Code	Enter the ICD diagnosis code for the condition established after study to be chiefly responsible for the admission. The following diagnosis codes *must* be used when billing for donor services: Z52001—Stem Cell Donor Z52011 – Autologous Stem Cell Donor Z52091 – Other blood Stem Cell Donor Z523—Bone Marrow Donor Z524—Kidney Donor

		Z526—Liver Donor Z5289—Other Specified Organ or Tissue Z005—Potential Donor (Organ or Tissue) Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book.
**67. a-d	Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received.
67. E-Q	Other Diagnosis Codes	Leave blank.
68.	Unlabeled Field	Leave blank
69.	Admitting Diagnosis	Leave blank.
70.	Patient's Reason for Visit	Leave blank.
71.	Prospective Payment system (PPS) Code	Leave blank.
72.	External Cause of Injury Code (E Code)	Leave blank.
73.	Unlabeled Field	Leave blank.
**74.	Principal Procedure Code and Date	Enter the full CPT code. The date on which the procedure was performed *must* be shown. Only month and day are required.
**74. a-e	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed.
75.	Unlabeled field	Leave blank.
**76.	Attending Provider Name and Identifiers	Enter the attending provider's 10 digit NPI. Enter the attending physician's name, last name first. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCb.
77.	Operating Provider Name and Identifiers	Physician's NPI is optional. Enter the operating physician's name, last name first. If applicable enter the corresponding 10-

		digit Provider Taxonomy code in Field 81CCc.
**78-79.	Other Provider Name and Identifiers	Physician's NPI is optional. Enter the physician's name, last name first. If applicable enter the corresponding 10-digit Provider Taxonomy code in Field 81CCd.
**80.	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc. Donor Services: Name of donor or potential donor and the relationship to the participant *must* be entered here (e.g., John Doe, potential donor, brother to Jim Doe or Sarah Doe, actual donor, sister to Jim Doe or Anonymous 010101010 actual donor to Jim Doe). This information is necessary to process any donor claim.
**81CCa.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 56. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCb.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 76. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCc.	Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in

	Field # 77. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.
**81CCd. Code-Code Field	Enter the B3 Provider Taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI reported in Field # 78-79. 1st Box: B3 qualifier 2nd Box: Provider taxonomy code.

* These fields are mandatory on *all* Inpatient UB-04 (CMS-1450) 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.

Attach a copy of the itemized bill for the inpatient hospital services provided for the day(s) being billed.

Organ transplant claims *must* include a copy of the invoice from the organ procurement agency showing the acquisition charges. Any other related costs submitted to the hospital from an outside source and passed through as a charge on the inpatient bill *must* also be documented by invoice.

If the claim for the deductible and/or coinsurance does *not* directly cross over from Medicare to MO HealthNet, refer to Section 16, Medicare/MO HealthNet Crossover Claims, for further information.

15.6 CMS-1500 CLAIM FILING INSTRUCTIONS

THE FOLLOWING INSTRUCTIONS HAVE BEEN DEVELOPED FOR USE IN BILLING TRANSPLANT SERVICES: PHYSICIAN, LABORATORY, X-RAY AND OTHER NON-INSTITUTIONAL, NON-PHARMACY TRANSPLANT SERVICES. Refer to Section 14 of this manual for any special documentation requirements. Refer to the Physician Manual, Section 15 for billing instructions for services *not* addressed by the transplant addendum.

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. All claims related to the transplant stay (date of transplant through date of discharge or

significant change in diagnosis not related to the transplant surgery) and any claims for donor services, harvest, cryopreservation and processing and storage *must* be mailed to the attention of:

Transplant Coordinator
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

If the participant is a managed health care enrollee, contact the participant's health plan for instructions on submission and reimbursement of the claim.

Information about ordering claim forms and provider labels is in Section 3 of this manual.

