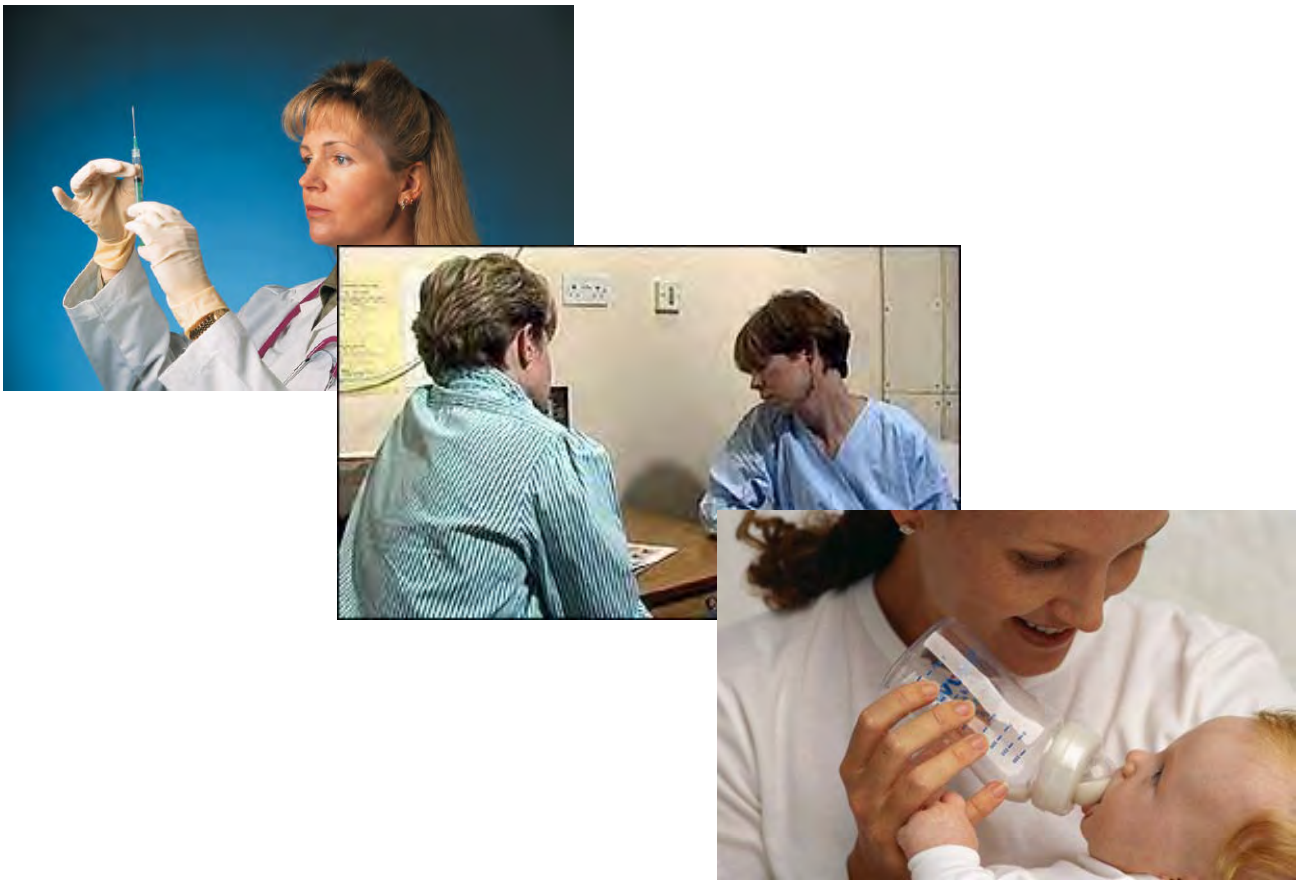
Local Public Health Agency Billing Book



Published by the Provider Education Unit
MO HealthNet Division

PREFACE

The MO HealthNet *Local Health Department Billing Book* contains information to help local public health agencies/departments submit claims correctly to the MO HealthNet program. The book is not all inclusive of program benefits and limitations. Providers should refer to specific program manuals for complete information.

TABLE OF CONTENTS

Section	1.	MO HealthNet Program Resources
Section	2.	CMS-1500 Claim Filing Instructions
Section	3.	Injection (Pharmacy) Claim Filing Instructions
Section	4.	The Remittance Advice
Section	5.	Adjustments & Resubmissions
Section	6.	Healthy Children and Youth Program
Section	7.	Family Planning Services
Section	8.	DHSS WIC Program
Section	9.	Local Public Health Departments and Managed Care Health Plans
Section	10.	Case Management
Section	11.	SAFE/CARE Examinations
Section	12.	Laboratory Services
Section	13.	Environmental Lead Assessment
Section	14.	Resource Publications for Local Health Departments
Section	15.	Participant Liability Nondiscrimination Policy Statement

SECTION 1
MO HealthNet PROGRAM RESOURCES

CONTACTING MO HealthNet

PROVIDER COMMUNICATIONS
(573) 751-2896

The following phone number is available for MO HealthNet providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

Provider Communications (573) 751-2896

When you call the (573) 751-2896 number, you are transferred automatically to the IVR (interactive voice response). Anytime during the IVR options, you may select "0" to speak to the next available specialist. Your call will be put into a queue and will be answered in the order it was received.

Providers may send and receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk staff. This application is available through the MO HealthNet web portal page at emomed.com. Once logged in and on the eProvider/Welcome to eProvider page, click on “Provider Communications Management.” This opens the "Manage Provider Communications” page. Click on “New Request” to access the “Create new Request” form. Providers are limited to one inquiry per E-mail. The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry.

The Provider Communications Unit also processes written inquiries. Written inquiries should be sent to:

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

The interactive voice response (IVR) system also addresses participant eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR.

WIPRO INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK
(573) 635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Wipro Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers are required to notify Missouri Medicaid Audit Compliance, Provider Enrollment Section regarding changes to their Provider Master File. Changes include, but are not limited to, physical address, tax identification, ownership, individual's name or practice name, or NPI number.

Changes may be reported via E-mail at mmac.providerenrollment@dss.mo.gov or by mail to:

Missouri Medicaid Audit and Compliance
Provider Enrollment Section
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

(573) 751-2005

Call the Third Party Liability Unit to report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MO HealthNet participant.

PROVIDER EDUCATION

(573) 751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods, policies and procedures for MO HealthNet claims. Contact the Unit for training information and scheduling. You may also send an E-mail to the unit at mhd.provtrain@dss.mo.gov.

PARTICIPANT SERVICES

(800) 392-2161 or (573) 751-6527

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MO HEALTHNET PHARMACY AND MEDICAL PRE-CERTIFICATION HELP DESK

(800) 392-8030

Providers can call this toll free number to: request a pre-certification for a radiological procedure (MRI, MRA, CT, CTA, PET, ultrasound and cardiac imaging studies); to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program; to request information on Medicare Part D; or, to request a drug prior authorization. The MO HealthNet fax line for non-emergency service or equipment exception requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470. Do **not** use either of these numbers for requests for pre-certifications of MRI, MRA, CT, CTA, PET, ultrasound and cardiac imaging studies procedures.

MHD has implemented pre-certification for certain radiological procedures. In order for providers to be reimbursed for these services, the participant must meet certain medical criteria and the physician must obtain the pre-certification for the procedure unless performed in an inpatient hospital or emergency room setting.

The list of medical imaging procedures and durable medical equipment and supplies that currently require pre-certification along with the related medical criteria can be referenced at the MO HealthNet web site dss.mo.gov/mhd/cs/medprecert/pages/medprecert.htm.

Providers are encouraged to sign up for the MO HealthNet web tool – **CyberAccess** – which automates the pre-certification process. To become a CyberAccess user, contact the Xerox Care and Quality Solutions, Inc. help desk at 1-888-581-9797 or 573-632-9797, or send an e-mail to cyberacesshelpdesk@xerox.com . The CyberAccess tool allows each request for pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and CPT procedure codes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the *HIPAA-EDI Companion Guide* online by going to the MO HealthNet Division web page at dss.mo.gov/mhd and clicking on the "Providers" link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the right hand side of the page. This will take you directly to the EDI Companion Guide.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Wipro Infocrossing Healthcare Services Help Desk, (573) 635-3559.

INTERACTIVE VOICE RESPONSE (IVR) (573) 751-2896

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 751-2896 requires a touchtone phone. The ten-digit MO HealthNet National Provider Identifier **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 0 — Provides access to a MO HealthNet phone specialist
If all the specialists are busy with other calls, the caller is put into a queue until the next specialist is available. Calls are taken in the order in which they are received. Callers selecting this option are limited to three inquiries per call. Limiting the number of inquiries to three allows communications specialists to respond to more provider calls.

Option 1 Participant Eligibility

Participant eligibility **must** be verified **each** time a participant presents and should be verified **prior** to the service. Eligibility information can be obtained by a participant's MO HealthNet number (DCN), social security number and date of birth, or if a newborn, using the mother's MO HealthNet number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status

After entering the participant's MO HealthNet number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MO HEALTHNET PROVIDERS

The MO HealthNet Division, in cooperation with Wipro Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers, emomed.com. MO HealthNet providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify participant eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The web site address for this service is emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved

to be electronic billers can enroll and utilize the web site services. To participate in the service, the provider must apply online at dss.mo.gov/mhd/providers/.

Each user is required to complete this online application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the emomed.com web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Wipro Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This web site, emomed.com, allows for the submission of the following HIPAA compliant transactions.

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated.

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET

Providers can access MO HealthNet participant eligibility files via the web site. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MO HealthNet CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

837 - Health Care Claim
Professional
Dental
Institutional (hospital inpatient and outpatient, nursing home, and home health care)
Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

Note – Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Wipro Infocrossing Internet web service: Sterilization Consent, Acknowledgement of Receipt of Hysterectomy Information, the PI-118 Referral (Lock-In) forms, Certificate of Medical Necessity or the Invoice of Cost.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The MO HealthNet program discontinued the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. All providers and billers must have Internet access to obtain the printable electronic RA via the Wipro Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to MO HealthNet. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Wipro Infocrossing Internet service.

Sterilization Consent,
PI 118 Referral (administrative lock-in)
Acknowledgment of Receipt of Hysterectomy Information
Certificate of Medical Necessity
Invoice of Cost

MO HealthNet PROVIDER MANUALS AND BULLETINS ONLINE dss.mo.gov/mhd/providers

MO HealthNet provider manuals are available online at the MHD web site, dss.mo.gov/mhd/providers. Scroll to the bottom of the Provider Participation page and click on the "Provider Manuals" link. The next page displays a State of Missouri MO HealthNet web portal page with an alphabetical listing of the MO HealthNet provider manuals. Click on the appropriate manual link and when it opens, choose the section you want to view. The entire section, portions of a section or the current page displayed can be printed using the print feature on the computer toolbar.

