



Missouri CareSM
AN AETNA HEALTH PLAN

Provider Manual
January 2011

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Missouri CareSM

AN AETNA HEALTH PLAN

Missouri Care Overview

1.1 ORGANIZATION

Missouri Care, owned by Schaller Anderson, Incorporated (Schaller Anderson), an Aetna Company, has worked with the MO HealthNet Division for more than 10 years to improve access to cost effective, quality health care for eligible MO HealthNet participants throughout the Central Region. We established a strong record of improving the health of Missourians through increased accessibility, high quality care, effective communications and member-centered wellness and care management programs. In 2009, Missouri Care added the Eastern and Western MO HealthNet Managed Care Regions.

We offer integrated behavioral (including substance abuse) and physical health programs, using sophisticated risk assessment tools to develop proactive, preventive plans of care for individuals. Our comprehensive care management programs, designed specifically for MO HealthNet populations, have been extremely successful in increasing access to care, improving clinical outcomes and reducing costs. Missouri Care currently subcontracts our vision services to March Vision and dental services to DentaQuest. We are adept at communicating with members and providers, and at building long-lasting relationships with stakeholders. Our focus on the individual and our commitment to personalized care enables Missouri Care to create a health care environment that empowers members to take responsibility for their own health care and supports them in reaching their personal health goals

1.2 MISSOURI CARE'S OPERATIONAL PHILOSOPHY

Missouri Care's managed care philosophy is the administration of efficient, effective, and quality health care to our members through a network of independent, credentialed health professionals under contract with Missouri Care. The member's health care is centered on the Primary Care Provider (PCP) who manages the complete health care needs of the member. The PCP arranges for necessary, covered medical services through a network of contracted health care professionals, hospitals and ancillary providers.

Missouri Care utilizes industry-accepted standards of credentialing, prior authorization, concurrent and retrospective review, coordination of discharge planning and case management to promote effective provision of covered services to our members. In addition, Missouri Care has a comprehensive and integrated quality management program which includes monitoring, evaluating and improving the continuity, quality, accessibility and availability of health care and services provided to members. Our program is designed to assess members' care, delivery systems, and satisfaction while optimizing health outcomes and managing costs. The program is integrated throughout Missouri Care, and its provider and community network. If you would like further information on our Quality Management Program contact us at 1-800-322-6027.¹

1.3 SERVICE AREA

- Central Region - Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, and Shelby counties.
- Eastern Region – Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties and St. Louis City
- Western Region – Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon counties

¹ NCQA QI 2C-2

1.4 CONTACT INFORMATION

Please visit our website at: www.MissouriCare.com

MISSOURI CARE

IMPORTANT CONTACT INFORMATION

<p>CUSTOMER SERVICE DEPARTMENT (24 hours a day, 7 days a week)</p> <p>(800) 322-6027</p>	<p>CASE MANAGEMENT SERVICES</p> <p>(800) 322-6027</p> <p>FAX (866) 946-1104</p>
<p>TRANSPORTATION SERVICES</p> <p>MTM (800) 695-5791</p>	<p>VISION SERVICES</p> <p>MARCH Vision (888) 493-4070</p>
<p>DENTAL SERVICES DentaQuest (888) 696-9533</p>	<p>Missouri Care Compliance Hotline</p> <p>(877) 436-5288</p>
<p>PROVIDER RELATIONS DEPARTMENT</p> <p>PHONE (800) 322-6027 FAX (800) 946-1105 EMAIL PROVIDERRELATIONS3@AETNA.COM</p>	<p>24-HOUR HEALTH ADVICE LINE (24 hours a day, 7 days a week)</p> <p>Informed Health Line</p> <p>(800) 556-1555</p>
<p>BEHAVIORAL HEALTH SERVICES (24 hours a day, 7 days a week)</p> <p>(800) 889-4073 or Web-Portal via www.MissouriCare.com or FAX (866) 543-2385</p>	<p>PRIOR AUTHORIZATION (24 hours a day, 7 days a week)</p> <p>(800) 322-6027 or Web-Portal via www.MissouriCare.com or FAX (866) 946-2052</p>
<p>CLAIMS DEPARTMENT Claims Questions: (800) 322-6027 FAX (866) 946-1204</p> <p>Submit Claims to: Missouri Care Health Plan Attn: Claims Submission P.O. Box 61625 Phoenix, Arizona 85082-1625</p>	<p>Submit <i>Corrected</i> Claims to:</p> <p>Missouri Care Health Plan Attn: Claims Adjustments P.O. Box 61625 Phoenix, Arizona 85082-1625</p>

Section 2 MEMBER ENROLLMENT AND ELIGIBILITY

2.1 MO HealthNet MANAGED CARE PROGRAM

MO HealthNet oversees the managed care program serving MO HealthNet participants. Missouri Family Support Division eligibility specialists determine eligibility for MO HealthNet. An individual may be eligible under the MO HealthNet Program if they are in one of the following eligibility categories:

Group	ME Codes	ME Code Description
TANF and Refugee	05	ADC Caretaker (ADC-AD)
	06	ADC Dept (ADC-CD)
	40	Medicaid for Children
	60	Newborn
	62	MFC Health Initiative Fund
	10	Vietnamese Refugee
	19	Cuban Refugee
	21	Haitian Refugee
	24	Russian Jew Refugee
	26	Ethiopian Refugee
	18	Pregnant Women – MAF
	43	Pregnant Women - 60 days
	44	Postpartum
	45	Pregnant Woman-60 days Poverty
	61	Pregnant Woman Poverty 133%-185% HIF
Other Children	07	AFDC Foster Care
	08	CWS-FC
	29	Div of Youth Svcs FYS-FC
	30	JC-FC
	36	Adoption Subsidy – FFP
	37	Title XIX-FFP/HDN
	38	Independent Foster Care Children age 18-21
	50	DYS-Poverty
	52	DYS-GR
	56	Adoption Subsidy-4E Elig.
	57	Adoption Subsidy-Homeless, Dependent, Neglected Children (HDN)
	64	JC – Group Home - HIF
	66	Child Welfare – HIF
	68	DYS-HIF
69	JC-HIF	
MO HEALTHNET CHIPS	70	JC-Poverty
	71	WVR, 134-150%, Age 1-5
	72	WVR, 101-150%, Age 6-18
	73	WVR, 151-185%, Age 1-18
	74	WVR, 186-225%, Age 0-18
	75	WVR, 226-300%, Age 0-18

Missouri Care staff is not involved in the eligibility process. After an individual has been determined eligible for the MO HealthNet Managed Care Program, they either choose or are assigned to one of the State's contracted MO HealthNet Program managed care organizations. Missouri Care is one of the contracted managed care organizations for Eastern, Central and Western Missouri.

2.2 ASSIGNMENT TO MISSOURI CARE

With the exception of newborns enrolled at birth, Missouri Care is assigned MO HealthNet Program eligible participants daily. Missouri Care is responsible for managing the member's care on the first effective day of the member's enrollment until the member is disenrolled from Missouri Care or, if hospitalized when disenrolled, until discharge. If the member loses Medicaid eligibility altogether while hospitalized, Missouri Care is not responsible for any services provided after the date of disenrollment. Disenrollment decisions are made by the State and are not determined by Missouri Care.

If the member requires health care in the days prior to the effective date of enrollment with Missouri Care, the State of Missouri or another managed care organization (not Missouri Care) is the financially responsible party.

2.3 PRIMARY CARE PROVIDER (PCP) MEMBER ASSIGNMENT

Each enrolled Missouri Care member is assigned to a Primary Care Provider (PCP) who has been credentialed by Missouri Care and has a contract to provide services to Missouri Care members. Missouri Care allows members the freedom to choose and/or change their own PCPs from among those in the Missouri Care network. Each new member who does not choose a PCP is assigned a PCP and sent written confirmation of the assignment within five (5) business days following notification by MO HealthNet of their enrollment. Each member is then given fifteen (15) calendar days to choose another PCP. If the member does not notify Missouri Care of his/her preferred PCP within the fifteen (15) calendar days, the member will remain with the assigned PCP.

Missouri Care performs PCP assignments based upon factors such as current member/Provider relationships, language needs, special health care needs, and member residence. Specialists may be assigned as a PCP when medically appropriate, and pregnant women may elect to transfer their care to a primary care obstetrician (PCO) for the course of the pregnancy and the sixty (60) days postpartum. Contracted providers are free to see a Missouri Care member that presents themselves for care, regardless of the PCP assignment on the member card, when providing primary care services.

2.4 MEMBER ROSTERS

Member rosters are available online at www.missouricare.com via the secure web portal. A password is required to access this information; please contact your Provider Relations representative for more information. For those providers who do not have internet access, Missouri Care may print and distribute rosters upon request. Providers are advised to check eligibility through the state Interactive Voice Response (IVR) Unit before rendering services as eligibility may change daily.

2.5 ELIGIBILITY VERIFICATION

Once a member has been assigned to a PCP, the assignment is recorded in the Missouri Care computer system and the information is downloaded to the State eligibility system. A PCP should always check the Interactive Voice Response (IVR) Unit at 573-635-8908, to determine eligibility.

The MO HealthNet Program assigns members to Missouri Care on a daily basis based on eligibility determination. In turn, Missouri Care assigns members to PCPs on a daily basis. Members may change MO HealthNet Managed Care health plans for any reason during the first 90 days after they become a MO HealthNet Managed Care health plan member. Members will also be able to change during their annual open enrollment time.

If a member presents at the office, the PCP should check the IVR (573-635-8908) to verify eligibility and PCP assignment. If the PCP assignment is not available, call the Missouri Care Member Services Department at (800) 322-6027. Member Services can also verify the date that the member was assigned to a particular PCP.²

The MO HealthNet Program assigns members to Missouri Care on a daily basis based on eligibility determination. In turn, Missouri Care assigns members to PCPs on a daily basis. Members may change their PCP two (2) times per year without cause.

If a member presents at the office, the PCP should check the IVR (573-635-8908) to verify eligibility. If the PCP assignment is not available, call the Missouri Care Member Services Department at (800) 322-6027. Member Services can also verify the date that the member was assigned to a particular PCP.

2.6 REMOVING MEMBERS FROM A PROVIDER ROSTER

Should a PCP want an assigned member taken off his/her roster due to the member's non-compliance or disruptive behavior in the office, the PCP can request the member's removal. The request must be directed to the Provider Relations Department in writing. Missouri Care will review the request and if deemed appropriate and within the parameters of Missouri Care's policy for PCP changes, the member will be removed from the PCP's roster. The change will be effective at the end of thirty (30) days, following approval by Missouri Care or immediately if a new PCP is chosen by the member. The PCP will remain responsible for the member's primary care until the change becomes effective. A letter from the PCP must also be sent to the member allowing them adequate time, at least thirty (30) days, to request a new PCP.

² RFP 2.12.14

2.7 IDENTIFICATION CARD

Upon enrollment with Missouri Care, each member is issued an identification card showing the member's name and date of birth, Missouri Care ID number, and the selected PCP's name. The member's Missouri Care ID card and red or white Health Insurance (MO HealthNet) card should be presented to the Provider's office each time the member presents for service but services should not be denied if no card is presented. The ID card **does not guarantee** that the member is still eligible for the MO HealthNet Program and the Provider should check the IVR.