NOTE: One asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed only as applicable. Two asterisks (**) beside descriptions indicate required fields in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed, check the MO HealthNet box and if the participant has both Medicare and MO HealthNet, check both boxes.
*1a. Insured's I.D. Number	Enter the transplant patient's eight-digit MO HealthNet identification number for the patient's own services and for the services of any potential donor or the actual donor. Do *not* use alpha characters.
*2. Patient's Name	Enter the transplant participant's last name, first name, and middle initial. If the claim is for a donor or potential donor, the donor's last name, first name and middle initial would be used in this field. If the donor is an anonymous/National Marrow Donor Program (NMDP) donor, an anonymous/NMDP Assigned identification number *must* be entered here (e.g., NMDP 010101010 or Anonymous 010101010).

	If the claim is for the donor or potential donor, the relationship to the participant *must* be supplied in Field #19.
3. Patient's Birthdate	Enter month, day, and year of birth.
Sex	Mark appropriate box.
**4. Insured's Name	If there is an 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.
5. Patient's Address	Enter the address and telephone number if available.
**6. Patient Relationship to Insured	Mark "SELF" if the claim is for the transplant participant. Mark "OTHER" when billing for the services of the donor or potential donor.
**7. Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available.
8. Patient's Status	Not required.
**9. Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name.
**9a. Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. (See Note)(1)
**9b. Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. (See Note)(1)
**9c. Employer's Name	Enter the secondary policyholder's employer name. (See Note)(1)
**9d. Insurance Plan	Enter the secondary policyholder's insurance plan name.
	If the insurance plan denied payment for the

		service provided, attach valid denial from the insurance plan. (See Note)(1)
**10a-10c.	Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. **If the services are *not* related to an accident, leave blank.** (See Note)(1)
10d.	Reserved for Local Use	May be used for comments/descriptions. (See Note)(1)
**11.	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. (See Note)(1)
**11a.	Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. (See Note)(1)
**11b.	Employer's Name	Enter the primary policyholder's employer name. (See Note)(1)
**11c.	Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan.* (See Note)(1)
**11d.	Other Health Plan	Indicate whether the participant has a secondary health insurance plan; if so, complete Fields #9-#9d with the secondary insurance information. (See Note)(1)
12.	Patient's Signature	Leave blank.
13.	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the

		policyholder requiring the provider to collect insurance benefits from the policyholder.
14-16.		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 This is a required field for all *Independent Laboratories and Independent Radiology Groups* and physicians with a specialty of 30 for radiology/radiation therapy. .
**17a.	Other ID	Enter ID, and the MO HealthNet legacy number of the provider. *Required for independent laboratory and radiology providers and physicians with a specialty of 30 for radiology/radiation therapy*
**17b.	NPI	Enter the NPI of referring, ordering, or supervising provider.
**18.	Hospitalization Dates Related to Current Services	*This field is required if the place of service is "21," Inpatient Hospital.* Show the actual admission and discharge dates for the stay as for any other patient. Donor Services: Enter the date of admission for the marrow harvest or stem cell recruitment (procedure code 38230); donor hepatectomy (procedure code 47133); OR donor nephrectomy (procedure code 50320) thru the date of discharge.
19.	Reserved for Local Use	Use this field to draw attention to attachments, for example, operative notes,