MO HealthNet provider bulletins are also available at the MO HealthNet web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear online at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIM PROCESSING SCHEDULE FOR FISCAL YEAR 2014

FINANCIAL CYCLE DATE**		PROVIDER CHECK DATE	
Friday	06/21/2013	Friday	07/05/2013
Friday	07/12/2013	Friday	07/19/2013
Friday	07/26/2013	Tuesday	08/06/2013
Friday	08/16/2013	Friday	08/23/2013
Friday	08/30/2013	Tuesday	09/10/2013
Friday	09/13/2013	Tuesday	09/24/2013
Friday	09/27/2013	Monday	10/07/2013
Friday	10/11/2013	Tuesday	10/22/2013
Friday	10/25/2013	Tuesday	11/05/2013
Friday	11/08/2013	Wednesday	11/20/2013
Friday	11/22/2013	Thursday	12/05/2013
Friday	12/13/2013	Friday	12/20/2013
Friday	12/27/2013	Tuesday	01/07/2014
Friday	01/10/2014	Thursday	01/23/2014
Friday	01/24/2014	Wednesday	02/05/2014
Friday	02/07/2014	Thursday	02/20/2014
Friday	02/21/2014	Wednesday	03/05/2014
Friday	03/07/2014	Thursday	03/20/2014
Friday	03/21/2014	Friday	04/04/2014
Friday	04/04/2014	Friday	04/18/2014
Friday	04/18/2014	Friday	05/02/2014
Friday	05/09/2014	Friday	05/16/2014
Friday	05/23/2014	Thursday	06/05/2014
Friday	06/06/2014	Friday	06/20/2014

****Closeout is 5:00 p.m. on the date shown**

State Holidays

July 4, 2013 Independence Day

September 2, 2013 Labor Day

October 14, 2013 Columbus Day

November 11, 2013 Veteran's Day

November 28, 2013 Thanksgiving Day

December 25, 2013 Christmas Day

January 1, 2014 New Year's Day

January 20, 2014 Martin Luther King's Birthday

February 12, 2014 Lincoln's Birthday

February 17, 2014 Washington's Birthday

May 8, 2014 Truman's Birthday

May 26, 2014 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

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

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 and 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.
1a.*	Insured's I.D.	Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the patient's ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

Field number and name		Instructions for completion
6.**	Patient Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient 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. If no private insurance is involved, leave blank. [See Note (1)]
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. If no private insurance is involved, leave blank. [See Note (1)]
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.**	Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.**	Insurance Plan Name or Program Name.	Enter the secondary policyholder's insurance plan or program name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
10a.-10c.**	Is Patient's Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. **If the services are not related to an accident, leave blank.** [See Note (1)]

Field number and name	Instructions for completion
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or FECA 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. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box for the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name or Program Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any 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.

Field number and name		Instructions for completion
14.**	Date of Current Illness, Injury or Pregnancy	*This field is required when billing global prenatal, global OB and delivery services*. The date should reflect the last menstrual period (LMP).
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.**	Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1) referring provider; 2) ordering provider; or, 3) supervising provider. If the physician is nonparticipating in the MO HealthNet program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).*
17a.**	Other ID	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in 17b. *This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).*
17b.**	NPI	Enter the NPI number of the referring, ordering or supervising provider *This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).*

Field number and name	Instructions for completion
18.** Hospitalization Dates	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required if services were provided in an inpatient hospital setting.
19. Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
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 Number	Leave blank**.**
24a.* Date of Service	Enter the date of service under “from” in the month/day/year format using the six digit format in the unshaded area of the field. 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 is shaded and is the location for reporting supplemental information. It is **not** intended to allow the billing of 12 lines of service.

Field number and name	Instructions for completion
24b.* Place of Service	Enter the appropriate place of service code in the unshaded area of the field. See Section 15.8 of the MO HealthNet *Physician's Provider Manual* for the list of appropriate place of service codes. Place of service for local health departments is "71" when services are provided in the agency's facility/clinic.
24c. EMG-Emergency	Enter a Y in the unshaded area of the field. If this is not an emergency, leave this field blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.)
24e.* Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21 in the unshaded area of the field.
24f.* Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. 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 in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank. Anesthesia—Enter the total number of minutes of anesthesia. Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B."

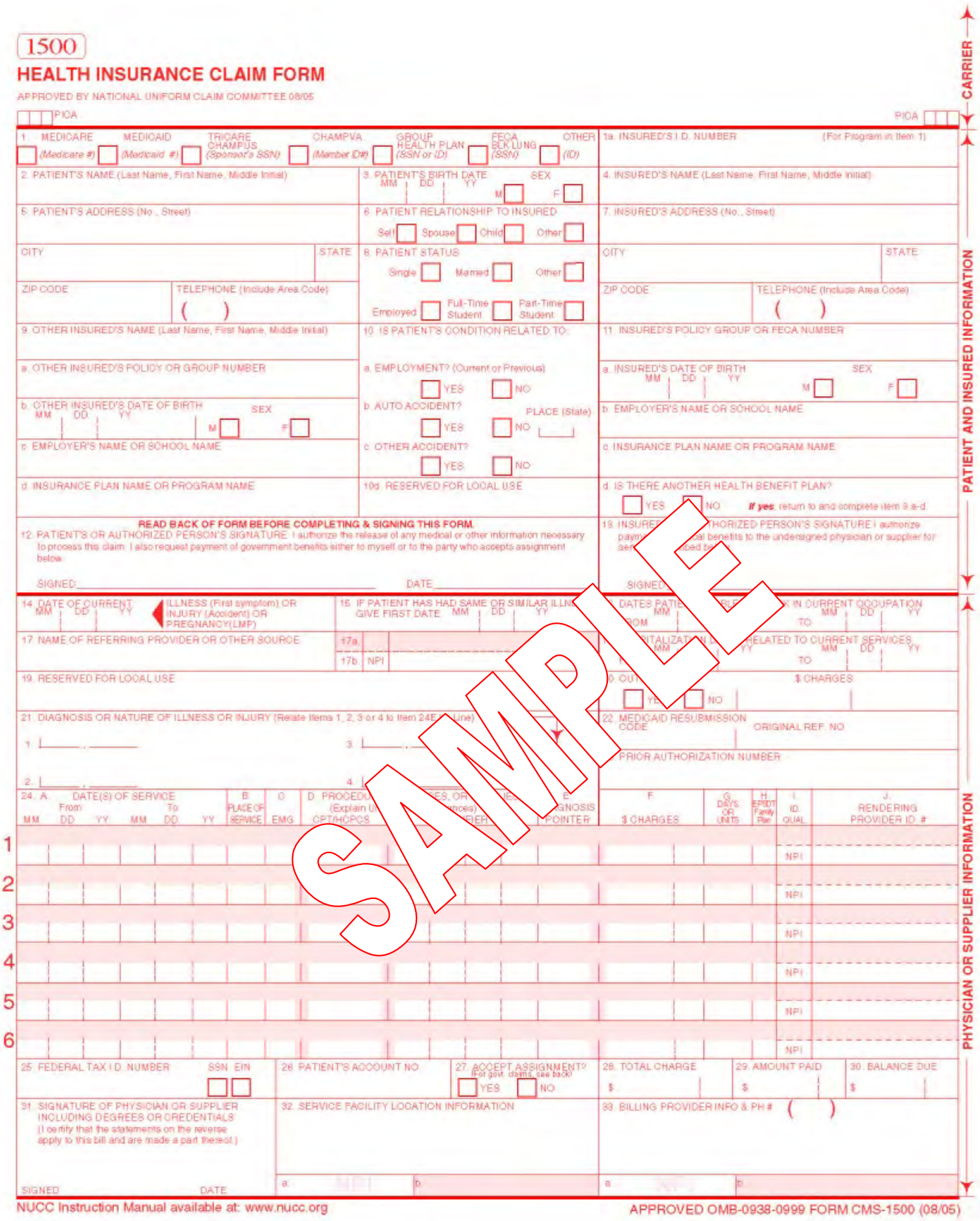
Field number and name		Instructions for completion
24i.	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the health department's rendering/performing provider is required to report a Provider Taxonomy Code to MO HealthNet.
24j.**	Rendering Provider ID	If the Provider Taxonomy qualifier was reported in 24i, enter the 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering/performing the service in the unshaded area. This should be the NPI of the health department's nurse practioner or supervising physician.
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	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 received by all other insurance resources. **Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Balance Due	Enter the difference between the total charge (field 28) and any insurance amount paid (field 29).
31.	Provider Signature	Leave blank.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or health department clinic, enter the name and location of the facility.

Field number and name	Instructions for completion
32.** Name and Address of Facility (cont.)	This field is required when the place of service is other than the home or the health department clinic.
32a.** NPI Number	Enter the 10 digit NPI number of the service facility location reported in field 32.
32b.** Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number.
33.*Provider Name/ Number/ Address	Enter the health department's name, address, and telephone number.
33a.* NPI Number	Enter the health department's NPI number.
33b.** Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 33a if the health department is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the 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 of the MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.


1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
PICA
1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student
CITY STATE
ZIP CODE TELEPHONE (Include Area Code)
ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? PLACE (State) YES NO
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? $ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 3.
2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. $ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. b.
33. BILLING PROVIDER INFO & PH #
a. b.
NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
SAMPLE

SECTION 3
PHARMACY CLAIM
FILING INSTRUCTIONS

All local health department pharmacy claims must be submitted electronically either through a clearinghouse, billing agent or the MO HealthNet Web site at emomed.com for billing and to maintain the business relationship with the MO HealthNet Division (MHD).

MANAGED CARE HEALTH PLAN PHARMACY "CARVE OUT"
Effective October 1, 2009, the MO HealthNet managed care health plans no longer provide pharmacy services for their members. Pharmacy claims for all MO HealthNet Managed Care members are processed by the MO HealthNet Fee-for-Service Pharmacy Program. Existing Fee-for-Service Pharmacy Program clinical editing parameters and Preferred Drug List criteria apply for coverage of pharmacy claims, and can be found at the following link.

http://dss.mo.gov/mhd/cs/pharmacy/pages/clinedit.htm

The carve out of pharmacy services in relation to public health departments includes all injections and birth control devices administered in the health department clinic setting. Note – injection administrations, including VFC vaccine administrations, must still be billed to the participant's managed care health plan and not MO HealthNet.

MEDICATION BILLING

The quantity to be billed for pharmacy items (e.g. birth control devices and systems) and injectable medications dispensed to MHD patients must be calculated as follows:

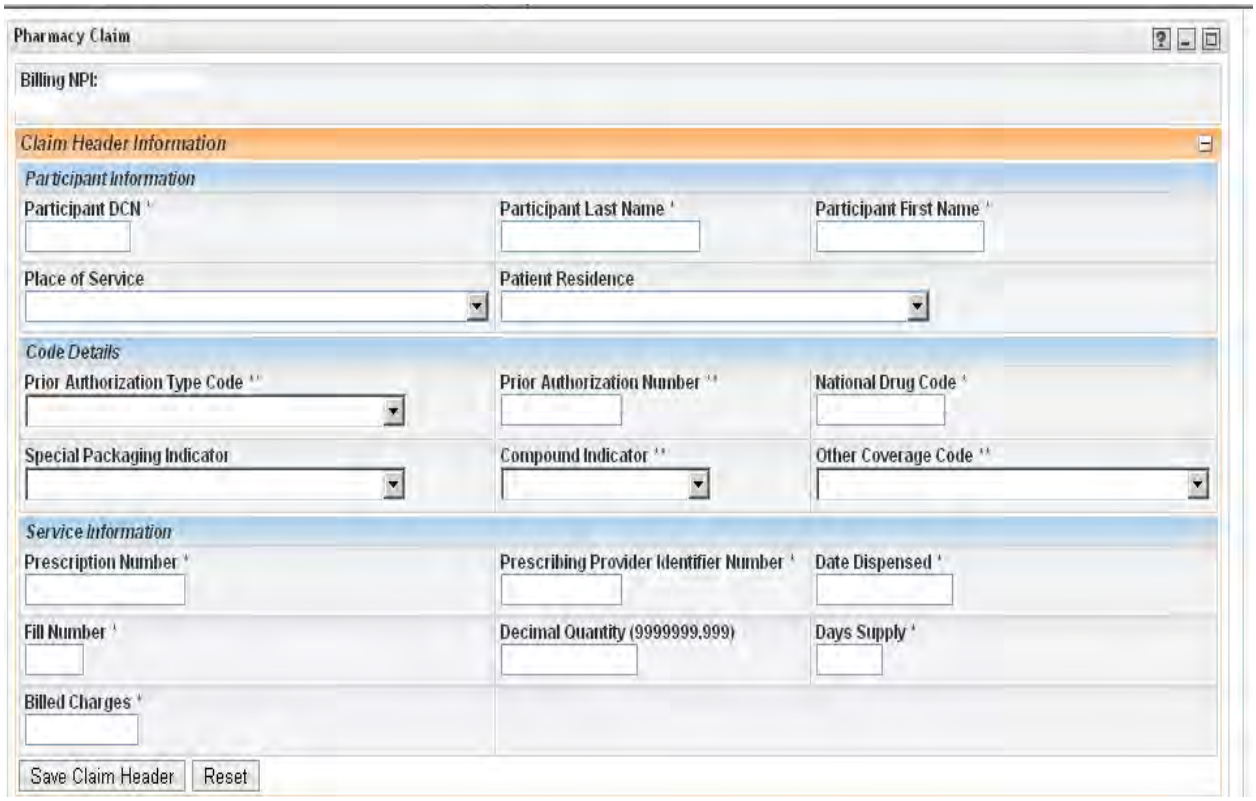
- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) must be billed by the exact cubic centimeters or milliliters (cc or ml), even if the quantity includes a decimal (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Claims billed incorrectly are identified through a dispute resolution process. When these claims are identified, providers are notified and required to file adjustments to accurately reflect the quantity dispensed.

