MO HEALTHNET MANAGED CARE POLICY STATEMENTS

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AIDS WAIVER

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are not required to provide services included in the AIDS Waiver. Members enrolled in the AIDS Waiver will be disenrolled once identified. MO HealthNet Managed Care health plans are required to provide services that non-AIDS Waiver members with HIV/AIDS require. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

The AIDS Waiver program provides services in addition to the standard MO HealthNet benefit package. These services are covered by MO HealthNet as a cost effective alternative to nursing home placement. Services available to members with HIV/AIDS, or disabling related illnesses, are private duty nursing, waiver personal care, waiver attendant care, and supplies (diapers, underpads, and gloves).

PROGRAM LIMITATIONS

Children age 0-20 are not enrolled in the AIDS Waiver program as they receive the sameservices under the Healthy Children and Youth Program (HCY) through the MO HealthNet Managed Care health plan, when medically necessary. Members with ME codes of 02, 08, 52, 57, 64, and 65 are not eligible for services through the AIDS Waiver program.

Members who are 21 years of age or older that receive services through the AIDS Waiver program will be disenrolled from MO HealthNet Managed Care once identified. AIDS Waivermembers are not readily identifiable based on their type of assistance code. There is no automated means within the Fee-for-Service system to show that members are in the AIDS Waiver. During the transition from MO HealthNet Managed Care to fee-for-service, MO HealthNet Division will reimburse AIDS Waiver services fee-for-service. All other covered services will be the responsibility of the MO HealthNet Managed Care health plan until the member is disenrolled from the MO HealthNet Managed Care health plan.

A member is determined to be eligible for the AIDS Waiver program if they have been diagnosed with AIDS or HIV, would otherwise require nursing home care, and have a need for atleast one of the services covered through the AIDS Waiver. Members are assessed for waiver eligibility by case managers who contract with the Department of Health and Senior Services.

MO HealthNet Managed Care health plans may have members with an HIV/AIDS diagnosiswho do not wish to participate in the AIDS Waiver.

The AIDS Waiver does not cover protease inhibitors. Protease inhibitors are a regular state plan benefit, reimbursable through the pharmacy program. Protease inhibitors are not the responsibility of the MO HealthNet Managed Care health plans and are reimbursable on a fee-for-service basis for MO HealthNet Managed Care members.

MISCELLANEOUS

The AIDS Waiver Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

AMBULATORY SURGICAL CENTER

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Ambulatory Surgical Center (ASC) program services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The Ambulatory Surgical Center program provides a place for operative procedures that can be safely performed inan outpatient setting. The procedures must be able to be completed within the maximum time of 90 minutes (42 CFR 416.65). This is the maximum length of time that a member may be placedunder anesthesia in an ASC. The ASC program closely approximates the coverage of Medicare in identifying the procedures that may be performed in an ASC.

Providers must be Medicare certified as an ASC and licensed by the Department of Health and Senior Services. Providers are required to have an agreement with a local hospital for purposesof providing emergency medical coverage on an as needed basis.

Note: Physician's professional services are reimbursed directly to the physician or other provider performing the service.

MISCELLANEOUS

The Ambulatory Surgical Center Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

ANESTHESIA SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide anesthesia services. Servicesmust be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Anesthesia services are covered when performed by an anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA). Medical direction of anesthetists by an anesthesiologist is also a covered service.

The concurrent medical direction of at least two (2), but not more than four (4), anesthetists iscovered if the following additional requirements are met.

For each member, the physician:

- Performs and documents a pre-anesthetic examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan including induction and emergency
- Ensures that all procedures in the anesthesia plan that they do not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at frequent intervals
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

PROGRAM LIMITATIONS

Administration of local infiltration, digital block, or topical anesthetic by the operating surgeonor obstetrician is included in the surgery or delivery fee. A separate fee for administration is not allowed.

The anesthesia agents or supplies used when performing any surgical procedure in the office are included in the reimbursement for the surgical procedure and are not covered separately.

Local anesthesia is included in the procedure/surgery if provided in the physician's office. If provided in an ambulatory surgical center or outpatient department of the hospital it is includedin the facility charge. If provided on an inpatient basis it is included in the accommodation revenue code for the facility.

There may be an occasional need for anesthesia during CT scan services as a result of medically necessary circumstances, (e.g. child with hyperactivity or behavioral health conditions, etc.).

Medical direction or supervision of students in a teaching, training, or other setting is not covered.

Anesthesiologists may only report one procedure per date of service (operative setting). When anesthesia is administered for multiple surgical procedures for the same member on the same date of service, during the same operative setting, only the major surgical procedure should bereported.

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

PROC CODE	DESCRIPTION
99100	Anesthesia for patient of extreme age, under one year and over seventy.
99116	Anesthesia complicated by utilization of total body hypothermia.
99135	Anesthesia complicated by utilization of controlled hypotension.
99140	Anesthesia complicated by emergency conditions (specify).

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

Consent forms for anesthesia services for surgical procedures requiring Certification of Medical Necessity for Abortion, Sterilization Consent, or Acknowledgement of Receipt of Hysterectomy Information must be properly executed.

Anesthesia for dental services is covered for those members who are unable to cooperate in a dental office due to age, handicap, or mental health concerns. Anesthesia when administered by a dentist or oral surgeon is reportable as a dental service using CDT codes. When performed by an anesthesiologist, AA or CRNA, CPT codes are used.

Any surgical procedure listed as non-covered for surgery is also non-covered for anesthesiology. The provider of anesthesia services will be responsible to ensure the procedure is a covered service.

Anesthesiologist monitoring telemetry in the operating room is non-covered.

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

Anesthesiologist, AA, and CRNA services are not covered in the recovery room. Anesthesia should be billed using the appropriate CPT anesthesia procedure codes (00100-01999) with one of the following appropriate modifiers:

AA – Anesthesia services performed personally by the anesthesiologist.

QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
QX – CRNA/AA service; with medical direction by a physician.
QZ – CRNA service; without medical direction by a physician.

MISCELLANEOUS

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

ASTHMA PROGRAM

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide asthma prevention education, counseling, and in-home assessments. This program is a statewide asthma prevention education, counseling, and in-home assessment program for asthma triggers focusing on youth members who have evidence of uncontrolled asthma. Members under the age of 21 who have evidence of uncontrolled asthma are eligible.

PROGRAM LIMITATIONS

Member Eligibility

For members to be eligible for asthma education and asthma environmental assessment services, the member must meet the following criteria:

- ❑ Currently enrolled in MO HealthNet
- ❑ Younger than 21 years of age
- ❑ Have a primary diagnosis of asthma
- ❑ Had one of the following events as a result of asthma in the last 12 months:
  - ➢ One (1) or more inpatient hospital stays
  - ➢ Two (2) or more emergency department (ED) visits
  - ➢ Three (3) or more urgent care visits
  - ➢ A high utilization of rescue inhalers (short-acting inhaled beta-2 agonists) defined as four (4) or more prescription refills
  - ➢ Underutilization of ICS (inhaled corticosteroids) defined as missing four (4) or more refills based on their enrollment months, and at least one (1) ED or Urgent Care visit.

Prior Authorization

Asthma education and asthma environmental assessments require a referral from a physician and a prior authorization.

Place of Services

All asthma education and asthma environmental assessment services must take place in the member's home. The place of service (POS) code must be 12 (Home).

Procedure Codes and Limits

The following table details the billable codes for asthma education and asthma environmental assessments. The annual limit of asthma education visits will be dependent on the codes used, but shall not exceed one (1) hour per year with the exception of one (1) 90 minute self-management session. Asthma educators may use a combination of codes S9441, 99401, and 99402 to bill for services, but may not bill over one (1) hour, unless using code 98960. If code 98960 is billed, all other asthma education codes may not be billed.

ASTHMA EDUCATION

PROC CODE	DESCRIPTION
S9441	Asthma education non-physician (30 minutes per unit) Maximum one hour per year
99401	Preventive medicine counseling, individual (15 minutes per unit) Maximum one hour per year
99402	Preventive medicine counseling, individual (30 minutes per unit) Maximum one hour per year
98960	Self-management education using standardized effective curriculum, individually, either incident to a clinical encounter or as preventive service (90 minutes per unit) Maximum once per year

ASTHMA ENVIRONMENTAL ASSESSMENTS

PROC CODE	DESCRIPTION
S9441	Asthma environmental assessment, non-physician
Modifier SC	Maximum two times per year

Authorizations for additional asthma education and environmental assessment requests beyondthe initial authorization must be submitted as a new prior authorization request and must be deemed medically necessary.

PROVIDER QUALIFICATIONS

Asthma Educator:

- ❑ Nation Asthma Educator Certification (AEC)
- ❑ Missouri State Certification

Asthma Assessor:

- ❑ National Certification – National Environmental Health Association (NEHA) Healthy Home Specialist or a NEHA Healthy Home Evaluator Micro-Credential
- ❑ Missouri State Certification

Providers should reference 13 CSR 70-3.260 *for more details regarding certification.*

RESOURCES FOR PROVIDERS

MHD maintains a list at https://apps.dss.mo.gov/fmsMedicaidProviderSearch/. Prescribing providers can also find a list of asthma educators and asthma in-home environmental assessors at

http://www.asthmabridge.com/provider-network.html; services are subject to prior authorization.

MISCELLANEOUS

The Physicians Manual (section 13.72) and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

BEHAVIORAL HEALTH SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide behavioral health (which encompasses mental health and substance use disorder treatment) services included in the comprehensive benefit package for members in Category of Aid (COA) 1, 2, 4, 5, and 6. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services may only be limited by medical necessity. Please refer to the policy statement on Behavioral Health Fee-For-Service Coordination for information on specific behavioral health services that are not included in the comprehensive benefit package.

Members in COA 4 (children in the care and custody of the State) are covered under the Show Me Healthy Kids Health Plan (Specialty Plan) managed by Home State Health. They receive CCS Rehabilitation Services and Non-Emergency Medical Transportation, which are additional behavioral health services on top of those covered through the general plan.

MO HealthNet Managed Care health plan policies and procedures shall permit members to contact an in-network behavioral health provider directly to access behavioral health serviceswithout prior authorization requirements.

Outpatient Facility, Psychiatry, Psychology, and Counseling

MO HealthNet Managed Care health plans are required to provide psychiatry, psychology, counseling, and outpatient facility services for members in Category of Aid (COA) 1, 2, 4, 5, and 6. Providers for adults and children may include:

- Licensed psychiatrists
- Licensed or provisionally licensed psychologists
- Supervised psychology interns
- Licensed clinical social workers
- Licensed master social workers
- Licensed or provisionally licensed professional counselors
- Licensed psychiatric clinical nurse specialists
- Licensed psychiatric nurse practitioners
- Licensed or provisionally licensed marital and family therapists (PLMFT/LMFT)
- Missouri certified behavioral health programs

Medicaid State Plan psychiatry services are included under the physician program. Please refer to the Physician/Advanced Practice Nurse Services, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) policy statement for more detail regarding physician services.

Please refer to the policy statement on Behavioral Health Fee-For-Service Coordination for information on specific behavioral health services that are not included in the comprehensive benefit package.

Show Me Healthy Kids managed by Home State Health (Specialty Plan) is required to develop, monitor, and maintain a comprehensive provider network that meets the unique and complex needs of Specialty Plan members, maximizes the availability of community-based, trauma-informed, and integrated services and reduces any unnecessary utilization of inpatient, emergency services, and out-of-home/out-of-state (hereinafter referred to as OOS) placements. The Specialty Plan shall increase network access to prevention, community-based and specialty providers (e.g., developmental-behavioral pediatricians, trauma therapists and dental/orthodontic specialists) and promote the use of natural and informal supports.

Show Me Healthy Kids is required ensure that PCPs assess for the signs, symptoms, and risks of trauma to inform treatment approaches and trauma-informed service needs. Also, that they include behavioral health service providers in Comprehensive Community Support Services and practitioners certified in one or more of the following evidence-based practices (EBPs):

- Eye Movement Desensitization Reprocessing (EMDR)
- Trauma Focused Cognitive-Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)

Show Me Healthy Kids (Specialty Plan) is required to offer and provide care management (CM) to all Specialty Plan members with a focus on improving health outcomes and member/family experiences. The Specialty Plan's CM program shall utilize a person-centered, integrated approach to meet the complex physical health, behavioral health and psychosocial needs of Specialty Plan members and their families.

EPSDT/HCY Behavioral Health Services for Children

The MO HealthNet Managed Care health plans are required to provide the following behavioralhealth services for members under the age of 21:

- Psychological services include testing, assessment, evaluation, development of atreatment plan, and the treatment of behavioral health conditions
- Counseling services cover counseling for behavioral health conditions
- Psychotherapy for Crisis is a face-to-face contact to diffuse a situation of immediatecrisis. The situation must be of significant severity to pose a threat to the member's wellbeing or the member is a danger to themselves or others;
- Developmental/behavioral health screen is a screening of social/languagedevelopment and fine/gross motor skill development.

Psychiatric Inpatient Facility

MO HealthNet Managed Care health plans are required to provide inpatient psychiatric hospitalization. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised plan of care.

Covered settings for members under the age of 21 include acute care hospitals, private psychiatric hospitals, and state psychiatric hospitals.

Covered settings for members between the ages of 21 and 64 include acute care hospitals and freestanding psychiatric hospitals with 16 or fewer beds.

MO HealthNet Managed Care health plans may elect to cover inpatient psychiatric services in an Institution for Mental Disease (IMD)as an in lieu of setting for stays of 15 days or less within the month.

Detoxification Services

MO HealthNet Managed Care health plans are required to provide detoxification services duringthe intoxication and withdrawal stages of a substance use disorder. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The initial length of stay is limited to three (3) days. The attending physician or hospital may request additional days if extended acute care is medically necessary.

Court Ordered Services

MO HealthNet Managed Care health plans are required to provide services in the comprehensive benefit package that are court ordered and for involuntary commitments, including 96 hour detention, regardless of medical necessity.

Children in Category of Aid 4

Members in COA 04 (children in the care and custody of the State) are covered under the Show Me Healthy Kids Health Plan (Specialty Plan) managed by Home State Health.

Services In An Educational Setting

For a member under the age of 21 who is receiving behavioral health services identified in the child's Individualized Education Program (IEP), the services are billed fee-for-service and are not the responsibility of the MO HealthNet Managed Care health plan. Please refer to the policy statement on Services In An Educational Setting for further information.

PROGRAM LIMITATIONS

- Inpatient care that is not medically necessary are not covered
- Services provided at a non-acutecare level are not covered
- Neuropsychological evaluations are not covered.

MISCELLANEOUS

The MO HealthNet Managed Care health plan network must include, although not be limited to, qualified behavioral health professionals (QBHP) and substance use disorder or co-occurring treatment professionals that are certified by the Missouri Credentialing Board as defined in the contract.

The state agency, in conjunction with the Department of Mental Health,has developed community-based services with an emphasis on the least restrictive setting. The MO HealthNet Managed Care health plan shall consider, when appropriate, using such services in lieu of using out-of-home placement settings for members.

Please refer to the policy statement on Behavioral Health Fee- For-Service Coordination for information on specific behavioral health services that are not included in the comprehensivebenefit package.

The Behavioral Health Services Manual, Hospital Manual, Physician Manual, and provider bulletins are all available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

BEHAVIORAL HEALTH FEE-FOR-SERVICE COORDINATION

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are not required to provide:

- Comprehensive SubstanceTreatment and Rehabilitation (CSTAR)
- Community Psychiatric Rehabilitation (CPR)
- Targeted Case Management (TCM)
- DD Home and Community Based Waiver services offered through the Department of Mental Health (DMH Waiver)
- Applied Behavior Analysis (ABA) services

The MO HealthNet Fee-For-Service Program will provide these services according to the terms and conditions of the MO HealthNet program when:

- Provided by DMH certified providers
- For ABA, when provided by MO HealthNet enrolled providers.

CSTAR, CPR, TCM, DD Home and Community Based Waiver Services, and ABA services are available to individuals who meet the eligibility criteria for these specific services on the same basis as the services are available to MO HealthNet/MO HealthNet Fee-For-Service referrals.

For individuals enrolled in MO HealthNet Managed Care, application can be made for CSTAR, CPR, and related TCM services by the member or guardian in conjunction with the MO HealthNet Managed Care health plan. Applications for DD Home and Community Based Waiver Services may be made by the member or guardian or with assistance from the MO HealthNet Managed Care health plan for individuals, by contacting the local DD Regional Office. All ABA services require precertification.

Each MO HealthNet Managed Care health plan should work with DMH providers and regionaloffices in their area to develop protocols to assist in coordination of services and identify needsand capacity for these services.

Referrals from MO HealthNet Managed Care health plans willbe accepted as the current capacity of these services allows. If access to these services is not available at the time of referral, the MO HealthNet Managed Care health plan remains responsible for provision of all medically necessary services included in the comprehensive benefit package.

Comprehensive Substance Treatment and Rehabilitation (CSTAR)

CSTAR programs provide services to MO HealthNet members who are assessed as needingsubstance use treatment. CSTAR programs provide a continuum of treatment services and supports tailored to the needs of the member.

The following populations have first priority for service:

1) Pregnant women
2) Post-partum women
3) IV Drug Users
4) HIV patients

Referrals from MO HealthNet Managed Carehealth plans will be accepted as the current capacity of these services allows.

Non-Emergency Medical Transportation (NEMT) is available to use as an option to assist members enrolled in the CSTAR program in accessing their appointments with their physician or advance practice nurse who is managing and prescribing their medications. NEMT does not include visits for the administration of other medications or methadone dosing.

CSTAR services are "carved out" of the MO HealthNet Managed Care Program andare administered separately by the Department of Mental Health's Division of Behavioral Health. CSTAR MO HealthNet-enrolled providers are reimbursed on a fee-for-service basisby the Division of Behavioral Health. It is essential for quality of care that there is timely communication among the CSTAR providers, the MO HealthNet Managed Care health plans, and their behavioral health subcontractors.

A protocol for coordinating care for pregnant members accessing CSTAR services is outlined below:

1) A substance use screening form is completed by a primary care provider or otherpractitioner to determine whether a substance use disorder is present.
2) A positive response to one or more questions should lead to brief intervention, further assessment or referral to a CSTAR provider.
3) Brief intervention is defined as advising the member to abstain from alcohol or otherdrugs.
4) Referral to a CSTAR provider by the MO HealthNet Managed Care health plan participating provider should occur when (1) There is a need for more thorough assessment, (2) The member has failed to cut down or remain abstinent, or (3) Themember has a substance use disorder that is evident based upon evaluation and history.
5) The CSTAR provider will obtain a signed multiple party consent form from the clientthat will allow them to communicate with the MO HealthNet Managed Care health plan.
6) The CSTAR provider will provide notice to the MO HealthNet Managed Care healthplan of the date of admittance. Following discharge of the client, a copy of the discharge plan will be provided to the MO HealthNet Managed Care health plan or their behavioral health subcontractor.
7) CSTAR providers and MO HealthNet Managed Care health plans shall collaborate toobtain needed psychiatric services for CSTAR enrolled patients.

Community Psychiatric Rehabilitation (CPR)

The DMH Division of Behavioral Health through its Administrative Agents provide CPR which includes a range of essential community-based mental health services designed to maximize independent functioning and promote the recovery and self-determination of individuals. In addition, they are designed to increase interagency coordination and collaboration in all aspects of the treatment planning process. Ultimately they help to reduce inpatient hospitalizations and out-of-home placements.

CPR is carved out of the MO HealthNet Managed Care Program. The MO HealthNet Fee-For-Service Program will reimburse CPR certified providers according to the terms and conditions of the MO HealthNet program. It is essential for quality of care that open and consistent dialogue exists between the CPR providers, the MO HealthNet Managed Care health plans and their mental health subcontractors.

The MO HealthNet Managed Care health plans and their behavioral health subcontractors will refer members seeking CPR services to a CPR certified provider.The CPR provider will conduct an assessment to determine eligibility and the appropriate level of care.

If the member refuses to receive care at a CPR provider, the MO HealthNet ManagedCare health plan remains responsible for providing psychiatric services as required by the contract and may provide alternative services to divert the member from higher levels of care.

The MO HealthNet Managed Care health plan and the CPR provider are jointly responsible for coordinating services which may include participation in Family Support Teams for children/youth to outline the individual's needs, strengths, andservices/supports across all involved parties.

The CPR provider and MO HealthNet Managed Care health plan are responsible for documentation of services provided and denial of any services.