- To verify eligibility and enrollment – Check the IVR
- To verify PCP assignment – Call Missouri Care Member Services

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the Missouri Care ID card (attachment A) against another form of identification, such as a driver's license or some other photo identification. This type of verification not only deters fraudulent use of the MO HealthNet Program, but also protects the Provider against performing a service for which payment may be denied.

2.8 MEMBER HANDBOOK

At the time of enrollment with Missouri Care, a member receives a copy of the Missouri Care *Member Handbook*. The handbook covers such topics as: how to select or change PCPs, appointment procedures, covered benefits, grievance and appeal process, how to report suspected fraud and abuse, prior authorization, and explains the member's rights and responsibilities in obtaining health care through Missouri Care. Providers may obtain a copy of the *Member Handbook* by contacting their Provider Relations Representative.

2.9 CO-PAYMENTS FOR MISSOURI CARE MEMBERS

MO HealthNet Managed Care members do not have co-payments.

2.10 MEMBER RIGHTS AND RESPONSIBILITIES

Each Missouri Care member is entitled to medical treatment without unlawful bias and according to the general community standards for the delivery of health care. No member may be denied the benefits of, or participation in, covered services on the basis of race, color, sex, sexual preference, age, handicap, religion or national origin. In turn, no Provider may discriminate in the delivery of medical and behavioral health covered services, on the basis of race, color, sex, sexual preference, age, handicap, religion or national origin.

MEMBER RIGHTS AND RESPONSIBILITIES³

Member, Parent or Legal Guardian Rights

- Missouri Care will comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to members.
- Each member has the right to receive information about Missouri Care, its services, its practitioners and providers, and member rights and responsibilities.⁴
- Each member is guaranteed the right to request and receive a copy of his or her medical records and to request that they be amended or corrected, as specified in 45 CFR, part 64.
- Each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way Missouri Care or its providers or the state agency treat the member.
- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.⁵
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Each member has the right to a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.⁶
- Each member has the right to make recommendations regarding Missouri Care's member rights and responsibilities policy.⁷
- Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.⁸
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

Missouri Care members have additional rights to:

- Voice grievances or appeals about Missouri Care or the care it provides
- Make recommendations regarding the member rights and responsibilities policy for Missouri Care
- Receive information about Missouri Care, its services, its providers and their rights and responsibilities;
- An open discussion of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage

³ See NCQA RR 2A-3,4

⁴ NCQA RR 1, A-1

⁵ NCQA RR 1, A-2

⁶ NCQA RR 1, A-4

⁷ NCQA RR 1, A-6

⁸ NCQA RR 1, A-3

Member, Parents or Legal Guardian Responsibilities

Missouri Care expects members to cooperate responsibly and to the full extent possible in matters regarding their health care. These include the following:

- The member must present his or her Missouri Care identification card and the MO HealthNet insurance card to each provider before receiving service. Members are encouraged to carry a second form of identification. The member is responsible for providing, to the extent possible, any and all information needed by their provider supplying treatment and care.⁹
- The member is responsible for contacting their primary care provider as their first point of contact when needing medical care.¹⁰
- The member must obtain approval or authorization from the Primary Care Provider (PCP) before obtaining treatment.
- Each member is responsible for scheduling and canceling appointments for services, including transportation. If the member cannot keep a scheduled appointment, he or she must call the provider at least twenty-four (24) hours in advance to cancel the appointment.
- Each member must act in a responsible manner at a provider's facility and when speaking with providers or Missouri Care personnel and not use abusive language or aggressive body language toward any providers or other Missouri Care personnel.
- Each member must inform the provider if he or she does not understand the provider's explanation(s) concerning the member's medical care and to participate in developing a mutually agreed-upon treatment goals, to the degree possible.¹¹
- Each member is responsible for complying with the provider's treatment plan for medications, diet and exercise that they have mutually agree upon.¹²
- Members must bring immunization records to every appointment for members 21 years old or younger.
- Members are responsible for scheduling periodic checkups for infants and children in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Program and for keeping the appointments. Prenatal members must schedule obstetrical checkups at the recommended intervals. Members are encouraged to participate in other available prevention and wellness programs that correlate with their check ups and treatments.¹³
- Each member must notify the Missouri Department of Social Services, Family Support Division of address changes, any changes in family size or changes that

⁹ NCQA RR 1A-7

¹⁰ See State Contract § 2.14.8.b.2

¹¹ NCQA RR 1A-9

¹² NCQA RR 1A-8

¹³ See State Contract § 2.14.8.b.3

may affect eligibility or enrollment (e.g., marriage, birth, adoption, divorce, death or guardianship).

- Each member must follow the procedures outlined in the Missouri Care Member Handbook to obtain services or present questions or concerns.
- Co-payment requirements do not apply to MO HealthNet Managed Care members.
- Each member is responsible for informing Missouri Care and/or the Missouri Department of Social Services, Family Support Division if he or she is covered by any other insurance, including Medicare or if they have an accident at work, have a car accident, or are involved in a personal injury or malpractice lawsuit.
- Members with questions concerning benefits, grievances, appeals, medical provider qualifications, changing PCPs etc., are to contact the Missouri Care Member Services Department.¹⁴

Members are responsible for scheduling periodic checkups for infants and children in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Program and for keeping the appointments. Prenatal members must schedule obstetrical checkups at the recommended intervals. Members are encouraged to participate in other available prevention and wellness programs that correlate with their check ups and treatments

SECTION 3 COVERED SERVICES

As a managed care organization contracted with the MO HealthNet Program, Missouri Care is required to make available a specific list of Covered Services to its enrolled members.

All covered services, except behavioral health services, well-woman exams, mammograms and family planning services must be provided by or arranged by the member's PCP. Some services must be prior authorized by Missouri Care.

MO HealthNet beneficiaries may not be balance billed for services included in their benefit package.

The specific services to be delivered to Missouri Care members are described in detail in the MO HealthNet Policy Statement. If you have questions as to whether a service is covered, contact the Missouri Care Prior Authorization Department or Member Advocacy and Customer Service Department at (800) 322-6027.

¹⁴ NCQA RR 1A-5

3.1 BENEFIT PACKAGE

Missouri Care members are entitled to benefits covered by the MO HealthNet program. Not all benefits covered under the MO HealthNet program are available to all members or are the financial responsibility of the managed care health plans.

3.2 BEHAVIORAL HEALTH SERVICES LIMITATIONS

All members classified within Category of Aid 4 (foster children) are eligible to receive all Medically Necessary behavioral health and substance abuse services included in the comprehensive benefit package through Missouri Care's provider behavioral health and substance abuse networks. Children in MO HealthNet's Category of Aid 4 (foster children) receive behavioral health services such as inpatient and outpatient behavioral health, substance abuse and comprehensive community support services through the MO HealthNet fee-for-service program.

Missouri Care is required to coordinate medical services for Children in Category of Aid 4 (foster children) with the MO HealthNet fee for service behavioral health/substance abuse providers.¹⁵

The health plan is financially responsible for all dual diagnosis (physical and behavioral/substance abuse use-related) inpatient admissions where the primary, secondary, or tertiary diagnosis is a combination of physical or behavioral/substance use-related health. These admissions are subject to Missouri Care's prior authorization and concurrent review policies.

3.3 EXCLUDED SERVICES

The following services are examples of services that are not provided by MO HealthNet or Missouri Care. Specific excluded services are described in the MO HealthNet Policy Statement. When services are not in the comprehensive benefit package and prior to providing the services, the provider is required to inform the member the services are not covered by Missouri Care or MO HealthNet. In the event the member still requests the non-covered service(s) the provider is required to have the member acknowledge in writing the services are self-pay. This informed consent and acknowledgement must be obtained prior to rendering the non-covered service. The non-covered services may be billed to the member provided the afore mentioned process of informed consent and acknowledgment of payment have been properly followed.¹⁶

¹⁵ RFP 2.10.4.a-c

¹⁶ RFP2.6.3.b

NON-COVERED SERVICES INCLUDE:

- Acupuncture
- Hair transplants
- Removal of tattoos
- Routine foot care
- Physical Therapy, Occupational Therapy and Speech Therapy services for those over twenty-one (21) with the exception of pregnant woman in the MO HealthNet eligibility categories of 18, 43, 44, 45, and 61
- Sex change operations and reversal of voluntarily induced sterilization
- Services or items furnished only for cosmetic purposes
- Services (procedures, technologies, or non-drug therapies) determined by the MO HealthNet Program or Missouri Care Chief Medical Officer to be experimental, investigational or provided primarily for the purpose of research
- Personal care items such as toothbrushes and television sets in hospital rooms
- Services not rendered in accordance with the Missouri MO HealthNet Program rules or contractual requirements
- Services that are not Medically Necessary
- Methadone detoxification services
- Preparation of reports
- Services rendered when a physician is not in attendance and in direct supervision of the service

3.4 EXCLUDED PLAN SERVICES COVERED BY THE STATE

The following are examples of Covered Services for member but are the responsibility of MO HealthNet and not Missouri Care:

- Pharmacy is provided by MO HealthNet on a fee-for-service basis for all medications and pharmaceuticals administered on an outpatient basis, including physician administered drugs, covered over-the-counter (OTC), all drugs dispensed by outpatient pharmacies, medications administered in the outpatient department of a hospital, or other outpatient clinics.¹⁷
- Abortion services (subject to MO HealthNet program benefits and limitations)¹⁸
- Physical, occupational and speech therapy services for children included in:
 - 1) The Individual Education Plan (IEP); or
 - 2) The Individual Family Service Plan (IFSP)¹⁹

¹⁷ RFP 2.10.6.a, c

¹⁸ RPP 2.10.1

¹⁹ RFP 2.10.10.a

- Environmental lead assessment for those children with elevated blood lead levels²⁰
- Parents as Teacher (PAT) ²¹
- Comprehensive Community Support Services²²
- Lab tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
- Newborn Screening Kits
- Special Supplemental Nutrition for Women, Infants and Children (WIC) ²³
- Sexual Assault Forensic Examination (SAFE) and Child Abuse Resource Education (CARE) exams and all related diagnostic studies furnished by a SAFE trained MO HealthNet enrolled provider²⁴
- MRDD waiver services for MRDD waiver participants ²⁵
- Bone marrow/stem cell and solid organ transplant services (corneal tissue transplants) are covered the responsibility of MO HealthNet. Services include the hospital stay from the date of the transplant through the date of discharge, procurement, and physician services related to the transplant and procurement procedures. Pre-transplant and post-discharge services are the responsibility of Missouri Care.
- Behavioral health services for Category of Aid 4 children in State care and custody
 - 1) Inpatient Services – any psychiatric stay in an acute care hospital, or in a private or State psychiatric hospital. Members with a dual diagnosis admission (physical and behavioral) have their hospital days covered by Missouri Care.
 - 2) Outpatient Services – behavioral health visits are not the responsibility of Missouri Care when rendered by a:
 - a. Comprehensive Substance Treatment and Rehabilitation Center (CSTAR) provider
 - b. Licensed psychiatrist
 - c. Licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed professional counselor or provisional licensed professional counselor
 - d. Licensed psychiatric advanced practice nurse or licensed home health psychiatric nurse
 - e. Missouri certified substance abuse counselor or state certified behavioral health or substance abuse program. ²⁶

²⁰ RFP 2.10.8

²¹ RFP 2.10.10.b

²² RFP 2.10.4.c

²³ RFP 2.10.8.b-d

²⁴ RFP 2.10.9

²⁵ RFP 2.10.5

²⁶ RFP 2.10.4 a.b

- Services provided by a Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Provider are not the responsibility of Missouri Care. Services provided by a C-STAR MO HealthNet provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. Inpatient detoxification services will remain the responsibility of Missouri Care. Populations served by CSTAR include pregnant women, women with children, adolescents and men eligible and receiving MO HealthNet benefits. Members seeking CSTAR services will be provided a list of CSTAR Providers from which to choose.
- Home Birth Services²⁷
- Targeted Case Management for Behavioral Health Services²⁸

3.5 Self Referral Services

Missouri Care members are not restricted to use Missouri Care contracted providers for certain self referral services. Federal and state regulation allows members access to certain services outside of Missouri Care without a referral. Members may access these specific services through any participating MO HealthNet provider. Missouri Care is responsible for paying for these services if medically necessary and furnished by an out of network provider.