Reimbursement for pharmacy items and injectable medications is made on the basis of the lower of the following:

1. Applicable Federal Upper Limit;
2. Applicable Missouri Maximum Allowable Cost (MAC);
3. Applicable Wholesaler Acquisition Cost (WAC), plus 10%; or,
4. Usual and customary charge.

For specific questions concerning pharmacy items and injectable medication billing, contact the Pharmacy and Clinical Services Administration Unit at (573) 751-6963.



Electronic Pharmacy Claim Form Filing Instructions

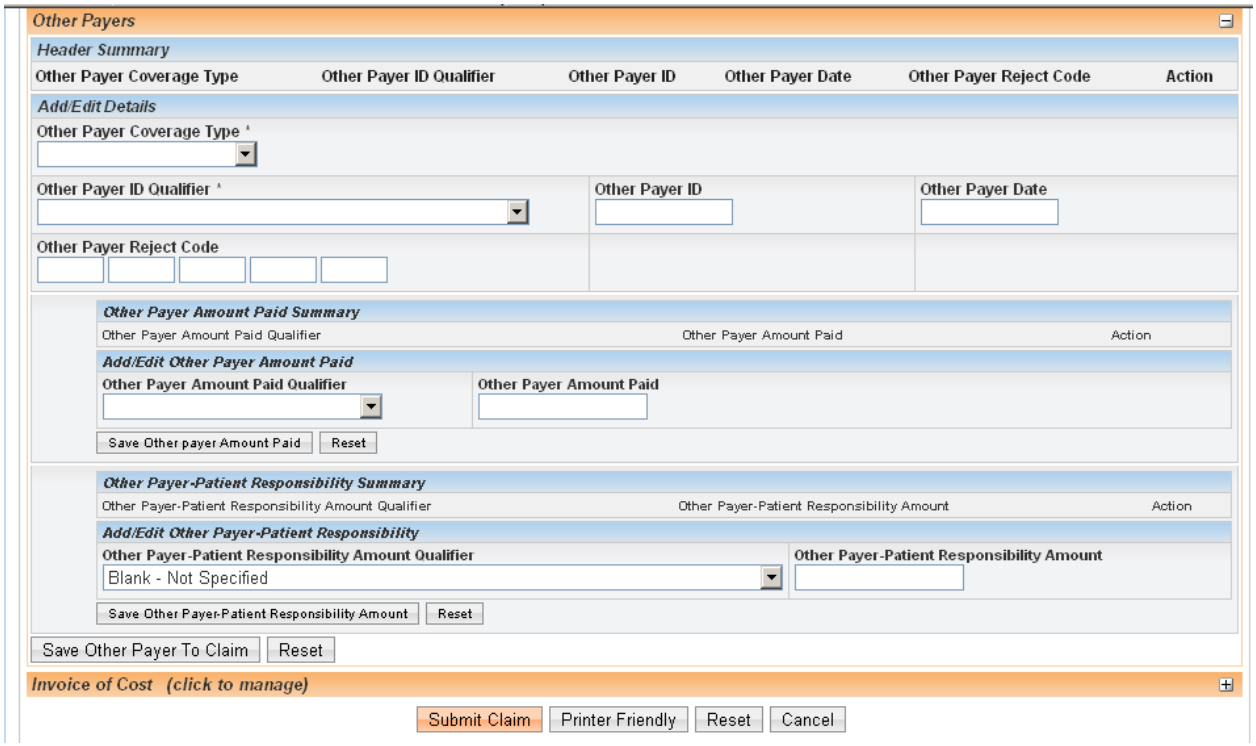
NOTE: * These fields are required on all Pharmacy claim submissions.
** These fields are required only in specific situations, as described below.
NPIs with alpha characters are case sensitive.

FIELD	INSTRUCTIONS FOR COMPLETION
Participant's DCN*	Enter the participant's eight digit MO HealthNet identification number (DCN).

FIELD	INSTRUCTIONS FOR COMPLETION
Participant's Last Name*	Enter the participant's last name.
Participant's First Name*	Enter the participant's first name.
Place of Service	Required only for pharmacy providers.
Patient Residence	Required only for pharmacy providers.
Patient Location**	Required only for pharmacy providers.
Prior Authorization Type** Code.	The valid values are: 0 Not Specified 1 Prior Authorization 2 Medical Certification 3 EPSDT 4 Exemption from Co-pay 5 Exemption from Prescription 6 Family Plan 7 AFDC 8 Payer Defined Exemption
Prior Authorization Number	Enter the Prior Authorization number, if applicable. Otherwise, leave blank.
National Drug Code	Enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
Special Packaging Indicator	Indicate the type of unit dose dispensing. The valid values are: 0 Not Specified 1 Not Unit Dose 2 Manufacturer Unit Dose 3 Pharmacy Unit Dose
Compound Indicator**	If billing for a compound drug, the first ingredient of a compound must be billed with a compound indicator of 0-First Ingredient. All other ingredients must be billed with

FIELD	INSTRUCTIONS FOR COMPLETION
	a compound indicator of 1-Additional Ingredient... Otherwise, leave blank.
Other Coverage Code**	Indicate whether the patient has a secondary health insurance plan. If so, choose the appropriate value. The valid values are: 0 Not Specified 1 No Other Coverage identified 2 Other Coverage Exists – Payment Collected 3 Other Coverage Exists – This Claim Not Covered 4 Other Coverage Exists – Payment Not Collected
Prescription Number*	Enter the number assigned by the physician's office or the clinic. Enter a sequential identification number in this field. If the billing provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injection administered on the same date of service. NOTE – This number is used to sort claims submitted electronically on the pharmacy remittance pages.
Prescribing Provider Identifier Number*`	Enter the prescribing provider's NPI
Date Dispensed*	Enter the date the drug was dispensed or administered.
Fill Number*	The code indicating whether the prescription is an original or a refill. Enter a two-digit value. 00 = Original dispensing, 01-99 = Refill number
Decimal Quantity*	Enter the decimal quantity dispensed or used in Administration. Note- Use the guidelines outlined on page 3.1 of this billing booklet, titled Medication Billing.
Day's supply*	Enter the estimated duration of the prescription supply in days. **If billing for an administration in a physician's office/clinic, the value must always be 1**
Billed Charges*	Enter the charge for this medication.
Save Claim Header (button)	Click Save Claim Header to save the Pharmacy Claim Header information.

Pharmacy Other Payer Attachment



FIELD	INSTRUCTIONS FOR COMPLETION
Other Payer Coverage Type*	Determines the order in which the claim was paid by other payers
Other Payer ID Qualifier*	Choose from the options that best describes the Other Payer, options are: 01 National Payer ID 1C Medicare Number 1D Medicare Number 02 Health Industry Number (HIN) 03 Bank Information Number (BIN) 04 National Association of Insurance Commissioners (NAIC) 05 Medicare Carrier Number 99 Other
Other Payer ID	Determines the ID of prior payers, not a required field
Other Payer Date	The date prior payer processed the claim, not a required field

FIELD	INSTRUCTIONS FOR COMPLETION
Other Payer Reject code	Indicate the reason the prior payer did not pay the claim. Up to 5 reject codes can be entered. This field will be required if the Other Coverage Code is populated with 3 Other Coverage Exists- This Claim Not Covered. A list of NCPDP reject codes can be located on pages 3.8 and 3.9 of this training booklet.
Other Payer Amount Paid Qualifier	Indicates the type of payment made by a prior payer. This is a required field if other payer amount paid is populated for the corresponding occurrence. The options are: 01 Delivery 02 Shipping 03 Postage 04 Administrative 05 Incentive 06 Cognitive Service 07 Drug Benefit 09 Compound Preparation Cost **Note: Only the Other Payer Amount Paid Qualifier value of 07- Drug Benefit will be used to determine the Third Party Liability amount that will be considered for payment.**
Other Payer Amount Paid	Indicated the amount paid by a prior payer. This is a required field if the Other Coverage Code is populated with 2 or 4.
Save Other Payer Amount Paid (button)	Click to Save Other Payer Amount Paid
Patient Responsibility Amount Qualifier	The type of patient responsibility amount returned by prior payer. This is required if Other Payer Patient Responsibility Amount is populated. The options are: 01 Amount Applied to Periodic Deductible 02 Amount Attributed to Product Selection/Brand Drug 03 Amount Attributed to Sales Tax 04 Amount Exceeding Periodic Benefit Maximum 05 Amount of Copay 06 Patient Pay Amount 07 Amount of Coinsurance

FIELD	INSTRUCTIONS FOR COMPLETION
	08 Amount Attributed to Product Selections/Non-Preferred Formulary Selection 09 Amount Attributed to Health Plan Assistance Amount 10 Amount Attributed to Provider Network Selection 11 Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12 Amount Attributed to Coverage Gap 13 Amount Attributed to Processor Fee **Note: Only the Patient Responsibility Amount Qualifier value of 06- Patient Pay Amount will be considered for payment.**
Patient Responsibilit Amount**	Indicates the patient responsibility amount returned by prior payer. This will be required when there is a 2 or 4 in the Other Coverage Code field.
Save Other Payer-Patient Responsibility Amount (button)	Click to Save Other Payer-Patient Responsibility Amount
Save Other Payer To Claim (button)	Click to Save Other Payer to claim
Reset/Cancel (button)	Click on reset or cancel to remove any data entered and revert to the previous values or blank form.
Submit Claim (button)	Click Submit Claim to submit the claim.
Printer Friendly (button)	Click Printer Friendly to open the claim in a printer friendly PDF format.
Reset (button)	Click Reset to discard all claim information entered.
Cancel (button)	Click Cancel to discard all claim information entered and return to Claim Management.

NCPDP Valid Other Payer Reject Codes

Reject Code	Code Description
40	Pharmacy Not Contracted With Plan On Date Of Service
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
65	Patient is not covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
76	Plan Limitations Exceeded
78	Cost Exceeds Maximum
80	Drug-Diagnosis Mismatch
81	Claim Too Old
88	DUR Reject Error
569	Provide Beneficiary with CMs Notice of Appeal Rights
3Y	Prior Authorization Denied
4Y	Patient Residence not supported by plan
4Z	Place of Service Not Support By Plan
6Z	Provider Not Eligible To Perform Service/Dispense Product
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
9G	Quantity Dispensed Exceeds Maximum Allowed,
9K	Compound Ingredient Component Count Exceeds Number Of ingredients Supported
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
A5	Not Covered Under Part D Law
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
E7	M/I Quantity Dispensed
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network

Reject Code	Code Description
G8	Pharmacy Not Contracted in Long Term Care Network
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MR	Drug Not on Formulary
N1	No patient match found.
PA	PA Exhausted/Not Renewable
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations

SECTION 4
THE REMITTANCE ADVICE

MO HealthNet has discontinued printing and mailing paper Remittance Advices (RAs). The RAs both current and aged are available through the MO HealthNet web portal at www.emomed.com. Some providers utilize an electronic HIPAA 835 transaction to retrieve their RA.

Using emomed.com, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the MO HealthNet Division web site, www.dss.mo.gov//mhd/providers/index.htm, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through direct bank deposit approximately two weeks after the cycle run date. (See the Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – CMS 1500 paper claim
49 – Internet claim

50 – Individual Adjustment Request
55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1513001000000 is read as a CMS-1500 paper medical claim entered in the processing system on January 1, 2013.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the web portal and the printable RA. To apply online go to the MO HealthNet web portal www.emomed.com and click on Register Now.

On the Welcome to eProvider page, click on File Management, then select Printable RAs and the date you wish to view, you may print or upload files to your system. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readstep2.htm to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

FIELD	DESCRIPTION
PARTICIPANT'S NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MO HEALTHNET ID	The participant's 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient co-pay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.