Targeted Case Management (TCM)

TCM services include the following:

- Arrangement, coordination, and participation in the assessment to ensure that all areas of the family and individual's lives are assessed to determine unique strengths and needs.
- Coordination of the service plan implementation, including linking individuals andfamilies to services, arranging the supports necessary to access resources, and facilitating communication between service providers.
- Monitoring the service delivery plan with the individual and family participation to determine the adequacy and sufficiency of services and supports, goal attainment, need for additional assistance, and continued appropriateness of services and goals.
- Documentation of all aspects of intensive targeted case management services including case openings, participation in assessments, plans, referrals, progress notes,contacts, rights and grievance procedures, discharge planning, and case closure.

TCM services are carved out of the MO HealthNet Managed Care program. MOHealthNet Fee-For-

Service will reimburse TCM services provided by DMH Division of Behavioral Health administrative agents.

The MO HealthNet Managed Care health plans and their behavioral health subcontractors will refer members seeking TCM services to the appropriate administrative agent/community mental health center (CMHC) in the area. The CMHC will conduct an assessment to determine if the individual meets criteria as having a serious emotional disorder or serious behavioral health disorder and is eligible for TCM.

The MO HealthNet Managed Care health plan remains responsible for all services included in the comprehensive benefit package.

The MO HealthNet Managed Care health plan and CMHC are jointly responsible for coordinating services which may include participation in Family Support Teams to outline the individual's and family's needs, strengths and services/supports acrossall involved parties.

The TCM provider and MO HealthNet Managed Care health plan are responsible for documentation of services provided and denial of any services

Developmental Disabilities (DD) Home and Community Based Waivers:

The Division of DD, within the Department of Mental Health, administers four MO HealthNet Home and Community Based Waivers. Individuals eligible for MO HealthNet and who have intellectual/developmental disabilities may apply to participate in:

- DD Comprehensive Waiver
- Missouri Children's Developmental Disabilities Waiver (MOCDD)
- DD Community Support Waiver
- Partnership for Hope Waiver

The Division of DD's regional offices determine which members have access to waiver participation.

Members must have intellectual/developmental disabilities that result in functional limitations in three or more areas. The members must also be determined to qualify for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) institutional services, and would require those services in the absence of services through the waiver. The four DD waivers contain services including but not limited to:

- Transportation
- Personal assistant
- Community specialist
- Support broker
- Behavior analysis service
- Professional assessment and monitoring
- Person centered strategies consultation
- Environmental accessibility adaptations

- Specialized medical equipment and supplies

Residential supports are only available in the DD Comprehensive Waiver. Participants in the DD Community Support Waiver are limited to an annual service package that does not exceed $28,000 and the Partnership for Hope not to exceed $12,000. Exceptions to these cost limitations can be granted on a case by case basis to assure health and safety. The average cost of all participants in the DD Comprehensive Waiver cannot exceed the average cost of all participants in the ICF/ID program.

Every individual who is determined eligible for Division of DD services is eligible for case management services. Case management for individuals who are MO HealthNet eligible, including participants in DD Home and Community Based Waivers, is provided as targeted case management. Targeted case management services are provided by qualified developmental disabilities professionals (QDDPs) employed by the Division's regional offices and County Senate Bill 40 Boards and other not for profit entities that contract with the Division of DD to provide case management services**.**

Applied Behavioral Analysis (ABA) Services

In order to be eligible for ABA services, members must be under 21 and have a diagnostic evaluation performed by a licensed physician or licensed psychologist, resulting in a diagnosis ofAutism Spectrum Disorder (ASD), and recommending ABA services as medically necessary.

The diagnostic evaluation should be performed in accordance with *Autism Spectrum Disorders: Missouri Best Practice Guidelines for Screening, Diagnosis, and Assessment,* published by the Missouri Autism Guidelines Initiative. These guidelines can be found at: http://autismguidelines.dmh.mo.gov/pdf/Guidelines.pdf.

All ABA services require precertification, and instructions for requesting precertification are found in this bulletin:http://dss.mo.gov/mhd/providers/pdf/bulletin38-15_2015oct20.pdf.

Services Funded Through General Revenue (GR)

Comprehensive Psychiatric Services (CPS) provides an array of GR services that are not MO HealthNet covered and are, therefore, not considered an entitlement and may have limited capacity. The availability and capacity of any specific GR service varies across geographic areas. These services include but are not limited to:

- Respite care
- Residential care

General Procedures:

- Any individual in Missouri may access these GR services based on eligibility and availability of the service as well as availability of funding.
- Individual/families may be assessed a monthly fee for these GR services under theState's Standard Means Test.

- Individuals are assessed for eligibility and prioritized based upon acuity of clinicalneed and access to other health coverage and supports. There is no entitlement or guarantee of access to these services for any individual.
- Individuals enrolled in MO HealthNet Managed Care may access these GR services under the above conditions. MO HealthNet Managed Care health plans are encouraged to develop plans with the appropriate community mental health center(s)in their geographic catchment area to aid in the assessment of the geographic area's capacity needs.
- MO HealthNet Managed Care health plans may also provide similar services if cost effective as a diversion from more intensive levels of care.
- If an individual is placed on a waiting list for any of these GR services due to capacity limitations, the MO HealthNet Managed Care health plan remains responsible for the services covered under the comprehensive benefit package.
- The MO HealthNet Managed Care health plan must demonstrate the need for theadditional GR services to be provided by the CMHC.
- The CMHC is responsible for determining eligibility for service provision, and in conjunction with the legal guardian in determining the appropriate level and types of services to be provided.

Child/Adolescent Procedures:

- When a child is receiving services through CPS, the administrative agent shall facilitate a Family Support Team to develop a coordinated treatment plan. Team members should include the youth when appropriate, the youth's parents or legal guardian, and all involved parties including the MO HealthNet Managed Care healthplan's clinical representative. The health plan staff shall actively participate in all Family Support Team meetings as the health plan remains responsible for coordination of care if the child is receiving intensive services through the administrative agents Community Psychiatric Rehabilitation (CPR) Programs.
- The administrative agent will notify all parties, including the MO HealthNet ManagedCare health plan representative of the first Family Support Team meeting.
- After the first meeting, it is the responsibility of the MO HealthNet Managed Care health plan representative to inform the administrative agent how they wish to receivenotification of future Family Support Team meetings as it was noted above that the health plans shall continue to provide intensive case management when a child/youth is in the CPR program.
- Services identified in the coordinated treatment plan that are covered by the MOHealthNet Managed Care health plan will be provided by the network of the MOHealthNet Managed Care health plan.
- The administrative agent shall coordinate with the MO HealthNet Managed Carehealth plan for authorization of these services.
- The administrative agent shall document the involvement of the MO HealthNet Managed Care health plan in the record as well as authorization of the medically necessary services, and if denied, the reason for denial and any alternative servicesauthorized.

Child Inpatient and Residential Services:

- If a child enrolled with a MO HealthNet Managed Care health plan requires and is receiving inpatient psychiatric hospitalization, it is the MO HealthNet Managed Carehealth plan's

responsibility, in conjunction with the contracted inpatient provider, to plan for and obtain appropriate aftercare services.

- If a recommendation has been made for residential placement due to the intensityand/or chronicity of the child's needs, a referral can be made to the CMHC for residential treatment services.
- It is the responsibility of the MO HealthNet Managed Care health plan to obtain all necessary information required to complete the application for placement through theDivision of Behavioral Health and to demonstrate that community-based and less restrictive treatment options have been attempted in the care of the member and have not been successful, and that there are no appropriate services that might otherwise beavailable to keep the member in his or her home and community.
- The CMHC will conduct an assessment to determine if the child requires out of home placement, and is eligible for CPS funding.
- Funding for residential care is limited as well as the availability of residential beds that would meet the child's specific, individualized needs. Until an appropriate residential bed is available and funding has been obtained for residential services, the MO HealthNet Managed Care health plan is responsible for providing all services thatare included in the comprehensive benefit package. It should be noted that residential services are not in any way an entitlement through CPS. If the community mental health center does not have the funding, or does not agree with a recommendation for residential placement, there is not mandate that the CMHC admit to residential. It would then remain the responsibility of the health plan to meet all the healthcare needs of the child.
- If and when the child is placed in residential care through the administrative agent, the MO HealthNet Managed Care health plan is responsible for providing all services that are included in the comprehensive benefit package. That would include continuing to provide intensive case management since the child is receiving an intensive level of care.
- If a MO HealthNet Managed Care enrolled child is receiving residential services through CPS, at least one month prior to the scheduled discharge the administrativeagent shall communicate with the appropriate clinical representative from the MO HealthNet Managed Care health plan regarding the status of the child and aftercareplanning.

Transition From MO HealthNet Managed Care to MO HealthNet Fee-For-Service

MO HealthNet Managed Care health plans remain responsible for all medically necessary services included in the comprehensive benefit package until the member is finally disenrolled from the MO HealthNet Managed Care health plan.

- For children known to be at risk to be disenrolled or to choose to opt-out, MO HealthNet Managed Care health plans and DMH providers will offer and encourage aFamily Support Team Treatment Plan as described above.

MISCELLANEOUS

The DD Waiver, C-STAR, and Community Psychiatric Rehabilitation (CPR) program manuals,as well as provider bulletins, are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

DEPARTMENT OF MENTAL HEALTH PROTOCOL DEFINITIONS

Case Management

The arrangement and coordination of an individual's treatment and rehabilitation needs, as wellas other medical, social, and educational services and supports; coordination of services and support activities; monitoring of services and support activities to assess the implementation ofthe client's individualized plan and progress towards outcomes specified in the plan.

Residential Treatment

This service consists of domiciliary care provided those who have been discharged from a mental health facility and those who would, without such services require inpatient care. Service provided includes room, board and habilitative services.

Respite Care – Youth

Temporary care provided by trained, qualified personnel, on a time limited basis, with the purpose of meeting family needs and providing behavioral health stabilization for families with children with severe emotional disturbance (SED). The service must be prescribed in the treatment or service plan as an essential clinical or supportive intervention for children and youthwith SED under the age of 18. Respite may be provided in or out of the client's home, community or at a DMH licensed site. Respite care supports the family or primary caregiver in maintaining a child with SED at home.

Targeted Case Management

Case management services include the following:

- Arrangement, coordination, and participation in the assessment to ensure that all areas of the individual's and family's life are assessed to determine unique strengths and needs
- Coordination of the service plan implementation, including linking individuals and families to services, arranging the supports necessary to access resources and facilitating communication between service providers
- Monitoring the service deliver plan with the individual and family participation to determine the adequacy and sufficiency of services and supports, goal attainment, needfor additional assistance and continued appropriateness of services and goals; and
- Documentation of all aspects of intensive targeted case management services including case openings, participation in assessments, plan, referrals, progress notes, contact, rights and grievance procedures, discharge planning and case closure.

Administrative Agent

The agency provides a consortium of treatment services to consumers (both children and adults).The administrative agent and its approved designee are authorized by the Division of BehavioralHealth as entry and exit points into the state behavioral health service delivery system for a geographic

service area defined by the Division of Behavioral Health.

Family Assistance Worker

These services are provided for a child/adolescent. The services can be provided in the home or in a variety of settings, i.e., school, travel to and from school, home, social/peer settings, or in a group or one-to –one supervision. Services may be provided during varying hours of the day tobest fit the need of the child/adolescent/family. Activities provided in the delivery of services may include home living and community skills, communication and socialization, and leisure activist for the child/adolescent.

The Family Assistance worker can provide one-on-one services to assist the child/adolescent with activities of daily living or to assure arrival at school or other commitments. The worker can teach appropriate social skills through hands-on experiences: i.e., displaying appropriate social interactions with the child/adolescent, or resolving conflicts with sibling or peers, etc. Other referral agencies used may include leisure community resources, recreation therapy itself,appropriate school resources, or other available community resources.

Family Support

Activates are designed to develop a support system for parents of children who have a serious emotional disturbance. Activities must be directed and authorized by the treatment plan.
Activities may include, but are not limited to, problem solving skills, emotional support, disseminating information, linking to services and parent-to-parent guidance.

Community Psychiatric Rehabilitation (CPR):

A certified CPR program provides the following services:

- Evaluation services--determines whether the individual is eligible for admission to theCPR program and that the individual is among the priority populations of Comprehensive Psychiatric Services.
- Community Support--activities designed to ease an individual's immediate and continued adjustment to community living by coordinating delivery of behavioralhealth services with services provided by other practitioners and agencies and monitoring client progress in organized treatment programs.
- Family Support – This service may involve a variety of related activities to the development or enhancement of the service delivery system. Activities are designed to develop a support system for parents of children who have a serious emotional disturbance. Activities must be directed and authorized by the treatment plan. Activities may include, but are not limited to, problem solving skills, emotional support, disseminating information, linking to services and parent to parent guidance.
- Intensive Community Psychiatric Rehabilitation -- level of support designed to help consumers who are experiencing an acute psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient or residential setting. It is a comprehensive, time limited, community-based service delivered to consumerswho are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.
- Psychosocial Rehabilitation (PSR) -- Services cover a combination of goal-orientedservice

functions delivered through a group activity in the context of a therapeutic community which promotes development of a personal support system, social skill development, training and rehabilitation in community living skills and pre-vocational skills according to individual need.

- A CPR program must be certified by the Department of Mental Health or accredited by the Council on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or Council on Accreditation (COA).
- Family Support Team-- Comprised of the child, family, care manager/service worker,and representatives of other involved agencies (e.g., behavioral health plan, Children's Division, Division of Youth Services, courts, schools) and other involved individuals (neighbors, minister). Teams are formed around the specific needs of an individual child and family therefore, the size and membership of the team varies. This team carries out and supports the service planning and delivery process.

Child/Youth Eligibility Criteria for Community Psychiatric Services

Serious Emotional Disturbance is a term used to describe children and youth who have serious disturbances in psychological growth. There are a number of characteristics that may distinguish these youth. The definition of serious emotional disturbance in the State of Missouri is defined as:

- Children and youth under 18 years.
- Children and youth exhibiting substantial impairment in their ability to function at a developmentally appropriate level due to the presence of a serious psychiatric disorder. They must exhibit substantial impairment in two or more of the following areas:
  - Self-care including their play and leisure activities;
  - Social relationships: ability to establish or maintain satisfactoryrelationships with peers and adults;
  - Self-direction: includes behavioral controls, decision making, judgment, and value systems;
  - Family life: ability to function in a family or the equivalent of a family (for a child birth through six years, consider behavior regulation and physiological, sensory, attentional, motor or affective processing and an ability to organize a developmentally appropriate or emotionally positivestate);
  - Learning ability;
  - Self-expression: ability to communicate effectively with others
- Children and youth who have a serious psychiatric disorder as defined in Axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). An "exclusive" diagnosis of V Code, conduct disorder, mental retardation, developmental disorder, or substance abuse as determined by a Department of Mental Health, Comprehensive Psychiatric Services Provider does not qualify as a serious emotional disturbance. Children from birth through three years may qualifywith an Axis I or Axis II diagnosis as defined in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC- 03).
- Children and youth whose inability to function, as described, require behavioral health intervention. Further, judgment of a qualified behavioral health professional should indicate that treatment has been or will be required longer than six months.
- Children and youth who are in need of two or more State and/or community agencies or

services to address the youth's serious psychiatric disorder and improve their overall functioning.

Serious emotional disturbance occurs more predictably in the presence of certain risk factors. These factors include family history of behavioral health conditions, physical or sexual abuse or neglect, alcohol or other substance abuse and multiple out of home placements. While these risk factors are not classified as specific criteria in the definition of serious emotional disturbance, they should be considered influential factors.

Adult Eligibility Criteria for Community Psychiatric Services

Serious and Persistent Mental Illness is a term used to describe adults suffering from severe,disabling mental illness. Must be age 18 years or over and meet each of the three criteria:

- Adults exhibiting substantial impairment in each of the following areas:
  - Social role functioning—ability to functionally sustain the role of worker, student or homemaker; and
  - Daily living skills—ability to engage in personal care (grooming, personal hygiene, etc.) and community living activities (handling personal finances, using community resources, performing household chores, etc.) at an age-appropriate level.
- Adults with a primary diagnosis of one of the DSM-V Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Revised in 2013 listed below:
  - Schizophrenia disorder
  - Delusional (paranoid) disorder
  - Schizoaffective disorder
  - Bipolar disorder
  - Atypical psychosis
  - Major depression, recurrent
  - Major depression, single episode (age 60 and over)
  - Obsessive-compulsive disorder
  - Post-traumatic stress disorder
  - Borderline personality disorder
  - Generalized anxiety disorder
  - Severe phobic disorder
- The individual must also meet at least one of the following criteria:
  - Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization.)
  - Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantlydisrupted the normal living situation.
  - Has exhibited the disability specified in bullets above for a period of noless than a year.

BIOPSYCHOSOCIAL TREATMENT OF OBESITY

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Biopsychosocial Treatment of Obesity Services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Biopsychosocial Treatment of Obesity is a six (6) month program, with the ability to be extended for an additional six (6) months, aimed at improving health outcomes for both the youth (5-20 years of age) and adult (21 years of age or older) population by managing obesity and associated comorbidities, including the prevention of comorbidity, such as diabetes. Biopsychosocial Treatment of Obesity provides an integrated medical nutrition therapy and behavioral health services through Intensive Behavioral Therapy (IBT) and Medical Nutrition Therapy (MNT). Eligible members may not participate in both the Diabetes Prevention Program (DPP) and Biopsychosocial Treatment of Obesity. MO HealthNet Managed Care eligible members ages five (5) and above with specific BMIs are eligible to participate in Biopsychosocial Treatment of Obesity:

- For youth participants a BMI percentile equal to or greater than the ninety-fifth (95^{th}) percentile for age and gender on the pediatric BMI chart.
- For adult participants a BMI equal to or greater than thirty (30).
- Not concurrently receiving authorization for other MO HealthNet reimbursed weight reduction services.

Biopsychosocial Treatment of Obesity services for youth include a six (6) month period of intervention that allows a maximum of four (4) hours of IBT and twenty-two (22) hours of group IBT for a total of twenty-six (26) hours of behavior therapy and one (1) hours and (45) minutes of MNT. An additional six (6) month continuation of the program may be granted if the continuation criteria is met and final determination is provided by the prescribing provider.

Biopsychosocial Treatment of Obesity services for adults include a six (6) month period of intervention that allows a maximum of three (3) hours of individual IBT and nine (9) hours of group IBT for a total of twelve (12) hours of behavior therapy and one (1) hour forty-five (45) minutes of MNT. An additional six (6) month continuation of the program may be granted if the continuation criteria is met and final determination is provided by the prescribing provider.

Continuation of Biopsychosocial Treatment of Obesity Services for months seven (7) through twelve (12) include an additional one (1) hour of individual IBT and two (2) hours of group IBT for a maximum of three (3) hours of IBT and an additional thirty (30) minute of MNT for both youth and adults.

A participant that is unable to meet the continuation criteria for the additional six (6) months of Biopsychosocial Treatment of Obesity services has the option, after twelve (12) months, to re-enroll for services if the participant meets the established criteria and has an approved prior authorization.

MISCELLANEOUS

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

CERTIFIED NURSE MIDWIFE

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide certified nurse midwife services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Certified nurse midwives may furnish all medically necessary services that are within their scope of practice. Prenatal care, deliveries, and postpartum care are within the scope of practice of a certified nurse midwife and are covered benefits. The scope of practice for certified nurse midwives is limited to females 15 years of age and over. A certified nurse midwife may also provide newborn care to infant's age 0 through 2 months.

Certified nurse midwives may provide family planning services and well woman checks within their scope of practice. The MO HealthNet Managed Care health plans must cover family planning services even when provided out of plan. In addition to the office visit, covered family planning services include: Norplant (including insertion and removal), medroxyprogesterone acetate injections, oral contraceptives, and insertion of an intrauterine device. Also covered are any lab and x-ray procedures related to family planning and/or well woman checks. Refer to the Family Planning Policy Statement for additional information.

Covered Services

Services include:

- Management and provision of the care of a pregnant woman and her unborn/newborn infant throughout the maternity cycle which includes pregnancy, labor, and post-partum care not to exceed 6 weeks for the woman and eight weeks (2 months) for the infant
- Prenatal care includes history, physical, nutrition counseling, blood pressure, fetal heart tones, and routine lab.
- Vaginal Delivery with or without episiotomy and/or forceps or breech delivery and sixweeks post-partum care
- Vaginal Delivery with or without episiotomy and/or forceps or breech delivery and six weeks post-partum care
- Global Care includes all prenatal, delivery, and post-partum care
- Newborn Care-Physical exam or HCY screen, Hospital care - limited to one visit per day
- Family Planning may be provided within the scope of practice. This service must be covered by the MO HealthNet Managed Care health plan regardless whether or not the certified nurse midwife is enrolled with the MO HealthNet Managed Care health plan. This includes all laboratory and prescriptions related to the family planning service.
- EPSDT/HCY Screens may be provided by a certified nurse midwife to female patients 15-20 years of age and infants 0-2 months of age if within the scope of practice. Refer to the EPSDT/HCY Policy Statement for specific information.
- Well Woman Checks within the scope of practice and related laboratory and prescriptions.