The following are self referral services in MO HealthNet:

- Services rendered for treatment of an emergency medical condition
- Family planning services are those services provided to individuals of childbearing age

SECTION 4 PROVIDER REQUIREMENTS and RESPONSIBILITIES

Missouri Care is responsible for arranging for the provision of Covered Services to thousands of members, and accomplishes this through a comprehensive Provider network of independent practitioners, clinics and facilities. This network is comprised of participating health care professionals such as primary care physicians, practitioners, qualified behavioral health providers, specialist physicians, Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, local health agencies, medical facilities, allied health professionals and ancillary service providers under contract with Missouri Care. The network provides an integrated and coordinated health delivery system.

²⁷ 2.12.18.d.1)

²⁸ RFP 2.10.3.b

The network is carefully developed to include those participating health care professionals that meet certain criteria such as availability, geographical area, specialty, acceptance of financial considerations, hospital privileges, quality of care, and acceptance of Missouri Care managed care principles. Participation in the Missouri Care provider network will be limited to providers who accept, as payment in full, the amounts paid by Missouri Care plus any fee amount required of the member and collected by the provider.

Participating healthcare contractual agreements with Missouri Care determine what Covered Services are to be provided to Missouri Care members, whether primary care, specialty or ancillary services.

All participating healthcare subcontractors are required to provide services to multi-lingual Missouri Care members, utilizing translators for non-English speaking members, telecommunications devices for deaf members, and TTY for blind members. Missouri Care will assist in the provision of these multi-lingual services when requested by Providers.

Contracted participating health care professionals are required by contract to coordinate member care within the Missouri Care Provider network. That means all referrals for Missouri Care members should be to Missouri Care contracted Providers.

Referrals outside of the network must be approved with a prior authorization from Missouri Care.

A current list of the Missouri Care Provider network is available online at www.missouricare.com and provided in print form upon request. Questions concerning the Missouri Care network should be directed to the attention of your assigned Provider Relations Representative at (800) 322-6027.

Contracted participating health care professionals are also required to report to Missouri Care and the State of Missouri all cases of suspected fraud and abuse incidents, inappropriate practices, and inconsistencies of which they become aware within the MO HealthNet program. Missouri Care is committed to conducting all activities in compliance with ethical, legal and contractual requirements. Any act that is non compliant, whether accidental or on purpose, is a compliance issue. Report a compliance issue or possible fraud and abuse concern, to the Missouri Care Compliance Program Hotline at 1-877-436-5288. This toll-free Hotline is available twenty-four (24) hours a day, seven (7) days a week.

If a Provider has a non-compliant member, e.g., one who is missing appointments, not following treatment plans, exhibiting abusive behavior, etc.; the Provider is encouraged to contact Missouri Care Case Managers at (800) 322-6027 for assistance in bringing the member into compliance.

4.1 Appointment Standards

The health plan providers must maintain appointment standards as dictated by the State. The appointment standards are as follows:

- The average waiting times for primary care appointments must not exceed one hour from scheduled appointment times. This includes time spent both in the lobby and in the room before provider examination. Providers can be delayed when they "work in" urgent cases, when a serious problem is found, or when the member had an unknown need that requires more services or education than was described at the time the appointment was made.
- Emergency services must be available at all times.

General Standards

- Urgent, but non-life threatening care appointments must be available within 24 hours (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services).
- Routine care appointments, with symptoms must be available within one (1) week or five (5) days (e.g. persistent rash, recurring high-grade temperature, nonspecific pain, fever).
- Routine care appointments must be available within thirty (30) calendar days (e.g. well child exams, routine physical exams).

Behavior Health Services Appointment Standards

- Routine appointments must be available within ten (10) business days.
- Urgent appointments (including telephone access) must be available within forty-eight (48) hours.
- Non-life threatening emergency appointments must be available within six (6) hours.
- Behavioral health and substance abuse services aftercare appointments must be available within seven (7) calendar days after a hospital discharge.

Maternity Care Appointment Standards

- First trimester within seven (7) calendar days of first request.
- Second trimester within seven (7) calendar days of first request.
- Third trimester within three (3) calendar days of first request.
- High risk pregnancies within three (3) calendar days of identification of high risk to the Health Plan or maternity care provider, or immediately if an emergency exists.

Note: Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for members who require emergency obstetrical care.

The health plan monitors providers for compliance.

4.2 PCP/PCO MEDICAL RECORDS ²⁹

The following standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and MO HealthNet Managed Care Quality Assurance Reform Initiative (QARI) as the minimum acceptable standards within the Missouri Care Primary Care Network.

1. ORGANIZATION -- (a) Medical records must be organized systematically and uniformly. (b) Papers must be firmly attached. Individual unit medical records are recommended as opposed to family medical records.
2. PATIENT IDENTIFICATION -- Each page in the medical record must contain patient name or patient identification number.
3. PERSONAL/BIOGRAPHICAL DATA -- Personal/Biographical data must be noted. This may include address, employer, date of birth, sex, marital status, consent forms, guardianship information, home and work telephone numbers.
4. PROVIDER IDENTIFICATION -- All entries including dictation must be identified by the author and authenticated by his or her entry. Authentication may include signatures or initials thereby verifying that the report is complete and accurate. Medical record notes generated/stored electronically by computer are considered authenticated if there is a demonstrated password protected entry with a time-limited edit capability.
5. ENTRY DATE -- All entries must be dated.
6. LEGIBLE -- The medical record must be legible to someone other than the writer.
7. LISTS:
 - (a) PROBLEM LIST -- Significant illnesses and medical conditions are indicated on the problem list. If the patient has no known medical illness or condition, the medical record must include a flow sheet for health maintenance.
 - (b) MEDICATION LIST -- Current medications are listed.
8. ALLERGIES --

²⁹ NCQA CR 6, A-1

- (a) Allergies/No known allergies (NKA) must be documented in a uniform location on the medical record.
 - (b) Medication allergies and adverse reactions must be listed if present. List no known allergies (NKA) if applicable.
9. PAST MEDICAL HISTORY (for patients under age twenty-one (21), on first visit // for patients age twenty-one (21) or over, seen three (3) or more times// for obstetrical patients, a risk assessment tool is used) -- Past medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. For pediatric patients, birth history must be documented.
10. (a) SMOKING/ALCOHOL (for patients seen three (3) or more times) -- Notation concerning cigarettes and alcohol is present.
- (b) SUBSTANCE USE (for patients seen three (3) or more times) -- Notation concerning recreational/illicit substance use is present.
11. PHYSICAL EXAM (COMPLETE)
- (a) All body systems must be reviewed for patients under age twenty-one (21), at each EPSDT visit // for adults, within two (2) years of the first clinical encounter and every two (2) years thereafter.
- | | | |
|-------|-------|----------------------|
| HEENT | Lungs | Neck |
| Heart | Neuro | Back and Extremities |
- (b) Height, weight, blood pressure and temperature must be documented on the initial visit.
12. SUBJECTIVE AND OBJECTIVE INFORMATION -- Subjective patient information and objective physical findings are obtained and noted at each visit for the presenting complaints.
13. ASSESSMENT / WORKING DIAGNOSIS -- Working diagnosis is consistent with findings (provider's medical impression).
14. PLAN/TREATMENT -- Documentation of plan of action and treatment are consistent with diagnoses.
15. PATIENT EDUCATION/INSTRUCTIONS -- Documentation is present as applicable for:
- (a) Problems and current diagnosis. In addition, lifestyle management/preventive health information is documented to include, but not be limited to:

- (b) Family planning, sexually transmitted disease education per Missouri Care Family Planning Guidelines (See Section 8.2).
 - (c) Cancer prevention/detection (i.e., sun exposure, breast self-exam, testicular self-exam teaching.)
 - (d) Injury prevention -- at least one (1) of the following: Vehicle safety belts, or occupational hazards, or home safety such as smoke alarms.
 - (e) Or (for members' birth through twenty (20) years) EPSDT Anticipatory Guidance items as listed on the HCY Tracking Form.
16. CONSULTS/X-RAY/LAB/IMAGING REPORTS/REFERRALS/RECORDS -
 - (a) Reports are filed in the medical record and initialed by the primary care Provider thereby signifying review. (b) Consultation and abnormal lab imaging study results should have an explicit notation in the medical record of follow-up plans. Referrals, past medical records, hospital records, e.g. operative and pathology reports, admission and discharge summaries, consultations and ER reports should be filed in the medical record and initialed within sixty (60) days.
17. FOLLOW-UP/RETURN VISITS -- Encounter forms or notes have a notation concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or as necessary. Unresolved problems from previous visits are addressed in subsequent visits.
18. MEDICAL CARE/SERVICES/CONSULTS -- A general overview of the medical care/services and consults ordered will be reviewed. If any potential quality issues are identified, the reviewer will refer to Missouri Care's designated Medical Director for further direction.
19. IMMUNIZATION RECORD --
- (a) A separate, distinguishable immunization record is maintained.
 - (b) Immunizations are administered per the following recommended schedule or notations are present for exceptions to the schedule:
- For all adult members age twenty-one (21) and older, record must indicate patient's immunization status for Td. For all female members of childbearing age, record must indicate blood titer and/or immunization status for rubella.
- For members age sixty-five (65) and older, record must indicate immunization status for influenza and pneumococcal.

For all members age twenty-one (21) and over and at high risk, record must indicate immunization status for influenza, pneumococcal and/or hepatitis B.

For members under age twenty-one (21), immunizations are given according to the Centers for Disease Control (CDC) immunization recommendations. There must be a complete immunization record documented. If no record is available, documentation must be present regarding immunization status e.g. "Up To Date" (UTD), stating who reported the status and that a copy was requested for the medical record. Re-immunizations must be considered for all school age children without vaccine records. "Catch-up immunizations" where it is evident that the age-appropriate series lacks full completion of the recommended number of vaccines, must also be considered. Each vaccine in the series must be documented in order for the record of immunization to be complete.

20. PREVENTIVE SERVICES (for MO HealthNet members under age twenty-one (21)) - Preventive health services must be provided according to the MO HEALTHNET mandated Early Periodic, Screening, Diagnosis and Treatment (EPSDT) periodicity schedule which is the same as the Healthy Children and Youth (HCY) program.