FIELD	DESCRIPTION
QTY	The units of service submitted
BILLED AMOUNT	The submitted billed amount for the specific detail line
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PER PROV	The National Provider Identifier (NPI) for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a

FIELD	DESCRIPTION
REMARK CODES (cont.)	supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

SECTION 5
ADJUSTMENTS & RESUBMISSIONS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Wipro Infocrossing web portal at, www.emomed.com; Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25 minimum limitation does not apply.

Adjustments for claim credits submitted via the Internet receive an immediate confirmation after submission to confirm the acceptance and indicate the status of the adjustment.

See Section 4 of the MO HealthNet *Provider Manual* for timely filing requirements for adjustments and claim resubmissions.

PAID CLAIM OPTIONS on emomed.com

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

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 click on the highlighted 'submit claim' button. The claim now has been submitted to be voided or credited in the system.

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 click on the highlighted 'submit claim' button. The replacement claim with corrections has now been submitted.

DENIED CLAIM OPTIONS on emomed.com

If there is a denied claim in the MO HealthNet 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.

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

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 click on the highlighted submit claim button. The claim has now been submitted with the corrections made.

COPY CLAIM – Advanced- This option is used when the claim was filed using the wrong NPI number or wrong claim form. 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. Example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

CLAIM STATUS OF THE CLAIM IS GIVEN AFTER THE CLAIM IS SUBMITTED

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.

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SECTION 6
HEALTHY CHILDREN AND YOUTH PROGRAM

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 in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). MO HealthNet covers any physical or mental illness identified by the HCY screen regardless of whether the services are covered under the state MO HealthNet plan. Services that are beyond the scope of the MO HealthNet state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope and prognosis. A Prior Authorization (PA) may be required for some services.

When the initial application for public assistance is made, all qualified applicants (or his/her guardian) under age 21 are informed of the HCY program. However, it is advisable for providers to notify their patients when HCY screenings are due in accordance with the following periodicity schedule:

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

FULL SCREENING

A full screen must be performed by an enrolled MO HealthNet physician, nurse practitioner or nurse midwife *(only infants age 0-2 months and females age 15-20 years)* and must include all of the components listed below. If all of the components are not included, a local health department cannot bill for a full screen and is to bill only for a partial screen.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment (Provider must use the *HCY Lead Risk Assessment* form)
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

It is mandatory that the age appropriate *HCY Screening Guide* be used to document that all components of a full or partial screen are met. The *HCY 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.** *HCY Screening Guides* can be obtained by downloading them from the Internet at http://dss.mo.gov/mhd/providers/.

The paper copy of the *Healthy Children and Youth Screening Guide* and the *Lead Risk Assessment Guide* is not the only method a local health department can use to document in the patient's medical record that a service was provided. The department can also document the screenings in an electronic medical record.

If the local health department uses an electronic medical record, the electronic version must contain all of the components listed on the *HCY Screening Guide* and the *Lead Risk Assessment Guide* for the patient's appropriate age group. The *HCY Screening Guide* and the *Lead Risk Assessment Guide* can also be scanned into a patient's electronic medical record. The components of the *HCY Screening Guide* must be available in an easily accessible format. The *Lead Risk Assessment Guide* must contain the questions included on the paper form as well as responses and the date and the results of the blood level test administered to the patient. Each component of each guide must be entered into the patient's electronic medical record, and must be made available to the MO HealthNet program upon request.

Note: A local health department cannot bill for an office visit and an HCY screen on the same date of service for a patient unless documentation in the medical record indicates a medical need for the office visit. The department must include a "Certificate of Medical Necessity" with the claim when submitting it for payment.

DIAGNOSIS CODES FOR FULL, PARTIAL OR INTERPERIODIC SCREENS

Public health agencies must use V20.2 as the primary diagnosis on claims for HCY screening services. There are two exceptions. CPT codes 99381EP and 99391EP **must** be billed with diagnosis code V20.2, V20.31 or V20.32. CPT codes 99385 and 99395 **must** be billed with diagnosis code V25.01-V25.9, V70.0 or V72.31.

FULL SCREENING PROCEDURE CODES (New Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 2	Fee
99381*	EP	$60.00
99382*	EP	$60.00
99383*	EP	$60.00
99384*	EP	$60.00
99385*	EP	$60.00

FULL SCREENING PROCEDURE CODES (Established Patient)

Procedure Code (Use Age Appropriate Code)	Modifier 2	Fee
99391*	EP	$60.00
99392*	EP	$60.00
99393*	EP	$60.00
99394*	EP	$60.00
99395*	EP	$60.00

Modifier "UC" must be used if child was referred for further care as a result of the screening

PARTIAL SCREENING

Different providers may provide segments of the full medical screen. 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 screening service to have a referral source to refer the child for the remaining components of a full screening service.

An unclothed physical and history screen (CPT codes 9938152EP-9938552EP and 9939152EP-9939552EP) includes the first five sections of the age appropriate screening guide including:

- Interval history;
- Unclothed physical exam;
- Anticipatory guidance;
- Laboratory/Immunizations; and
- Age appropriate lead screening. Federal regulations require a mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age. The provider must use the *HCY Lead Risk Assessment* form.

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (New Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99381*	52	EP	$20.00
99382*	52	EP	$20.00
99383*	52	EP	$20.00
99384*	52	EP	$20.00
99385*	52	EP	$20.00

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (Established Patient)
(Provider must complete Sections 1-5 of the HCY Screening Guide)

Procedure Code (Use Age Appropriate Code)	Modifier 1	Modifier 2	Fee
99391*	52	EP	$20.00
99392*	52	EP	$20.00
99393*	52	EP	$20.00
99394*	52	EP	$20.00
99395*	52	EP	$20.00

Modifier "UC" must be used if child was referred for further care as a result of the screening.

PARTIAL SCREENING CODES – DENTAL

Procedure Code	Modifier 1	Modifier 2	Fee
99429			$20.00
99429	UC		$20.00

PARTIAL SCREENING CODES – DEVELOPMENTAL/MENTAL HEALTH

Procedure Code	Modifier 1	Modifier 2	Fee
99429	59		$15.00
99429	59	UC	$15.00

PARTIAL SCREENING CODES – HEARING

Procedure Code	Modifier 1	Modifier 2	Fee
99429	EP		$5.00
99429	EP	UC	$5.00

PARTIAL SCREENING CODES – VISION

Procedure Code	Modifier 1	Modifier 2	Fee
99429	52		$5.00
99429	52	UC	$5.00

DESCRIPTION OF MODIFIERS USED FOR HCY SCREENINGS

- **EP -** Service provided as part of MO HealthNet early periodic, screening, diagnosis, and treatment (EPSDT).
- **52 -** Reduced services. Modifier 52 must be used when all the components for the unclothed physical and history procedure codes (99381-99395) have not been met according to CPT. Also used with procedure code 99429 to identify that the components of a partial HCY vision screen have been met.
- **59 -** Distinct Service. Modifier 59 must be used to identify the components of an HCY screen when only those components related to developmental and mental health are being screened.

- **UC -** EPSDT Referral for Follow-Up Care. The modifier UC must be used when the child is referred on for further care as a result of the screening.

NEWBORN EXAMINATIONS

Initial newborn examinations have been identified as HCY screenings and providers **must** use either procedure code 99460 or 99461. When billing for either of these codes, field 24h on the CMS-1500 form **must** be marked with an "E." This indicates an EPSDT/HCY exam. The newborn's medical record must document that the billing provider performed all components of a full HCY examination appropriate to the child's age and circumstances.

DENTAL EXAMINATIONS

When a child receives a full HCY medical screen, it includes an oral examination that is **not** a full dental exam. A referral to a dental provider must be made where medically indicated when the child is under the age of one year. When the child is one year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. Providers or participants can use the MO HealthNet Internet web page, http://dss.mo.gov/mhd/participants/, to search for an enrolled dental provider in their area or other area of the state. On the web page, the patient should click on the "MO HealthNet Provider Search" link and follow the instructions.

IMMUNIZATIONS

HCY screening providers, including local health departments, are responsible for giving required immunizations. Immunizations are recommended in accordance with guidelines of the Advisory Committee on Immunization Practices (ACIP). 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.

Local health departments must use the free vaccine provided by the Missouri Department of Health and Senior Services through the Vaccine for Children (VFC) program. To receive the free vaccine, a local health department must be enrolled with the Department of Health and Senior Services. Additional information on the VFC program appears later in this section.

LEAD SCREENING AND TREATMENT

All children ages six months to 72 months must be verbally assessed for lead poisoning using the questions contained in the *HCY Lead Risk Assessment Guide* (download the guide from the Internet at http://dss.mo.gov/mhd/providers/). The *HCY Lead Risk Assessment Guide* is designed to allow the same document to follow the child for all visits from 6 months to 72 months of age. The 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. When an answer to any verbal question is "yes", a blood lead test must be done at that time.

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

- If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure.
- If the answer to any question is positive, a child is considered high risk for high doses of lead exposure and must receive a blood lead test.
- Blood level testing is mandatory at ages 12 and 24 months regardless to the response of the verbal assessment or where a child resides.

Effective April 18, 2010 the Healthy Children and Youth Screening and Lead Risk Assessment Guides became available in an electronic format through MO HealthNet's web tool, CyberAccess. Providers are strongly encouraged to complete the Assessment Guides electronically through the CyberAccess tool. As the Cyber Access tool becomes more widely used for various MO HealthNet Division (MHD) programs, the EPSDT feature will enhance the overall usefulness. This will allow the completed forms to be part of the participant's MO HealthNet electronic health record (EHR). The use of the EHR to enable better continuity of care for MHD participants is a State goal. The information provided in the assessment guides will be available to other health care providers and will provide helpful information when making treatment decisions.

For additional information on HCY/EPSDT, providers should reference Section 9 of the MO HealthNet *Provider Manual* at http://dss.mo.gov/mhd/providers.

INTERPERIODIC SCREENS

Interperiodic Screens are medically necessary screens outside the periodicity schedule that do not require the completion of all components of a full screen and 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 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 V20.2 diagnosis should be entered in the secondary diagnosis field.

Interperiodic Screens commonly are used for school and athletic physicals. A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis code V20.2 should be used as the primary diagnosis. This also applies for other school physicals when required as conditions for entry into or

continuance in the educational process. Use the age appropriate code from the following lists.

INTERPERIODIC SCREEN – REDUCED- (New Patient)

Procedure Code (Use Age Appropriate Code)	Fee
99381	$23.00
99382	$23.00
99383	$23.00
99384	$23.00
99385	$32.50

INTERPERIODIC SCREEN – REDUCED – (Established Patient)

Procedure Code (Use Age Appropriate Code)	Fee
99391	$15.00
99392	$15.00
99393	$15.00
99394	$15.00
99395	$24.00

WELL WOMAN EXAMINATION

A well woman exam for a female patient 18-20 years of age can be billed using the age appropriate preventive medicine code and modifiers with diagnosis code V72.31.

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services are covered by MO HealthNet. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis. Additional information on SAFE-CARE examinations can be referenced in Section 13.15 of the MO HealthNet physician manual located on the Internet at: http://dss.mo.gov/mhd.providers/.

SAFE/CARE EXAM PROCEDURE CODES

Procedure Code	Modifier 1	Modifier 2	Fee
99205	U7		$187.50
99205	U7	52	$106.38

VACCINES FOR CHILDREN (VFC) PROGRAM

Through the VFC Program, federally provided vaccine is available at no charge to public

and private providers for MO HealthNet eligible children ages 0 through 18 years. MO HealthNet requires providers, including local health departments, who administer immunizations to qualified MO HealthNet eligible children to enroll in the VFC program. The VFC program is administered by the Department of Health and Senior Services. Providers should contact the DHSS as follows:

Missouri Department of Health and Senior Services
Section for Communicable Disease Prevention
Vaccines for Children Program
P.O. Box 570
Jefferson City, MO 65102
(800) 219-3224, (573) 526-5833

MO HealthNet will pay an administration fee per dose to a health department to administer the free vaccine.

Immunizations for Managed Care Health Plan Participants

Managed care health plans and their providers must use the VFC vaccine for MO HealthNet Managed Care eligible participants. Plan providers must enroll in the program through the Department of Health and Senior Services. Providers should contact the appropriate managed care health plan for proper billing procedures.