MISCELLANEOUS

Refer to the MO HealthNet Managed Care Physician/Advanced Practice Nurse Services Policy Statement for additional information on this benefit package.

The Certified Nurse Midwife Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

CHIROPRACTIC SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Chiropractic services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Chiropractic services are limited to examinations, diagnoses, adjustments, manipulations and treatments of mal-positioned articulations and structures of the body.

PROGRAM LIMITATIONS

The annual limit of chiropractic visits shall not exceed twenty (20) visits.

MISCELLANEOUS

Please refer to Section 13 of the Missouri MO HealthNet Physician Manual and provider bulletins available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

COMMUNICATION PLAN

PURPOSE

The purpose of the Communication Plan is to facilitate communication between the State agencyand the MO HealthNet Managed Care health plans for business functions and requirements under the contract. This plan addresses communication with the units responsible for compliance, enrollment, marketing and member education, quality and systems issues.

Please note that the process for submitting all reports required under the contract are addressed in Reporting Requirements located and periodically updated on the MO HealthNet Website: https://dss.mo.gov/business-processes/managed-care/docs/reporting-schedule-SFY23.pdf.

PROCESS

Communication by email should be directed to the staff indicated in the Communication Plan. Communication by postal or delivery service or phone should be made to:

USPS:
MO HealthNet Managed Care
P.O. Box 6500
Jefferson City, MO 65102-6500

Deliver service other than USPS:
MO HealthNet Managed Care
615 Howerton Court
Jefferson City, MO 65109

MO HealthNet Managed Care phone numbers
Main Number: (573) 526-4274
Fax: (573) 526-3946

COMPLIANCE

Requests for MO HealthNet Policy Clarification

MO HealthNet Managed Care health plans may have questions regarding MO HealthNet policy. Please direct your questions via email to facilitate a response to your question unless otherwise directed.

Please define your request and its purpose. Provide any beneficial background information. Attach examples and supporting documentation when appropriate. A sample template for submission of such requests is provided on the next page. Please address your questions to the following:

Constituent Services
MHD.MCCommunications@dss.mo.gov
(573) 526-4274

MO HealthNet MANAGED CARE HEALTH PLAN POLICY CLARIFICATION REQUEST					
Title of Request:					
Define the request and purpose. State any beneficial background information. Attach examples and supporting documentation when appropriate.					
Requestor	Health Plan	Tele No	Fax	Email	Date

ENROLLMENT ISSUES

Direct member enrollment questions to:
Constituent Services
MHD.MCOperations@dss.mo.gov
(573) 526-4274

MARKETING AND MEMBER EDUCATION MATERIALS

Direct all marketing and member education submissions, requests for additional benefits orincentive programs to the Marketing Unit at MHD.MCMarketing@dss.mo.gov Additional contact information for the Marketing Unit is:

MHD.MCMarketing@dss.mo.gov
(573) 526-4274
Fax: (573) 526-946

The Evidence-Based Decision Support Unit handles evaluation of process measures, data reporting, and service utilization rates.

Dr. Paul Stuve
Paul.Stuve@dss.mo.gov
(573) 526-6079
Fax: (573) 526-4650

Mihai Popa
Mihai.Popa@dss.mo.gov
(573) 526-2823

The Quality Oversight Unit can assist with quality improvement processes such as the Performance Withhold Program, network adequacy, and EQRO activities.

Kelly Connell
Kelly.Connell@dss.mo.gov
573-526-4274

Jay Carver
Donel.J.Carver@dss.mo.gov
573-526-4274

Amanda Boehmler
Amanada.Boehmler@dss.mo.gov
573-526-4274

Danica Bialczyk
Danica.Bialczyk@dss.mo.gov
573-526-4274

Amy Lage
Amy.Lage@dss.mo.gov
573-526-4274

Evaluation of quality for clinical outcomes are handled by:

Jenny Lockhart (Managed Care)
Jenny.L.Lockhart@dss.mo.gov
573-526-4274

Lori Buschner (Fee-For-Service)
Lori.A.Buschner@dss.mo.gov
573-751-5132

Michelle Kohrmann
Michelle.R.Kohrmann@dss.mo.gov
573-751-1168

Dr. Timothy Kling
Timothy.G.King@dss.mo.gov
573-751-5210

Dr. Eric Martin
Eric.D.Martin@dss.mo.gov
573-522-8336

SYSTEM ISSUES

Questions concerning file layouts and transactions/processing rules, file transactions in the Health Plan Record Layout Manual, encounter voids, encounter rejections, Provider Demographic File, cycle dates, RA processes and hard copy fee schedules should be directed to:

Megan Beeler
Megan.R.Beeler@dss.mo.gov
(573) 751-8672

Policy questions related to system issues such as billing codes, how to bill a service, written requests for changing codes to Pl-W and carve out services should be directed to:

Amanda Fahrendorf
Amanda.Fahrendorf@dss.mo.gov
(573) 751-0352

COMPLEMENTARY HEALTH AND ALTERNATIVE THERAPY FOR CHRONIC PAIN MANAGEMENT

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide complementary health and alternative therapy for chronic pain management services. The purpose of this program is to provide alternatives to opioid use for the treatment of chronic pain, to reduce opioid misuse, toimprove chronic pain management skills, to reduce avoidable costs, and to improve health outcomes. Adults age twenty-one (21) or older with chronic pain are eligible for this program.

PROGRAM LIMITATIONS

Member Eligibility

For members to be eligible for complementary health and alternative therapy services, theindividual must meet the following criteria:

- ❑ Be currently enrolled in MO HealthNet; and
- ❑ Be 21 years of age or older; and
- ❑ Have chronic pain; and
- ❑ Have a diagnosis within the chronic pain list provided in the MO HealthNet Physician's Manual for this program.

Prior Authorization

All complementary health and alternative therapy services require a referral from a physician and a prior authorization. Authorizations for additional complementary health and alternative therapies requests beyond the initial authorization must be submitted as a new prior authorizationrequest and must be deemed medically necessary by the prescribing physician.

Places of Service

All complementary and alternative therapy services for chronic pain can take place either in the inpatient or outpatient setting.

Covered Services and Limits

The annual limit of complementary health and alternative therapy visits will be dependent on the codes used, but shall not exceed thirty (30) visits or one hundred twenty (120) unites per year with one (1) unit equaling fifteen (15) minutes.

MISCELLANEOUS

Please refer to Section 13 of the Missouri MO HealthNet Physician Manual and provider bulletins at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

COMPREHENSIVE DAY REHABILITATION

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide comprehensive day rehabilitation services to members under the age of 21 and adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Comprehensive day rehabilitation services are for certain members with disabling impairments as the result of a traumatic head injury. Comprehensive day rehabilitation services begin early post trauma as part of the coordinated system of care. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive, and coordinated treatment plan. The treatmentplan must be developed, implemented, and monitored through an interdisciplinary assessment designed to restore a member to optimal level of physical, cognitive, and behavioral function. (See RSMo 208.152)

MO HealthNet Managed Care health plans are responsible for providing rehabilitation servicesto survivors of a traumatic brain injury (TBI) as follows:

- Assessment
- Service Plan Development
- Individual Counseling
- Group Counseling
- Cognitive Training
- Physical Therapy
- Behavior Therapy

PROGRAM LIMITATIONS

Description of Services

- Half-day evaluation/assessment
- Full-day evaluation/assessment
- Half-day rehabilitation service
- Full-day rehabilitation service

The evaluation/assessment should identify the specific functional outcomes for the member to achieve with regard to the degree of personal and independent living level of work productivity,and psychological adjustment. The evaluation is one of the chief basis for determining the member's program eligibility according to disability and need for rehabilitation.

Comprehensive day rehabilitation services cover a combination of goal-oriented rehabilitation services provided according to a multiple hour schedule over a week's time. Services are designed to maintain and improve the member's ability to function as independently as possible in the community.

Members age 21 and over (except for pregnant women) are not eligible for comprehensive day rehabilitation services.

MISCELLANEOUS

The Comprehensive Day Rehabilitation Program Manual and provider bulletins are available atthe MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

DENTAL

PROGRAM DESCRIPTION

MO HEALTHNET MANAGED CARE CHILD MEMBERS (under the age of 21)

MO HealthNet Managed Care health plans are required to provide dental services for child members under the age of 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Dental servicesinclude, but are not limited to, diagnostic, preventive, and restorative procedures, post orthodontic services, and medically necessary oral and maxillofacial surgeries. Expanded services, such as comprehensive orthodontics, are covered.

Required Screening

The MO HealthNet Managed Care health plans must conduct early periodic screening, diagnosis,and treatment (EPSDT) screens to identify health and developmental problems. In Missouri, this program is known as the Healthy Children and Youth (HCY) Program.

It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six (6) months or as medically indicated. Although an oral screening may be part of a physical examination, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), states that it does not substitute for examination through direct referral to a dentist.

Orthodontics

Orthodontic procedures are covered as expanded EPSDT/HCY services. Orthodontics will only be approved for the most severe malocclusions and in cases of medical necessity as determined by the state orthodontic consultant when the treating orthodontist/dentist submits documentationsupporting medical necessity.

When an eligible participant is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the participant to a qualified dentist or orthodontist for preliminary examination to determine if the treatment will be approved.

The fact that the participant has moderate or even severe orthodontic problems, or has been advised by a dentist ororthodontist to have treatment is not, by itself, a guarantee that the participant will qualify for orthodontia services through MO HealthNet. Coverage is determined solely by meeting the criteria listed below in subsections A and B, or in C.

Requirements for Orthodontic Care

A. General Requirements

To be eligible for orthodontia services, the participant must meet all of the following general requirements:

- ❑ Be under twenty-one(21) years of age
- ❑ Have god oral hygiene documented in the child's treatment plan
- ❑ Have all dental work complete
- ❑ Have permanent dentition. Exceptions to having permanent dentition are as follows:
  - Participant has a primary tooth retained due to ectopic or missing permanenttooth
  - Participant may have primary teeth present if they have cleft palate, severetraumatic deviations, or an impacted maxillary central incisor
  - Participant may have primary teeth if they are thirteen (13) years of age orolder
  - The orthodontia provider has submitted to the state written documentation which proves that orthodontic treatment is medically necessary under one of the criteria in subsection C.

B. Handicapping Labio-Lingual Deviation (HLD) Index

The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions in Section 14.3 of the MO HealthNet Dental Provider Manual and must be submitted with the Prior Authorization (PA) form.

MO HealthNet will approve orthodontic services when the participant meets all the criteria in subsection A above and one (1) of the criteria listed in below:

1. Has a cleft palate
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissueof the palate (lower incisor contact only on the palate is not sufficient)
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine millimeter (9mm) or reverse over-jet of greater thanthree and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores twenty-eight (28) points or greater on the HLD Index.

C. Medical Necessity

If the participant meets all of the criteria in subsection A above, but does not meet any of the criteria insubsection B, MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary.

MO HealthNet Managed Care health plans shall consider additional information of a substantial nature about the presence of severe deviations affecting craniofacial health. Other deviations shall be considered to be severe if, left untreated, they wouldcause irreversible damage to the teeth and underlying structures, resulting in disease related bone and tooth loss, or craniofacial deformities associated with developmentaldisabilities in chewing or speaking.

Other evidence shall include information of a substantial nature about the presence of a medical condition which is directly affected by the condition of the mouth or underlying structures. Orthodontic treatment shall be considered to be medically necessary if, without the orthodontic treatment, the medical condition would be adversely affected and would result in pain, infection, illness or significant and immediate impact on the normal function of the body and the individual's ability to function. In addition, such orthodontic treatment must be demonstrated to be:

1) Of clear clinical benefit to the eligible participant
2) Appropriate for the injury or illness in question
3) Conform to the standards of generally accepted orthodontic practice as supported by applicable medical and scientific literature.

In addition to documentation from an orthodontist or dentist, a recommendation for orthodontic treatment in relation to a medical condition must also be supported by documented evidence of the medical condition from a licensed medical doctor, board certified todiagnose the medical condition.

In addition, MO HealthNet Managed Care health plans may consider information of a substantial nature about the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions, as defined in the most current edition of the *Diagnostic Statistical Manual* of the American Psychiatric Association, and which may be caused by the participant's daily functioning as it related to a dentofacial deformity. The MO HealthNet Division will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation must clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavioral problems and must clearly and substantially document that orthodontic treatment is medically necessary and will significantly ameliorate the problems.

Orthodontic treatment shall not be considered to be medically necessary when:

- The orthodontic treatment is for aesthetic or cosmetic reasons only
- The orthodontic treatment is to correct crowded teeth only, if the child can adequately protect the periodontium with reasonable oral hygiene measures; or
- The child has demonstrated a lack of motivation to maintain reasonable standardsof oral hygiene and oral hygiene is deficient.

Medical Necessity Documentation

If the participant does not meet the HLD Index requirements and the treating orthodontist/dentistfeels the orthodontia services are medically necessary, as indicated in Section 13.42.C. of the MO HealthNet Dental Provider Manual a written, detailed explanation of the medical necessity of the orthodontia services must be submitted along with the complete HLD Index, study modelsand the prior authorization request form.

All documentation must be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical condition, which left untreated, the medical condition would be adversely affected and would result in pain, infection, illness or significant and immediate impact

on the normal function of the body and theindividual's ability to function.

Additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services must be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services must be submitted along with the required documentation from the treating orthodontist/dentist. The evaluation must clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional and/or behavioral problems and must clearly and substantially document that orthodontic treatment is medically necessary and will significantly ameliorate the problems.

Comprehensive orthodontic treatment includes, but is not limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the member (both removable and fixed appliances);
- All necessary adjustments;
- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the member for a proper period of time (approximately 18 to 24 months).

For severe skeletal cases, extended treatment times should be considered.

Regular Dental Care/Oral Hygiene For Orthodontic Patients

The member should be a good candidate for comprehensive orthodontic treatment in that he/she has exhibited a history of good oral hygiene. The MO HealthNet Managed Care health plan may provide case management if necessary. The member should also be under the care of a dentist forroutine care and all necessary dentistry, e.g. prophylaxis or fillings, should be completed. Extractions in the Fee-For-Service Program are not included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

Orthognathic Surgery

In some situations, orthodontics alone may not correct the malocclusion and orthognathic surgery is required. Orthognathic surgery is a medical service and is the MO HealthNet ManagedCare health plan's responsibility.

Dental Hygienists

A dental hygienist who has been in practice at least three years and who is practicing in a public health setting may provide fluoride treatments, teeth cleaning, and sealants, if appropriate, to MO HealthNet eligible children without the supervision of a dentist.

In accordance with 19 CSR 10-4.040, a public health setting is defined as a location where dental services authorized by Section 332.311 RSMo are performed so long as the delivery of services are sponsored by a governmental health entity which includes:

- Department of Health and Senior Services
- A county health department
- A city health department operating under a city charter
- A combined city/county health department
- A nonprofit community health center qualified as exempt from a federal taxation under section 501 (c) (3) of the Internal Revenue Code including a community health center that received funding authorization by section 329, 330, and 340 of the United States Public Health Services Act.

The procedures covered under the dental hygienist program are:

- Prophylaxis-adult-both arches ages 13-20
- Prophylaxis-child-both arches ages 0-12
- Topical application of fluoride-prophylaxis not included-child
- Topical fluoride varnish ages 0-20
- Sealants
- Unspecified adjunctive procedure
    - Office notes, invoice of costs or operative report are required with claim.
    - For prophylaxis more often than every six months, or panorex morethan 24 months, office notes are required with claim explaining medical necessity or emergency nature of the service.

MO HEALTHNET MANAGED CARE ADULT PREGNANT MEMBERS WITH ME CODES 18, 43, 44, 45, 61, 95, 96, and 98

The MO HealthNet Managed Care health plan is responsible for coverage of:

- Dentures
- Trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury
- Treatment of a disease/medical condition without which the health of the individual would be adversely affected
- Preventive services
- Restorative services
- Periodontal treatment
- Oral surgery
- Extractions
- Radiographs
- Pain evaluation and relief
- Infection control
- General anesthesia and all other Medicaid State Plan dental services for pregnant members

with ME Codes 18, 43, 44, 45, 61, 95, 96, and 98

Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

MO HEALTHNET MANAGED CARE ADULT MEMBERS (Age 21 AND OVER)

The MO HealthNet Managed Care health plan is responsible for reimbursement of services for adults limited to the following services and may require prior authorization:

- Trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury
- Treatment of a disease/medical condition without which the health of the individual would be adversely affected
- Preventive services
- Restorative services
- Periodontal treatment
- Oral surgery
- Extractions
- Radiographs
- Pain evaluation and relief
- Infection control
- General anesthesia

Please see Section 13.1 of the MO HealthNet Dental Provider Manual.

MEDICATIONS

Medications prescribed by a dentist for MO HealthNet Managed Care health plan members of any age are the responsibility of the MO HealthNet Fee-For-Service Program. Refer to the MOHealthNet Fee-For-Service Provider Manual for pharmacy coverage requirements.

PROGRAM LIMITATIONS

MO HealthNet limitations for certain dental services include, but are not limited to, specific time intervals, age, or primary or permanent teeth.

PRIOR AUTHORIZED SERVICES

If the MO HealthNet Managed Care health plan approves special dental services or items such as dentures for members which are delivered or placed after enrollment in the MO HealthNet Managed Care health plan ends, the MO HealthNet Managed Care health plan who approves thedental services or items such as dentures is responsible for payment. This does not apply to orthodontia services or items.

MISCELLANEOUS

The Dental Provider Manual , Dental Fee Schedule, and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

DIABETES PREVENTION PROGRAM (DPP)

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Diabetes Prevention Program services. The purpose of these services is to utilize the Center for Disease Control and Prevention (CDC) National Diabetes Prevention Program guidelines to provide structured lifestyle interventions that include, but are not limited to, dietary coaching, lifestyle intervention and moderate physical activity to facilitate behavior changes to manage obesity and associated comorbidities. The goal of these services is to improve health outcomes for the adult populationat risk for developing diabetes by managing obesity and associated co-morbidities. Adults age twenty-one (21) or older are eligible for this program.

PROGRAM LIMITATIONS

Member Eligibility

For members to be eligible for diabetes prevention program services, the individual must meet all of the following criteria:

- ❑ Be currently enrolled in MO HealthNet
- ❑ Be 21 years of age or older; and
- ❑ Not currently pregnant
- ❑ Have, as of the date of attendance at the first core session, a BMI equal to or greater than 25 or a BMI of 23 if of Asian descent
- ❑ Have no previous diagnosis of type one (1) or two (2) diabetes with the exception of gestational diabetes
- ❑ Within the last twelve (12) months have one or more:
  - Hemoglobin A1C test with a value of 5.7% to 6.4%
  - A fasting plasma glucose of 100 mg/dl to 125 mg/dl
  - A 2-hour plasma glucose of 140 to 199 mg/dl after the 75 oral glucose tolerance test.

For participants to be eligible for the ongoing maintenance services the participant must achieve and maintain a minimum of 5% weight loss at the end of the first 12 months.

Prior Authorization

All diabetes prevention program services require a referral and/or a prescribed service in the member's plan of care by a physician or other licensed practitioner, and require a prior authorization for the first 12 months of services. For member's that meet the continuation criteria an additional prior authorization will be required for the additional 12 months of ongoingmaintenances sessions.

Places of Service

Providers of diabetes prevention program services include individuals and/or organizations with diabetes prevention programs that have pending, preliminary, or full recognition status from the CDC Diabetes Prevention Recognition Program, and enrolled as MO HealthNet providers.

Covered Services and Limits

The annual limit of diabetes prevention program sessions will be dependent on the codes used, but shall not exceed twenty-six (26) sessions per year with one (1) unit equaling a minimum of sixty (60) minutes. Additional ongoing maintenance sessions shall not exceed four (4) sessions per year.

MISCELLANEOUS

Please reference Section 13 of the Missouri MO HealthNet Physician Manual and provider bulletins available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

DIABETES SELF-MANAGEMENT TRAINING

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide diabetes self-management training services for child members under 21 years of age and adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98 with gestational, Type 1 or Type II diabetes. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Services include an initial assessment that must be at leastone hour, and two education sessions of at least 30 minutes. The education sessions may be provided on an individual basis or in a group session of no more than 8 members.