21. GROWTH CHARTS must be maintained in the medical record until eighteen (18) years of age. Height, weight and head circumference must be plotted on children twelve (12) months and under; height and weight on children over twelve (12) months.

4.3 OFFICE SITE STANDARDS³⁰

Physical Accessibility and Appearance	
Handicapped accessible	A path exists from the parking lot to the facility that is flat or has gently sloping ramps. Doorways are wide enough for wheelchair access. At least 1 bathroom has handrails & adequate space to accommodate a wheelchair.
Waiting area is clean, quiet, well-lit, and well maintained	No excess trash lying around and unnecessary noise is eliminated. No repairs are needed that could pose a safety issue to patients or their children.
Adequate # of exam rooms.	2 per provider.
Adequate # of waiting room seats	5 per physician.
Office hours are clearly posted	Office hours clearly posted.
Exits are clearly marked & unobstructed	Exits are marked with well-lighted signs.

³⁰ NCQA CR 6, A-1

4.4 RECORDS MAINTENANCE AND RETENTION ³¹

For all contracted providers, providers must adhere to the following requirements:

1. All services must be adequately documented in the medical record and follow the Missouri Code of State Regulations: 13 CSR 70-3.030.
2. All medical records must contain, at a minimum, the following as applicable to the services rendered:
 - History and physicals
 - Allergies and adverse reactions
 - Problem list
 - Medications
 - Documentation of clinical findings and evaluation for each visit
 - Preventive services/risk screening

Provider Records / Location

All providers shall treat member's records as confidential and shall comply with all applicable federal and state laws, rules, and regulations governing said record. Confidential information shall be safeguarded pursuant to 42. CRF part 431, subpart F and 42 CRF, Part 2 Privacy Standards under HIPAA and state rules and regulations.

All member records must be stored securely. Access must be restricted to only authorized personnel. Staff must receive periodic training on member information confidentiality.

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

Providers, in accordance with Missouri Care and MO HealthNet standards, will maintain records and books relating to the provision of services to Missouri Care members. Specifically:

- (a) Patient records remaining under the care, custody and control of the physician shall be maintained by the physician, or the physician's

³¹ NCQA CR 6, A-2

designee, for a minimum of seven (7) years from the date of when the last professional service was provided.

- (b) Any correction, addition, or change in any patient record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition or change.
- (c) A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.
- (d) When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior or prior to the next scheduled appointment to the new primary care provider.

Providers must comply with the State's timeframes for provision of medical records. Providers must make available access to all members' medical records within thirty (30) days should MO HealthNet request any or all of them. Non-expedited requests for records shall be provided within thirty (30) days of request. The Provider must also make medical records available within five (5) calendar days of date received of written request for a single or small volume of records. Immediate access to the records shall be afforded for on-site reviews of records. Emergency requests for medical records will be sent via fax or overnight mail.

MO HealthNet is not required to obtain written approval from a member before requesting the member's record from the Provider or other Provider agency. Upon written request of a member or legal guardian, the Provider shall make a copy without charge of the medical record of the member's health history and treatment rendered.

4.5 CONFIDENTIALITY

All Providers shall treat members' records as confidential and shall comply with all applicable federal and State laws, rules, and regulations governing said records. Confidential information shall be safeguarded pursuant to 42 C.R.F. part 431, Subpart F and 42 C.R.F. part 2, Privacy Standards under HIPAA, and State rules and regulations.

4.6 ADVANCE DIRECTIVES (PATIENT SELF DETERMINATION ACT)

The Patient Self-Determination Act of 1990 that became effective December 1, 1991, requires health professionals and facilities serving those covered by

Medicare and MO HealthNet to give adult members written information about the members' right to have an Advance Directive. Advance Directives are written statements either outlining a member's choices for medical treatment or naming a person who should make choices if the member temporarily or permanently loses the ability to make decisions.

Missouri Care's Member Services Department includes information about Advance Directives in the member handbooks sent to new adult members. Providers may be asked questions related to the printed information. If you would like a copy of the Advance Directives information, please contact your Provider Relations Representative.

Missouri Care Providers are required to follow all federal and State Advance Directive policies and procedures.

4.7 RELEASE FOR ETHICAL REASONS

Missouri Care does not require a Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles or policies. Missouri Care does not prohibit a Provider from making a referral to another contracted Provider licensed to provide care appropriate to the member's medical condition.

If a Provider feels he/she has an ethical impediment to performing a covered service or procedure, Missouri Care will make every effort to assist the Provider in referring the member to an alternate Provider. At no time will any Missouri Care Provider or employee suggest, authorize or prescribe an unlawful procedure or service.

4.8 NON-DISCRIMINATION

To ensure mainstreaming of members, Providers certify that Covered Services are provided without regard to race, color, creed, gender, religion, age, national origin, ancestry, marital status, sexual preference, health status, or physical or mental handicap or veteran's status, except where medically indicated; they do not maintain nor provide for their employees any segregated facilities, nor will the Providers perform services at any location where segregated facilities are maintained. Providers will comply with values honoring a member's beliefs, being sensitive to cultural diversity, and fostering attitudes and interpersonal communication styles that respect each member's cultural diversity.

4.9 **MARKETING GUIDELINES**

Providers shall not influence a member's enrollment. They are prohibited from the following:

- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet managed care.
- Requiring or encouraging the member and/or guardian to use the SSI "opt out" as an option in lieu of delivering health plan benefits
- Mailing or faxing health plan enrollment forms
- Aiding the member in filling out health plan enrollment forms
- Photocopying blank health plan enrollment forms
- Distributing blank health plan enrollment forms
- Allowing the member to use his/her phone to enroll or change health plans from the Provider's office site.
- Participating in three way calls to the MO HealthNet managed care enrollment helpline
- Suggesting a member transfer to another health plan
- Participating in other activities in which Missouri Care, its representatives, or Providers are engaged in activities to enroll in a particular health plan or in any way assisting a member to enroll in a health plan.

Providers must submit to the State agency, for prior written approval, all materials used to advise members of the health plans with which they have contracts. The following list constitutes approved material:

- A list of all health plans with which the Provider has contracts;
- A letter to previous fee-for-service recipients who may be eligible for MO HealthNet managed care, informing them of all health plan(s) with which the Provider has contracted;
- A display of all contracted health plan logos in an equal fashion;
- A listing of all contracted health plan phone numbers;
- Access to all contracted health plan directories and member handbooks as a member resource but not for distribution; and
- Displaying enrollment helpline phone number.

The Provider shall provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information.

Providers shall request State agency prepared mandatory MO HealthNet managed care materials from the State agency and will make the general public aware of the MO HealthNet program by providing the following:

- General MO HealthNet eligibility information;
- MO HealthNet applications to complete and mail
- MO HealthNet toll free phone number (888-275-5908).

4.10 FRAUD AND ABUSE

To report a possible fraud and abuse situation, call the Missouri Care Compliance Program Hotline at 1-877-436-5288. This toll-free hotline is available twenty-four (24) hours a day, seven (7) days a week in English or Spanish. All reports received through the hotline will be reviewed according to Compliance Program policies and procedures and appropriate corrective actions will be taken. Providers may also report a compliance issue in writing to Missouri Care Compliance Program, 2404 Forum Blvd., Columbia, MO 65203.

4.11 PCP SPECIFIC RESPONSIBILITIES

Missouri Care Primary Care Providers' (PCPs) responsibilities include but are not limited to:

- ❖ Providing instruction or arranging for emergent Services as defined in your contract, including emergency medical services, to Members on a 24-hour per day basis, seven days per week.
- ❖ Verify the enrollment and PCP assignment of the member on the day of, but prior to the provision of covered services. The PCP should utilize the Interactive Voice Response (IVR) system, operated by the Missouri Division of Medical Services. Failure to verify member enrollment and PCP assignment may result in claim denial.
 - PCP will provide covered services to members while in a hospital, nursing home, or other health-care facility as determined to be Medically Necessary by the PCP or Medical Director.
 - Provide preventive health services in accordance with the MO HealthNet Program rules and Missouri Care medical policies. The preventive health services shall include but not be limited to:
- ❖ Periodic health assessments for all assigned members twenty-one (21) years of age and older that include major medical, social, and family history within a two (2) year time frame.
- ❖ Immunizations and other measures for the prevention and detection of disease, including instruction in personal health care measures and information on proper and timely use of appropriate medical resources pursuant to Missouri Care medical policy. Immunizations follow the most recent immunization recommendations designated by the State Agency.

- ❖ Tuberculosis screening, including the use of Mantoux PPD skin test. Tuberculosis screening shall be in accordance with current Centers for Disease Control/American Thoracic Society Guidelines: treatment of tuberculosis and tuberculosis infection in adults and children, or their equivalent.
- ❖ Childhood lead poisoning prevention services including verbal lead assessments beginning at age six (6) months and continuing through age seventy-two (72) months. Lead screening shall follow guidelines of the Health Care Financing Administration in effect for the specific time period and Centers for Disease Control guidelines:
 - Screening Young Children for Lead Poisoning.
 - ◆ Blood level testing is mandatory at twelve (12) and twenty- four (24) months and when indicated from the lead screening assessment.
 - ◆ Upon identification of a member having a blood lead level greater than ten (10) µg/dl, the PCP will refer the member to Missouri Care for lead case management services.
 - ◆ The State of Missouri has developed a mandatory HCY Lead Screening Guide. The form must be signed and dated by the screener and retained in the medical record. The State of Missouri supplies the tools at no cost to the provider. The forms can be ordered by calling MO HealthNet Provider Services at 573-751-2896 or by accessing the MO HealthNet web site at www.dss.state.mo.us/dms.
 - For questions regarding childhood lead poisoning prevention and treatment, please contact Missouri Care Health Plan at 1-800-322-6027 or the Department of Health and Senior Services at 573-526-4911.
- ❖ Early Periodic Screening Diagnosis and Treatment also known as Healthy Children and Youth (EPSDT and HCY) for all assigned members up to the age of twenty-one (21) years. The PCP is required to keep immunizations and screenings current according to the EPSDT periodicity schedule. Missouri Care Health Plan strongly recommends annual exams for all children over the age of two. Missouri Care Primary Care Physicians are required to:
 - Assume responsibility for the provision and documentation of EPSDT screening service for all assigned members under the age of twenty-one (21) years in accordance with the MO HealthNet EPSDT periodicity schedule. The State of Missouri follows the American Academy of Pediatrics schedule for preventive pediatric health care as a minimum standard for screening frequency.

- Use the standardized EPSDT tracking forms. The Healthy Children and Youth [HCY Screening] and the HCY Lead Risk Assessment Guide are both mandatory screening tools. Both forms must be signed and dated by the screener and retained in the medical record. The State of Missouri supplies the tools at no cost to the provider. The forms can be ordered by calling MO HealthNet Provider Services at 573-751-2896 or they can be downloaded from the Division of Medical Services web site at: <http://manuals.momed.com/manuals/presentation/forms.jsp>. In addition, the forms can be ordered from Infocrossing HealthCare Services, PO Box 5600, Jefferson City, MO 65102.
- Refer members under age twenty-one (21) years as necessary for follow-up, diagnosis and treatment, ensuring that treatment is initiated within sixty (60) days of screening services.
 - Have an adequately equipped office with equipment and supplies necessary to provide EPSDT services.
 - Utilize clinical encounters to address EPSDT services to avoid missed opportunities and assess the immunization status of all children during each encounter.
 - Report all EPSDT encounters on the required claim form using correct CPT/EPSDT codes.
- ❖ Abide by the Missouri Care pediatric and minimum medical record standards and practice according to the standards for pediatric immunization practices.
- ❖ Participate in an annual review to assure compliance with Missouri Care medical record standards, pediatric standards and EPSDT program services, which includes chart reviews.
- ❖ Agree to adhere to practice guidelines consistent with those contained within Missouri Care's Health and Wellness Policies.
- ❖ Refer eligible members to the Women, Infants and Children (WIC) Supplemental Food Program.
- ❖ Agree to refer members to participating hospital emergency rooms for emergent care only. PCP shall make a concerted effort to educate and instruct members about the proper utilization of the PCP office in lieu of hospital emergency rooms.