	TPL denial, etc. If the claim is for services provided to an actual donor or potential donor, the donor's name and their relationship to participant *must* be supplied here (e.g., John Doe, potential donor, brother to Jim Doe or Sarah Doe, actual donor, sister to Jim Doe or Anonymous 010101010 actual donor to Jim Doe). Donor claims are *not* processed without this information.
**20. Outside Lab	*If billing for laboratory charge, mark* the *appropriate box*. If lab work is referred out, these services may *not* be billed by the referring provider.
*21. Diagnosis or Nature of Illness or Injury	Enter the complete ICD diagnosis code. For transplant patients this is usually the illness that affected the need for the transplant. Additional diagnoses may be entered by number 2, 3, and 4. The following diagnosis codes *MUST* BE USED when billing for donor services: Z52001—Stem Cell Donor Z52011 – Autologous Stem Cell Donor Z52091 – Other blood Stem Cell Donor Z523—Bone Marrow Donor Z524—Kidney Donor Z526—Liver Donor Z5289—Other Specified Organ or Tissue Z005—Potential Donor (Organ or Tissue)
**22. MO HealthNet 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	Leave blank.
*24a. Dates of Service	Enter the date of service under "from" in month/day/year format, using six-digit format. All line items *must* have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. 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. **When billing the transplant surgery, enter the actual date of surgery. No more than six line items may be billed per claim.
*24b. Place of Service	Valid place of service (POS) codes for transplant related claims. 11 Office, Community Health Centers 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room-Hospital 65 End Stage Renal Disease Treatment Facility 81 Independent Laboratory When billing for services in an outpatient hospital *clinic* setting, use POS "11," office.
*24c. EMG-Emergency	Enter the appropriate emergency code Y—emergency N—*not* an emergency

*24d. Procedures, Services, or Supplies	Enter the appropriate CPT or other HCPCS procedure codes corresponding to the services rendered. When billing for the transplant surgery or donor excision, use the appropriate code. NOTE: All surgical procedures require a copy of the operative report. Anesthesia procedures may be documented by the anesthesia chart(s).
*24e. Diagnosis Pointer	Enter 1, 2, 3, 4, or the actual diagnosis code(s) from Field #21.
*24f. Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
*24g. Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. When inpatient hospital visits (procedure codes 99231-99233) are performed on *consecutive* days, enter the total number of days corresponding to the number of days shown in Field #24A (Date of Service). NOTE: Routine post-op care (wound check, etc.) by the transplant surgeon is included in the reimbursement for the surgery when the global surgery is billed. When billing for anesthesia services, *the total number of minutes of anesthesia must* be entered in this field.
**24h. EPSDT/Family Planning	If the service is an HCY/EPSDT screening service or referral, enter "E".
24i. ID Qualifier	Enter ID in the shaded area of Field #24i. The ID# of the rendering provider is reported in the shaded area of Field #24j.

24j. Rendering Provider ID	*The individual rendering the service is reported in Field #24j. See instructions in Field #24i.* *This field is required for a clinic, teaching institution, or group practice only.*
25. Federal Tax I.D. Number/SS#	Leave blank.
26. Patient's Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Accept assignment	Not required on MO HealthNet claims.
*28. Total Charge	Enter the sum of the line item charges.
29. Amount Paid	Enter the total amount paid by all other health insurance resources. Previous MO HealthNet payments, Medicare payments and cost sharing and copay amounts are *not* to be entered in this field.
30. Balance Due	Enter the difference between the total charge (Field #28) and the insurance amount paid (Field #29).
31. Signature of Physician	Not required.
**32. Name and Address of Facility	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 Inpatient Hospital (21).
**32a. NPI#	Enter the 10-digit NPI of the service facility location in Field # 32.
**32b. Other ID#	Enter the MO HealthNet legacy number.
*33. Provider Name/Number/Address	Enter provider's name, telephone number and address.
**33a. NPI#	Enter the NPI of the billing provider in Field #33.
**33b. Other ID#	Enter the MO HealthNet legacy number.

* These fields are mandatory on *all* CMS-1500 claim forms.
** These fields are mandatory only in specific situations, as described.
(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.

15.7 REVENUE CODES—ACCOMMODATIONS

Reference the covered and noncovered revenue codes shown in Section 19 of the Hospital Manual.

15.9 INSURANCE COVERAGE

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Divisions' participant file. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use 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 or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PARTICIPANT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual, Third Party Liability.

15.10 DONATED FUNDS

Refer to Section 12.1 for information regarding donated funds

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SECTION 16—MEDICARE/MEDICAID CROSSOVER CLAIMS

16.1 GENERAL INFORMATION

Refer to Section 16 of the Physician's manual or Section 16 of the Hospital Manual for information on Medicare/Medicaid claims information.