The following professionals provide the service:

- Certified Diabetes Educator (CDE):
  - Must hold current certification from the National Certification Board for Diabetes Educators (NCBDE) through the American Association of Diabetes Educators (AADE)
  - The CDEs practice under the Scope of Practice for Diabetes Educators developed by AADE
- Registered Dietician (RD):
  - Must hold current certification from the Commission on Dietetic Registration through the American Dietetic Association (ADA).
  - The RDs practice under American Dietetic Association Standards of Professional Practice by the ADA
- Registered Pharmacist (RPh):
  - Must be both currently licensed pharmacist and completed at least one of these certifications:
    - National Community Pharmacists Association (NCPA) “Diabetes Care Certification Program”
    - American Pharmaceutical Association (AphA)/AADE certification program “Pharmaceutical Care for Patients with Diabetes”

PROGRAM LIMITATIONS

The program covers training upon initial diagnosis of diabetes, any significant change in the member’s symptoms, conditions, or treatment, and when there is a documented need for re-education or refresher training. A prescription from a physician or other health care providerwith prescribing authority is required.

The initial assessment may only be performed by a physician or certified diabetes educator. One assessment per lifetime is covered.

The subsequent educational visits may be provided by a CDE, RD, or RPh as described above. Education visits are limited to two per rolling year, per member, and may be a combination of group and individual visits. Additional visits require documentation of medical necessity from aphysician or health care provider with prescribing authority.

MISCELLANEOUS

Information pertaining to diabetic supplies and equipment is found in the Durable Medical Equipment policy statement. Section 13.71 of the Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

DURABLE MEDICAL EQUIPMENT

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Durable Medical Equipment (DME) items. DME is equipment that is necessary and reasonable for the treatment of the member's illness or injury or to improve the functioning of a malformedor permanently inoperative body part. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. These items must be for use in the MO HealthNet Managed Care member's home when ordered by the MO HealthNet Managed Care member's PCP or nurse practitioner.

PROGRAM LIMITATIONS

Benefits under the DME program are limited to the following:

- All medically necessary non-sterile ostomy supplies for ostomates are covered
- Augmentative communication devices
- Equipment such as wheelchairs, walkers (including batteries and accessories), hospitalbeds, canes, crutches, and decubitus care equipment
- Ventilators
- CPAP and BiPap devices
- Continuous glucose monitors (CGMs) and Tubeless Insulin Pumps – standalone CGMs(e.g. Dexcom, FreeStyle Libre) and tubeless insulin pumps (e.g. OminiPod), shall be covered through the FFS Pharmacy Program
    - Other Diabetic equipment and supplies shall continue to be covered by the Managed Care health plan
- Orthotic and prosthetic devices
- Six prosthetic sheaths or socks are allowed per limb, per member, per 12-month period
- Orthopedic shoes are covered only if they are an integral part of a brace. “Integral”means that the shoes are necessary for completeness of the brace
- Orthopedic shoes for a member with a diagnosis of diabetes are covered. The shoes do not have to be an integral part of a brace
- Home parenteral nutrition.

Children under the age of 21

DME benefits for children include items such as diapers, medical supplies, enteral nutrition, PKU nutrition, and positioning equipment. Benefits under the DME program for children under the age of 21 may only be limited by medical necessity. Medically necessary items or services identified as a result of a physician or health care provider visit or exam must be covered for members under the age of 21.

MISCELLANEOUS

The Durable Medical Equipment Provider Manual, clinical criteria documents, and providerbulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

EPSDT/HCY SCREENING SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are responsible for ensuring that early and periodic screening, diagnostic, and treatment (EPSDT) screens are performed on MO HealthNet Managed Care members under the age of 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

This program is referred to nationally as the EPSDT Program. In Missouri, this program is referred to as the Healthy Children and Youth (HCY) Program. Missouri follows the AmericanAcademy of Pediatrics' (AAP), July 1991, schedule for preventive pediatric health care as a minimum standard for frequency of providing full HCY screens.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that MO HealthNet provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified byan EPSDT screen regardless of whether or not the services are covered under the Medicaid State Plan. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The MO HealthNet Managed Care health plan is responsible for providing all EPSDT/HCY services for their eligible members.

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

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

Appropriate providers may provide partial screens, which are segments of the full screen. The purpose of this is to increase access to care to all children. Providers of partial screens are required to have a referral source for the full screen. For MO HealthNet Managed Care health plan members, this should be the primary care provider who may be a physician, nurse practitioner or midwife. A partial screen does not replace the need for a full medical screen thatincludes all of the above components. See Section 9 of the MO HealthNet provider manual for specific information on partial screens.

MO HealthNet Managed Care health plans are responsible for required immunizations and recommended laboratory tests. Lab services performed during the screen are reported separately.

MO HealthNet Managed Care health plans must provide immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice. MO HealthNet Managed Care health plans are to report vaccines according to the guidelines outlined in the Vaccine for Children Program policy statement.

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

The medical record must document that all required components of the screening were performed. If for some reason a portion of a component of the screen was not performed, the medical record must document why it was not provided and that follow-up is required. Use of the Lead Screening Guide is mandatory for all children age 6-72 months and must be retained in the medical record in paper or electronic format. The Healthy Children and Youth Screening and Lead Risk Assessment Guides are available in an electronic format through MO HealthNet'sWeb tool, CyberAccess[sm].

Elevated Blood Lead Levels

The Managed Care health plans shall demonstrate processes of obtaining notification of lab results pertaining to elevated blood lead levels and offer case management (CM) within the following timeframes to all children when knowledge of elevated blood levels is present:

- Action levels include outreach time requirements for CM:
  - 10 to 19 □g/dL within one to three (1-3) business days
  - 20 to 44 □g/dL within one to two (1-2) business days
  - 45 to 69 □g/dL within twenty four (24) hours
  - 70 □g/dL or greater – immediately.

CM activities include the following services for children with elevated blood lead levels. This includes confirmation of capillary tests using venous blood according to the timeframes listed below:

- 10-19 □g/dL – Within two (2) months
- 20-44 □g/dL – Within two (2) weeks
- 45-69 □g/dL – Within two (2) days
- >=70 □g/dL – Urgently as emergency test immediately.

Ensure that the Childhood Blood Lead Testing and Follow Up Guidelines are followed as required:

- 10-19 □g/dL - Early follow up testing-Within two to three ¬¬months. Later follow up testing after BLL declining three to six months
- 20-70 □g/dL - Early follow up testing-Within one to two months or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:
  - BLL remains less than 15 □g/dL for at least six months
  - Lead hazards have been removed
  - There are no new exposures

- When the above conditions have been met, proceed with retest intervals and follow-up for BLLs 10-19 □g/dL.

MISCELLANEOUS

Reference Section 9 of the Environmental Lead Assessmenet Manual and provider bulletins available online at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

FAMILY PLANNING

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide family planning services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. MO HealthNet Managed Care health plans must provide freedom of choice for family planning and reproductive health services which may be accessed out of network.

Examples of reproductive health services are:

- Family planning counseling/education on various methods of birth control
- Contraception management
- Insertion of Norplant
- IUD
- Depo Provera injections
- Pap test
- Pelvic exams
- Sexually transmitted disease (STD) testing

Sterilization procedures are not covered for members under the age of 21. The member must sign the (Sterilization) Consent Form at least 30 days, but not morethan 180 days, prior to the date of the sterilization procedure.

The MO HealthNet Managed Care health plans must ensure:

- ❑ All lab and x-ray services provided as part of a family planning encounter are payable as family planning services
- ❑ All exams, laboratory, and x-ray services for family planning purposes are covered for children and adults
- ❑ 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 payable as family planning services;
- ❑ A pregnancy test is family planning related:
  - When provided at the time at which family planning services are initiated for an member
  - At points after the initiation of family planning services where the member may not have used the particular family planning method properly
  - If the member is having an unusual response to the family planning method
- ❑ Services are provided/prescribed by physician/advanced practice nurse for medically approved diagnosis, treatment, counseling, drug, supply, or device to members of childbearing age
- ❑ For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering a member permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR 441.250 - 441.259;
- ❑ The (Sterilization) Consent Form, PSFL-200, meets all the criteria required by the Centers

for Medicare and Medicaid Services in 42 CFR 441.250 through 441.259

- ❑ A properly completed (Sterilization) Consent Form, PSFL-200, is obtained from the performing provider

Federal regulations 42 CFR 441.250 - 441.259 require the following:

- ❑ Informed consent has been given
- ❑ The member must be mentally competent
- ❑ The member must be at least 21 years of age on the date of signing the consent form
- ❑ The member must sign the (Sterilization) Consent Form at least 30 days, but not more than 180 days, prior to the date of the sterilization procedure. The day after the signing is considered the 1st day when counting the 30 days. The only exceptions to this time requirement are premature delivery or emergency abdominal surgery:
  - o For premature delivery, the consent form must be completed and signed by the member at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery
  - o For emergency abdominal surgery, the consent form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.
- ❑ The following procedures require a (Sterilization) Consent Form, PSFL-200:
  - o Vasectomy, unilateral or bilateral (separate procedure), including post-op semen examination(s)
  - o Laparoscopy, surgical-with fulguration of oviducts (with or without transection)
  - o Laparoscopy, surgical-with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
  - o Ligation or transection of fallopian tube(s), abdominal or vaginal approach,unilateral or bilateral
  - o Ligation or transection of fallopian tube(s), abdominal or vaginal approach,postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
  - o Ligation or transection of fallopian tube(s) when done at the time of cesareansection or intra-abdominal surgery (not a separate procedure)
  - o Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

PROGRAM LIMITATIONS

These services are not covered:

- Condoms and family planning devices or supplies available as non-prescribed, over-the-counter products
- Reversal of a sterilization procedure
- Abortions for the purpose of family planning. Abortions are not family planning services, and should not be reported as such
- Hysterectomies for the purpose of family planning
- Procreative management, i.e. tubal reversal, artificial insemination, etc.

MISCELLANEOUS

The Physician's Manual, the Certified Nurse Midwife Manual, the (Sterilization) Consent Form, and

provider bulletins are available online at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

The MO HealthNet Managed Care Physician/Advanced Practice Nurse Services Policy Statement also provides more information.

FRAUD, WASTE, AND ABUSE

PROGRAM DESCRIPTION

In accordance with 42 CFR Part 438, MO HealthNet Managed Care contract requirements and policy statements regarding fraud, waste, and abuse, the MO HealthNet Managed Care health plans must perform fraud, waste, and abuse prevention, coordination, detection, investigation, enforcement activities.

The MO HealthNet Managed Care health plans must report to and cooperate with Department of Social Services agencies such as Missouri Medicaid Audit and Compliance (MMAC) Unit, MO HealthNet Division (DSS/MHD), MO HealthNet Managed Care Unit, and other key players as appropriate.

DEFINITIONS OF FRAUD, WASTE, AND ABUSE

The first step in combating fraud, waste, and abuse is to identify fraud, waste, and abuse. Thissection provides definitions of fraud, waste, and abuse to assist in preventing, coordinating, detecting, investigating, enforcing and reporting fraud, waste, and abuse.

MO HealthNet/MO HealthNet Managed Care Fraud: Any type of intentional deception or misrepresentation made by an entity or person in a MO HealthNet Managed Care health plan with the knowledge that the deception could result in some unauthorized benefit to the entity, themselves, or some other person.

MO HealthNet/MO HealthNet Managed Care Abuse: Practices in the MO HealthNet Managed Care health plans that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MO HealthNet Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. A MO HealthNet Managed Care health plan, contractor, subcontractor, provider, or MO HealthNet Fee-For-Service/MO HealthNet Managed Care member, among others, can commit the abuse. It also includes beneficiary practices in the MO HealthNet Managed Care health plans that result in unnecessary cost to the MO HealthNet program or MO HealthNet Managed Care health plan, contractor, subcontractor, or provider. It should be noted that MO HealthNet funds paid to a MO HealthNet Managed Care health plan, then passing to subcontractors, are still MO HealthNet funds from a fraud and abuse perspective.

KEY PLAYERS IN CONTROLLING FRAUD, WASTE, AND ABUSE

There are several key players who have roles and responsibilities in controlling fraud, waste, and abuse. Key players include, but are not limited to:

- MO HealthNet Division (MHD) MO HealthNet Managed Care Unit
- Missouri Medicaid Audit and Compliance (MMAC) Unit
- Family Support Division (FSD)
- MO HealthNet Managed Care health plans

- State Medicaid Fraud Control Unit (MFCU) (Provider Fraud-Attorney General's Office)
- Welfare Investigation Unit (WIU)

PROCEDURE

In accordance with the MO HealthNet Managed Care contract each MO HealthNet Managed Care health plans must maintain and implement a fraud, waste, and abuse plan.

The fraud, waste, and abuse plan must contain internal controls, policies and procedures for prevention, coordination, detection, investigation, enforcement and reporting of fraud, waste, and abuse. The MO HealthNet Managed Care health plan's fraud, waste, and abuse plan must designate a Compliance Officer and compliance committee that are responsible for the fraud, waste, and abuse program and activities.

Prevention

The MO HealthNet Managed Care health plan must have activities in place for fraud, waste, and abuse prevention. The health plan prevention activities should include, but are not limited to:

- Organization of resources to respond to complaints of fraud, waste, and abuse
- Training on what fraud, waste, and abuse is and how and where to report it
- Education of MO HealthNet Managed Care health plan's employees, subcontractors, providers, and members about their responsibilities, and the responsibilities of others
- Identification of debarred individuals or excluded providers
- Policies and procedures to promptly act upon information received from MHD or MMAC regarding network providers who have been debarred or suspended from MOHealthNet FFS or providers who have been sent correspondence from MHD or MMAC regarding inappropriate billing practices or medical record documentation
- Monitoring to ensure the MO HealthNet Managed Care health plan's policies and procedures comply with contractual requirements, and are being followed by MO HealthNet Managed Care health plan employees, subcontractors, and providers.
- Monitoring of subcontractor activities to ensure compliance with subcontractor agreements

Coordination

The MO HealthNet Managed Care health plan must have fraud, waste, and abuse coordination activities in place. Health plan coordination activities should include, but are not limited to:

- Networking with MHD, MFCU, and MMAC
- Communication with fraud, waste, and abuse key players as MO HealthNet Managed Care health plan providers may participate in more than one MO HealthNet ManagedCare health plan or MO HealthNet delivery system.

Detection

The MO HealthNet Managed Care health plan must have fraud, waste, and abuse detectionactivities

in place. Health plan detection activities should include, but are not limited to:

- Monitoring of member requests to change PCPs;
- Monitoring of member grievances and appeals and provider complaint, grievances and appeals;
- Developing procedures to monitor providers and subcontractors for:
  - Patterns of over and underutilization of services,
  - False billing practices as defined in RSMo 375.991, as amended:
    - Unbundling-claiming a number of medical procedures were performed instead of a single comprehensive procedure;
    - Upcoding-claiming that a more serious or extensive procedure wasperformed than was actually performed;
    - Exploding-claiming a series of tests was performed on a single sample of blood, urine, or other bodily fluid, when actually the series of test was part of one battery of tests; or
    - Duplicating-a medical, hospital or rehabilitative insurance claim made by a health care provider by resubmitting the claim through another health care provider in which the original health care provider has an ownership interest.
    - Delay or failure of the PCP to perform necessary referrals for additionalcare.
- Developing procedures to monitor members for:
  - Patterns of over utilization of services
  - Access to services, (i.e. inappropriate utilization of services), such as narcotics use and selling, inappropriate emergency room care or card-sharing.

Investigation

When the MO HealthNet Managed Care health plan becomes aware of a possible fraudulent or abusive situation, the MO HealthNet Managed Care health plan must initiate an investigation within seven (7) business days to gather facts regarding the possible fraud, waste, or abuse by provider or members. At this point, the MO HealthNet Managed Care health plan does not haveenough facts to determine if fraud, waste, and abuse is suspected. Investigation activities shouldinclude, but are not limited to:

- Review or creation of additional data such as claims reports, interviews, etc.
- Procedures for exchange of information and collaboration among all parties to gather additional information.

Enforcement

Once fraud, waste, or abuse has been investigated and suspected by the MO HealthNet Managed Care health plan, enforcement activities shall be initiated. Enforcementactivities should include, but are not limited to:

- Education of the member and/or provider
- Corrective action plans
- Recoupment of payments

- Provider sanctions
- Member lock-in to providers
- Referral to other key players when appropriate.
    - It is appropriate to refer providers to MMAC for MFCU referral when providers have been identified as being enrolled in MO HealthNet and contracted with the MO HealthNet Managed Care health plan.
    - It is appropriate to refer to MMAC for WIU referral when members have been identified as having potentially performed a criminal act.

Reporting

The MO HealthNet Managed Care health plan must report fraud, waste, and abuse activities to the MO HealthNet Division on a quarterly basis per the MO HealthNet Managed Care Quality Assessment and Improvement Reporting Periods, Exhibit 1, Attachment 6-MHD Quality Improvement Strategy of the MO HealthNet Managed Care contract. The Quarterly Fraud and Abuse Report must be submitted to the MHD Managed Care Unit via a secure electronic system.The Fraud and Abuse quarterly report shall be in the format specified by MHD as amended.

If the health plan's preliminary investigation supports a finding of suspected fraud or abuse on the part of a provider or member, the health plan must submit a referral form to the state agency and the MFCU as soon as possible and no later than two (2) business days of the finding. The referral may be submitted using the *Missouri Fraud, Waste, and Abuse Referral Form* or the health plan's own form; however, the information documenting the investigation for referral to the state agency and the MFCU shall include the following information:

- ❑ The allegation, date, and source of the original complaint or tip
- ❑ The provider's name, Medicaid provider number, or provider's National ProviderIdentifier (NPI)
- ❑ The relevant statutes and regulations violated
- ❑ The details and results of the investigation, including:
    - The period of time at issue
    - The encounter data submitted by the provider during the time period at issue
    - The estimated identified overpayment
    - A summary of the interviews conducted
- ❑ All supporting documentation obtained associated with the investigation.

Credentialing

The MO HealthNet Managed Care health plan must have written credentialing and re-credentialing policies and procedures. These procedures are for the purpose of determining and assuring that all in-network providers are licensed by the state in which they practice and are qualified to perform their services.

As part of credentialing and re-credentialing, the MO HealthNet Managed Care health plans must collect from their contracted providers full and complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379

of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001 and 42 CFR 1001.1551.

The MO HealthNet Managed Care health plan must collect this information:

- During the provider credentialing and re-credentialing
- Upon execution of the provider agreement
- Within thirty-five (35) calendar days of any change in ownership of the provider
- At the request of the state agency, for any or all of the information described in this section, within thirty-five (35) calendar days of the request

The MO HealthNet Managed Care health plans must forward to the state agency information concerning failure of a provider to make timely or accurate disclosures.

The MO HealthNet Managed Care health plans must include provisions in their subcontracts for health care services notifying the provider, or benefit management organization, to provide the disclosures to the MO HealthNet Managed Care health plan.

The state agency will, in accordance with 42 CFR 455.106(b), notify the HHS Office of the Inspector General (HHS-OIG) within twenty (20) working days from the date it receives the disclosures made by providers under 42 CFR 455.106 (relating to criminal convictions of the provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider).

The MO HealthNet Managed Care health plans must promptly notify the state agency of any denial of provider credentialing or re-credentialing. This requirement is in addition to the requirement for the MO HealthNet Managed Care health plans to report provider terminations as part of its quarterly fraud and abuse report. In making such disclosures, the MO HealthNet Managed Care health plans must use the template provided in Attachment 6b.

The state agency will, pursuant to 42 CFR 1002.3(b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing when:

- The denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program,
- The provider has failed to renew their license or certification registration,
- The provider has a revoked professional license or certification;
- The provider has been terminated by the state agency;
- The provider has been excluded by OIG under 42 CFR 1001.1001 or 1001.1551.

During credentialing, re-credentialing, and on a monthly basis, the MO HealthNet Managed Care health plans must screen all health care service subcontractors to determine whether the subcontractor, or any of their subcontractors or employees, has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B(f) of the Act), or have failed to renew their license or certification registration, or have revoked professional license or certification; or have been terminated by the state agency. The screening must consist, at a minimum, of consulting the following databases:

- The National Plan and Provider Enumeration System (NPPES), located online at https://nppes.cms.hhs.gov/
- The List of Excluded Individuals / Entities (LEIE) - https://oig.hhs.gov/exclusions/, and the Excluded Parties List System(EPLS) - https://sam.gov/content/exclusions, at least monthly;
- The Missouri Professional Registration Boards website: https://pr.mo.gov/licensee-search.asp.