4.12 PRIMARY CARE OBSTETRICIANS (PCO) SPECIFIC RESPONSIBILITIES

Missouri Care requires PCOs to follow the standard for prenatal care set by the American College of Obstetricians and Gynecologists (ACOG).

Missouri Care Primary Care Obstetricians (PCOs) responsibilities include but are not limited to:

- ❖ Verify the enrollment and assignment of the member prior to the provision of covered services. This is done through the State Interactive Voice Response (IVR) System. Failure to verify member enrollment and assignment may result in claim denial.
- ❖ Provide or arrange for covered services to members as defined herein, including Emergency Medical Services, on a twenty-four (24) hour per day, seven (7) days per week basis.
- ❖ The PCO must notify Missouri Care of all members receiving prenatal care by completing the Pregnancy Risk Screening and Notification form and faxing within 2 days of initial visit to Missouri Care. Once the Pregnancy Risk Screening Form is received, a global authorization number is issued and returned to the PCO. The Pregnancy Risk Screening Form serves as an authorization for global ob services and is required for reimbursement.
- ❖ Agree to provide medically necessary covered services to members while in a hospital or other appropriate contracted facility and provide or arrange appropriate postpartum care in compliance with Chapter 197 RSMo.
- ❖ Not refer or direct members to any, (including participating) hospital emergency rooms for non-emergent medical services at any time during the term of the Agreement. PCO's should make a concerted effort to educate and instruct members about the proper utilization of the PCO office in lieu of hospital emergency rooms.
- ❖ Compensate any Provider, who upon request of the PCO, provides Covered Services that are included under the OB global package rate. Financial reimbursement to any Provider who upon request of the PCO provides Covered Services that are included under the OB global package rate shall be a matter decided between the two (2) Providers involved. Missouri Care shall not be responsible for payment to the covering Provider.
 - Maintain responsibility for care until the first of the month following sixty (60) days after delivery with a minimum of one (1) postpartum visit at approximately six (6) weeks postpartum or within seven (7) days of request.
 - Conduct an appropriate substance abuse screening as part of each member's initial appointment or baseline physical and at future appointments if indicated by the member's behavior. Agreeing to (A) offer a more detailed

screening/assessment to members identified as being at risk for substance abuse; (B) identify the most appropriate level of care for the member, using standardized placement criteria; (C) inform the member of comprehensive substance abuse treatment and rehabilitation (C-STAR) programs and/or contracted certified substance abuse treatment providers.

- Provide preventive health service in accordance with MO HealthNet rules and regulations and Missouri Care medical policies. The preventive health services include but are not limited to:
 - Periodic health assessments for all assigned members twenty-one (21) years of age and over which includes major medical, social and family history within a two (2) year time frame.
 - Immunizations and tuberculosis screening, and other measures for the prevention and detection of disease, including instruction in personal health care measures and information on proper and timely use of appropriate medical resources pursuant to Missouri Care medical policy provided by or through Missouri Care. Immunizations are recommended in accordance with the Advisory Committee of Immunization Practice (ACIP) guidelines and a separate schedule for hepatitis B immunizations of adolescents. (See Preventive Care Toolkit CD or www.missouricare.com for most current information concerning these guidelines)
 - Early Periodic Screening Diagnosis and Treatment, also known as Healthy Children and Youth, (EPSDT or HCY) for all assigned members up to the age of twenty-one (21) years in accordance with the EPSDT periodicity schedule, and includes tracking forms and specific behavioral health services for certain eligible members. PCO is required to keep immunizations and screening current according to schedules specified by the State (See Preventive Care Toolkit CD or www.missouricare.com for most current information concerning these guidelines)
- ❖ Upon identification of a member having a blood lead level greater than ten (10) µg/dl, the PCO will refer the member to Missouri Care for lead case management services.
- ❖ Home Birth Services: In accordance with the MO HealthNet managed care home birth policy statement, if a member elects a home birth, the member shall be disenrolled from Missouri Care. The disenrolled member shall then receive services through the MO HealthNet fee-for-service program for the home birth.

4.13 BEHAVIORAL HEALTH PROVIDERS SPECIFIC RESPONSIBILITIES

Missouri Care Provider responsibilities include but are not necessarily limited to:

- ❖ Providing or arranging for urgent Covered Services as defined in your contract, including emergency medical/behavioral services, to Members on a 24-hour per day basis, seven days per week.
- ❖ Verifying the enrollment of the member on the day of, but prior to the provision of covered services via the Interactive Voice Response (IVR) system, at 573-653-8908. Failure to verify Member enrollment and assignment may result in claim denial.
- ❖ Providing to Members:
 - Office visits during regular office hours
 - Office visits or other services during non-office hours as determined to be medically necessary
 - Response to phone calls within 30 minutes during normal business hours and on an on-call basis 24 hours per day, seven days per week.
- ❖ Notifying the Missouri Care Behavioral Health Dept. of psychiatric/behavioral emergency stabilization services within 24 hours or, on weekends or holidays, the next business day. Further disposition following psychiatric/behavioral emergency stabilization services will require authorization prior to service delivery.
- ❖ Working with health plan case managers in developing plans of care for members receiving case management services.

Behavioral Health Additional Provider Information

Missouri Care is responsible for providing clinically necessary and appropriate behavioral health services for members who meet criteria for these services. Missouri Care program benefits are provided for children, adolescents and adults who have been determined by the State as qualified to receive benefits and enrolled with Missouri Care. Members may self-refer or may be referred to behavioral health services provided by Missouri Care Behavioral Health, without prior authorization. If a member goes directly to a network Provider, the clinician may provide routine outpatient behavioral health services without prior authorization.

**IF YOU NEED ASSISTANCE REGARDING COVERED BENEFITS OR REFERRAL PROCESSES, PLEASE CALL 1-800-889-4073.
COORDINATION OF CARE**

Continuity and coordination of care between physical and behavioral health is an important aspect in the delivery of quality health care, as behavioral and medical disorders can interact to affect an individual's health. Behavioral health providers are responsible for completing the Coordination of Care Form at the time of initiation of treatment and update as necessary to reflect significant changes in the member's treatment plan or medications (see attachment F). The completed form should be sent to the member's PCP for inclusion in the medical record³².

As a Missouri Care Provider, you may refer your patients who are in need of behavioral health services directly to a behavioral health Provider by utilizing the number above or the Missouri Care Provider Directory. PCPs should follow established communication and coordination protocols to ensure that treatment provided to members is appropriate and well coordinated.

Behavioral Health appointments must be scheduled according to the following guidelines:

- ❖ Non-life threatening emergency care appointments must be available within six (6) hours of request.
- ❖ Urgent care, with symptoms, appointments must be available within forty-eight (48) hours of request.
- ❖ Routine care, without symptoms, appointments must be available within ten (10) business days.
- ❖ Aftercare appointments within seven (7) calendar days after hospital discharge.

4.14 SPECIALISTS SPECIFIC RESPONSIBILITIES

Missouri Care contracted specialist physicians' (PSPs) responsibilities include but are not limited to:

- ❖ Under the direction of the PSP, Covered Services shall be offered to members in accordance with customary standards of practice.
- ❖ Provide Covered Services to members during the term of the Agreement pursuant to Missouri Care's prior authorization and referral policies as incorporated within the current Missouri Care Provider Manual. Failure to comply with Missouri Care prior authorization and referral policies may result in claim denial.
- ❖ Verify the enrollment of the member prior to the provision of Covered Services. Failure to verify member enrollment may result in claim denial.

- ❖ Refer members in accordance with Missouri Care prior authorization and referral policies as incorporated within this current Missouri Care Provider Manual. The PSP will maintain documentation of referrals including feedback and outcome of the referrals. Failure to comply with the Missouri Care prior authorization and referral policies may result in claim denial.

4.15 ANCILLARY AND ALLIED PROVIDERS

Ancillary and Allied Providers include pharmacy, home health, durable medical equipment, infusion care, vision, dental, therapy, transportation, laboratory, home and community based service Providers and other non-physician professional Providers. Missouri Care has developed a comprehensive ancillary Provider network that PCPs, PCOs, and specialist providers are required to utilize.

Missouri Care contracted ancillary and allied Providers are responsible for:

- ❖ Rendering covered services to Missouri Care members in accordance with the specific contract.
- ❖ Maintaining sufficient facilities, equipment and personnel to provide timely access to medically necessary covered services.
- ❖ Rendering covered services to all Missouri Care members in an appropriate, timely, and cost effective manner. The Provider will cooperate and participate in Missouri Care quality management, utilization review, and grievance procedures.

4.16 ADDITIONAL PROVIDER RESPONSIBILITIES

Coordinate the provision of covered services to members by:

- ❖ Counseling members and their families regarding member's medical care needs;
- ❖ Initiating referrals of members for specific covered services to participating specialty health care Providers;
- ❖ Monitoring progress of members' care and managing utilization of specialty services to facilitate the return of member's care to PCP as soon as medically appropriate.

- ❖ Maintain staff membership and admission privileges in good standing at one of Missouri Care's contracted hospitals unless otherwise specifically authorized by Missouri Care.
- ❖ Use only Missouri Care contracted hospitals or appropriately licensed medical facilities for the admission of members. Otherwise prior authorization must be obtained from Missouri Care. In the case of an emergency where use of a contracted hospital or other facility is not feasible for medical reasons, a prior authorization is not required.
- ❖ Agree to follow all of Missouri Care's policies and procedures, including Quality Management and Utilization Management.
- ❖ Abide by the Missouri Care Referral and Prior Authorization policies found in Section 5.7C .
- ❖ Use Missouri Care contracted hospital(s), specialists, ancillary Providers and other health care professionals.
- ❖ Obtain authorization for all hospital admissions, and all outpatient surgeries and related medical procedures.
 - Identify and bill other third-party carriers or insurers first. Missouri Care has a third party liability (TPL) unit that will assist in verifying primary insurance.
 - Continue to provide services to a member transitioning to another Provider and/or health plan until such time that member is safely transferred; cooperating with the receiving Provider and/or health plan in transferring relevant records.
 - Perform and bill only for those lab tests for which provider is CLIA certified to perform in the office.

4.17 PARTICIPATING PROVIDER HOSPITAL (PPH) RESPONSIBILITIES

- ❖ The PPH shall provide Medically Necessary hospital services, including emergency, outpatient and inpatient, to members on a twenty-four (24) hour per day basis, seven (7) days per week.
- ❖ The PPH agrees to render services to members who are diagnosed as having human immunodeficiency virus (HIV) in the same manner and to the same extent as other members and under the compensation terms set forth in the contract.
- ❖ The PPH shall verify member's eligibility status for each date of service through the State of Missouri Interactive Voice Response system (IVR) at 573-635-8908. Failure to verify member enrollment may result in payment denial.