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~~SECTION 17-CLAIMS DISPOSITION~~

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SECTION 18 - DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field on the claim form. The accuracy of the code that describes the participant's condition is important.

The physician's letter to MO HealthNet Division requesting prior authorization for the transplant *must* include a written description of the diagnosis.

Diagnosis codes *must* be entered on the claim form exactly as they appear in the current ICD coding manual. ICD diagnosis codes have between 3 and 7 characters depending upon the patient's diagnosis. Codes with three characters are included in ICD as a heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th and 6th characters. Digits 4-6 provide greater detail of etiology, anatomical site, and severity. A code using only the first three digits is to be used only if it is not further subdivided.

A code is invalid if it has not been coded to the full number of characters required. This does not mean that all ICD codes must have 7 characters. The 7th character is only used in certain chapters to provide data about the characteristic of the encounter. Examples of where the 7th character can be used include injuries and fractures.

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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.

The CPT and HCPCS books may be purchased at any medical bookstore.

19.1 CPT CODES

Except for those circumstances wherein specific reference is made to certain CPT procedure codes throughout the manual, lists of CPT procedure codes are *not* being reproduced in this section.

The professional services of physicians, anesthesiologists, CRNAs/AAs, etc., are *not* to be billed on the UB-04, but instead are to be billed by the hospital (or physician) on the CMS-1500.

A copy of the *Physician's Current Procedural Terminology (CPT)* may be purchased by writing to the following address:

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: (800) 621-8335
Fax Orders: (312) 464-5600

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SECTION 20-EXCEPTION PROCESS

20.1 EXCEPTION PRINCIPLE

Under certain conditions of medical need, the MO HealthNet Division may authorize payment for a MO HealthNet eligible participant to receive an *essential* medical service or item of equipment that otherwise exceeds the benefits and limitations of any one of the various medical service programs administered by the Division. Under specific criteria and on a case-by-case basis, an administrative exception may be made to limitations and restrictions set by agency policy. No exception can be made where requested items or services are restricted or specifically prohibited by state or federal law or regulation, or excluded under the restrictions section of this rule. The director of the MO HealthNet Division has the final authority to approve payment on a request made to the exception process. These decisions are made with appropriate medical or pharmaceutical advice and consultation.

With the exception of group 2 and group 3 pressure reducing support surfaces, mattress rentals, all services for individuals under age 21 determined to be medically necessary, may be considered for coverage under the EPSDT/HCY Program. Reference Section 9 for more information. Group 2 and group 3 pressure reducing support surface, mattress rentals, *must* be approved through the Exception Process prior to being dispensed, regardless of the participant's age.

Exception requests are only accepted from authorized health care prescribers licensed as a physician or advanced practice nurse.

20.2 REQUIREMENTS

Requirements for consideration and provision of a service as an exception to the normal limitations of MO HealthNet coverage are as follows:

- A prescriber *must* certify that MO HealthNet covered treatment or items of services appropriate to the illness or condition have been determined to be medically inappropriate or have been used and found to be ineffective in treatment of the participant for whom the exception is being requested;
- While requests may be approved, documentation verifying that all third party resource benefits have been exhausted *must* accompany claims for payment before the MO HealthNet Program pays for any item or service; for example,

  —Medicare
  —Private Insurance
  —The American Diabetes Society
  —The Veterans Administration

—The American Cancer Society
—A United Way Agency;

Except in the case of retroactive MO HealthNet eligibility determination, requests *must* be submitted prior to delivery of the service. Do *not* wait until after receipt of documentation of noncoverage from an alternative payor to submit the completed Exception Request form.