The MO HealthNet Managed Care health plans must deny credentialing or re-credentialing to any subcontractor identified as a result of this screening. In addition, the MO HealthNet Managed Care health plans must terminate the provider contract of any subcontractor identified through a routine monthly check. The MO HealthNet Managed Care health plan may choose to use the template provided in Attachment 6b to memorialize these monthly screenings.

HABILITATIVE SERVICES FOR THE ADULT EXPANSION GROUP (AEG)

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Habilitative Services to the Adult Expansion Group (AEG) who are adults, age nineteen (19) to sixty-four (64) years of age.

Habilitative therapy services are physical, occupational or speech therapy services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for an individual whose abilities (e.g. walking or talking) are not age appropriate. Services are limited to twenty (20) visits on a rolling year basis.

MISCELLANEOUS

Physician, Hospital and Home Health provider manuals and provider bulletins are available atthe MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

HEARING AID

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide audiometric and hearing aid services for members under the age of 21 and adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Other adult members age 21 and over are not eligible for hearing aids and associated testing services. Hearing Aid Program services are to be delivered for the purpose of and in conjunction with the dispensing ofa hearing aid.

Providers of hearing aid program services must be an audiologist or hearing instrument specialistwho has a current permanent license to practice in accordance with the licensing provisions of the state in which he/she operates or practices.

PROGRAM LIMITATIONS

Benefits for members under age of 21 may only be limited by medical necessity. All medically necessary items or services such as diagnostic testing, auditory trainers, FM systems post cochlear implant training, hearing aid batteries, and Auditory Brainstem Response (ABR) are covered for members under age 21. Cochlear rehabilitation, repair/replacement of external cochlear parts, and replacement of the external speech processor, following cochlear implant surgery, are covered for members under the age of 21 and pregnant women with ME codes 18,43, 44, 45, 61, 95, 96, and 98.

Benefits for MO HealthNet Managed Care members under the age of 21 and adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98 are limited to the following:

- One new hearing aid and related services (testing, fitting, dispensing and post fitting evaluation) per member every four years
- The replacement of a hearing aid within four years of its purchase date is covered for a lost hearing aid, a destroyed aid or an aid which cannot be repaired
- Repairs and post-fitting adjustments are limited to a combined total of three per hearing aid per rolling 12 months
- A hearing aid is covered if the member's pure-tone average (PTA) for air-conduction thresholds at 500, 1,000, and 2,000 Hz is 30 dB or greater in the better ear
- Word recognition testing (with phonetically balanced 25 or 50 word lists) is required for participants seven (7) years of age and above. Ten (10) word lists are not acceptable
- Before being fitted with a hearing aid, all members must have a medical ear examination for pathology or disease
- Replacement ear molds are covered
- Only new hearing aids are purchased. Each hearing aid will be warranted by the provider for a minimum of one year from the dispensing date against premature breakdown and defects in manufacture
- New hearing aids will not be purchased within six months of the repair of an old hearing aid
- Any hearing aid for the purpose of binaural amplification must be prescribed by an

otolaryngologist, otologist, or otorhinolaryngologist. A binaural hearing aid is only covered for educational purposes, learning of language for children and a member who is blind.

Services in an Educational Setting

For a member who is receiving hearing aid services identified in an Individualized Education Program (IEP), the services are billed fee-for-service and are not the responsibility of the MO HealthNet Managed Care health plan. Please refer to the policy statement on Services In An Educational Setting for further information.

Hearing Aid (HCY)

MO HealthNet Managed Care health plans are required to provide HCY hearing aid services for members under the age of 21. This includes all medically necessary hearing aid services identified as a result of a physician, hearing instrument specialist, audiologist or other health care professional visit or exam. Additional benefits through the HCY Program include:

- Hearing assistive wireless technology such as FM/Bluetooth personal listening systems.
- Two (2) new hearing aids (binaural hearing aid fitting) and related services (testing, fitting, dispensing, and post-fitting evaluation) every four (4) years (for binaural hearing aid users only), and one (1) hearing assistive wireless technology, such as FM/Bluetooth personal listening systems every four (4) years.
- For members under 21 years of age, the following audiometric threshold criteria (measured by earphone, sound field, or auditory brainstem response testing or auditorysteady-state response testing) *must* be met:
  - ❑ Pure-tone threshold average for the frequencies 500, 1000, and 2000 Hz of 20 dB HL or greater;
  - ❑ Pure-tone threshold of 25 dB HL at two (2) consecutive high frequencies for 2000,3000, 4000 Hz; and
  - ❑ Pure-tone threshold of 25 dB HL at three (3) consecutive high frequencies for 3000, 4000, and 6000 Hz.

PRIOR AUTHORIZATIONS

If the MO HealthNet Managed Care health plan approves hearing aids which are delivered or placed after enrollment in the MO HealthNet Managed Care health plan ends, and repair of hearing aids beyond the scope of the warranty which are performed after enrollment in the MO HealthNet Managed Care health plan ends, the MO HealthNet Managed Care health plan who approves these hearing aid items and services is responsible for payment.

MISCELLANEOUS

The Hearing Aid Program Manual and provider bulletins are available at the MO HealthNetDivision website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

HOME BIRTH SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care members who request a home birth service, may be disenrolled from the MO HealthNet Managed Care health plan at the request of the MO HealthNet Managed Care health plan. However, there are a number of steps that a MO HealthNet Managed Care health plan must have completed prior to making the request to the state agency.

The MO HealthNet Managed Care health plan must educate the member regarding the importance of prenatal care and the risks associated with home births with special emphasis if the member has any high risk factors.

The MO HealthNet Managed Care health plan must determine if the member is receiving prenatal care and if the member has a home birth provider in place.

Additionally, the MO HealthNet Managed Care health plan must fully explain the options available to the member for delivery, e.g. a hospital stay, a short hospital stay, a birthingcenter, etc.

The MO HealthNet Managed Care health plan must document all communication to the member both orally and in writing regarding education and the options available to the member. A certified letter must be sent to the member detailing the education and options previously explained to the member. During this process, the MO HealthNet Managed Care health plan shall encourage the member to seek ongoing prenatal care.

Once the educational component is completed and the member still indicates the desire for a home birth, the MO HealthNet Managed Care health plan may forward a written request to the state agency asking that the member be disenrolled. The request must include any pertinent medical records, case management records, and correspondence to the member that documents the educational efforts done by the MO HealthNet Managed Care health plan. Once the requestis received from the MO HealthNet Managed Care health plan, the state agency will confirm the information with the member. A disenrollment form will be sent to the member for her signature.

The member will be disenrolled from the MO HealthNet Managed Care health plan upon receipt of the form or if the member refuses to sign, effective in three days. The member will remain disenrolled from the MO HealthNet Managed Care health plan if eligible under the MO HealthNet for Pregnant Woman category. If the member is not in the MO HealthNet for Pregnant Woman category, the member will be enrolled six weeks post-partum or after a hospital discharge, whichever is later. The baby will be enrolled into a MO HealthNet Managed Care health plan once a Departmental Client Number (DCN) is assigned or after a hospital discharge, whichever is later.

Attached are copies of letters the Division will send to the member and language for the MO HealthNet Managed Care health plan to use in its letter to the member.

Date

Dear (MPW Case):

You told us that you want to have your baby at home. We want to be sure that you have all the facts you need. In the box below are some points that we want to make sure you know about. Please read them and sign so we know that you have this.

- I got facts from my MO HealthNet Managed Care health plan about safely giving birth and healthy babies.
- I got facts from my MO HealthNet Managed Care health plan about other places to have my baby.
- I know that my MO HealthNet Managed Care health plan will not cover home births.
- I know that I will be disenrolled from my MO HealthNet Managed Care health plan if I want to have a home delivery.
- I know that I must find an approved provider, if I want MO HealthNet to pay for a home birth.
- I know I will not be enrolled in a MO HealthNet Managed Care health plan after giving birth unless I am eligible for other MO HealthNet benefits.
- I know I need to contact my Family Support Division eligibility specialist after giving birth, so my baby can get enrolled in MO HealthNet.

- ❑ I need a list of approved providers.
- ❑ I still want to have a home birth.
- ❑ I have changed my mind.

Signature_____ Date_____

Please return this in the envelope provided. You do not need a stamp. We will let you know if you will be disenrolled from your MO HealthNet Managed Care health plan and when that will happen. If you have any questions, please call Participant Services at 800-392-2161 or 573-751-6527.

Date

Dear (Non MPW Case):

You told us that you want to have your baby at home. We want to be sure that you got all the facts you need. In the box below are some points that we want to make sure you know about. Please read them and sign so we know that you have this.

- I got facts from my MO HealthNet Managed Care health plan about safely giving birth and healthy babies.
- I got facts from my MO HealthNet Managed Care health plan about other places to have my baby.
- I know that my MO HealthNet Managed Care health plan will not cover home births.
- I know that I will be disenrolled from my MO HealthNet Managed Care health plan if I want to have a home delivery.
- I know that I must find an approved provider, if I want MO HealthNet to pay for a home birth.
- I know I will not be enrolled in a MO HealthNet Managed Care health plan after giving birth unless I am eligible for other MO HealthNet benefits.
- I know I need to contact my Family Support Division eligibility specialist after giving birth, so my baby can get enrolled in MO HealthNet.

- ☐ I need a list of approved providers.
- ☐ I still want to have a home birth.
- ☐ I have changed my mind.

Signature_____ Date_____

Please return this in the envelope provided. You do not need a stamp. We will let you know if you will be disenrolled from your MO HealthNet Managed Care health plan and when that will happen. If you have any questions, please call Participant Services at 800-392-2161 or 573-751-6527.

HOME HEALTH

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide physician ordered home health services for MO HealthNet Managed Care members. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Home health services provide primarily medically oriented treatment or supervision to members with an acute illness, or an exacerbation of a chronic or long term illnesswhich can be therapeutically managed at home. Home health services include skilled nurse visits, home health aide visits, and medical supplies. Individuals under the age of 21 and adult pregnant women with ME Codes 18, 43, 44, 45, 61, 95, 96, and 98 may also receive physical, occupational, and speech therapy services through the Home Health Program.

PROGRAM LIMITATIONS

Home health services must be provided in the member's home. Home is considered the member's primary place of residence. Home health services must follow a written plan of treatment established and periodically reviewed by a physician.

The home health program is divided into two distinct segments based on the age of the member. Members under age 21 are classified as children and are eligible to receive expanded home health services as part of the Healthy Children and Youth federal mandate. Members who are 21 years of age and older are defined as adults.

Home health services must be provided in accordance with Missouri State licensure laws.

HOME HEALTH SERVICES FOR CHILDREN

The basic home health benefits extended to members under age 21 mirror the benefits that are available to the adult population; however, for children, a broader range of services are covered and service limitations are less restrictive. Home health services for children are covered based on a child's documented need.

Children may receive two evaluation visits per year for each of the following:

- Skilled nurse visits
- Occupational therapy
- Speech therapy
- Physical therapy

Therapy services for children must be provided based solely on medical necessity and may not be limited. Developmental as well as maintenance services must be covered. Home Health PT, OT, and ST visits identified in an official Individualized Education Program (IEP) generated by the public school or an Individualized Family Service Plan (IFSP) will be reimbursed by MO HealthNet fee-

for-service. All other therapy services are the responsibility of the MO HealthNetManaged Care health plan.

HOME HEALTH SERVICES FOR ADULTS

To be eligible for home health services, the member's condition must meet either of the following criteria:

- The member must require intermittent skilled nursing care which is reasonable andnecessary for the treatment of an injury or illness.
- The member is an adult pregnant woman with a ME Code of 18, 43, 44, 45, 61, 95, 96,or 98 and requires physical, occupational, or speech therapy.

The combined total of all skilled nurse, psychiatric nurse and home health aide visits reimbursed on behalf of the member is limited to 100 visits per calendar year.

- Skilled nursing care services are covered when the services are reasonable and necessary to the treatment of an illness or injury; the services are performed by licensed nurse; the services are required on an intermittent basis; and the services areordered by and included in the plan of care established by a physician.
- Psychiatric nursing services are covered when the following criteria are met:
  - The member has one of the following primary ICD-9CM psychiatric diagnoses certified in writing by a psychiatrist;
    - Schizophrenic disorders (295.2x, 295.3x, 295.4x, 295.6x, 295.7x, or295.9x);
    - Paranoia (297.1);
    - Bipolar disorders (296.4x to 296.5x, or 296.6x);
    - Unspecified psychosis (298.9);
    - Major depression recurrent (296.3x);
    - Dementia and other conditions complicated with delusional disorder, mooddisorder or anxiety disorder (290.12, 290.13, 290.20, 290.21, 290.42, 290.41, 290.43, 300.21 or 300.22).
  - The member requires active treatment under the care of a physician on either an outpatient or inpatient basis as a result of a psychiatric disorder;
  - The services are prescribed by a physician and provided in accordance with a planof care which clearly documents the need for services and is reviewed by the physician at least every sixty days;
  - The services are delivered by a nurse with specialized psychiatric training; and
  - The objectives of the prescribed active treatment are measurable by physical criteria (i.e., increased appetite, increased energy level, appropriate affect) and thetreatment and results are well documented.
- Home health aide visits are a covered service when the aide services are needed concurrently with skilled nursing or physical, occupational, or speech therapy services. The services of the aide must be supervised by a registered nurse or otherappropriate professional staff member.
- Physical, Occupational, and Speech Therapy services are covered for pregnant women with ME Codes of 18, 43, 44, 45, 61, 95, 96, and 98 when the therapy services relate directly and specifically to an active written Plan of care by the physician, and the skilled therapy services

are reasonable and necessary to the treatment of the member's illness or injury. The course of therapy must show evidence that therapy objectives and goals are being worked towards and met. Thisservice was not designed to be a long- term benefit, but was designed to allow members to reach their optimum potential. Physical, occupational, and speech therapy services provided through the Home Health Program are not covered for members age 21 and over (except as noted).

- Non-routine supplies are covered and are defined as items that, due to their therapeutic or diagnostic characteristics, are essential in enabling the home health agency personnel to carry out effectively the care that the physician has ordered forthe treatment of the diagnosis relative to the member's illness or injury. Examples include but are not limited to:
  - Catheters
  - Needles and syringes;
  - Surgical dressings and materials used for dressings such as cotton gauze and adhesive bandages;
  - Materials used for aseptic techniques.

POST DISCHARGE VISIT

Post discharge home skilled nurse visits are covered if a member is discharged from inpatient care less than 48 hours after a vaginal delivery or less than 96 hours after a C-section delivery. All criteria for an early inpatient discharge and the post-discharge visits as outlined by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists must be met and be documented in the member's medical record. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The first visit will occur within 48 hours of discharge and the second visit will occur within two weeks of discharge. The attending physician shall determine the location and schedule of the post-discharge visits.

Services provided by the registered professional nurse or physician shall include, but not be limited to:

- Physical assessment of the newborn and mother
- Parent education, assistance, and training in breast or bottle feeding
- Education and services for complete childhood immunizations
- The performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the State laboratory

MISCELLANEOUS

The Home Health Program Manual and online provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

HOSPICE

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide hospice services when a terminally ill MO HealthNet Managed Care member elects hospice. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

The hospice benefit is designed to meet the needs of members with life-limiting illnesses and to help their families cope with related problems and feelings. Hospice care is an approach to treatment that recognizes that the impending death of a member warrants a change in focus from curative care to palliative care. Hospice utilizes an interdisciplinary team to provide comprehensive services that are primarily directed toward keeping the member at home with minimal disruption in normal activities and keeping the member and family as physically and emotionally comfortable as possible. To be eligible to elect hospice care in the Fee-For-Service Program, a physician must certify members as terminally ill with a life expectancy of six months or less if the disease runs its normal course.

Hospice care cannot be prescribed or ordered by a physician. The member must elect hospicecare and agree to seek only palliative care for the duration of the hospice election.

PROGRAM LIMITATIONS

Hospice benefits include, but are not limited to, home care, physician care, inpatient care, nursing home room and board, and all services for the palliation and management of the terminal illness. If a member elects hospice and then enters a nursing home, the MO HealthNet Managed Care health plan is responsible for the nursing home costs.

The following is a list of covered services included in the hospice benefit:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor'sdegree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a physician
- Physician services performed by a doctor of medicine or osteopathy to meet the general medical needs of the member to the extent that these needs are not met by the attending physician
- Counseling services, including dietary counseling, provided to both the member and the family members or other persons caring for the member at home. Counseling services must be available and may be provided both for the purpose of training the member’s family or other caregiver and for helping the member and the caregivers to adjust to the member’s approaching death
- Dietary counseling, when required, must be provided by a qualified individual
- Spiritual counseling, including notice to the member as to the availability of clergy
- Counseling provided by members of the interdisciplinary group as well as by otherqualified professionals as determined by the hospice

- Bereavement services under the supervision of a qualified professional. There must be an organized program for the provision of these services
- Short term inpatient care required for procedures necessary for acute or chronic symptom management or for pain control
- Short term inpatient respite care (maximum of 5 days per calendar month) furnished as a means of providing respite for the member's family or other persons caring for the member at home
- Medical appliances and supplies. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the member's terminal illness
- Room and board in a MO HealthNet-certified nursing facility
- Home health aide services furnished by certified aides and homemaker services. Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the general supervision of a registered nurse
- Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills
- All drugs (prescription and over the counter) and biologicals used primarily for pain or symptom control of the terminal illness are covered under the MO HealthNet Fee-For-Service Program.

CONCURRENT CARE FOR CHILDREN IN HOSPICE

Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made. The hospice provider continues to be responsible for all services related to the palliation and support services for the terminally ill.

MISCELLANEOUS

All care related to the terminal illness is part of the hospice benefit. Medically necessarycare not related to the terminal illness must continue to be available from the MO HealthNet Managed Care health plans.

The Hospice Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

HOSPITAL (INPATIENT/OUTPATIENT)

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide inpatient/outpatient hospital services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

INPATIENT HOSPITAL DEFINITION

An acute inpatient service, which requires the submission of an inpatient claim, is one in which the hospital expects to provide service to the member in the hospital for a 24 hour period or longer. The stay is considered inpatient upon the issuance of written physician orders to that effect. The service is still considered inpatient if the intent is to stay 24 hours or longer even though the member dies, is discharged, or is transferred to another institution and does not actually stay in the hospital 24 hours. Services in an observation room, regardless of the length of time, without a formal admission are not considered inpatient services.

Hospitalizations at the Time of Enrollment and Disenrollment

With the exception of newborns and members moving from a general health plan to the Specialty Plan (or from the specialty plan to a general health plan), the plan shall not assume financial responsibility for members who are hospitalized in an acute setting on the effective date of coverage until an appropriate acute inpatient hospital discharge.

If a member moving from a general plan to the Specialty Plan (or from the Specialty Plan to a general plan) is in a NICU, the NICU payment shall be allotted according to the number of NICU-related inpatient hospital days in which the member was enrolled in each respective plan.

After July 1, 2023, payment for NICU stays will not be separate issues, but will be collapsed into the capitation rates.

The following provision applies only to the members who moved from a general plan to the Specialty plan on the *specific day* of July 1, 2022. If the member moved to the Specialty Plan on any day other than July 1, 2022, this provision does not apply: Members who were enrolled in the Specialty Plan effective July 1, 2022, but who were enrolled in another health plan (a general plan) at the time of acute inpatient hospitalization and up to July 1, 2022, shall remain with that health plan (the general plan) for fifteen (15) calendar days, with July 1, 2022, being the first day. After the fifteenth calendar day, MO HealthNet will enroll the member into the Specialty Plan.

Mandatory Length of Stay

House bills number 1069, 794, 807, 936, 1128, 1153, and 102 were enacted by the 88th General Assembly to mandate that insurance coverage is provided for inpatient maternity benefits.
Coverage shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly

born child.

A shorter length of hospital stay for services related to maternity and newborn care may be approved only if:

1. The shorter stay meets with the approval of the attending physician after consulting with the mother.
    - The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization
2. The insurance entity provides coverage for post-discharge care to the mother and her newborn.

Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. Services provided by the registered professional nurse or physician shall include, but not be limited to:

- Physical assessment of the newborn and mother
- Parent education
- Assistance and training in breast or bottle feeding
- Education and services for complete childhood immunizations
- The performance of any necessary and appropriate clinical tests
- Submission of a metabolic specimen satisfactory to the state laboratory

Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality observed by the nurse, in the condition of the mother or the child, shall be reported to the attending physician as medically appropriate.

"Attending physician" shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.