Immunizations Given Outside the VFC Guidelines

If an immunization is given to a MO HealthNet participant who does not meet the VFC guidelines, use the standard procedure for billing injections. Local health departments must bill injections on the Pharmacy Claim Form using the National Drug Code (NDC). The health department may bill either procedure code 90471 or 90472 for the administration of the immunization if that is the only service provided. If a significant, separately identifiable Evaluation and Management (E&M) service (codes 99201-99205; 99211-99215) is performed, the appropriate E&M code may be billed in addition to the administration code.

VFC ADMINISTRATION CODES

Local health departments must use the SL modifier when billing for the VFC administration codes.

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	M\HD FEE
DTaP	DTaP	Infanrix DAPTACEL Tripedia	90700SL	$15.00
DTaP, Hepatitis B, and Polio	DTaP/HB/IPV	Pediarix	90723SL	$25.00
DTaP, Hib, and Polio	DTaP/Hib/IPV	Pentacel	90698SL	$25.00
DTaP and Polio	DTaP/IPV	KINRIX	90696SL	$20.00
DT	DT		90702SL	$10.00
Td	Td, Preservative Free	DECAVAC	90714SL	$10.00
Tdap	Tdap	BOOSTRIX ADACEL	90715SL	$15.00
Polio	EIPV	IPOL	90713SL	$5.00
Hepatitis A	Hepatitis A	Havrix VAQTA	90633SL	$5.00
Hepatitis B	Hepatitis B	Engerix B Recombivax HB	90744SL	$5.00
Hepatitis B and Hib	Hepatitis B/Hib	COMVAX	90748SL	$10.00
Hib	Hib	PedvaxHIB ACTHib	90647SL 90648SL	$5.00 $5.00
HPV	HPV quadrivalent types 6,11,16,18	Gardasil	90649SL	$5.00
	HPV bivalent Types 16,18	Cervarix	90650SL	$5.00

VACCINE FAMILY	VACCINE NAME	PRODUCT NAME	CPT CODE	M\HD FEE
Influenza	Influenza (injectable)	Influenza, Preservative Free	90655SL	$5.00
		Influenza, Preservative Free	90656SL	$5.00
		Influenza	90658SL	$5.00
	Influenza, live attenuated	FluMist	90660SL	$5.00
Meningococcal	Meningococcal	Menactra	90734SL	$5.00
MMR	MMR	MMRII	90707SL	$15.00
MMR and Varicella	MMRV	ProQuad	90710SL	$20.00
Pneumococcal	Pneumococcal 7-valent (conjugate)	Prevnar	90669SL	$5.00
	Pneumococcal 13-valent (conjugate	Prevnar 13-valent	90670SL	$5.00
	Pneumococcal 23-valent (polysaccharide)	Pneumovax 23	90732SL	$5.00
		Pnu-Immune 23		
Rotavirus	Rotavirus	RotaTeq	90680SL	$5.00
		Rotarix	90681SL	$5.00
Varicella	Varicella	Varivax	90716SL	$5.00

SECTION 7
FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider, including local health departments, to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, a health department must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter "F" in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A local health department may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
  Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- A breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

Billing for Birth Control Devices and Systems

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs, and local health departments must bill for birth control devices electronically. The only exceptions are diaphragms and cervical caps.

A provider must submit a claim for a birth control device or system on an electronic Professional ASC X12N 837 Health Care claim transaction or by manually entering a claim at MO HealthNet's billing web site, www.emomed.com utilizing the Pharmacy Claim form option. The system automatically generates a claim for the NDC to process as a pharmacy claim and will appear as a separate claim on the provider's Remittance Advice.

This is the same method currently used by physicians when billing for injectables dispensed in the office or clinic.

COPPER INTRAUTERINE DEVICE (IUD), LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, VAGINAL RING, AND DEPO-PROVERA INJECTION

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments must bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing website, emomed.com, or using the Pharmacy Claim form on emomed.com.

The fee for procedure code 58300 (insertion of IUD) covers insertion of the IUD. The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be submitted with claims for these services for manual pricing.

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments can bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing website, emomed.com, or using the Pharmacy Claim form on emomed.com. An invoice of cost is not required if billed using the NDC.

IMPLANTABLE CONTRACEPTIVE CAPSULE SYSTEM

Physicians, nurse practitioners, nurse midwives, clinics, FQHCs and local health departments must bill for these items using the National Drug Code (NDC) on the electronic Professional ASC X12N 837 Health Care claim transaction, by entering an electronic CMS-1500 claim on MO HealthNet's billing website, emomed.com, or using the Pharmacy Claim form on emomed.com.

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the system.

11976 - removal, implantable contraceptive capsules

11981 – insertion, non-biodegradable drug delivery implant
11982 – removal, non-biodegradable drug delivery implant
11983 – removal with reinsertion, non-biodegradable drug delivery implant

An office visit code may not be billed in addition to any of the above procedure codes.

STERILIZATIONS

A *Sterilization Consent* form is a required attachment for all claims containing the following procedure codes: 55250, 58565, 58600, 58605, 58611, 58615, 58670, and 58671. **The MO HealthNet participant must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The participant must have given informed consent voluntarily in accordance with Federal and State requirements.

The *Sterilization Consent* form must be completed and signed by the participant at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E (1) of the *MO HealthNet Provider Manua*l available on the Internet at www.dss.mo.gov/mhd/providers/index.htm).

The *Sterilization Consent Form* can be submitted also through the emomed Internet web site. The provider must still maintain a properly completed paper form in the patient's files and must provide a copy of the paper form to the hospital if the service was performed in the hospital.

Essure - The Essure procedure is a permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

MO HealthNet covers the Essure procedure (CPT code 58565). If the service is provided in the office setting (POS11), FQHC setting (POS 50), or local public health agency clinic (POS 71), bill CPT 58565 without a modifier. If the service is provided in the hospital outpatient (POS 22) or inpatient (POS 21) setting, bill CPT 58565 52.

The *Sterilization Consent Form* must be completed and signed at least 31 days prior to the sterilization.

MISSOURI'S WOMEN'S HEALTH SERVICES (ME CODES 80 and 89)

MO HealthNet offers Women's Health Services to uninsured women who lose MO HealthNet eligibility 60 days after the birth of their child for up to one year. Services include family planning and limited testing and treatment of Sexually Transmitted Diseases. The treatment of medical complications occurring from the STD is **not**

covered by this program. Eligible participants are enrolled under Medicaid Eligibility (ME) code 80.

The Centers for Medicare and Medicaid Services (CMS) has approved the Missouri Department of Social Services' request to extend Women's Health Services effective January 1, 2009 to additional women. Eligible participants for the expanded Women's Health Services program will be enrolled under ME code 89. Services for ME codes 80 and 89 are provided on a fee-for-service basis only.

ELIGIBILITY CRITERIA

To qualify for the expanded Women's Health Services Program, a woman must be:

- Uninsured, defined as not having creditable coverage for family planning services;
- 18 to 55 years of age;
- have a net family income at or below 185% of the Federal Poverty Level (FPL); and
- have assets totaling no more than $250,000.

These women are not limited to one year of coverage and remain eligible for the program as long as they continue to meet eligibility requirements and require family planning services.

BENEFIT PACKAGE

Women's health services benefits for both ME code 80 and 89 include:

- Department of Health and Human Services approved methods of contraception;
- family planning counseling/education on various methods of birth control;
- diagnosis, testing and treatment of a sexually transmitted disease found during a family planning visit including pap tests and pelvic exams; and,
- drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements).

All services must be billed with a primary diagnosis of V25-V25.9 or payment for the services will be denied. A list of covered services is listed on the following pages in this section.

Procedure Code	Description
00851	ANESTHESIA FOR TUBAL LIGATION/ TRANSACTION
00952	ANESTHESIA FOR HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY
11976	REMOVABLE, IMPLANTABLE CONTRACEPTIVE CAPSULES
11981	INERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
56820	COLPOSCOPY OF THE VULVA
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY

Procedure Code	Description
57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX, IF PRESESNT
57421	COLPOSCOPY OF THE ENTIRE VAGINA
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA
57454	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX AND ENDOCERVICAL CURETTAGE
57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH BIOPSY OF THE CERVIX
57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH ENDOCERVICAL CURETTAGE
57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA WITH LOOP ELECTRODE BIOPSY OF THE CERVIX
57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER VAGINA, WITH LOOP ELECTRODE COLONIZATION OF THE CERVIX
57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)
57510	CAUTERY OF CERVIX, ELECTRO OR THERMAL
57511	CAUTERY OF CERVIX, CRYOCAUTERY, INITIAL OR REPEAT
57513	CAUTERY OF CERVIX; LASER ABLATION.
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY OR HYSTEROSALPINGOGRAPHY
58565	HYSTEROSCOPY, WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS
58600	LIGATION OR TRANSECTION OF FALLOPIAN TUBES
58611	LIGATION OR TRANSECTION OF FALLOPIAN TUBES
58615	OCCLUSION OF FALLOPIAN TUBES BY DEVICE
58670	LAPAROSCOPY, SURGICAL; W/ FULGURATION OF OVIDUCTS BY DEVICE (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (E.G., BAND, CLIP, ETC.)
74740	HYSTEROSALPINGOGRAPHY RADIOLGOICAL SUPERVISION AND INTERPRETATION
74742	TRANSCERVICAL CATHETERIZATION OF FALLOPIAN TUBE RADIOLOGICAL SUPERVISION AND INTERPRETATION
76830	ULTRASOUND TRANSVAGINAL
76831	ECHO EXAM UTERUS
76856	US EXAM PELVIC COMPLETE
76857	ULTRASOUND PELVIC (NONOBSTETRIC) B-CAN &/OR REAL TIME W/ IMAGE DOCUMENTATION
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZE)
80048	BASIC METABOLIC PANEL (CLIA PANEL PROC)
80050	GENERAL HEALTH PANEL

Procedure Code	Description
80051	ELECTROLYTE PANEL (CLIA PANEL PROC)
80055	OBSTETRIC PANEL
80074	ACUTE HEPATITIS PANEL
81000	URINALYSIS BY DIPSTICK/TABLET REAGENT; NON- AUTOMATED W/MICROSCOPY
81001	URINALYSIS ETC. AUTOMATED WITH MICROSCOPY
81002	URINALYSIS BY DIP STICK/TABLET REAGENT;NON-AUTOMATED W/OUT MICROSCOPY(CLIA WAIVER LIST)
81003	URINALYSIS BY DIP/TABLET;AUTOMATED W/O MICROSCOPY
81005	URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE EXCEPT IMMUNOASSAYS
81015	URINALYSIS MICROSCOPIC ONLY (PPMP CLIA LIST)
81020	URINALYSIS; 2 OR 3 GLASS TEST (PPMP CLIA LIST)
81025	URINE PREGNANCY TEST BY VISUAL COLOR COMPARISON METHODS (CLIA WAIVER LIST)
82105	ALPHA-FETOPROTEIN; SERUM
82120	AMINES VAGINAL FLUID QUALITATIVE
82670	ESTRADIOL
82671	ESTROGENS FRACTIONATED
82672	ESTROGENS TOTAL
82677	ESTRIOL
82679	ESTRONE
82947	GLUCOSE; QUANTITATIVE (CLIA WAIVER LIST)
82948	GLUCOSE; BLOOD REAGENT STRIP
82962	GLUCOSE BLOOD BY GLUCOSE MONITORING DEVICE(S) CLEARED/ FDA SPECIFICALLY/HOME USE
83001	GONADOTROPIN FOLLICLE STIMULATING HORMONE (FSH)
83002	GONADOTROPIN LUTEINIZING HORMONE (LH)
84144	PROGESTERONE
84146	PROLACTIN
84702	GONADOTROPIN CHORIONIC (HCG); QUANTITATIVE
84703	GONADOTROPIN CHORIONIC QUALITATIVE (CLIA WAIVER LIST)
85004	AUTOMATED DIFF WBC COUNT
85007	BL SMEAR W/DIFF WBC COUNT
85008	BL SMEAR W/O DIFF WBC COUNT
85009	MANUAL DIFF WBC COUNT B-COAT
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT(CLIA WAIVER LIST)
85014	HEMATOCRIT
85018	HEMOGLOBIN
85025	COMPLETE CBC W/AUTO DIFF WBC
85027	COMPLETE CBC AUTOMATED
85032	MANUAL CELL COUNT EACH
85610	PROTHROMBIN TIME (CLIA WAIVER LIST)
85652	SEDIMENTATION RATE ERYTHROCYTE; AUTOMATED