- ❖ The PPH agrees to adhere to Missouri Care's managed care philosophy and principles, including the sharing of each member's relevant medical information with the member's assigned Primary Care Provider or Missouri Care Health Plan.
- ❖ The PPH shall comply, if applicable, with Federal Regulations of the Occupational Safety and Health Administration including, without limitation, the regulations concerning Bloodborne Pathogens Standards @ 29 C.F.R Part 1910.1030, which became effective January 1, 1992.

4.18 REFERRAL AND PRIOR AUTHORIZATION

The PPH shall provide Covered Services to members during the term of the Agreement pursuant to Missouri Care Prior Authorization (PA) and Referral Policies. Failure to comply with the Missouri Care Prior Authorization and Referral Policies identified in this manual may result in claim denial.

- ❖ Some facility specific considerations for Referral and Prior Authorization are as follows:
 - All inpatient admissions require authorization from Missouri Care.
 - All room charges require prior authorization
 - Some outpatient procedures require PA with the exception of specific radiology, laboratory and those procedures outlined in Section 5.
 - Facilities must verify PA with Missouri Care Health Plan PA Unit before admission or outpatient procedure (except for specific radiology and laboratory).
 - Facilities should not schedule outpatient procedures without first ensuring that a PA is in place, except in an emergency situation.

4.19 EMERGENCY MEDICAL SERVICES

- ❖ The PPH agrees to provide Emergency Medical Services to members and acknowledges that life-threatening emergencies should be treated immediately without regard to prior authorization. If the member is admitted as inpatient or observation status, notification requirements apply.
- ❖ The PPH realizes and recognizes that Missouri Care will not reimburse the PPH for any financial costs associated in the performance of services found to be non-emergent, pursuant to Missouri Care retrospective physician medical review.
- ❖ The PPH agrees to provide Medical Evaluation services by licensed Providers.
- ❖ The PPH agrees to notify Missouri Care Behavioral Health, when a member presents in a psychiatric emergency.

4.20 OUTPATIENT SERVICES

The PPH agrees to provide members with outpatient Covered Services upon receipt and validation of a prior authorization number, when necessary, from Missouri Care.

4.21 SHORT STAY/OBSERVATION STAY

The PPH agrees to request and secure a prior authorization from Missouri Care for an elective short stay or observation encounter. The short stay/observation unit is identified as a clinical unit, where the member's condition does not meet acute care criteria nor warrant an inpatient stay; yet observation or other outpatient services are considered medically necessary. Such charges shall be billed and paid as outpatient services. If a member subsequently becomes an inpatient, Missouri Care must be notified of the status change by the next business day or the inpatient stay may be denied due to lack of prior authorization. When the member's status changes from observation to inpatient, the observation day will be paid as the first day of the inpatient stay, as long as Missouri Care has been appropriately notified of the status change.

4.22 INPATIENT SERVICES

1. Non-Emergency Admissions (Elective Admissions)

The PPH agrees to admit Missouri Care members on a non-emergency basis only upon receipt and validation of a prior authorization number from Missouri Care. Failure to validate the PA number with Missouri Care prior to admission will result in payment denial to the PPH.

2. Inpatient Care Services

The PPH agrees to provide members with medically necessary inpatient care services, with appropriate authorizations. All scheduled inpatient admissions require prior authorization. Urgent or emergent admissions require notification by the next business day.

3. Maternity Services

The PPH shall provide inpatient hospital services to members, for a minimum of forty-eight (48) hours following a vaginal delivery and a minimum of ninety-six (96) hours following a cesarean section, for a mother and her newly born child unless a shorter stay meets with the approval of the attending physician after consulting with the mother, and is in keeping with federal and State law. PPH shall notify Missouri Care within twenty-four (24) hours of all births to members. Missouri Care shall in turn notify the State of all births to members.

4.23 MANAGED CARE

- ❖ The PPH agrees to permit Missouri Care personnel to initiate visits with appropriate PPH staff immediately upon admission, and to examine the record of the member to evaluate appropriateness of admission and continued stay.
- ❖ The PPH agrees to designate appropriate PPH staff personnel to facilitate and coordinate Missouri Care telephonic or onsite utilization reviews (both concurrent and retrospective), discharge planning, and quality management. The PPH assures Missouri Care staff timely accessibility to member medical records to facilitate utilization review, discharge planning and quality management. Missouri Care agrees to comply with the PPH policies and procedures relative to confidentiality of member Medical Records.
- ❖ The PPH agrees to initiate discharge planning at time of admission, with utilization of appropriate alternate levels of care and keep Missouri Care informed of discharge plan and use Missouri Care participating Providers for care following discharge.
- ❖ Missouri Care agrees to provide qualified discharge planning/case management staff to act as a resource and liaison with the PPH's discharge planning staff and participate actively in discharge planning activities.
- ❖ The PPH may seek assistance from the Missouri Care Member Services Department for all non-emergent, but Medically Necessary ground transport in accordance with the Missouri Care member transportation policy.
- ❖ The PPH agrees to comply with utilization and quality management criteria used by Missouri Care in review of clinical care.
- ❖ The PPH agrees to send medical records to Missouri Care within five (5) working days of receipt of request.

4.24 BILLING

- ❖ **PROFESSIONAL SERVICES** - Professional services are governed by a separate Participating Health Provider Agreement for Primary Care Provider, Primary Care Obstetrician or Specialist. All professional fees must be billed on a HCFA 1500. This includes those professional fees for services rendered in the emergency room or outpatient clinic.
- ❖ For every Covered Service for which the PPH seeks reimbursement, the PPH agrees to submit a claim to Missouri Care within one hundred eighty (180) days of date of service, on a properly completed current HCFA 1500 form (for professional services) or a UB 92 for inpatient services, emergency services or outpatient services. Missouri Care reserves the right to request and receive from

the PPH, additional medical records or supporting documentation requested for reinsurance purposes in a prompt and timely manner.

- ❖ The PPH agrees to bill only for dates of service that have been prior authorized by Missouri Care or, in the case of Emergency Medical Services only, where notification was given to Missouri Care within twenty-four (24) hours or next business day, after the member presented for services. The PPH agrees not to bill Missouri Care for the day of member discharge.
- ❖ At a minimum, all claims shall provide the information and data required within the UB92 and HCFA 1500 forms. (see Section 7.3 & 7.8)
- ❖ The PPH agrees to submit a claim to Missouri Care only for the physical health component of the inpatient hospital days required for a Category of Aid 4 member presenting with a dual (behavioral and physical) diagnosis. The concurrent review processes of Missouri Care and PPH shall be used to prorate inpatient days required for the physical problem. PPH shall submit a claim to the State for inpatient days required for the behavioral health component of members eligible under Category of Aid 4.
- ❖ Failure to submit any of the above information and data or failure to respond to a request from Missouri Care for additional information or data within the prescribed time period may result in payment delay and/or denial.
- ❖ Missouri Care encourages all hospital providers to submit electronic claims. If you are not yet submitting electronically, please contact your Provider Relations representative at 800-322-6027 for information.
 - Paper claims are to be mailed and addressed to Missouri Care claims department only at the following address:

**MISSOURI CARE HEALTH PLAN
ATTN: CLAIMS SUBMISSION
P.O. Box 61625
Phoenix, AZ 85082-1625**

SECTION 5 Health Services

Missouri Care's Health Services Department is responsible for the integrated operations of prior authorization, concurrent review, retrospective review, and case management for medical, behavioral health, and substance abuse services. The Health Services management team, under the direction of Missouri Care's Chief Medical Officer, has the responsibility for the implementation of policies and procedures to promote timely, quality focused access to care for eligible members while insuring the care/service is based on sound evidence-based clinical practice criteria/guidelines. The structure, implementation, and monitoring of these departments policies and procedures are intended to promote the best possible outcome for eligible members based on the care/service provided is a covered benefit; determine medical necessity has been clearly demonstrated; care is provided by a quality health care team at the most cost effective setting appropriate for the condition being treated; and has the ability to analyze and report on the outcome of quality care initiatives.³³

Chief Medical Officer (CMO)

Missouri Care's Chief Medical Officer oversees and may participate in the prior authorization, concurrent review and case management processes. The CMO insures only appropriately licensed physicians/practitioners with similar or same expertise and professional experience are used to review the medical necessity of requested covered medical and behavioral health/substance abuse services.³⁴ Missouri Care decisions regarding utilization management are based only on appropriateness of care and service and existence of coverage.³⁵ Missouri Care does not reward health care providers for denying, limiting or delaying coverage of health care services.³⁶ We also do not give monetary incentives to our staff making medical necessity decisions to provide less health care coverage or services.³⁷

Missouri Care requires contracted providers/practitioners and vendors to comply with utilization and quality management policies, procedures, and criteria used by the health plan in review, coordination, and reporting of medical, behavioral health and substance abuse care provided to eligible members.

In the support of reviewing or analyzing services provided or at the request of MO HealthNet, Missouri Care may require member medical records from the provider. It is Missouri Care's expectation that the provider forward the requested records to the health plan within five (5) working days of receipt of request.

³³ UM1.3 & UM2.B

³⁴ UM4 A.1; UMB.1;

³⁵ NCQA UM4 F.1

³⁶ NCQA UM4 F.2

³⁷ NCAQ UM4 F.3

5.1 UTILIZATION MANAGEMENT³⁸

Utilization Management is the managed care practice comprised of preauthorization, concurrent review, retrospective review and discharge planning processes that track, trend, monitor and report on the health plan's ability to effectively manage health care benefits of eligible members as well as demonstrate compliance to MO HealthNet contract standards.

To facilitate access to UM staff and to answer any questions about the UM process Missouri Care has the following access points available:³⁹

- UM staff are available via a toll-free telephone number (800) 322-6027 during normal business hours Monday – Friday 8:00 AM to 5:00 PM.⁴⁰
- After normal business hours, staff can receive communication via voicemail messaging, fax services, and web-based authorization submissions. In special circumstances for after hours communication with staff a provider or health care team member will be instructed how to contact staff via their direct phone line numbers⁴¹
- All return communications regarding inquiries about UM will be made during normal business hours, unless otherwise agreed upon.⁴²

To make sure that you are speaking with an authorized Missouri Care representative, all staff will identify themselves by name, title and that they represent Missouri Care.⁴³

5.2 Prior Authorization (PA)

Requests for authorization can be submitted to Missouri Care by:

- contacting the PA department directly at (800) 322-6027;
- submitting via fax the required supporting documentation to fax number (866) 946-2052; or
- submitting the required supporting documentation via Missouri Care's web-based prior authorization portal at www.missouricare.com.

Prior authorization decisions for medical and behavioral health/substance abuse services are communicated in a timely manner based on the receipt date of the request.