OUTPATIENT HOSPITAL DEFINITION

An outpatient hospital that is licensed by its state's licensing authority and certified under Medicare Conditions of Participation may participate in the MO HealthNet Outpatient Hospital Program. For the purposes of the MO HealthNet Fee-For-Service Program an off-site entity is considered to be an outpatient hospital if it is designated by Medicare as part of the hospital and given a Medicare number assigned to the hospital.

Off-site satellite clinics or remote clinics not designated by Medicare as part of the hospital may not participate in the MO HealthNet Outpatient Hospital Program. Such entities may be enrolled as MO HealthNet clinic providers.

Outpatient hospitals may be organized as clinics and/or emergency room departments. Outpatient clinics are established to provide services on a scheduled basis. Outpatient emergency rooms are established to provide services on an unscheduled basis as response treatment of an emergency medical condition. In the Fee-For-Service Program, when non- emergency services are provided in the emergency room, they are considered clinic services.

Outpatient hospital services are those services provided to a member not admitted by the hospital as an inpatient, but is registered on the hospital records as an outpatient and receives services from the hospital.

The following types of treatment and services are covered when provided in the outpatient hospital clinic or emergency room and under the direct supervision of a physician, nurse practitioner or podiatrist:

- Preventive
- Diagnostic
- Therapeutic
- Palliative
- Therapies including
  - Chemotherapy
  - Radiation therapy
  - Physical therapy
    - Effective 09/01/05 physical therapy will only be covered by MHD in the outpatient setting for children under the age of 21, blind, pregnant women, and nursing home residents.
  - Routine dialysis treatment
- Medical and surgical supplies
- Administration cost of medications given on site
- Injections and immunization (but not administration of such)
- Observation up to 24 hours
- Observation from 24 up to 72 hours only when administering and monitoring

PROGRAM LIMITATIONS

Inpatient care that is not medically necessary and services not provided at an acute care level are not covered. Most inpatient admissions must be pre-certified by the MO HealthNet Managed Care health plan using criteria that is based on sound medical evidence. Specialty pediatric hospitals, as defined in 13 CSR 70-15.010 (2) (P), use criteria specified by the Fee-For-Service Program.

Emergency admissions are exempt from the pre-certification process. A post-admission certification must be requested following the emergency admission.

Retrospective reviews are done for admissions if no admission pre-certification was done because the time requirements were not met or the member's eligibility is not established on the date of admission.

Hospitals should contact Conduent at (800) 766-0686 for certification for inpatient days that are not included in the comprehensive benefit package for the MO HealthNet Managed Care health plan and are included as a fee-for-service benefit.

MISCELLANEOUS

The Hospital Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

Refer to 2.7.21 for information on the Hospital Reimbursement process.

HYSTERECTOMY SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide hysterectomy services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. In accordance with Federal Regulations 42 CFR441.251, 42 CFR 441.252, 42 CFR 441.255, and 42 CFR 441.256, a hysterectomy is a covered service only when:

- ❑ The person who secured authorization to perform the hysterectomy has informed the member and her representative (e.g., legal guardian, spouse, etc.), orally and in writing, that the hysterectomy will make the member permanently incapable of reproducing.
- ❑ Exceptions to the requirement for an Acknowledgment of Receipt of Hysterectomy Information form may be made in the following situations:
  - The member was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the member was already sterile at the time of the hysterectomy and state the cause of the sterility. This must be documented by an operative report or admit and discharge summary.
  - The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible. The physician must certify in writing to this effect, and include a description of the nature of the emergency.
  - The member was not MO HealthNet eligible at the time the hysterectomy was performed but eligibility was made retroactive to this time. The physician who performed the hysterectomy must certify in writing to one of the following situations:
    - The member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing.
    - The member was already sterile before the hysterectomy.
    - The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible.
- ❑ The following procedures require an Acknowledgment of Receipt of Hysterectomy Information form:

  58550, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 59525, 58290, 58291, 58292, 58293, 58294, 58550, 58552, 58553, 58554, 58570, 58571, 58572

The paragraph at the bottom of the form indicates that it must be signed by the member or her representative prior to the surgery, but there are no time limits. The Centers for Medicare and Medicaid Services (CMS) has given guidelines on this policy that in exceptional cases, the

member or their representative may sign the form after surgery if the member or representative was informed of the hysterectomy procedure prior to the surgery.

PROGRAM LIMITATIONS

Requirements concerning hysterectomies apply to a member of any age. A hysterectomy is not covered when performed solely for the purpose of rendering the member permanently incapable of reproducing, or the hysterectomy was part of a larger procedure, but was performed only for the purpose of rendering the member permanently incapable of reproducing.

MISCELLANEOUS

The Physicians Manual, Acknowledgment of Receipt of Hysterectomy Information form and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

MATERNITY PRENATAL CARE AND DELIVERY

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide maternity prenatal care and delivery services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

MANDATORY LENGTH OF STAY

House bills number 1069, 794, 807, 936, 1128, 1153, and 102 were enacted by the 88th General Assembly to mandate that insurance coverage is provided for inpatient maternity benefits. Coverage shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly born child.

A shorter length of hospital stay for services related to maternity and newborn care may be approved only when both conditions are met:

- ❑ The shorter stay meets with the approval of the attending physician after consulting with the mother.
  - The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and

- ❑ The insurance entity shall provide coverage for post-discharge care to all mothers and her newborns.
  - Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician.
  - Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.
  - Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending physician as medically appropriate.
  - The first visit will occur within 48 hours of discharge and the second visit willoccur within two weeks of discharge.
  - Services provided by the registered professional nurse or physician shall include, but not be limited to:
    - Physical assessment of the newborn and mother,
    - Parent education,
    - Assistance and training in breast or bottle feeding,
    - Education and services for complete childhood immunizations,

- The performance of any necessaryand appropriate clinical tests and
- Submission of a metabolic specimen satisfactory to the state laboratory.

"Attending physician" shall include the attending obstetrician, pediatrician, or other physician attending the mother or newly born child.

FEE-FOR-SERVICE GLOBAL PRENATAL/DELIVERY POLICY

It is not required that MO HealthNet Managed Care health plans adhere to the MO HealthNet fee-for-service policy regarding global prenatal/delivery reimbursement. The policy is presented here for the MO HealthNet Managed Care health plan's education regarding MO HealthNet fee-for-service policy.

Under the current MO HealthNet Fee-For-Service Program, the global prenatal/delivery fee is reimbursable when one provider, or provider group, renders the majority of the prenatal care. Prenatal/delivery care includes four or more consecutive individual prenatal visits, routine urinalysis testing during the prenatal period, all care for pregnancy-related conditions (e.g. nausea, vomiting, cystitis, vaginitis), completion of a Risk Appraisal, initial hospital visit, delivery and postpartum care. Billing for global services may not occur until the date of delivery. The date ofdelivery is the date of service used when billing the global procedure codes.

In addition to the global reimbursement, a total of two visits are allowed by MO HealthNet under the Fee-for-Service Program to allow the initial provider (not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. As an example, many members utilize theirlocal public health agency to establish their pregnancy, then are referred to another practitioner for continuing care of their pregnancy. In addition, two consultations may be paid by MO HealthNet under the Fee-For-Service Program to another provider and still allow the referring provider to bill globally.

Providers may bill separately for the global antepartum care along with a separate code for the delivery. In the MO HealthNet Fee-For-Service Program, the reimbursement for the global antepartum care plus the delivery procedure is the same as the reimbursement for one of the global OB codes.

When billing a global prenatal/delivery procedure code, the date of service on the claim mustalways be the date of delivery. It is not necessary for the provider of service to report on the claim each date of service as it occurs. Documentation for all services rendered must be maintained in the member's medical record and must be available for review by the MO HealthNet Division or its appointed representative, upon request.

Postpartum care after delivery (6 weeks) is included when billing any global OB procedure code. When providers bill separately for a delivery, they have the option to bill delivery with postpartum, delivery only - no postpartum, or postpartum care only.

RISK APPRAISAL

A risk appraisal must be completed for every pregnant woman. A risk appraisal must be completed at the onset of prenatal care and is a covered service. Any woman who meets any one of the risk factors shown on the risk appraisal form is eligible for case management services. An additional risk appraisal may be done if there are any changes in the woman's health or social situation.

A risk appraisal form for pregnant women must be a part of the member's record. MO HealthNet Managed Care health plans may use the MO HealthNet Division (MHD) form or anyform that contains, at a minimum, the information required in the MHD Risk Appraisal form.

These forms may be obtained in the Physician Provider manual available from the MHD website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

TRANSITION FROM FEE-FOR-SERVICE TO MO HEALTHNET MANAGED CARE

For additional information on transitioning pregnant women into MO HealthNet Managed Careplease reference the "Transition of Pregnant Women into MO HealthNet Managed Care" MO HealthNet Managed Care Policy Statement.

THIRD PARTY LIABILITY

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

The health plan shall apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum services.

The health plan shall make payments without regard to potential TPL for pediatric preventive services, unless they have made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

The health plan shall make payments to providers if payment has not been made from a third party liability derived from a medical support enforcement order within 100 days after the provider has initially submitted a claim to such third party for payment of Medicaid services.

MISCELLANEOUS

Refer to the Physician/Advanced Practice Nurse Services Policy Statement for additional information.

The Physicians and Certified Nurse Midwife Manuals, risk appraisal form for pregnant women and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

NEWBORN ENROLLMENT

AUTOMATIC ELIGIBILITY FOR NEWBORNS

Members who give birth while enrolled in the MO HealthNet Managed Care health plan will have automatic coverage for the newborn from the date of birth under the mother's MO HealthNet Managed Care health plan.

The following statement is provided from the Family Support Division (FSD) Income Maintenance Eligibility Manual about the automatic eligibility provision for MO HealthNet mothers and the automatic addition of the infant for MO HealthNet coverage.

Verify the Birth:

If the hospital calls to notify FSD of the birth and to obtain a MO HealthNet ID number, also known as the Departmental Client Number (DCN), the eligibility specialist will request the following information:

- Mother's name (case name)
- Mother's DCN
- The newborn's name
- The newborn's date of birth
- The newborn's race and sex
- A copy of the hospital certificate

If the mother notifies FSD of the birth and does not have verification, the eligibility specialist is to call the hospital, physician, or certified nurse midwife to obtain the verification and request a copy of the hospital certificate.

It is not necessary to have a copy of the hospital certificate prior to adding the child as anautomatic eligible. A signed application is not required to receive automatic eligibility.

The eligibility specialist will assign a DCN and provide this number to the hospital.

Mothers who wish to receive cash benefits for the child are required to complete an application.

PREGNANT WOMEN IN STATE CARE AND CUSTODY

Pregnant MO HealthNet Managed Care members who are in state care and custody are eligible for automatic newborn coverage.

The following statement is provided by the Children's Division (CD) regarding the automatic eligibility provision for the addition of the infant for automatic MO HealthNet coverage: The CD worker for the child in State care and custody is aware of the medical needs and condition of the child in care including pregnancy. At the time of birth, the CD worker will assign a DCN and complete a tracking form to report the birth of the child. The tracking form generates the information

to the eligibility system. The hospital may contact the CD worker to obtain the newborn's DCN. Applications for assistance for the newborn are referred to the Family Support Division benefit program specialist for processing.

Per staff with the Division of Youth Services: Pregnant members are discharged from the Youth Services facility prior to the birth of the child and are transferred to another type of assistance when appropriate. The automatic eligibility provisions of the new category of assistance are in effect at the time of birth.

MO HEALTHNET MANAGED CARE HEALTH PLAN RESPONSIBILITY

According to the MO HealthNet Managed Care contract, the MO HealthNet Managed Care health plans must have written policies and procedures for enrolling the newborn children of program members effective to the time of birth. Newborns of program eligible mothers who were enrolled at the time of their birth will be automatically enrolled with the mother's MO HealthNet Managed Care health plan.

The MO HealthNet Managed Care health plans must have a procedure in place to refer newborns to FSD to initiate eligibility determinations. A mother of a newborn may choose a different MO HealthNet Managed Care health plan for her child. Unless a different MO HealthNet Managed Care health plan is requested, the child will remain with the mother's MO HealthNet Managed Care health plan.

The mother's MO HealthNet Managed Care health plan shall be responsible for all medically necessary services provided under the standard benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one (1). The MO HealthNet Managed Care health plan shall provide services to the child until the child is disenrolled from the MO HealthNet Managed Care health plan.When the newborn is assigned a DCN, the MO HealthNet Managed Care health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the MO HealthNet Managed Care health plan.

If there is an administrative lag in enrolling the newborn and costs are incurred during that period, it is essential that the member be held harmless for those costs. The MO HealthNet Managed Care health plan is responsible for the cost of the newborn.

MO HEALTHNET MANAGED CARE HEALTH PLANS NEWBORN ENROLLMENT PROCESS

The mother's MO HealthNet Managed Care health plan is responsible for reporting the birth of a child to the local FSD office to initiate eligibility determinations. The local FSD office will add the newborn within ten days of receiving notification of the birth.

To add a newborn, the local FSD office needs the mother's name, their DCN, the child's name,date of birth, race, sex, and verification of the birth. The MO HealthNet Managed Care health plan must also include the name of the hospital. If a newborn's full name is not available it is permissible to use "baby boy" or "baby girl" as the child's name. The local FSD office will contact the hospital to obtain the child's full name if the MO HealthNet Managed Care health plan reports the child's name

as “baby boy” or “baby girl”.

MISCELLANEOUS

Refer to Section 1 of the provider manuals for more information on automatic eligibility for newborns. Provider manuals and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

OPTICAL PROGRAM

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide optical services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Optical services include one comprehensive or one limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition including eye prosthetics, and one pair eyeglasses every two years.

Additionally, some services are covered for children and pregnant members.

- ❑ Services to child members under age 21 include one comprehensive or one limited eye examination per year for refractive error and HCY/EPSDT optical screens and services.
- ❑ Services to adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98include one comprehensive or one limited eye examination per year for refractive error.

Optical services are provided by licensed optometrists, opticians, and optical clinics that have a current permanent license to practice in accordance with the licensing provisions of the state inwhich he/she operates or practices.

PROGRAM LIMITATIONS

Benefits under the optical program are limited by the following:

- One complete or one limited eye examination is allowed during a 12-month period of time or when there is a .50 or greater diopter change for children under the age of 21 and adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98.
- One complete or one limited eye examination is allowed during a 24-month period of time or when there is a .50 or greater diopter change for other adults 21 and over.
- Office visits are limited to one visit per member, per provider, per day.
- An office visit (regardless of the level of service) may not be billed on the same date of service as a complete or limited eye exam.
- One (1) pair of frames and lenses is allowed per member every 24 months. Lens replacement(s) are covered within the rolling 24-month period following the date of service of the MO HealthNet purchased lens/lenses if there is a prescription change of at least 0.50 diopters for one (1) eye or 0.50 diopters for each eye. MO HealthNet will only replace the lens for the eye with the 0.50 or greater diopter change.
- Replacement frames and lenses are covered for members under age 21 if broken, lost, or if the lenses are scratched during the 24-month period following the placement of the glasses.
- An office visit on the same date as any of these services is non-covered:
  - Orthoptic/pleoptic training
  - Visual fieldexam
  - Quantitative perimetry
  - Serial tonometry
  - Tonography

    - Electro-oculography
    - Visually evoked potential study
    - Color vision exam
    - Dark adaptation exam
- Contact lens/lenses are covered for member's under the age of 21 for a medically necessary reason such as for anisometropia of 4.00 diopters or greater, keratoconus and aphakia
- An office visit is not covered if the visit is only to obtain a pharmaceutical or eyeglass prescription.
- Orthoptic and pleoptic training is covered when there is a prognosis for substantial improvement or correction of an ocular or vision condition.
- Photochromatic tinting is a covered service.
- Rose I and II lenses are covered if medically necessary;
- Frame and lenses are covered when the member's prescription is at least 0.75 dioptersfor one eye or 0.75 diopters for each eye. Prescriptions for less than 0.75 may be covered if a member under age 21 requires glasses for school performance, if a member's visual acuity is 20/40 or less, or for protective eye wear members with sight in one eye.
- Contact lenses (except where previously stated), eyeglass cases, monocles, magnifiers, nose pads, eyeglass adjustments, and sunglasses are not covered services.
- Contact lenses, regular lenses, and frames supplied incorrectly to the provider by the supplier or manufacturer are not covered.
- Replacement of lenses, complete eyeglasses, frames, and artificial eyes suppliedincorrectly to the member by the optical provider are not covered.

When it is medically necessary for an optical procedure to be performed in an inpatient or outpatient hospital facility, emergency room, or ambulatory surgical center, the facility chargesand ancillary services associated with the optical procedure is the responsibility of the MO HealthNet Managed Care health plan.

OPTICAL (HCY):

MO HealthNet Managed Care health plans are required to provide HCY optical services for child members under the age of 21. This includes all medically necessary optical services, including EPSDT optical screens, treatment, prosthetic eyes, and replacement eyeglasses. Contact lenses are also covered when medically necessary.

PRIOR AUTHORIZED SERVICES

If the MO HealthNet Managed Care health plan approves optical items which are delivered or placed after enrollment in the MO HealthNet Managed Care health plan ends, the MO HealthNetManaged Care health plan that approves the optical items is responsible for payment.

MISCELLANEOUS

The Optical Program provider manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

PERSONAL CARE

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide personal care services. They should adhere to Electronic Visit Verification (EVV) for Personal Care Service (PCS) providers. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Personal care services are tasks which assist a member in activities of daily living related to a stable chronic condition. Personal care servicesinclude basic personal care, advanced personal care, and authorized nurse visits. Personal care services are provided as a cost effective alternative to nursing home placement.

Basic Personal Care

Basic personal care services are services related to a member's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. It also includes services essential to the health and welfare of the member, such as housekeeping chores, preparing meals, bed making, dusting, and vacuuming.

Examples of basic personal care services include but are not limited to:

- Planning, preparation, and clean-up of meals
- Making beds and changing sheets
- Brushing, combing, and shampooing hair
- Giving bed baths and assisting with other baths
- Brushing teeth and cleaning dentures.

Advanced Personal Care

Advanced personal care tasks are maintenance services provided to assist members when such assistance requires devices and procedures related to altered body functions.

Advanced personal care services are:

- Routine personal care for members with ostomies and external, indwelling, and suprapubic catheters
- Removal of external catheters, inspection of skin, and reapplication of catheter
- Administration of prescribed bowel programs
- Application of medicated lotions or ointments, and dry, non-sterile dressing to unbroken skin
- Use of a lift for transfer
- Assistance with oral medications
- Provision of passive range of motion
- Application of non-sterile dressings to superficial skin breaks as directed by a RN or LPN

Nurse Visits

Nurse visits provided by a RN or LPN in the personal care program are authorized to provide increased supervision of the aide, assessment of the member's health and the suitability of the care plan to meet the member's needs as well as referral and/or follow-up action. In addition, this service must include one or more of the following when appropriate to the needs of the member:

- Fill a one week supply of insulin syringes
- Set up oral medication for a member who self-administers prescribed medications
- Monitor a member's skin condition when a member is at risk of skin breakdown
- Provide nail care for a diabetic or member with other medically contraindicating conditions
- Monthly assessments of the member's condition and the adequacy of the service plan for members receiving advanced personal care
- Provide task observation and certification to advanced personal care aides
- Other nursing services in other situations, subject to the needs of the member

PROGRAM LIMITATIONS

Adults

Personal care services are provided as a cost effective alternative to nursing home placement. Federal law does not require that a physician prescribe personal care services. Fee-for-servicepersonal care is available to any member who is assessed by the Department of Health and Senior Services, Division of Senior and Disability Services at a nursing home level of care.

Members are considered eligible for personal care services when an initial in-home assessment completed on a Home and Community Based Referral/Assessment form scores 21 points or greater.

MO HealthNet Managed Care health plans must provide all medically necessary personal care services. MO HealthNet Managed Care health plans must continue to provide personal care services to members who are receiving personal care services when they become enrolled in aMO HealthNet Managed Care health plan.

Maximum monthly payment for personal care services is limited to 100% of the average monthly fee-for-service cost for care in a nursing facility.

Consumer Directed Services

MO HealthNet Managed Care members with ME code E2 (AEG) who request to be assessed for personal care services have the option to choose Consumer Directed Services (CDS) instead of the state plan personal care. These services, which are administered through the Department of Health and Senior Services (DHSS), will be reimbursed by the state agency on a fee-for-service basis.