- Any requested medical, surgical or diagnostic service which is to be provided under the authority of the treating prescriber, *must* be listed in the most recent publication of *A Comprehensive Guide to Current Procedural Terminology,* (CPT) or the CMS-approved list of HCPCS codes. The CPT and HCPCS books may be purchased at any medical bookstore;
- Any individual for whom an exception request is made *must* be eligible for MO HealthNet on the date the item or service is provided. If requested, approval may be granted in the case of retroactive MO HealthNet eligibility determinations.
- The provider of the service *must* be an enrolled provider in the MO HealthNet Program on the date the item or service is provided;
- The item or service for which an exception is requested *must* be of a type and nature that falls within the broad scope of a medical discipline included in the MO HealthNet Program and does *not* represent a departure from the accepted standards and precepts of good medical practice. *No* consideration can be given to requests for experimental therapies or services;
- All requests for exception consideration *must* be initiated by the treating prescriber of an eligible participant and *must* be submitted as prescribed by policy of the MO HealthNet Division, 13 CSR 70-2.100;
- Requests for exception consideration *must* support and demonstrate that one (1) or more of the following conditions is met:
    1. The item or service is required to sustain the participant's life;
    2. The item or service would substantially improve the quality of life for a terminally ill patient;
    3. The item or service is necessary as a replacement due to an act occasioned by violence of nature without human interference, such as a tornado or flood; or
    4. The item or service is necessary to prevent a higher level of care.
- All requests *must* be made and approval granted before the requested item or service is provided. An exception to that requirement may be granted in cases in which the participant's eligibility for MO HealthNet is retroactively established or when emergency circumstances preclude the use of the established procedures for submitting a request, and a

request is received *not* more than one (1) state working day following the provision of the service.

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

- All exception requests *must* represent cost-effective utilization of MO HealthNet funds. When an exception item or service is presented as an alternative, lesser level-of-care than the level otherwise necessary, the exception *must* be less program costly; and
- Reimbursement of services and items approved under this exception procedure shall be made in accordance with the MO HealthNet established fee schedules or rates for the same or comparable services. For those services for which no MO HealthNet-established fee schedule or rate is applicable, reimbursement is determined by the state agency considering costs and charges.

20.3 RESTRICTIONS

The following are examples of types of requests that are *not* considered for approval as an exception. This is *not* an all-inclusive list:

- Requests for restricted program areas. Refer to Section 1 for a list of restricted program areas.
- Requests for expanded HCY/EPSDT services (individuals under age 21). These should be directed to the HCY/EPSDT coordinator. (Reference manual Section 9).

- Requests for orthodontic services;
- Requests for inpatient hospital services;
- Requests for alternative services (Personal Care, Adult Day Health Care, AIDS Waiver, Aged and Disabled Waiver, Hospice, and Respite Care) regardless of authorization by the Missouri Department of Health and Senior Services;
- Requests for chiropractic services;
- Requests for services that are provided by individuals whose specialty is *not* covered by the MO HealthNet Program;
- Requests for psychological testing or counseling *not* otherwise covered by the MO HealthNet Program;
- Requests for waiver of program requirements for documentation, applicable to services requiring a second surgical opinion, hysterectomy, voluntary sterilizations, and legal abortions;
- Requests for drug products excluded from coverage by the MO HealthNet Program;
- Requests relating to the failure to obtain prior authorization or pre-certification as required for a service otherwise covered by MO HealthNet;
- Requests for payment of dentures and/or partials placed after the participant is ineligible when fabrication occurred prior to that time;
- Requests for delivery or placement of any custom-made items following the participant's death or loss of eligibility for the service;
- Requests for removal from the Lock-In or Prepaid Health Programs;
- Requests for additional reimbursement for items or services otherwise covered by the MO HealthNet Program;
- Requests for air ambulance transportation;
- Requests for Qualified Medicare Beneficiary (QMB) services;
- Requests for MO HealthNet Waiver services such as AIDS Waiver;
- Requests for services exceeding the limits of the Transplant Program;
- Requests for services exceeding the limits of the regular MO HealthNet Program.