Procedure Code	Description
85730	THROMBOPLASTIN TIME PARTIAL (PTT) PLASMA OR WHOLE BLOOD
86318	IMMUNOASSAY/INFECTI AGENT ANTIBODY QUALI/SEMIQUANTSINGLE STEP METHOD
86382	NEUTRALIZATION TEST VIRAL
86386	NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE
86403	PARTICLE AGGLUTINATION; SCREEN EACH ANTIBODY
86580	SKIN TEST TUBERCULOSIS INTRADERMAL (EXEMPT FROM CLIA EDITING)
86592	SYPHILIS TEST QUALITATIVE (EG VDRL RPR ART)
86593	SYPHILIS TEST QUANTITATIVE
86628	ANTIBODY; CANDIDA
86631	ANTIBODY; CHLAMYDIA
86632	ANTIBODY ; CHLAMYDIA IGM
86687	ANTIBODY; HTLV I
86688	ANTIBODY; HTLV-II
86689	ANTIBODY; HTLV OR HIV ANTIBODY CONFIRMATORY TEST (EG WESTERN BLOT)
86694	ANTIBODY; HERPES SIMPLEX NON-SPECIFIC TYPE TEST
86695	ANTIBODY; HERPES SIMPLEX TYPE I
86696	HERPES SIMPLEX TYPE 2
86701	ANTIBODY HIV 1
86702	ANTIBODY; HIV 2
86703	ANTIBODY; HIV-1 AND HIV-2 SINGLE RESULT
86706	HEPATITIS B SURFACE ANTIBODY (HBSAB)
86707	HEPATITIS BE ANTIBODY (HBEAB)
86762	ANTIBODY; RUBELLA
86787	ANTIBODY; VARICELLA-ZOSTER
86803	HEPATITIS C ANTIBODY
86900	BLOOD TYPING; ABO
86901	BLOOD TYPING; RH(D)
87015	CONCENTRATION (ANY TYPE) FOR PARASITES OVA OR TUBERCLE BACILLUS (TB AFB)
87040	BLOOD CULTURE FOR BACTERIA
87070	CULTURE BACTERIA OTHER
87071	CULTURE BACTERIA; QUANTITATIVE AEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87073	CULTURE BACTERIAL; QUANTITATIVE ANEROBIC WITH ISOLATION & PRESUMPTIVE IDENTIFICATION OF ISOLATES
87075	CULTURE BACTERIA EXCEPT BLOOD
87076	CULTURE BACTERIAL ANY SOURCE DEFINITIVE IDENTIFICATION EACH ANAEROBIC ORGANISM
87077	CULTURE BACTERIAL;AEROBIC ISOLATE ADDITONAL METHODS REQUIRED FOR DEFINITIVE IDENTIFICATION

Procedure Code	Description
87081	CULTURE BACTERIAL SCREENING ONLY FOR SINGLE ORGANISMS
87086	CULTURE BACTERIAL URINE QUANTITATIVE COLONY COUNT
87088	URINE BACTERIA CULTURE
87102	CULTURE FUNGI ISOLATION OTHER SOURCE (EXCEPT BLOOD)
87110	CULTURE CHLAMYDIA
87147	CULTURE TYPING SEROLOGIC METHOD AGGLUTINATION GROUPING PER ANTISERUM
87164	DARK FIELD EXAMINATION ANY SOURCE (EG PENILE VAGINAL ORAL SKIN)
87184	SENSITIVITY STUDIES ANTIBIOTIC DISK METHOD PER PLATE (12 OR LESS DISKS)
87186	SENSITIVITY STUDIES ANTIBIOTIC MICROTITER MINIMUM INHIBITORY CONCENTRATION (MIC)
87205	SMEAR PRIMARY SOURCE WITH INTERPRETATION ROUTINE STAIN
87206	SMEAR PRIMARY SOURCE WITH INTERPRETATION FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA FUNGI
87207	SMEAR SPECIAL STAIN
87210	SMEAR PRIMARY SOURCE WITH INTERPRETATION WET MOUNT WITH SIMPLE STAIN
87220	TISSUE EXAMINATION FOR FUNGI (EG KOH SLIDE)
87252	VIRUS IDENTIFICATION; TISSUE CULTURE INOCULATION AND OBSERVATION
87270	INFECT AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; CHLAMYDIA TRACHOMATIS
87273	INFECTIOUS AGENT ANTIGEN DETECTION BY FLOURESCENT ANTIBODY; HERPES SIMPLEX VIRUS TYPE 2
87274	INFECTIOUS AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECH; HERPES SIMPLEX VIRUS
87320	INFECT AGT ANTIGEN DETECTION BY ENZYME IMMUNOASSY METHOD; ADENOVIRUS ENTERIC TYPES 40/41 CHLAMYD
87340	HEPATITIS B SURFACE ANTIGEN
87350	HERPES SIMPLEX TYPE 2
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE
87390	HIV-1
87391	HIV-2
87470	INFECT AGT DETECT BY NUCLEIC ACID (DNA OR RNA); BARTONELLA HENSELAE AND BARTONELLA QUINTANA DIRECT
87480	CANDIDA SPECIES DIRECT PROBE TECHNIQUE
87481	CANDIDA SPECIES AMPLIFIED PROBE TECHNIQUE
87482	CANDIDA SPECIES QUANTIFICATION
87485	CHLAMYDIA PNEUMONIAE DIRECT PROBE TECHNIQUE
87486	CHLAMYDIA PNEUMONIAE AMPLIFIED PROBE TECHNIQUE

Procedure Code	Description
87487	CHLAMYDIA PNEUMONIAE QUANTIFICATION
87490	CHLAMYDIA TRACHOMATIS DIRECT PROBE TECHNIQUE
87491	CHLAMYDIA TRACHOMATIS AMPLIFIELD PROBE TECHNIQUE
87492	CHLAMYDIA TRACHOMATIS QUANTIFICATION
87495	CYTOMEGALOVIRUS DIRECT PROBE TECHNIQUE
87496	CYTOMEGALOVIRUS AMPLIFIED PROBE TECHNIQUE
87497	CYTOMEGALOVIRUS QUANTIFICATION
87510	GARDNERELLA VAGINALIS DIRECT PROBE TECHNIQUE
87511	GARDNERELLA VAGINALIS AMPLIFIED PROBE TECHNI
87512	GARDNERELLA VAGINALIS QUANTIFICATION
87528	HERPES SIMPLEX VIRUS DIRECT PROBE TECHNIQUE
87529	HERPES SIMPLEX VIRUS AMPLIFIED PROBE TECHNIQUE
87530	HERPES SIMPLEX VIRUS QUANTIFICATION
87531	HERPES VIRUS-6 DIRECT PROBE TECHNIQUE
87532	HERPES VIRUS-6 AMPLIFIED PROBE TECHNIQUE
87533	HERPES VIRUS-6 QUANTIFICATION
87534	HIV-1 DIRECT PROBE TECHNIQUE
87535	HIV-1 AMPLIFIED PROBE TECHNIQUE
87536	HIV-1 QUANTIFICATION
87537	HIV-2 DIRECT PROBE TECHNIQUE
87538	HIV-2 AMPLIFIED PROBE TECHNIQUE
87539	HIV-2 QUANTIFICATION
87590	NEISSERIA GONORRHOEAE DIRECT PROBE TECHNIQUE
87591	NEISSERIA GONORRHOEAE AMPLIFIED PROBE TECHNIQUE
87592	NEISSERIA GONORRHOEAE QUANTIFICATION
87620	PAPILLOMAVIRUS HUMAN DIRECT PROBE TECHNIQUE
87621	PAPILLOMAVIRUS HUMAN AMPLIFIED PROBE TECHNIQUE
87622	PAPILLOMAVIRUS HUMAN QUANTIFICATION
87660	TRICHOMONAS VAGIN DIR PROBE
87797	NOT OTHERWISE SPECIFIED DIRECT PROBE TECHNIQUE
87800	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; DIRECT PROBE TECHIQUE
87801	INFECT AGT DETECTION BY NUCLEIC ACID MULTIPLE ORGANISMS; AMPLIFIED PROBE TECHNIQUE
87810	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; CHLAMYDIA TRACHOMATIS
87850	INFECTIOUS AGT DETECTION BY IMMUNOASSY WITH DIRECT OPTICAL OBSERVATION; NEISSERIA GONORRHOEAE
88108	CYTOPATHOLOGY CONCENTRATION TECHNIQUE SMEARS AND INTERPRETATION (EG SACCOMANNO TECHNIQUE)
88141	CYTOPATHOLOGY CERVICAL OR VAGINAL
88142	CYTOPATHOLOGY CERVICAL OR VAGINAL, THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYS SUPERVISION

Procedure Code	Description
88143	CYTOPATHOLOGY CERVICAL OR VAGINAL, WITH MANUAL SCREENING AND RESCREENING
88147	CYTOPATHOLGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION
88148	CYTOPATHOLOGY SMEARS CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING
88150	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION
88152	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL; W/ MANUAL & COMPUTER-ASSISTED RESCREENING UNDER PHYS SUPERVISION
88153	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88154	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL; WITH MANUAL SCREENINGS AND COMPUTER-ASSISTED RESCREENING
88155	CYTOPATHOLOGY SLIDE CERVICAL OR VAGINAL DEFINITIVE HORMONAL EVALUATION
88160	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; SCREENING AND INTERPRETATION
88161	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; PREPARATION SCREENING AND INTERPRETATION
88162	CYTOPATHOLOGY SMEARS ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS
88164	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL(THE BETHESDA SYSTEM)
88165	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); UNDER PHYSICIAN'S SUPERVISION
88166	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING
88167	CYTOPATHOLOGY SLIDES CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING USING CELL SELECTION
88172	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; IMMEDIATE CYTOHISTOLOGIC STUDY
88173	EVALUATION OF FINE NEEDLE ASPIRATE W/ OR W/O PREPARATION OF SMEARS; INTERPRETATION AND REPORT
88174	CYTOPATH C/V AUTO IN FLUID
88175	CYTOPATH C/V AUTOMATED THIN LAYER PREPARATION, WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION
99070	SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED
99201-	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER

Procedure Code	Description
99205	OUTPATIENT VISIT
99211-99215	NEW PATIENT OR ESTABLISHED PATIENT - OFFICE OR OTHER OUTPATIENT VISIT
99383-99386	PREVENTATIVE MEDICINE SERVICES/NEW PATIENT
99393-99396	PREVENTATIVE MEDICINE SERVICES/ESTABLISHED PATIENT
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE
A4266	DIAPHRAGM
J7300*	INTRAUTERINE COPPER CONTRACEPTIVE
J7302*	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7303*	CONTRACEPTIVE VAGINAL RING
J7304*	CONTRACEPTIVE HORMONE RING
J7306*	LEVONORGESTREL IMPLANT
Q0111	WET MOUNTS, INCLUDING PREPARATIONS OF VAGINAL, CERVICAL, OR SKIN SPECIMENS
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE

*These items must be billed electronically with a National Drug Code (NDC) and a decimal quantity.