Children

Children under age 21 are determined to be in need of personal care services by medical necessity. Personal care needs for a child are demonstrated by their need for extra assistance in bathing,

toileting, eating or other activities of daily living because of a medical condition. The fact that a child has a caretaker does not make him or her ineligible for personal care services. The primary caretaker may not be present to deliver the required services or may lack the time orability to deliver the essential care.

The initial personal care plan for children is developed by a RN, unless the child is a member ofthe Department of Mental Health and has an Individual Habilitation Plan (IHP) that contains sufficient documentation of the need for personal care and the extent of the service required.

This is a non-exhaustive list of medical problems that, in children, would meet the criteria for medical necessity for personal care services:

- Poorly controlled seizures, other than severe generalized tonic/clonic (grandmal) seizures
- Immune deficiency diseases and metabolic diseases including AIDS
- Incontinent of bowel and/or bladder after age three
- Persistent and/or chronic diarrhea, regardless of age
- Significant central nervous system damage affecting motor control
- Organically based feeding problems
- Requiring assistance with orthotic bracing, body casts, or casts involving at least one full limb
- Requiring assistance with activities of daily living. This would apply to children unable to perform age appropriate functions of bathing, maintaining a dry bed and clothing, toileting, dressing, and feeding. Children with a diagnosis of developmental delay orintellectual disability may be eligible for personal care services.

Services In An Educational Setting

For a child who is receiving personal care services identified in the child's Individualized Education Program (IEP), the services are billed fee-for-service and are not the responsibility ofthe MO HealthNet Managed Care health plan. Please refer to the policy statement on Services in an Educational Setting for further information.

MISCELLANEOUS

MO HealthNet Managed Care health plans may access the MO HealthNet Personal Careprovider network to provide personal care services to eligible members.

The Personal Care Program Provider Manual, In-Home Services Worksheeet (DA-3a), and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

The Division of Senior and Disability Services Home and Community Services map is available at the Department of Health and Senior Services website: https://health.mo.gov/seniors/hcbs/careplanchangemap.php.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY FOR ADULT PREGNANT WOMEN WITH ME CODES 18, 43, 44, 45, 61, 95, 96, and 98

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide physical therapy, occupational therapy, and speech therapy for adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Physical therapy benefits are covered when:

- An adult pregnant woman is medically homebound through home health.
- The services are for adaptive training for a prosthetic ororthotic device in a rehabilitation center.

Occupational therapy benefits are covered when:

- An adult pregnant woman is medically homebound through home health.
- The services are for adaptive training for a prosthetic or orthotic device in a rehabilitation center.

Speech therapy benefits are covered when:

- An adult pregnant woman is medically homebound through home health.
- Speech therapy is covered for adaptive training for an artificial larynx in a rehabilitation center.

MISCELLANEOUS

The Therapy, Hospital, Rehabilitation Center, and Home Health provider manuals and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY FOR CHILDREN AND YOUTH

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide medically necessary Healthy Children and Youth Program services (HCY), physical therapy (PT), occupational therapy (OT), and speech therapy (ST) and supplies used for casting and splinting to child members under age 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Physical, occupational, and speech therapy services identified in a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) will not be the responsibility of the MO HealthNet Managed Care health plan. These services will be paid fee-for-service by the MO HealthNet Division. Therapy services are paid fee-for-service when they are included in an IEP as defined by the Individuals with Disabilities Education Act-Part B (34 CFR 300) or an IFSP as defined by the Individuals with Disabilities Education Act-Part C (34 CFR 303).

Medically necessary PT, OT, and ST services not identified in a child's IEP or IFSP are the responsibility of the MO HealthNet Managed Care health plan. This includes developmental as well as maintenance therapy. The health plan shall be financially liable and shall not delay the provision of any medically necessary services pending completion of the IEP or IFSP.

MO HealthNet Managed Care health plans shall have a written process for the coordination and collaboration of medically necessary therapy services including services provided in an educational setting. The child's primary care provider should be involved in the development of the IEP or IFSP even though the MO HealthNet Managed Care health plan is not responsible for payment of IEP/IFSP related PT, OT, and ST services. The MO HealthNet Managed Care healthplan must have written parental consent for a school to release IEP records.

Medically necessary equipment and supplies used in connection with the PT, OT, and STservices are the responsibility of the MO HealthNet Managed Care health plan.

MISCELLANEOUS

The Therapy, Hospital, Rehabilitation Center, Home Health Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

Refer to the policy statement for Physical, Occupational, and Speech Therapy for Adults forcoverage for this population.

PHYSICIAN/ADVANCED PRACTICE NURSE SERVICES, FEDERALLY QUALIFIED HEALTH CARE CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide physician/advanced practice nurse/FQHC and RHC services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity**.**

Physician/Advanced Practice Nurse Services

The following is a summary of benefits. This is an overview only and should not be considered a comprehensive statement.

- Services rendered in a private practice setting;
- The appropriate level of evaluation and management (E/M) procedure code, i.e., office/outpatient, inpatient hospital, consultations, emergency department, critical care, home visits, nursing facility services, newborn care, etc.;
- Healthy Children and Youth (HCY) screens
- Office medical supplies over and above those usually included in the office visit
- Office surgical procedures
- Hemodialysis and peritoneal dialysis services
- Continuous ambulatory peritoneal dialysis (CAPD) in the home
- Eye examinations or special ophthalmological services
- Vestibular functions tests
- Physical medicine services to assist in the diagnosis, recovery and rehabilitation ofmembers performed in the office, clinic, home, or outpatient department hospital
- Surgical procedures in the CPT range 10004-69990
- Foot care which involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement, or reduction), and other hygienic or preventivemaintenance when the member has a diagnosis of diabetes mellitus or other peripheral vascular disease and the member is eligible for these services
- Assistant-at-surgery if the procedure customarily requires the services of an assistantsurgeon and the surgery itself is a covered service
- Multiple surgical procedures performed on the same member, on the same date of service, by the same provider, for the same or separate body systems through separateincisions are to be reported with documentation
- Post-operative care for 30 days is included in the surgical procedure
- Injections/immunizations
- Radiology procedures
- Laboratory procedures
- Prenatal care
- Delivery services

- Neonatal intensive care
- Newborn resuscitation
- Newborn care in the hospital
- Newborn care other than hospital
- Gastroplasty and gastric bypass for morbid obesity are to be reported when performed as treatment of hypothalamic lesion, Cushings syndrome, hypothyroidism, cardiac and respiratory diseases, diabetes mellitus or hypertension and require prior authorization (PA)
- Allergy sensitivity tests
- Immunotherapy (desensitization, hyposensitization)
- Therapeutic allergens;

FQHCs and RHCs

FQHCs and RHCs must be located in areas designated as health professional shortage areas or medically underserved areas by the Public Health Service and must be Medicare certified.

Federal regulations require "core" services be provided in an FQHC or RHC setting:

- Physician services
- Physician assistant services
- Nurse practitioner services
- Specialized nurse practitioner services
- Certified nurse midwife services
- Clinical psychologist services
- Clinical social worker services
- Services and supplies incident to physician, physician assistant, nurse practitioner,clinical psychologist, and/or clinical social worker
- Home nursing services (if the FQHC or RHC is located in a home health agencyshortage area)

RHCs are required to perform six basic laboratory services on site to be certified as an RHC.FQHCs must also provide primary preventive services in addition to the case services listed above.

PROGRAM LIMITATIONS

One adult preventive examination/physical (including a well woman exam) per 12 months iscovered. In addition, physicals are covered when required as a condition of employment.

Electrocardiograms (EKG) must be consistent with the diagnosis/medical condition for which care is received.

Abortion services are not a MO HealthNet Managed Care health plan benefit. The Fee-For-Service Program will reimburse Abortion services (including RU486) only in medical emergencies or when necessary to save the life of the mother.

MISCELLANEOUS

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

PODIATRY SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide podiatry services that are within the scope of practice of the podiatrist. Services must be sufficient in amount, duration,and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Services included within the scope of practice include, but are not limited to:

- Office, hospital, home, nursing home visits;
- Surgical procedures; casting materials;
- Suturing;
- Injections for pain;
- Debridement when amounts of devitalized or contaminated tissue are removed;
- Grafting or transplantation of skin based on size of graft, etc.

LIMITATIONS

The following procedures are not covered for adult members age 21 and over regardless of the provider performing the procedures

- 11719 Trimming of nondystrophic nails, any number
- 11720 Debridement of nail(s) by any method(s); one to five
- 11721 Debridement of nail(s) by any method(s); six or more
- 11750 Excision of nail and nail matrix, partial or complete
- 29540 Strapping of ankle and/or foot

There is an exception to this policy for adult pregnant women with ME codes 18, 43, 44, 45, 61, 95, 96, and 98.

MISCELLANEOUS

For more information, refer to the policy statement on Physician/Advanced Practice NurseServices.

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

PRIVATE DUTY NURSING

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide private duty nursing services. These services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

- The Managed Care Organizations (MCOs), that deliver private duty nursing (PDN)services, shall have policies that address these areas:
  - That every effort is made to ensure that all authorized PDN services are being provided in a timely manner.
  - That MCOs contract with a sufficient number of PDN providers so that if one agency cannot fully staff the PDN services that are authorized, the MCO has a procedure for quickly contacting another agency to fulfill the service delivery.
  - A procedure which outlines that a member may, at their choice, receive their assessed services from multiple PDN providers.
  - A procedure that outlines how PDN providers will contact the MCO when they are not able to staff services and how the MCO will contact a second agency to deliver those services in a timely manner.
  - A procedure that outlines the oversight of the delivery of authorized PDN services.
  - A procedure that outlines the responsibilities of care coordinators and care managers to ensure they are providing frequent contacts with members and providers to assist in any service provision issues.

Private duty nursing is the provision of individual and continuous care (in contrast to part-time or intermittent care) provided according to an individual plan of care approved by a physician, a Registered Nurse (RN), or a Licensed Practical Nurse (LPN) acting within the scope of the Missouri Nurse Practice Act.

MO HealthNet-eligible children under the age of 21 may be eligible for private duty nursing care under the Healthy Children and Youth Program (HCY) when there is a medical need for a constant level of care, exceeding the family's ability to independently care for the child at home on a long-term basis without the assistance of at least a 4-hour shift of nursing care per day. Children receiving private duty nursing care are high-risk children that are medically fragile. For example, they may be ventilator dependent or require G- tube feedings. Services authorized by the Bureau of Special Health Care Needs must be sufficient in specifying the amount, duration and scope of services.

Ensuring that children receiving PDN services will be assessed for all Medicaid reimbursable services for which they might quality, and other services no less than twice a year and that the assessments are separate for a full level of care completed by a physician.

The health plan shall coordinate services for its members who require PDN services. The health plan must identify any care gaps or areas of duplication. The health plan, PDN provider, and any additional health care team members shall communicate on a regular basis as mutually agreed upon by all involved parties, for example weekly, monthly, or quarterly. The communication should include

sharing of information regarding the member's needs; this should also include hospital discharge planning, home visits, and back up plans in case the PDN provider is not available on a scheduled date of service. Communication between all parties should include information on progress for the condition(s), home health services, transition of care information such as changes in the primary care physician, address changes, difficulty or inability to contact participants.

Services In An Educational Setting

For a child who is receiving private duty nursing services identified in the child's Individualized Education Program (IEP), the services are billed fee-for-service and are not the responsibility ofthe MO HealthNet Managed Care health plan. Please refer to the policy statement on Services In An Educational Setting for further information.

MISCELLANEOUS

The Private Duty Nursing Manual and provider bulletins are available at the MO HealthNetDivision website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

RADIOLOGY AND LABORATORY SERVICES

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide radiology and laboratory services. Services must be sufficient in amount, duration, and scope to reasonably achieve theirpurpose and may only be limited by medical necessity.

Under the Clinical Laboratory Improvement Amendments Act of 1988 (CLIA), all independent laboratories, hospital, physician offices, nursing homes, or other laboratory testing sites, as defined at 42 CFR 493.2, must have either a CLIA Certificate of Waiver, or Certificate of Registration, along with a CLIA identification number to legally perform clinical laboratory testing anywhere in the United States. Laboratories licensed by an approved state program are exempt from this policy.

Laboratories that perform lab procedures for the MO HealthNet Managed Care health plans mustbe registered to perform the procedures.

PROGRAM LIMITATIONS

Only one (1) trip fee, for mobile x-ray unit, is allowed per trip regardless of the number of members seen, whether in a nursing facility, custodial care facility, or the MO HealthNet member's home or other place of residence.

Laboratory tests for blood lead levels are mandated by CMS and MO HealthNet Services, for all children between 6 months and 72 months. A blood lead level test must be performed at 12 and24 months.

The MO HealthNet Managed Care health plans are responsible for the following laboratory procedures processed by the Department of Health and Senior Services, State Health Laboratory:

- 83655 Lead
- 82760 Galactose
- 82775 Galactose-1-phosphate uridyl transferase, quantitative
- 84437 Thyroxine, total requiring elution
- 84443 Thyroid stimulating hormone (TSH)
- 83020 Hemoglobin, electophoresis

MISCELLANEOUS

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

SAFE/CARE EXAMS

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are not required to provide Sexual Assault Forensic Examination (SAFE) and Child Abuse Resource Education (CARE) exams. MO HealthNet Managed Care health plans are required to provide follow up services. SAFE/CARE services arecovered for all members under age 19 by the MO HealthNet Fee-For-Service Program when performed by a SAFE/CARE-trained provider. SAFE/CARE providers receive specialized training in detecting sexual and physical abuse from the Department of Health and Senior Services.

The following examination and laboratory tests that ascertain the likelihood of sexual abuse are covered by MO HealthNet Fee-For-Service when performed or requested by a SAFE/CARE- trained provider:

LABORATORY TEST

- Anogenital Examination
- Colposcopy examination
- Pregnancy test (urine)
- Chlamydia test
- Chlamydia test, IgM
- Chlamydia test, culture
- RPR
- Gonorrhea culture
- Wet mount evaluation
- HIV
- HIV-Western Blot
- HIV-1
- HIV-2
- HIV-1, direct probe technique
- HIV-1, amplified probe technique
- HIV-1, quantification
- HIV-2, direct probe technique
- HIV-2, amplified probe technique
- HIV-2, quantification

Laboratory tests for a SAFE/CARE exam are not restricted to the tests or procedures listed aboveand may include any medically necessary tests ordered by the SAFE/CARE provider. MO HealthNet Managed Care health plans are not required to provide the specific tests or procedureslisted above. However, MO HealthNet Managed Care health plans are required to provide laboratory tests and/or procedures not included on this list but ordered by the SAFE/CARE provider, regardless if the SAFE/CARE provider is in or out of the network.

The Children's Division (CD) encourages their staff to use SAFE/CARE-trained providers but it is not mandatory. CD requests the non-offending parent to choose a provider for this exam from a list of certified SAFE/CARE providers. The non-offending parent does not have to take their child to a SAFE/CARE certified provider, they may take them to a physician, advanced practice nurse or an emergency room of their choice. CD requests a statement from the physician as to whether the injuries were due to child abuse and neglect (CA/N).

MO HealthNet Managed Care health plans are required to provide examinations for sexual or physical abuse performed by providers who are not SAFE/CARE certified. These examinations must include, at a minimum, all components of an HCY full screen. MO HealthNet Managed Care health plans are required to provide emergency services, including

additional laboratory, radiology, and other diagnostic testing, that are required as a result of sexual or physical abuse.

It is the responsibility of the SAFE/CARE-trained provider to contact the primary care providerto arrange for medically necessary services for children enrolled in MO HealthNet Managed Care. Services that are required as a result of the exam are the responsibility of the MO HealthNet Managed Care health plan, (e.g. x-rays, hospitalization, psychiatric services).

MISCELLANEOUS

The Physicians Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

Physicians and Advanced Practice Nurses who are a part of the MO HealthNet Managed Care health plan network and who are interested in becoming a SAFE/CARE-trained provider may request information by contacting the SAFE/CARE Network at 573-526-4405.

SERVICES IN AN EDUCATIONAL SETTING

PROGRAM DESCRIPTION

School Based Health Clinics

Schools may establish their own school based health clinics or screening services located at each school site. Schools may contact the MO HealthNet Managed Care health plans regarding the possibility of continuing the services at the school location with the services provided by the MO HealthNet Managed Care health plan's providers (e.g., physician or nurse practitioner for full screens, dentists for dental screens).

A child who is enrolled in a MO HealthNet Managed Care health plan may be seen and treated by the school nurse or the school based health clinic. The school based health clinic must refer the child to the MO HealthNet Managed Care health plan for follow-up. The school would contact the MO HealthNet Managed Care health plan to refer the child on for services, perhaps make an appointment for the child, or to simply notify the MO HealthNet Managed Care health plan of an incident.

Dental Services

MHD reimbursed dental providers for preventive dental services provided to children in a school setting. MHD is committed to the continuation of such programs for MO HealthNet Managed Care members enrolled with a MO HealthNet Managed Care health plan.

MO HealthNet Managed Care health plans are required to contract with and reimburse any licensed providers that provide services in a school setting. Such services include dental exams, prophylaxis, and sealants.

Individualized Education Program

Services included in a child's Individualized Education Program (IEP) as defined by the Individuals with Disabilities Education Act-Part B (34 CFR 300) will not be the responsibility of the MO HealthNet Managed Care health plan. These services will be paid fee-for-service by the MO HealthNet Division.

MO HealthNet Managed Care health plans shall be financially liable and shall not delay the provision of medically necessary services for MO HealthNet participants pending completion ofthe IEP.

These services are billed fee-for-service, and are not the responsibility of the MO HealthNet Managed Care health plan, in cases where the following services are identified in the child's Individualized Education Program (IEP):

- Occupational therapy
- Physical therapy
- Speech therapy

- Specialized transportation
- Hearing aid (audiology)
- Personal care
- Private duty nursing
- Behavioral health services

With parental consent, the school may be in contact with the child's primary care provider to inform him/her of the services the child is receiving.

There are circumstances where children can be enrolled in a school summer program and continue to receive IEP services; reimbursement will continue through the Fee-For-Service Program. When a child is not receiving IEP services during a summer school program and it is deemed medically necessary to continue through the summer months, it is the responsibility of the MO HealthNet Managed Care plan to reimburse for the services.

Individualized Family Service Plan

Services included in a child's Individualized Family Service Plan (IFSP), as defined by the Individuals with Disabilities Education Act-Part C (34 CFR 303), will not be the responsibilityof the MO HealthNet Managed Care health plan. Early Intervention services will be paid fee- for-service by the MO HealthNet Division.

The MO HealthNet Managed Care health plan shall be financially liable and shall not delay the provision of medically necessary services for MO HealthNet participants pending completion of the Individualized Family Service Plan (IFSP).

These services are billed fee-for-service, and are not the responsibility of the MO HealthNet Managed Care health plan, in cases where the following services are identified in the child's IFSP:

MO HealthNet Services	Corresponding First Steps Services
• Durable medical equipment	• Assistive technology
• HCY developmental assessment	• Developmental assessment
• Hearing aid	• Audiology
• Optical	• Vision services
• Personal care	• Nursing, health services and family training
• Physician	• Medical evaluation/diagnosis
• Psychology counseling	• Counseling, social work, psychological services
• Therapy	• Occupational, physical, and speech therapy

With parental consent, First Steps may be in contact with the child’s primary care physician toinform him/her of the services the child is receiving. IFSP services occur year round and are not affected by summer months.

TOBACCO CESSATION COUNSELING

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide tobacco cessation counseling. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

PROGRAM LIMITATIONS

Individual and Group Counseling

MO HealthNet Managed Care health plans are required to provide individual and group counseling for tobacco cessation. Providers of individual and group counseling for tobacco cessation may include:

- Licensed psychiatrists
- Provisionally licensed psychologists
- Licensed psychologists
- Licensed clinical social workers
- Licensed master social workers
- Provisionally licensed professional counselors
- Licensed professional counselors
- Licensed psychiatric clinical nurse specialists
- Licensed psychiatric nurse practitioners
- Supervised psychology intern
- Licensed marital and family therapists (LMFT)
- Provisional licensed marital and family therapists (PLMFT)
- Missouri certified behavioral health programs

In addition to the above providers, individual counseling for tobacco cessation may be provided by physicians, nurse practitioners, assistant physicians, and physician assistants.

Please refer to the Physician/Advanced PracticeNurse Services, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) policy statement for more detail regarding physician services.

MISCELLANEOUS

Please reference Section 13 of the Missouri MO HealthNet Behavioral Health Services Manual for details regarding benefits and limitations for Tobacco Cessation Counseling.