- Preservice Non-Urgent: two (2) business days
- Preservice Urgent: twenty-four (24) hours or one (1) calendar day
- Concurrent Non-Urgent: two (2) business days
- Concurrent Urgent: twenty-four (24) hours or one (1) calendar day
- Post-Service: thirty (30) calendar days

³⁸ NCQA 2010: UM 2; B – 1 & 2

³⁹ NCQA 2010: UM 3; Element A-6

⁴⁰ UM3.A.1

⁴¹ UM3.A.2 & 5

⁴² NCQA 2010: UM 3; Element A-3

⁴³ NCQA 2010: UM 3; Element A-4

Prior authorization is the initial process by which services are reviewed to verify:

- member eligibility;
- benefit availability
- medical necessity; and
- network availability

Primary Care Providers (PCP) initiate and coordinate requests for services with Prior Authorization staff. Missouri Care does allow in-network specialty care providers/practitioners and vendors to seek authorization for services within their specialty service areas.

To better support the prior authorization process the provider should be ready to submit the following information at the time prior authorization is being requested.

- Member name, date of birth, MO HealthNet or health plan identification number, and sex if requested
- Current member contact information
- Identify the requesting provider including contact information, such as name of contact person, telephone/fax number, NPI number and address if requested
- Identify the condition for which the provider is requesting the service by providing the appropriate International Classification of Diseases, 9th Edition (ICD-9) code/description
- Identify the service/treatment or equipment being requested with the appropriate Current Procedural Terminology (CPT) code(s)/description

The provider is required to submit medical necessity documentation that clearly supports the request for the service/treatment or equipment, such as clinical notes, laboratory and/or radiology findings, and treatment dates of service, required health plan and/or applicable objective evidence-based clinical practice guidelines at the time the request for the service is made.

Missouri Care will make a determination based on the submission of the above necessary or required documentation⁴⁴. In the event necessary or required documentation has been omitted at the time of the original request the health plan will not subject the request to a prior authorization review but reject the request back to the provider with an “Unable to Process Request” notice. The notice will inform the requesting provider of the information missing from the original request that if submitted would allow the prior authorization process to proceed.

Prior authorization staff is comprised of non-clinical data entry clerks working in collaboration with actively licensed state of Missouri clinical staff. The non-clinical staff performs member eligibility and benefit availability verification as well as initial data entry functions for the requested service. The licensed clinical staff is responsible for the medical necessity review of requested service/treatment. The clinical staff review all supporting clinical documentation presented at the time of the request, consider individual co-morbidities as well as the local community setting when reviewing the

⁴⁴ NCQA UM6.A

request against nationally recognized evidence-based medical necessity review criteria. The clinical guidelines used for prior authorization review are reviewed no less than annually to promote the use of the most current, appropriate clinical practices, use of new technology and to address updates in the management of service/treatment based on location or level of care. Providers may request a copy of the review criteria by calling (800) 322-6027. Clinical practice guidelines are also available on our website at www.missouricare.com.

When medical necessity has been determined the clinical staff will finalize the prior authorization process by giving the provider, via telephone, fax or the web-based portal the following:

- Verify the approved status of the service(s)/treatment
- Provide the authorization number specific to the service(s) requested
- Identify the number of units or visits authorized
- Identify the date range for which the service(s) are approved

Any change or update to the services authorized, i.e., date of service, treatment, etc, requires the provider to notify the health plan of the updated treatment plan. The updated information will be reviewed to determine benefit availability, re-verify member eligibility, and/or continued medical appropriateness.

In the event the clinical staff is not able to clearly establish medical necessity, the case and all available supporting documentation is forwarded to the health plan's medical director for review. Missouri Care has strict policies and procedures in place to insure only appropriately qualified health plan medical directors make adverse review determinations.

Missouri Care's medical director, when appropriate, may seek the consultation of a licensed professional with the same or similar experience or expertise of that of the requesting provider. ⁴⁵The physician consultant will review all the available documentation submitted and make a medical necessity determination recommendation. The health plan's medical director will review all the available documentation and any specialty provider recommendations when making the review determination.

When the medical director review determination is to approve the request the provider is notified of the decision based on the previously mentioned process.

When the medical director review determination results in an action (the denial, limitation, reduction or ending of a service) of a medical or behavioral health/substance abuse service the health plan's clinical staff will initiate the generation of a Notice of Action (NOA) letter. The NOA letter will specify what service has been denied, include the specific reason for the denial and the clinical criteria used in the review of the request. The notice of action letter will also include the process available to the member and provider on how to initiate an appeal.

⁴⁵ RFP 2.5.4.d.1

5.3 Denial

Providers may request a consultation to discuss denied authorizations with a medical or behavioral health physician reviewer by calling for the specific physician reviewer listed on the denial letter at (800)322-6027.⁴⁶

A copy of the clinical evidence-based criteria used to review a request for a service/treatment can be obtained by contacting the PA department at (800) 322-6027.⁴⁷

5.4 Peer to Peer Process

Discussions between a health plan medical director and a treating practitioner can occur for a number of reasons. The discussion may be prompted by a notice of action letter from the health plan to the requesting practitioner, and the requesting practitioner may want to discuss the case with the plan medical director. To discuss the case in a peer to peer format with the Missouri Care medical director or physician reviewer, please call the Health Services Department at (800) 322-6027 to have a representative arrange the peer to peer. Peer to peer discussions are made available when requested within one (1) business day of the denial determination. Two (2) attempts will be made to contact the treating practitioner and conduct the peer to peer discussion.

A peer-to-peer discussion is not part of the appeals process. While potentially valuable, the final result of the discussion will be either:

- Both physicians accept the original decision
- The treating practitioner decides to appeal the case
- The treating practitioner decides to submit a new request with new or additional clinical information (this would not apply in a concurrent review situation)

The treating practitioner has the opportunity to utilize the appeal process regardless of whether or not a peer to peer discussion was completed.

5.5 Emergency Medical Services

Emergency medical, behavioral health, and substance abuse services are defined as conditions, or in the instance of substance abuse, use-related condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child,) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;

⁴⁶ NCQA UM7 A.1 & 2

⁴⁷ UM2.B.1

- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.⁴⁸

The health plan does not apply prior authorization policies to emergency services or determine an emergency medical condition based solely on a list of diagnoses or symptoms⁴⁹. Emergency services are covered regardless of whether the provider is in-network or out-of-network⁵⁰. Out-of-network provider services will be reimbursed based on the MO HealthNet fee schedule in place at the time the service was rendered.

Missouri Care requires notification of the emergency service be made to the health plan within (10) calendar days of presentation for emergency services⁵¹ or the next business day from the start of the initial post-stabilization period. Post-stabilization care services are defined as the period when the emergency condition has been sufficiently addressed in order to maintain a stabilized condition, improve or resolve the member's condition.⁵²

5.6 Referrals

The health plan shall support the release of benefits for Covered Services to eligible members when medical necessity for the service has been demonstrated based on the term of the Agreement pursuant to Missouri Care Prior Authorization and Referral Policies. Due to date specific eligibility the provider is *strongly encouraged* to verify member eligibility on each date of service. Failure to comply with the Missouri Care Prior Authorization and Referral Policies, failure to verify member eligibility at the time services are being rendered, and/or any incorrect or inappropriate billing/coding of the claim may result in the denial of the claim.

Providers and practitioners agree to provide members with outpatient Covered Services upon receipt and validation of a prior authorization number. Validation that the service has been authorized can be made directly with the health plan's Prior Authorization Department or through the health plan's web-based portal at www.missouricare.com.

All non-emergent/elective services performed by an out-of-network provider require prior authorization.

⁴⁸ RFP 2.7.1.g.1

⁴⁹ RFP 2.7.1.g.2

⁵⁰ RFP 2.6.9.1-2

⁵¹ RFP 2.6.9.c

⁵² RFP 2.7.1.g.3

Missouri Care views the Primary Care Provider's role in managing the member as that of a "medical home". A medical home integrates patients as active participants in their own health and well being. The medical home physician leads the medical team and coordinates all aspects of preventive, acute and chronic medical, behavioral health and substance abuse service needs of patients using the best available evidence-based clinical guidelines and appropriate technology.

Missouri Care expects PCPs or other in-network providers directing care and treatment to do so within the health plan's provider network. In the event specialized care or the timely availability of an in-network provider are not available in-network, the requesting provider is required to contact the health plan's Prior Authorization department before referring non-emergent/elective services to an out-of-network provider. Contacting the health plan allows Missouri Care to identify additional available in-network providers to support the service/treatment being considered or to appropriately coordinate authorization and issues of reimbursement with the non-participating provider.

Providers can contact the Prior Authorization department to inquire about prior authorization requirements for services. In-network providers can also access prior authorization information 24/7 through Missouri Care's web-based portal at www.missouricare.com. Obtaining prior authorization is not a guarantee of payment as member eligibility, benefit availability, and information submitted on the claim may affect payment results.

The referred to provider/vendor is expected to communicate in a timely manner to the member's medical home the member's current health status, response to treatment, changes to the original treatment plan, and other pertinent information that allows the medical home to support the member's on going plan of care.

5.6A Self Referral Services

Missouri Care members are allowed to access certain covered services without a primary care provider referral or needing to obtain prior authorization in the following circumstances:

- Behavioral Health and Substance Abuse routine outpatient/office level services can be provided without prior authorization or primary care provider referral when performed by in-network providers.⁵³
- Dental services for children under age 21 include dental screens, routine dental services (dental examinations, fillings for cavities, or dental cleaning) and orthodontic services. It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six months or as medically indicated. Members may access dental providers directly or be referred by the PCP/PCO for routine services. *Orthodontic services require prior authorization.*

⁵³ RFP 2.5.6

- Dental services of pregnant women age 21 and over shall be limited to dentures and services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions are covered through the Fee for Service Program.
- Dental care for adults age 21 and over is limited to treatment related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Dental treatment of a disease/medical condition without which the health of the recipient would be adversely affected is covered through the Fee for Service Program.
- Emergency Services rendered for treatment of an emergency medical, behavioral health and/or substance abuse use-related condition⁵⁴ The emergency service provider should notify the PCP on the next business day regarding the presenting condition and services rendered.
- Family planning services with either an in-network or out-of-network provider in accordance with federal freedom of choice⁵⁵ Missouri Care allows the member freedom of choice and methods of accessing family planning services without requiring a referral from the PCP. Missouri Care shall reimburse clinics and Providers, including those funded by Title X of the Public Health Service Act, for all family planning services regardless of whether they are a participating or non-participating Provider. Unless otherwise negotiated, Missouri Care shall reimburse Providers of family planning services at the MO HealthNet Fee for Service rate.

Non-participating Providers are responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. Missouri Care is not responsible for the confidentiality of medical records maintained by non-participating providers.

Services include but may not be limited to:

- Information and counseling on sexually transmitted diseases (STDs), contraception, screening for STDs, contraception management (including, but not limited to oral and injected contraception, Norplant, IUDs), and sterilization;
- Routine breast and pelvic exams and Papanicolaou (PAP) tests
- Mammograms to any in-network Provider for a mammogram, one (1) time per year.
- Optical services for adults age 21 and over (except for pregnant women) are limited to a biennial eye examination only.

⁵⁴ RFP 2.7.g.1)

⁵⁵ RFP 2.7.h

- Vision/Optical services for children under the age of 21 and pregnant women include but are not limited to eye exams, office visits, treatment, prosthetic eyes, eyeglasses, and EPSDT/HCY optical screens and services. Pregnant women age 21 and over do not receive eyeglasses except for one pair following cataract surgery. Eyeglasses for pregnant women are covered through the Fee for Service Program.
- Well Woman Examinations to any in-network or out-of-network Provider one (1) time per year for a well woman examination, which includes a pap smear and any follow-up for abnormal findings.