Drug Class	Description
G2A	PROGESTATIONAL AGENTS (Used for Contraception)
G8A	CONTRACEPTIVES, ORAL
G8B	CONTRACEPTIVES, IMPLANTABLE
G8C	CONTRACEPTIVES, INJECTABLE
G8F	CONTRACEPTIVES, TRANSDERMAL
G9B	CONTRACEPTIVES, INTRAVAGINAL
L5A	KERATOLYTICS
Q4F	VAGINAL ANTIFUNGALS
Q4W	VAGINAL ANTIBIOTICS
Q5R	TOPICAL ANTIPAPASITICS
Q5V	TOPICAL ANTIVIRALS
W1A	PENICILLINS
W1B	CEPHALOSPORINS
W1C	TETRACYCLINES
W1D	MACROLIDES
W1F	AMINOGLYCOSIDES
W1K	LINCOSAMIDES
W1P	BETALACTAMS
W1Q	QUINOLONES
W1Y	CEPHALOSPORINS 3RD GENERATION
W2A	ABSORBABLE SULFONAMIDES
W3B	ANTIFUNGAL AGENTS
W3C	ANTIFUNGAL AGENTS (CONTINUED)
W4E	ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS
W5A	ANTIVIRAL, GENERAL
WG4	2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL
X1B	DIAPHRAMS/CERVICAL CAP
X1C	INTRA-UTERINE DEVICES
Z2G	IMMUNOMODULATORS (Aldera)

SECTION 8
DEPARTMENT OF HEALTH AND SENIOR SERVICES
WOMEN, INFANTS AND CHILDREN PROGRAM (WIC)

The Department of Health and Senior Services Women, Infants and Children (WIC) program is a special nutrition program which provides services to pregnant women, new mothers, infants and children up to their fifth birthday based on nutritional risk and income eligibility. The primary services provided by contracted providers are health screening, risk assessment, nutrition education and counseling, breastfeeding promotion and referrals to health care. Many of the persons may receive MO HealthNet benefits.

Local WIC providers are the contact point for participants receiving WIC services. There are approximately 242 clinics throughout the state. While most are local public health agencies some can be other agencies including Federally Qualified Health Centers (FQHCs) and hospitals. These providers contract with the Department of Health and Senior Services to provide WIC services in their communities.

What makes a participant eligible for WIC?
An applicant is considered eligible for WIC when they are determined categorically, residentially and income eligible. Being Categorically Eligible includes:

- Women who are:
  - Prenatal;
  - Breastfeeding postpartum, nursing a baby up to one year old; or
  - Non-breastfeeding postpartum, up to six months after a pregnancy has ended.
- Infants, a child under one year old;
- Children, from one year old up to age five.

Categorical Eligibility can be self-declared for participants unless you have reason to doubt a participant. In addition to Categorical Eligibility, participants must be residents and within income guidelines. These items must be documented on the WIC-30 along with a proof of ID.

Applicants or participants are adjunct income eligible when they can prove that they are eligible for MO HealthNet; or, who have presumptive eligibility for Temporary MO HealthNet and TANF; or, are members of a household eligible for TANF or Food Stamps; or, are members of a household with a prenatal or infant eligible for MO HealthNet. Adjunct Income Eligibility only applies to income eligibility.

Can a local public health agency bill MO HealthNet for WIC services?
Yes, under certain circumstances. To receive MO HealthNet reimbursement, a provider of WIC services must have a National Provider Identifier (NPI) and have entered into

and maintain a valid participation agreement with MO HealthNet. Authority to take such action is contained in Missouri Code of State Regulations, 13 CSR 70-3.020. Each provider type has specific enrollment criteria, e.g. licensure, certification, Medicare certification, etc., which must be met.

WIC agencies with MO HealthNet NPIs for the agency and the performing provider (physician or nurse practioner) may bill for a minimal office visit (CPT code 99211) and for a hemoglobin lab (CPT code 85018) performed during a certification or re-certification of MO HealthNet eligible WIC clients only if the agency is able to substantiate its costs exceed any amounts received from other sources of funding. Costs associated with the WIC services are non-reimbursable costs for Federally Qualified Health Centers (FQHCs).

If the WIC provider cannot substantiate that its costs do not exceed funds received from other sources, then the agency cannot bill MO HealthNet for the WIC services.

Typical procedure and diagnosis codes for a WIC service to a mother might be the following.

Minimal Office Visit	Procedure Code	99211
	Diagnosis Code	V70.3
Hemoglobin lab	Procedure Code	85018
	Diagnosis Code	V70.3

SECTION 9
LOCAL HEALTH DEPARTMENTS AND MO HEALTHNET MANAGED CARE HEALTH PLANS

ELIGIBILITY

MO HealthNet participants in certain counties within the state of Missouri are enrolled in one of the Managed Care health plans that have a contract with the MO HealthNet Division to provide benefits to these participants. With very few exceptions, a MO HealthNet participant MUST enroll in a MO HealthNet Managed Care health plan if they are in one of the designated categories of assistance and reside in one of the designated counties.

When the local health department checks the participant's MO HealthNet eligibility, if the participant is enrolled in a MO HealthNet Managed Care health plan, the name of the plan and other plan information will be provided. Eligibility can be checked either through MO HealthNet's Interactive Voice Response (IVR) at (573) 751-2896 or by logging on to the agency's Internet billing web portal, emomed.com. **PROVIDERS MUST VERIFY THE ELIGIBILITY STATUS AND MANAGED CARE HEALTH PLAN ENROLLMENT STATUS BEFORE PROVIDING SERVICES TO PARTICIPANTS. THE PLAN IS RESPONSIBLE ONLY FOR A CLAIM IF THE PARTICIPANT IS A MEMBER OF THE HEALTH PLAN ON THE DATE THE SERVICE IS PROVIDED.**

MO HealthNet Managed Care participants are given fifteen (15) calendar days from the time of their eligibility for managed care to select a health plan. All members of a family are encouraged to select the same health plan. If a family does not select a health plan within the fifteen (15) day window, the state agency will automatically assign the family to a health plan. The health plan will then auto assign the participant to a Primary Care Provider (PCP). Once a member chooses a health plan or is assigned to a health plan, the member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. This applies to the member's initial enrollment and to any subsequent enrollment periods where the member changed health plans.

All members will have a twelve (12) month lock-in to the selected health plan to provide a solid continuum of care. Under certain circumstances, participants may change their health plans and/or PCPs prior to the end of the twelve (12) month period. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. Unless the mother chooses a different health plan for her child, the child will remain with the mother's health plan.

Each participant receives Managed Care health plan educational material provided by the contracted enrolling agent, Wipro Infocrossing Healthcare Services. Wipro Infocrossing Healthcare Services is responsible for educating, enrolling, and entering the enrollment information into the proper systems.

Participants identified as eligible for MO HealthNet Managed Care are not enrolled in a health plan until sometime after the plan is selected. When providers check eligibility through IVR/emomed.com information for a specific date of service, if a plan is not listed, the participant's services are not MO HealthNet Managed Care and services should be billed MO HealthNet Fee-For-Service for that date of service. Managed Care health plan information on the IVR and emomed.com is subject to change daily.

SERVICES

When participants need medical care, they are instructed to call their Primary Care Provider (PCP) unless it is an emergency situation. The participant is instructed further that, if they need the care of a specialist, their PCP must first make the referral to the specialist. The PCP's responsibilities include but may not be limited to the following.

- Coordination of handling the participant's medical records
- Provision of check-ups and vaccinations
- Keeping track of medical records
- Referral to a specialist when necessary
- Prescribing medication
- Admission to a hospital when necessary

Some services provided by public health agencies remain outside those provided by MO HealthNet Managed Care health plans and are not considered plan benefit services even when provided to a qualified Managed Care health plan participant. These services are reimbursable on a fee-for-service basis by the MO HealthNet Division and include:

- SAFE/CARE examinations when furnished by a SAFE trained MO HealthNet enrolled provider
- Environmental lead assessments for children with elevated blood levels
- Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g. metabolic testing for newborns, blood lead testing, etc.)

There is freedom of choice for birth control and family planning services. The participant does not have to see their PCP. A qualified MO HealthNet provider, including local health departments, does not need a referral for those specific services. Claims for birth control and family planning services are to be sent to the appropriate MO HealthNet Managed Care health plan.

Managed Care health plan participants may go to a public health department for childhood immunizations and screenings, diagnosis and treatment for sexually transmitted diseases or tuberculosis, and to be tested for HIV/AIDS.

When a MO HealthNet Managed Care health plan participant has no form of transportation to a medical appointment, the participant is instructed to call their plan for assistance with transportation arrangements. However, some members' benefits do

not cover transportation.

COVERED SERVICES FOR LOCAL HEALTH DEPARTMENTS

When a local health department provides and bills a Managed Care health plan for eligible services provided to a MO HealthNet Managed Care participant, the health plan must reimburse the health agency at the current MO HealthNet Fee-for-Service reimbursement rate unless other reimbursement rates have been negotiated. This arrangement is outlined in the contract between the MO HealthNet Managed Care health plan and the MO HealthNet Division.

These services include:

- Childhood Immunizations
- STD and TB screening, diagnosis, and treatment
- HIV screening and diagnosis
- Family planning services
- Childhood lead screening, diagnosis, treatment follow-up

The managed care health plans use the CMS-1500 for billing paper claims. If a claim is denied, call the health plan's provider relations department for assistance in understanding the denial.

SECTION 10
CASE MANAGEMENT

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

CASE MANAGEMENT ENROLLMENT CRITERIA

To provide and bill for case management services, a local health department must be approved and enrolled as a case management provider with MO HealthNet. Upon approval, a specialty code of 90, Case Management, or A7, Targeted Case Management - Children EPSDT, is added to the existing provider enrollment file. In order to be eligible for participation as a MO HealthNet case management provider, the local health department must:

- have at least two years experience in the development and implementation of coordinated individual maternal and child health plans;
- be able to demonstrate the ability to assure that every pregnant woman and infant/child being case managed has access to comprehensive health services;
- have a minimum of one year experience in the delivery of public health or community health care services including home visiting.
- employ licensed registered nurses (R.N.); licensed clinical social workers with a minimum of 1 year experience as medical social work, certified nurse practitioners or licensed physicians (M.D. or D.O.) case managers who have knowledge of:
    - federal, state and local entitlement and categorical programs related to children and pregnant women such as Title V, WIC, Prevention of Mental Retardation, Children With Special Health Care Needs, etc.;
    - individual health care plan development and evaluation;
    - community health care systems and resources; and
    - perinatal and child health care standards (ACOG, AAP, etc.)

and the ability to:

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

- evaluate client progress in accessing appropriate medical care and other needed services; and,
- educate clients regarding their health conditions and implications of risk factors.

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

CASE MANAGEMENT FOR PREGNANT WOMEN

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

Risk Appraisal

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

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

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

Only MO HealthNet participating providers, including local health departments, who meet the prenatal case management criteria, as established by the MO HealthNet Division, are eligible for reimbursement of prenatal case management services for participants considered "at risk" as a result of the appraisal.

Providers who are interested in becoming case managers should contact the Provider Enrollment Unit for more information at:

MO HealthNet Division
Provider Enrollment Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Procedure Code for Risk Appraisal

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

Procedure Code	Description
H1000	Risk Appraisal, Pregnant Women

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

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

Procedure Codes for Case Management for Pregnant Women

Procedure Code	Description
H1001TS	Prenatal care, at risk enhanced service; antepartum management; follow up service
H1001	Prenatal care, at risk enhanced service; antepartum management
H1004	Prenatal care, at risk enhanced service; follow-up home visit
H1001TS52	Prenatal care, at risk enhanced service; antepartum management; follow-up, reduced service
G9012	Other specified case management service *not* elsewhere classified

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

Case management services are exempt from cost sharing.

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

HEALTHY CHILDREN AND YOUTH (HCY) CASE MANAGEMENT

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

Healthy Children and Youth (HCY) case management is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate

services for a participant rests with a specific individual or organization. It centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history and activating the examination/diagnosis/ treatment "loop."

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

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

Initial Month—HCY Case Management

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

Procedure Code	Description	Restrictions
T1016EP	Case Management, Child, Month with initial visit	Prior authorization required and limited to one per child per provider

Subsequent Months—HCY Case Management

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

Procedure Code	Description	Restrictions
T1016EPTS	Case Management, HCY	Prior authorization required

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

Prior Authorization Process for HCY Case Management

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

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

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

FAX Number: (573) 751-6010
Telephone Number: (573) 751-6246

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

More information on proper completion of the Prior Authorization Request from is found in Section 8 of the *MO HealthNet Provider Manual*.