20.4 REQUESTING AN EXCEPTION

All Exception Request forms *must* be signed by the treating prescriber of an eligible participant. The requests are to be submitted to the Exceptions Unit. This unit processes the request, obtains a decision from the appropriate medical or pharmaceutical consultant and/or administrative official,

and informs the treating prescriber, provider of service, and participant of all approved decisions. In the event of a denial, only the prescriber and participant are notified.

There are two categories of exception request—emergency and nonemergency, each of which are processed differently.

20.4.A LIFE-THREATENING EMERGENCY EXCEPTION REQUESTS

Requests for life-threatening emergencies may be submitted by the treating prescriber by calling the toll-free number (800) 392-8030. The office hours for the Exceptions Unit are from 8:00 A.M. to 5:00 P.M. Monday through Friday, except on observed holidays. All other provider inquiries regarding covered program benefits *must* be directed the Provider Communications Unit at (573) 751-2896.

The treating prescriber *must* provide Exceptions Unit personnel with information consistent with that required on the Exception Request form. The request is processed within one (1) state working day with notification of approval communicated by fax to the provider of service. If the request is denied, the prescriber is notified within one (1) state working day.

20.4.B NON-EMERGENCY EXCEPTION REQUESTS

In order to ensure access to the Exceptions Unit for life-threatening emergency requests, all non-emergency requests *must* be submitted on an Exception Request form. Requests may be faxed to (573) 522-3061.

Non-emergency requests may also be submitted by mailing to:

MO HealthNet Division
Exceptions Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Upon receipt, the MO HealthNet Division processes these requests within 15 state business working days, with notification letters being sent to the prescriber and participant. If approval is given, the provider of service also receives written notification.

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SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

Adult Day Health Care
Aged and Disabled Waiver
Ambulance
Ambulatory Surgical Centers
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
ID/DD Waiver
Nurse Midwife
Optical
Pharmacy
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

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SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant

	cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.
Basic/Urban/ Rural Counties	As defined in 20 CSR, the following counties are categorized as: • Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City; • Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney; • Rural – All other counties.
Broker	Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.
Call Abandonment	Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Call Wait Time	Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Clean Claim	A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.
Complaint	A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.
DCN	Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.
Denial Reason	The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: • Non-covered Service

- Lack of Day's Notice
- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some

	unauthorized benefit to the entity, himself/herself, or some other person.
Free Transportation	Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Grievance (Participant)	A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are *not* limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker's personnel, or failure to respect the participant's rights.
Grievance (Transportation Provider)	A written request for further review of a transportation provider's complaint that remains unresolved after completion of the complaint process.
Inquiry	A request from a transportation provider regarding information that would clarify broker's policies and procedures, or any aspect of broker function that may be in question.
Most Appropriate	The mode of transportation that accommodates the participant's physical, mental, or medical condition.
MO HealthNet Covered Services	Covered services under the MO HealthNet program.
Medically Necessary	Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could *not* have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services *must* be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Medical Service Provider	An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans

	Administration or Shriners Hospital.
NEMT Services	Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does *not* include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.
No Vehicle Available	Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All "no vehicle available" trips shall be reported as denials in the category of no vehicle available.
Participant	A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.
Pick-up Time	The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.
Public Entity	State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.
Transportation Provider	Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.
Urgent	A serious, but *not* life threatening illness/injury. Examples include, but are *not* limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do *not* require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant's medical provider.

Will Call	An unscheduled pick-up time when the participant calls the broker or transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.

If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
    a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. Urban-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. Basic-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. Rural-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

TRAVEL STANDARDS: MAXIMUM MILEAGE

Provider/Service Type	**Urban Access County**	**Basic Access County**	**Rural Access County**
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100

Infectious Disease	25	50	100
Nephrology	25	50	100
Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100

Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45
Residential mental health treatment providers	20	30	50
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care.

The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:

- Participant eligibility; and
- MO HealthNet covered service.