TRANSITION OF CARE

PROGRAM DESCRIPTION

The MO HealthNet Managed Care health plans are required to ensure an orderly and smooth transfer of responsibility and continuity of care for members transitioning from fee-for-service (FFS) to the health plan or out of the health plan and into another managed care health plan. Thehealth plans are required to facilitate continuity of care for medically necessary covered services.

TRANSITION FROM THE MO HEALTHNET FEE-FOR-SERVICE PROGRAM TO THE MOHEALTHNET MANAGED CARE PROGRAM

If the health plan receives new members who were previously FFS, the health plan must contact the member's provider within five (5) business days of the state agency's notification to the health plan of the member's anticipated enrollment date, to request the necessary medical records and information.

RELEVENT MEMBER INFORMATION

1) *Member Last Name
2) Member First Name
3) Member Middle Initial
4) *Member DCN
5) *Member DOB
6) Member Gender (Female or Male)
7) Member Contact Number
8) Interpreter Needed (Yes or No)
9) Caregiver Last Name
10) Caregiver First Name
11) Caregiver Address Line 1
12) Caregiver Address Line 2 (City, State & Zip Code)
13) Caregiver Contact Number
14) *PCP Last Name
15) PCP First Name
16) *PCP Individual NPI #
17) PCP Group NPI #
18) PCP TIN
19) *Pregnant (Yes or No)
20) Estimated Date of Confinement (EDC)
21) *Care Management (Yes or No)
22) *Care Management Critical/Urgent Risk (Yes or No)
23) Care Management Critical/Urgent Reason
24) *Active Disease Management (Yes or No)
25) *Disease Management Critical/Urgent Risk (Yes or No)

26) Disease Management Critical/Urgent Reason

* Mandatory fields to be shared by the health plans.

TRANSITION FROM A MO HEALTHNET MANAGED CARE HEALTH PLAN TO ANOTHER MO HEALTHNET MANAGED CARE HEALTH PLAN

The health plans must provide for the transfer of relevant member information, including medical records and other pertinent materials such that the transition of care shall be smooth.Upon contract award, the health plan shall provide the state agency with a contact person fortransition of care information.

If a member enrolls with the health plan from another health plan, the health plan shall, within five (5) business days from the date of the state agency's notification to the health plan of the member's anticipated enrollment date, contact the member to determine the name of the otherhealth plan in order to request relevant member information from the other health plan.

If the health plan is contacted by a member's new health plan requesting relevant member information, the health plan shall provide such data to the health plan within five (5) business days of receiving the request.

If the health plan becomes aware that a member will transfer to another health plan, the healthplan shall contact the other health plan within five (5) business days of becoming aware of the member's transfer and shall share relevant member information and respond to questions regarding the member's care needs and services.

The new health plan shall work with out-of-network providers and/or the previous health plan to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a medical health, behavioral health, or substance abuseprovider that is not in the health plan's network.

At a minimum, the health plan shall (1) facilitate the securing of a member's records from the out-of-network providers as needed, and (2) pay rates comparable to fee-for-service for these records, unless otherwise negotiated.

Members covered under the Show Me Healthy Kids Health Plan (Specialty Plan) managed by Home State Health do not have the option to transition to another health plan. However, if they lose their eligibility but retain eligibility under another managed care category, within 60 days, they will be automatically assigned to the same health plan that administers the Specialty Plan (Home State Health). If the break is longer than 60 days then they will be randomly auto-assigned to one of the three general plans.

MANAGED CARE ADMINISTRATIVE PROCEDURE FOR MEMBER TRANSITION OF CARE TO ANOTHER MANAGED CARE HEALTH PLAN

Managed Care Health Plan Responsibilities

The current health plan shall notify the new health plan within five (5) business days of becoming aware of any managed care health plan member who will or hastransferred from the current health plan to another health plan.

New Health Plan Responsibilities

The new health plan staff shall, within one (1) business day of receiving the relevant member information, evaluate the relevant member information for need of a clinical review. If the new health plan staff determine a clinical review is needed, the relevant member information will be forwarded to their clinical staff.

Examples of clinical transition include, but are not limited to, any member meeting the behavioral or physical health case or disease management eligibility requirements in the Managed Care Contract section 2.12.1, Care Management and 2.12.2, Disease Management.

Examples of Care Management eligibility, include, but are not limited to:

- Diabetes;
- Obesity
- Asthma;
- COPD;
- Congestive heart failure;
- Cancer;
- Chronic pain with opioid dependence;
- Hepatitis C in active treatment;
- HIV/AIDS;
- Sickle Cell Anemia;
- Organ failure requiring supportive treatment and potentially requiring transplant (e.g. ESRD and dialysis requirement or pancreatic/hepatic failure);
- Individuals with special health care needs including those with Autism Spectrum Disorder. Individuals with special health care needs are those individuals who without services such as private duty nursing, home health, durable medical equipment/supplies, and/or care management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:
    - Individuals with Autism Spectrum Disorder;
    - Individuals eligible for Supplemental Security Income (SSI);
    - Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a) (1)(D) of Title V, as defined by the state agency in terms of eitherprogram participant or special health care needs.
    - Serious mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, recurrent major depression, and moderate to severe substance use disorder.

Examples of disease management include, but are not limited to:

- Major depression,

- Asthma,
- Obesity,
- Diabetes,
- Hypertension, or
- Attention Deficit Hyperactivity Disorder (ADHD)

TRANSITION OF PREGNANT WOMEN INTO MOHEALTHNET MANAGED CARE HEALTH PLANS

PROGRAM DESCRIPTION

Transition of pregnant women into MO HealthNet Managed Care health plans will be an ongoing occurrence as members often become eligible as a result of their pregnancy. The MO HealthNet Managed Care health plans shall allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider, without prior authorization, until the birth of the child, cessation of the pregnancy, or loss of MO HealthNet eligibility.

A pregnant woman in her third trimester may elect to continue her established provider relationship for prenatal and obstetrical care regardless if the provideris in the MO HealthNet Managed Care health plan network or out of the MO HealthNet Managed Care health plan network. A relationship between a member and a provider is demonstrated by the member obtaining at least three prenatal visits from that provider.

Case Examples

Case One: The member is in her third trimester and currently receiving prenatal services. She has either selected a MO HealthNet Managed Care health plan or was auto-assigned. She wants to receive obstetrical services from an in-plan provider.

MO HealthNet Managed Care Health Plan Responsibility: The MO HealthNet Managed Care health plan does not require a referral from the member's assigned or selected PCP. The MO HealthNet Managed Care health plan reimburses the in-network provider at the MO HealthNet Managed Care health plan's negotiated rates.

Case Two: The member is in her third trimester and currently receiving prenatal services. Sheeither selected a MO HealthNet Managed Care health plan or was auto-assigned. She wants to continue to receive obstetrical services from an out-of-plan provider.

MO HealthNet Managed Care Health Plan Responsibility: The MO HealthNet Managed Care health plan does not require a referral from the member's assigned or selected PCP. The MO HealthNet Managed Care health plan reimburses the provider out-of-network rates according to 2.6.22 of the contract. If the provider only has admitting privileges in an out-of-network hospital, the MO HealthNet Managed Care health plan reimburses the hospital out-of-network rates according to 2.6.21 of the contract.

Transportation is the responsibility of the MO HealthNet Managed Care health plan. MO HealthNet Managed Care members with ME codes 73 through 75 and 97 are not eligible for non-emergency transportation.

NOTE: Providers should encourage pregnant women with ME code 71, 72, 73, 74, 75, or 97 toapply for regular MO HealthNet.

TRANSPLANTS

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are not required to provide transplants except as otherwise noted in this policy. MO HealthNet Managed Care health plans are required to provide pre-surgery assessment/evaluation, care and post-transplant discharge follow up care. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Covered transplants include: heart, lung, liver, kidney, pancreas, small bowel, and stem cell transplants (including bone marrow, peripheral, andcord blood stem cell) or any transplant approved by the MO HealthNet Division (MHD).

Transplant services provided by MO HealthNet Fee-For-Service are the organ/stem cell procurement charges and the inpatient stay for the transplant from the date of transplant throughthe date of discharge. In addition to services covered as part of the transplant, MO HealthNet Fee-For-Service covers the transplant surgeon's fee, all physician, lab, etc. charges incurred during the transplant stay (date of transplant through date of discharge).

If there is a significant change in diagnosis not related to the transplant during the transplant stay,the health plan will be responsible for those services not related to the transplant. Any additional services not related to the transplant will be considered post-transplant services and the responsibility of the health plan.

Effective October 1, 2020 the treating provider may choose the method of administration of CAR T-Cell therapy that is most appropriate for the member. MO HealthNet Fee-For-Service will continue to cover the cost of the drug but all other expenses will be paid by the health plan.

According to 42 CFR 431.51 MHD must ensure freedom of choice of providers for services provided to members when those services are paid on a fee-for-service basis. When the MO HealthNet Managed Care health plan identifies a member as a potential transplant candidate, theMO HealthNet Managed Care member must be referred to an approved MO HealthNet transplant facility of their choice without regard to MO HealthNet Managed Care health plan preference. If a member is being referred to an out-of-state or non-approved MO HealthNet transplant facility for the transplant assessment/evaluation, the MO HealthNet Managed Care plan must notify the MO HealthNet transplant coordinator with this information prior to servicesbeing rendered.

MO HealthNet Managed Care health plans are required to provide pre-surgery assessment/evaluation and care (excluding the organ procurement or stem cell harvest), post-transplant discharge follow-up care after the inpatient transplant discharge.

Pre-surgery assessment/evaluation and care includes inpatient, outpatient, and physician services for the assessment and evaluation of the transplant member. Even though performed during the pre-transplant period, the transplant facility will bill the organ procurement or stem cell harvest to MHD.

Post-transplant discharge follow-up care includes all necessary medical services provided after the inpatient transplant discharge. To assure continuity of care, the primary care provider must be

allowed to refer a transplant member to the transplant facility for follow-up transplant care.

Current fee-for-service guidelines for transplant coverage include:

For organ transplants-The member must meet the transplant facility protocol and beaccepted as a transplant member;

For bone marrow transplants:

- Members for bone marrow or peripheral stem cell transplantation must meet the member selection criteria established by the performing transplant facility;
- Each request for coverage is reviewed by a physician and when deemed necessary,by a bone marrow transplant consultant. The recommendations of the physician orconsultant are the basis for authorization or denial of the request for coverage.

Transplants must be prior authorized by MHD and must be performed at MHD approved transplant facilities.

Approved Fee-For-Service Transplant Facilities

Bone Marrow

- Barnes-Jewish Hospital (Adult)-St. Louis, MO
- Cardinal Glennon Children's Hospital-St. Louis, MO
- Children's Mercy Hospital of K.C.-Kansas City, MO
- Kansas University Medical Center-Kansas City, KS
- St. Jude Children's Research Hospital-Memphis, TN
- St. Louis Children's Hospital-St. Louis, MO
- St. Louis University-St. Louis, MO
- St. Luke's Hospital/The Cancer Institute-Kansas City, MO
- University of Nebraska-Omaha, NE

Heart

- Barnes-Jewish Hospital*-St. Louis, MO
- Cardinal Glennon Children's Hospital*-St. Louis, MO
- St. Louis Children's Hospital-St. Louis, MO
- St. Louis University-St. Louis, MO
- St. Luke's Hospital of K. C. *-Kansas City, MO
- University of Nebraska*-Omaha, NE

Kidney

- Barnes-Jewish Hospital*-St. Louis, MO
- Cardinal Glennon Children's Hospital*-St. Louis, MO

- Children's Mercy Hospital of K.C.*-Kansas City, MO
- Kansas University Medical Center*-Kansas City, KS
- St. Louis Children's Hospital*-St. Louis, MO
- St. Louis University*-St. Louis, MO
- St. Luke's Hospital of K.C.*-Kansas City, MO
- University of Missouri-Columbia*-Columbia, MO
- University of Nebraska*-Omaha, NE

Kidney/Pancreas

- Barnes-Jewish Hospital*-St. Louis, MO
- Kansas University Medical Center*-Kansas City, KS
- St. Louis University*-St. Louis, MO
- University of Nebraska*-Omaha, NE

Liver

- Barnes-Jewish Hospital*-St. Louis, MO
- Cardinal Glennon Children's Hospital*-St. Louis, MO
- Children's Mercy Hospital-Kansas City, MO
- Kansas University Medical Center*-Kansas City, KS
- St. Louis Children's Hospital-St. Louis, MO
- St. Louis University*-St. Louis, MO
- St. Luke's Hospital of K.C. – Kansas City, MO
- University of Nebraska*-Omaha, NE

Lung

- Barnes-Jewish Hospital*-St. Louis, MO
- St. Louis Children's Hospital-St. Louis, MO

Heart/Lung

- Barnes-Jewish Hospital*-St. Louis, MO

Intestine

- University of Nebraska*-Omaha, NE

*Medicare-Certified Transplant Facility

Requests for transplants involving transplant facilities not listed and/or outside of Missouri willbe considered on a case-by-case basis. Documentation from the referring physician to MHD indicating why the transplant member must have the procedure performed at an out-of-state facility must accompany the request.

MISCELLANEOUS

The Transplant Provider Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

TRANSPORTATION SERVICES EMERGENCY AND NON-EMERGENCY

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide emergency medical transportation by ground or air when medically necessary and appropriate. Non-emergency medical transportation (NEMT) must be provided to MO HealthNet Managed Care members who do not have the ability to provide their own transportation to and from health care services including health care services that are carved out of the MO HealthNet Managed Care contracts. Ancillary services related to the NEMT must also be provided.

NEMT services are covered for all Managed Care ME Codes except 08, 52, 57, 64, 73-75, and 97.

NEMT TRANSPORTATION REQUIREMENTS

MO HealthNet Managed Care health plans must arrange NEMT services for MO HealthNet Managed Care members accessing MO HealthNet covered services. In addition, MO HealthNetManaged Care health plans must arrange NEMT services for one parent/guardian or an attendant, if requested or appropriate, to accompany children under the age of 21. Participants under the age of 17 will require the presence of a parent/guardian or another adult while being transported. Transportation will not be provided for a child under the age of 17 who is unaccompanied unless they are an emancipated minor.

MO HealthNet Managed Care health plans are not required to provide transportation to MO HealthNet Managed Care members with access to free transportation at no cost to them, however, such MO HealthNet Managed Care members may be eligible for ancillary services.

MO HealthNet Managed Care health plans must ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary.

Also, MO HealthNet Managed Care health plans are not required to provide NEMT services to pharmacy services or to Durable Medical Equipment providers that provide free delivery or mail order services.

Some services already include NEMT. The MO HealthNet Managed Care health plan is not responsible to provide NEMT to these services. Examples are:

- Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) services;
- hospice services;
- Developmental Disability (DD) waiver services;
- adult day care services; and
- services provided in the home.

School districts must supply a ride to a child's Individual Education Program (IEP) services. Transportation to CSTAR assessments and CSTAR medication services is covered by the

Department of Mental Health CSTAR program and is not the responsibility of the Managed Care health plan. Transportation to Community Psychiatric Rehabilitation (CPR) medication servicesis covered by the Department of Mental Health CPR program and is not the responsibility of the Managed Care health plan. The Managed Care health plan is responsible for covering all other transportation services to behavioral health services except for psychosocial rehabilitation and community support.

The MO HealthNet Managed Care health plans must arrange the least expensive and most appropriate mode of transportation based on the MO HealthNet Managed Care member's medical needs. The modes of transportation that may be utilized include, but are not limited to:

- Public transit/bus tokens
- Gas reimbursement shall be made at no less than the IRS standard mileage rate formedical reasons in effect on the date of service. The reimbursement methodology must be consistent for each participant in a region.
- Para-lift van
- Taxi
- Ambulance
- Stretcher van
- Multi-passenger van

The MO HealthNet Managed Care health plan must not utilize public transit for the following situations:

- High-risk pregnancy
- Pregnancy after the eighth month
- High risk cardiac conditions
- Severe breathing problems
- More than three block walk to the bus stop

The MO HealthNet Managed Care health plan shall limit members to no more than three (3) transportation legs per day without requiring prior authorization.

NEMT ANCILLARY SERVICE REQUIREMENTS

The MO HealthNet Managed Care healthplan shall authorize and arrange the least expensive and most appropriate ancillary services if the medical appointment requires an overnight stay, and volunteer, community, or other ancillary services are not available at no charge to the MO HealthNet Managed Care member.

For participants under the age of 21, ancillary services may include an attendant or one parent/guardian to accompany the child.

The MO HealthNet Managed Care health plan shall authorize and arrange ancillary services for the parent/guardian when the child is inpatient in a hospital setting and meets the following criteria:

- ❑ The hospital does not provide ancillary services without cost to the participant's parent/guardian; and
- ❑ The hospital is more than 120 miles from the participant's residence; or
- ❑ Hospitalization is related to a MO HealthNet covered transplant service.

If the MO HealthNet Managed Care member meets the criteria specified above, the MO HealthNet Managed Care health plan shall also authorize and arrange ancillary services to eligible MO HealthNet Managed Care members who have access to free transportation at nocharge to the MO HealthNet Managed Care member or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

NEMT DEFINITIONS

Ancillary Services	Meals and lodging are part of the transportation package for participants when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services mayinclude an attendant and/or one parent/guardian to accompany the child.
Attendant	An individual who goes with a MO HealthNet Managed Care member under the age of 21 to the MO HealthNet covered service to assist the MO HealthNet Managed Care member because they cannot travel alone or a long distance without assistance. An attendant is an employee of, or hired by the MO HealthNet Managed Care health plan or a NEMT provider.
Free Transportation	Any appropriate mode of transportation that can be secured by the MO HealthNet Managed Care member without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Most Appropriate	The mode of transportation that best accommodates the MO HealthNet Managed Care member's physical, mental, or medical condition.
Public Entity	State, county, city, regional, non-profit agencies, and any other entities, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with theMO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.

MISCELLANEOUS

The Ambulance Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

TREAT NO TRANSPORT (TNT)

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide Treat No Transport (TNT) services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Certain services are covered when the member is not transported to an emergency department.

PROGRAM LIMITATIONS

On-Site Treatment, No Transport:

On-site treatment provided by an emergency medical technician is covered if the service meets the following criteria:

- ❑ Is the result of an emergent or immediate response made by a licensed ambulance service;
- ❑ The ambulance provider performs a medically necessary assessment;
- ❑ Treatment is provided to the participant; and
- ❑ The participant is *not* transported by the responding service provider to an emergency department.

On-Site Referral, No Transport:

When an on-site referral for further treatment is provided to the participant, the service is covered if it meets all of the following criteria:

- ❑ Is the result of an emergency or immediate response made by a licensedambulance service
- ❑ The EMS crew provides a medically necessary assessment
- ❑ A referral for further treatment is provided to the participant
- ❑ The participant is not transported by the responding service provider to an emergency department

Service Limitations:

The limit for treat no transport services shall not exceed one (1) per day.

MISCELLANEOUS

The Missouri MO HealthNet Ambulance Manual and provider bulletins are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.

VACCINES FOR CHILDREN

PROGRAM DESCRIPTION

Under the provision of the Omnibus Budget Reconciliation Act (OBRA) of 1993, vaccines are available free to providers who enroll with the Vaccines for Children (VFC) Program for children ages under age 19 who are MO HealthNet enrolled, uninsured, American Indian/Alaskan Native, or underinsured (RHC or FQHC only). MO HealthNet Managed Care health plan providers must enroll in the VFC Program administered by the Missouri Departmentof Health and Senior Services and must use the free vaccine when administering the vaccine to MO HealthNet Managed Care members under age 19 years of age.

A separate administration fee will not be paid to the MO HealthNet Managed Care health plans as the reimbursement is included in the capitation payment. MO HealthNet Managed Care health plans may have differing payment arrangements with their providers and the VFC administration fee is permissible to be included in the capitation payment from the MO HealthNet Managed Care health plan to the provider. The MO HealthNet Managed Care health plans shall reimburse the vaccine component to local public health agencies. However, the COVID-19 vaccine and the administration of the vaccine shall be carved out and provided through fee-for-service and reimbursed by the state agency according to the terms and conditionsof the MO HealthNet program.

MISCELLANEOUS

To enroll in the Vaccines for Children (VFC) Program contact:

Missouri Department of Health and Senior Services
Bureau of Immunization Assessment and Assurance
P.O. Box 570 920 Wildwood
Jefferson City, MO 65102-0570
1-800-219-3224 or 573-751-6124

Refer to the MO HealthNet Managed Care Physician/Advanced Practice Nurse Services Policy Statement for additional information.

The Physician's Manual and provider bulletins, which address the VFC program, are available at the MO HealthNet Division website: https://dss.mo.gov/mhd/providers/managed-care-providers.htm.