HCY Case Management Assessment and Care Plan

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

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

LEAD CASE MANAGEMENT FOR CHILDREN SERVICES

Children with one blood lead level of 20 µg/dL or greater, or who have had two venous tests at least three 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 the MO HealthNet Division. The following procedure codes have been established for billing lead case management. Prior authorization is not required:

Procedure Code	Description
T1016UA	Lead Case Management, with Initial Visit
T1016UATS	Lead Case Management, Subsequent Months

Procedure Code	Description
T1016UA	Lead Case Management, with Initial Visit For admission to case management within two weeks of receiving confirmatory blood-lead level. This includes client/family assessment, establishes a Plan of Care and reinforces education provided by health care providers. The client/family is provided the case manager's name and telephone number. (The higher the blood lead level, the more timely the initial visit should occur.)
T1016UATS	Lead Case Management, Subsequent Months Three month encounter following initial encounter to assess progress of affected child and review and reinforce client/family education and medical regime. and At six to seven months after initial encounter which includes discharge counseling regarding lead status and ongoing nutrition and environmental maintenance. Discharge is contingent upon the following three conditions being met: • Blood lead level remains less than 15 µg/dL for at least six months • Lead hazards have been removed; and • There are no new exposures Other reasons for discharge may include: • Blood lead level remains below 20 µg/dL for one year. This closure reason is intended for use in cases where all efforts to reduce a child's blood lead level have been made (i.e, hazards in the home environment have been reduced, personal hygiene, nutritional, and housekeeping behaviors have been appropriately modified, etc.), yet the child's body burden of lead causes the child's blood lead level to consistently remain between 15-20 µg/dL. • Refusal of service • The child is older than 72 months of age • Unable to locate • A minimum of three client/family case management encounters, all face-to face, are mandatory. If more than three case management fees are billed per participant, documentation of medical necessity and copies of progress notes are required for the additional visits and must be submitted with the claim. These encounters *must* be at two to three month intervals, all being face-to-face.

Documentation of Lead Case Management Services

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

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

Additional Lead Case Management Services

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

If a case management provider cannot be located for the child, contact the area Bureau of Special Health Care Needs office for case management services.

SECTION 11
SAFE/CARE EXAMINATIONS

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

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

Participant eligibility may be verified by contacting the county FSD office in which the child resides, by logging onto the agency Internet billing web site, www.emomed.com, or by calling the MHD interactive voice response system at (573) 751-2896. To use the interactive voice response system, the provider needs:

- 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)

Section 1 of the MO HealthNet *Provider Manual* contains information on eligibility.

SAFE/CARE SERVICES

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

PROCEDURE CODE	DESCRIPTION
99205U7	SAFE, Sexual Assault Findings Examination
99205U752	CARE, Child Abuse Resource Education Examination

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

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

PROCEDURE CODE	DESCRIPTION
57420 U7	Colposcopy of the entire vagina
57452 U7	Exam of cervix w/scope
81025 U7	Urine pregnancy test
86317 U7	mmunoassay for infectious agent antibody, quantitative
86592 U7	Syphilis test, qualitative (e.g. VDRL, RPR, ART)
86631 U7	Chlamydia
86632 U7	Chlamydia, IgM
86687 U7	HTLV-I
86688 U7	HTLV-II
86689 U7	HTLV or HIV antibody, confirmatory test
87076 U7	Anaerobic isolate, additional methods required for definitive identification, each isolate
87077 U7	Aerobic isolate, additional methods required for definitive Identification, each isolate
87110 U7	Chlamydia, culture, any source
87210 U7	Smear, wet mount saline/ink
87390 U7	HIV-1
87391 U7	HIV-II
87534 U7	HIV-1, direct probe technique
87535 U7	HIV-1, amplified probe technique
87536 U7	HIV-1, quantification
87537 U7	HIV-2, direct probe technique
87538 U7	HIV-2, amplified probe technique
87539 U7	HIV-2, quantification
99170 U7	Anogenital examination with colposcopic magnification in childhood for suspected trauma

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

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

SAFE/CARE EXAMINATION FORMS

Providers may obtain the SAFE/CARE (Sexual Assault Forensic Examination/Child Abuse Resource and Education) Network Medical Examination form by calling the Missouri Department of Health and Senior Services, at (573) 526-4405.

The request may be sent in writing to:

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

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

SECTION 12
LABORATORY SERVICES

Missouri MO HealthNet follows Medicare guidelines for billing of professional and technical and total components of laboratory tests.

Professional component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 80500 and 85097.

Technical component only codes – Modifiers 26 and TC cannot be billed with these codes. Examples - 81002 and 82270.

Total component codes – These codes have a professional, technical, and total component. When billing for the professional component, use the 26 modifier. When billing for the technical component, use the TC modifier. When billing for the total component, do not use any modifiers. Examples - 88104, 88300.

Clinical Laboratory Improvement Act (CLIA)

CLIA WAIVER PROCEDURES

MO HealthNet providers possessing a "Certificate of Waiver" are allowed to perform the following procedures. Laboratories/providers with this type of certificate can bill only the technical component.

G0328	82042	82465	83026	84450	96618	87999
80047	82043	82550	83036	84460	86701	89300
80048	82044	82565	83037	84478	86703	89321
80051	82055	82570	83518	84520	87077	
80053	82120	82679	83605	84550	87210	
80061	82150	82947	83655	84703	87210U7	
80069	82247	82950	83718	85013	87449	
80178	82270	82951	83721	85014	87804	
81002	82271	82952	83861	85018	87807	
81003	82272	82962	83880	85576	87808	
81025	82274	82977	83986	85610	87809	
81025U7	82310	82985	84075	85651	87880	
82010	82330	83001	84132	86294	87899	
82040	82374	83002	84443	86318	87905	

PHYSICIAN PERFORMED MICROSCOPY PROCEDURES (PPMP)

MO HealthNet providers possessing a PPMP certificate are allowed to perform all the waiver procedures as well as the following additional procedures. These PPMP procedures may be billed for only the technical component.

Q0111	Q0113	Q0115	81001	81020	89190
Q0112	Q0114	81000	81015	89055	

Questions regarding CLIA registration or accreditation should be directed to:

Bureau of Health Facility Regulation
Department of Health and Senior Services
P.O. Box 570
Jefferson City, Missouri 65102-0570
(573) 751-6318

SECTION 13
ENVIRONMENTAL LEAD ASSESSMENT

The purpose of the environmental lead assessment is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels.

In accordance with Center for Disease Control (CDC) and Missouri Department of Health and Senior Services guidelines, MO HealthNet will reimburse for an initial environmental lead assessment of the individual's primary place of residence if the following applies:

- Blood lead level of 15 ug/dL which remains elevated for two consecutive tests which are performed three-four months apart;
- Participant blood level test of 20 ug/dL or greater; and,
- Emergency priority – child hospitalized due to lead poisoning.

If more than one child in the home meets this criteria, services may be billed for only one of the children.

MO HealthNet reimbursement is limited to services provided in the individual's *primary residence only*. Although it may be necessary to assess additional sites and residences, federal Medicaid regulations prohibit MO HealthNet reimbursement for these additional sites.

BILLING FOR ENVIRONMENTAL LEAD ASSESSMENTS

For all environmental assessments performed, the following must be submitted:

- Copy of the home lead investigation;
- Date the assessment was performed;
- Type of hazard found, if any (e.g., lead-based paint, hobby);
- Lead paint XRF highest reading;
- Highest levels of lead found in paint chip, soil, water;
- Notation of actions to be taken (i.e., abatement or remediation) and due date; and,
- Date the actions were completed (on reassessments).

This information must be submitted within two weeks of the assessment to:

Childhood Lead Poisoning Prevention
Missouri Department of Health and Senior Services
P.O. Box 570,
Jefferson City, MO 65102
(573) 526-4911

Only one Initial Assessment (procedure code (T1029UATG) is permitted per year/per provider/per primary residence.

Environmental lead assessment services may only be billed if the service is provided on site at the primary residence. When several children in the same household have blood lead levels that qualify for an environmental lead assessment, only one environmental assessment may be billed to MO HealthNet.

INITIAL ENVIRONMENTAL LEAD ASSESSMENT

Procedure Code	Description
T1029UATG	Initial Environmental Lead Assessment

The following activities are included in the reimbursement for the initial environmental lead assessment.

- Upon receipt of referral for an individual with lead levels of 15 ug/dL or greater, evaluate proper level of response required, contact the individual or parent/guardian/building owner to obtain approval for inspection and make arrangements to actuate an investigation.
- Obtain information from child's care giver.
- Visually inspect for lead hazards, heavily used areas, and levels of sanitation. Delineate sampling locations and collect samples.
- Report results and negotiate compliance time frame. Set day and time for re-inspection. Counsel residents on interim exposure reduction methods.
- Refer individual to an enrolled case management agency of choice if not already receiving case management services.

First Reassessment

Procedure Code	Description
T1029UA	First Environmental Lead Reassessment

The following activities are included in the first environmental lead reassessment:

- Visit participant's primary residence to visually observe abatement procedures that have been completed, and collect any samples necessary to indicate the areas were contained properly and cleaned up adequately (i.e. soil or dust samples).
- If abatement procedures are complete and an adequate cleanup has taken place, verbal and written acknowledgment should be given to parent/guardian and building owner along with appropriate maintenance recommendations.
- If abatement procedures are *not* complete, another conference must take place to determine when the work is to be completed. If there appears to be a reluctance to comply, follow the instructions in the Department of Health and Senior Services Lead Manual. A date and time should be set for a second reassessment.

Second Reassessment

Procedure Code	Description
T1029UATF	Second Environmental Lead Reassessment

Follow the same procedure as the first reassessment. If compliance has not been completed, follow the instructions in the Department of Health and Senior Services Lead Manual.

Subsequent Reassessment

Procedure Code	Description
T1029UATS	Subsequent Environmental Lead Reassessment

Follow the same procedure as the first reassessment. Attach a *Certificate of Medical Necessity* form to claim to explain why the additional assessment is necessary.

Environmental Lead Assessment-Subsequent Reassessment requires that a *Certificate of Medical Necessity* is attached to the claim to explain why the additional assessment is necessary. If the documentation is not attached to the CMS-1500 claim form, the claim will be denied. The participant cannot be billed for services that are not considered medically necessary.

MO HEALTHNET MANAGED HEALTH CARE PLANS

The MO HealthNet managed health care plan is responsible for coverage of the lead screens and blood lead level determinations as well as the lead case management services for those children who are enrolled in the MO HealthNet managed health care plan program.

The MO HealthNet Division provides reimbursement for environmental lead assessments as a supplemental benefit to the MO HealthNet managed health care plan program when furnished by an enrolled Medicaid lead assessment provider. Lead assessment services should be coordinated with the managed health care plan when the blood lead level is elevated.

SECTION 14
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

MO HealthNet uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600
www.amabookstore.com

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Optum
P.O. Box 88050
Chicago, IL 60680-9920
800/464-3649
Fax Orders: 801/982-4033
www.Optumcoding.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

MO HealthNet also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

PMIC
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
Fax Orders: 800/633-6556
http://pmiconline.com

SECTION 15
PARTICIPANT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled MO HealthNet provider does not want to accept MO HealthNet as payment but instead wants the patient (participant) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that MO HealthNet will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

MO HealthNet PARTICIPANT REIMBURSEMENT

The MO HealthNet Participant Reimbursement program is devised to make payment to those participants whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Participants are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The participant is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call (800) 392-2161.

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS employees, applicants for employment, and contractors are to be treated equitably regardless of race, color, national origin, ancestry, genetic information, pregnancy, sex, sexual orientation, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain nondiscrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

DSS applicants for, or recipients of, services from DSS are to be treated equitably regardless of race, color, national origin, ancestry, sex, age, sexual orientation, disability, veteran status, or religion. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); or Relay Missouri for hearing and speech impaired at (800) 735-2466 (Voice); (800) 735-2966 (Text). Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability, or religion may also file a complaint by writing to:

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 (Voice); (816) 426-7065 (TDD)

Additionally, any person who believes they have been discriminated against because of race, color, national origin, age, sex, disability, religion, or political belief in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the:

U.S. Department of Agriculture
Office of Adjudication and Noncompliance
1400 Independence Avenue, SW
Washington, DC 20250-9410
(866) 632-9992 (Voice); (800) 877-8339 (TDD); (800) 845-6136 (Spanish)

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

April 2013