22.7 COPAYMENTS

The participant is required to pay a $2.00 copayment for transportation services. The $2.00 is charged regardless if the trip is a single destination trip, a round trip, or a multiple destination trip. The broker *cannot* deny transportation services because a participant is unable to pay the copay. The copay does *not* apply for public transportation or bus tokens, or for participant's receiving gas reimbursement. The following individuals are exempt from the copayment requirements:

1. Children under the age of 19;
2. Persons receiving MO HealthNet under a category of assistance for pregnant women or the blind:
   - 03 - Aid to the blind;
   - 12 - MO HealthNet-Aid to the blind; and
   - 15 - Supplemental Nursing Care-Aid to the blind;
   - 18 - MO HealthNet for pregnant women;
   - 43 - Pregnant women-60 day assistance;
   - 44 - Pregnant women-60 day assistance-poverty;
   - 45 - Pregnant women-poverty; and
   - 61 - MO HealthNet for pregnant women-Health Initiative Fund;
3. Residents of a skilled nursing facility, intermediate care nursing home, residential care home, adult boarding home, or psychiatric hospital;
4. Participants receiving NEMT services for CSTAR and CPR under DMH,
5. Foster care participants, and
6. Participant's attendant.

A participant's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the participant's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

If it is the routine business practice of a transportation provider to discontinue future services to an individual with uncollected debt, the transportation provider may include uncollected co-payments under this practice. However, a transportation provider shall give a MO HealthNet participant a

reasonable opportunity to pay an uncollected co-payment. If a transportation provider is *not* willing to provide services to a MO HealthNet participant with uncollected co-payment, the transportation provider *must* give the participant advance notice and a reasonable opportunity to arrange care with a different transportation provider before services can be discontinued.

22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that LogistiCare provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist LogistiCare by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;
- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.

3. **Kansas City Area Transit Authority/Share-A-Fare Program (KCATA)** Share-A-Fare provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.
4. **Bi-State Development Call-A-Ride** Call-A-Ride provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **Jefferson City Transit System, Handi-Wheels** Handi-Wheels is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Handi-Wheels is provided to all eligible individuals with disability without priority given for trip purpose. Handi-Wheels is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada Regional Medical Center (NRMC)** NRMC transports individuals who live within a 20 mile radius of Nevada.
8. **City of Columbia, Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;
2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a

transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

LogistiCare Solutions, LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.
2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

LogistiCare Solutions LLC
1807 Park 270 Drive, Suite 518
St. Louis, MO 63146

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a LogistiCare facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the LogistiCare facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, LogistiCare will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to LogistiCare.
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform LogistiCare of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.
6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to LogistiCare so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of

charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the LogistiCare Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A LogistiCare Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not be available, LogistiCare will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by LogistiCare.
3. LogistiCare will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice LogistiCare along with a copy of the LogistiCare Authorized Ancillary Services Form for the meals to LogistiCare MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.

5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the LogistiCare Facility Department, 1807 Park 270 Drive, St. Louis, MO 63146. They must reference the Job number and date of service on the receipt for reimbursement. The Job number or confirmation number is found on the authorization form faxed to the requesting facility.
6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (Job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR line. The LogistiCare staff determines where the driver is and ensures the participant is transported.
2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. LogistiCare's QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any LogistiCare representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.
2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call LogistiCare at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All LogistiCare-approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, LogistiCare's Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for LogistiCare.

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a LogistiCare Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive

more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a LogistiCare window decal is applied to the vehicle. This provides for a quick visual identification of a LogistiCare approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to LogistiCare through the WMR line referenced above. For reoccurring issues, the LogistiCare Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. LogistiCare will attempt to schedule transport with the preferred provider; however LogistiCare is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. LogistiCare will investigate any incident causing such a request.

END OF SECTION

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SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Certificate of Medical Necessity **(only for the Durable Medical Equipment Program)**

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102

These attachments may also be submitted to Wipro Infocrossing via the Internet when additional documentation is *not* required. The web site address for these submissions is www.emomed.com.

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

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