5.6B Referrals to Network Primary Care Obstetricians

A PCP may refer a pregnant member to a Primary Care Obstetrician (PCO), unless the PCP is also an obstetrical provider, immediately after the pregnancy is confirmed. Referral to an out-of-network PCO requires prior authorization by the health plan.

Missouri Care allows members in their third (3rd) trimester of pregnancy to continue to receive services from their PCO through the postpartum period regardless if the PCO is an in-network or out-of-network provider⁵⁶.

Missouri Care also understands the importance of and will allow the pregnant member to continue to receive services from their behavioral health and/or substance abuse treatment provider at least until the birth of the child, the cessation of the pregnancy, or loss of eligibility.⁵⁷

A PCP who is also an obstetrical provider (a physician, certified nurse midwife or nurse practitioner licensed to practice in the field of obstetrics /gynecology) may assume primary responsibility for supervising, coordinating and providing initial and primary care to pregnant member(s). In this case the PCP **must submit, either by mail, fax or via the web-based portal the Missouri Care Pregnancy Notification and Risk Screening form** (See attachment G). The Pregnancy Notification and Risk Screening form can be found at www.missouricare.com. Once on the website click Providers, then Provider Resources, and then forms. The form can be downloaded to the provider's medical record system or printed. Upon receipt of the Pregnancy Notification and Risk Screening form by Missouri Care, an authorization number is issued for an OB global authorization. The health plan must receive the Pregnancy Notification and Risk Screening form within two (2) business days of the initial obstetrical visit to insure authorization of global OB services and promote timely, appropriate reimbursement.

⁵⁶ RFP 2.5.8.d

⁵⁷ RFP 2.5.8.e

A member may also self-refer to a contracted PCO. In this instance, the PCO must **submit, either by mail, fax or via the web-based portal the Missouri Care Pregnancy Notification and Risk Screening form.** The health plan must receive the Pregnancy Notification and Risk Screening form within two (2) business days of the initial obstetrical visit to insure authorization of global OB services and promote timely, appropriate reimbursement.

Providers performing obstetrical services as is appropriate within their scope of clinical practice are required to make initial prenatal care appointments based on the following:

- First trimester appointment must be available within seven (7) calendar days of the first request;
- Second trimester appointments must be available within seven (7) calendar days of the first request;
- Third trimester appointments must be available within three (3) calendar days of the first request; and
- Appointments for high risk pregnancies must be available within three (3) calendar days of identification of high risk to the health plan or maternity care provider, or immediately if an emergency exists.⁵⁸

5.6C Ancillary Referrals

Contracted Providers may make referrals to in-network ancillary service Providers as follows:

Durable Medical Equipment (DME)

Durable Medical Equipment requests can be made directly to an in-network DME vendor by the authorized attending physician/practitioner. The authorized physician/practitioner must be able to provide the DME vendor with the medical necessity documentation that supports the request for the equipment. Prior Authorization staff will perform a medical necessity review of the request and determine benefit availability once contacted for authorization. The DME vendor should not dispense equipment prior to receiving authorization as medical necessity and benefit availability must be established before authorization can be given. Dispensing equipment prior to obtaining authorization may result in the denial of the claim.

Referral to an out-of- network DME vendor requires authorization by the health plan prior to the referral being made. In the event the health plan is able to identify an in-network DME vendor able to support the requesting providers treatment plan the authorization of the service/treatment will be made with the in-network vendor.

Infusion/Enteral Therapy

All infusion/enteral therapy services require prior authorization.

⁵⁸ RFP 2.5.3.c.1-4

PCPs/PCO and other in-network specialty providers may refer directly to contracted vendors for infusion/enteral services. The contracted referred to vendor is responsible for obtaining prior authorization of the treatment plan before rendering service.

Referral to an out-of network infusion/enteral therapy vendor must be coordinated by the requesting in-network provider with the health plan prior to requesting the services from the out-of-network vendor. In the event the health plan is able to identify an in-network vendor able to support the requesting providers treatment plan the authorization of the service/treatment will be made with the in-network vendor.

Laboratory Referrals

The PCP/PCO, or other in-network specialty provider may perform those lab tests in their office for which he/she is CLIA-certified and has contracted to perform. The provider may also refer eligible members to a contracted laboratory for medically necessary, covered service testing. Prior authorization is not required for routine in-network lab services. Prior authorization may be required if the lab service is considered specialized, high dollar, or performed by an out-of-network provider. Providers can verify any prior authorization requirements for lab services with the health plan's Prior Authorization department staff or through the health plans web-based portal at www.missouricare.com.

Referral to out-of- network laboratories requires authorization by the health plan prior to the laboratory test being drawn and performed. In the event the health plan is able to identify an in-network laboratory that is able to support the requesting providers treatment plan the authorization of the service/treatment will be made with the in-network vendor.

Radiology Referrals

The PCP/PCO, or other in-network specialty provider may perform contracted radiology procedures in the office or refer members to in-network radiology providers, either hospital based or free standing. Prior authorization is not required for routine in-network radiology services. Prior authorization may be required if the radiology service is considered specialized, high dollar, or performed by an out-of-network provider. Providers can verify any prior authorization requirements for radiology services with the health plan's Prior Authorization department staff or through the health plans web-based portal at www.missouricare.com.

Referral to an out-of- network radiology center requires authorization by the health plan prior to the service/treatment being performed. In the event the health plan is able to identify an in-network radiology provider that is able to support the requesting providers treatment plan the authorization of the service/treatment will be made with the in-network vendor.

5.6D Referrals to Out-of-Network Providers

Referrals may be made to a nonparticipating health professional ONLY if the member requires medical services that are not available or available based on mandated appointment standards with an in-network provider. **Out-of-network Provider referrals must always obtain prior authorization for non-emergent/routine/elective.** The out-of-network provider may be liable for any expenses incurred from services rendering services/treatment if prior authorization was not obtained and/or medical necessity could not be clearly established

5.6F Second Opinions

Members have a right to seek a second medical opinion from a qualified health care professional, at no cost to the member. Certain elective surgical procedures, pursuant to Missouri law, require second opinions prior to surgery. In the event the health plan receives a request for one of these procedures they will assist with coordinating the second opinion consultation for the member. A third surgical opinion can be performed when requested by a member who is not satisfied with the results of the second opinion because the opinion does not confirm the primary recommendation that there is a need for the specific surgical operation. The health plan's Prior Authorization department can assist in coordinating the second or third opinion with an in-network or out-of-network provider by calling (800) 322-6027.⁵⁹

5.7 CERTIFICATION OF OBSERVATION STAYS/ACUTE INPATIENT ADMISSIONS

5.7.A Short Stay/Observation Stay

Missouri Care requires notification of all observation stays. The short stay/observation unit is identified as a clinical unit, where the member's condition does not meet acute care criteria nor warrant an inpatient stay, yet observation or other outpatient services are considered medically necessary. Such charges shall be billed and paid as outpatient services.

Missouri Care adheres to the MO HealthNet policy that observation services will not exceed a maximum of twenty-four (24) hours. Charges for observation beyond the twenty-four (24) hour maximum will be absorbed as an expense to the provider.

In the event a member is transitioned to an acute inpatient admission status, Missouri Care requires the hospital or attending provider notify the health plan by the next business day of the transition to the inpatient status. The inpatient admission will be reviewed for medical necessity to insure it meets medical necessity for an acute level of care. In the event the inpatient level of care is met, the health plan will also inform the provider the level of care that is being assigned, such as medical, telemetry, ICU, etc.

⁵⁹ RFP 2.8

5.7.B Inpatient Admission Authorization/Notification

Some facility specific considerations for Referral and Prior Authorization are as follows:

- All routine/elective inpatient admissions require prior authorization from Missouri Care. Failure to obtain or validate authorization has been obtained could lead to the delay or denial of payment.
- All emergent inpatient admissions require timely notification, i.e., ten (10) calendar days from the date of the emergent service or within twenty-four (24) hours of the initial post-stabilization period.
- All accommodation/room charges require authorization.
- Some outpatient procedures require prior authorization with the exception of specific radiology, laboratory and procedures identified on the Missouri Care Provider Prior Authorization Search Tool at www.missouricare.com.
- Facilities should not schedule outpatient procedures without first insuring required authorization has been secured, except in an emergency situation.

Involuntary detentions (96 hour detentions or court order detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect.⁶⁰

Initial admission reviews are conducted within one (1) business day of notification of a concurrent admission. Subsequent or concurrent reviews for an active inpatient admission are conducted regularly under the direction of the health plan's Concurrent Review Nurse. Post-admission concurrent reviews are addressed through the health plans' provider or member appeals process.

The admission review process is designed to:

- determine the appropriateness for the admission level and level of care assigned;
- estimate probably length of stay based on optimal recovery guidelines and associated co morbidities;
- identify and initiate discharge planning needs such as home health care, durable medical equipment, or case management support;
- assess potential risks; and
- identify other payer sources.

5.7.C Maternity Admissions

The admitting facility or the attending provider shall notify Missouri Care within twenty-four (24) hours of all delivery admissions. Missouri Care will authorize a minimum of forty-eight (48) hours following a vaginal delivery and a minimum of ninety-six (96) hours following a cesarean section⁶¹, for a mother and her newly born child upon notification of the delivery and admission of the newborn to the well newborn nursery. Shorter admission stays can be authorized only upon the approval of the attending Physician after consulting with the mother, and in keeping with federal and State law.⁶²

⁶⁰ RFP 2.5.4.6

⁶¹ RFP 2.7.1.n.1

⁶² RFP 2.7.1.n.2

Admission information required includes at a minimum:

- the mother's date and time of admission and delivery;
- method of delivery;
- any ante-partum, delivery, or post-partum complications;
- newborn date and time of birth;
- newborn apgar scores, birth weight, gestational birth age;
- any newborn delivery complications or status changes;
- newborn admission level or transfer admission level; and
- mother and newborn discharge date.

In the event a newborn has a direct admission or is transferred to a Neonatal Intensive Care Unit (NICU) level of care the health plan must be informed of the date of the admission to the NICU. The clinical indications for the NICU admission are to be presented to the health plan so a medical necessity review can be performed to authorize the appropriate NICU level of care.

5.7.D Sterilization Consent Forms

If the Provider is performing a sterilization procedure, which may **only** be performed on patients age twenty-one (21) and above who appear to be mentally competent, the federal Sterilization Consent Form (Attachment H) must be completed. Missouri Care must be notified upon completion of Sterilization form of the planned date for the procedure. Receipt of the notice regarding the sterilization procedure must be received by the health plan prior to rendering the service.

Providers must wait thirty (30) days between the patient signing the consent form and performing the procedure. The surgery should be scheduled on or beyond the 31st date from the date of the signing of the form up to 180 days. The exception to this date rule is in the case of premature delivery or emergency abdominal surgery. Once the thirty (30) days have elapsed, fax or mail the consent form to Missouri Care and Missouri Care will provide your office with a PA number. You will not receive a PA number if the thirty (30) day requirement has not been satisfied. A new consent form is required if the procedure is to be performed after the 180 day period as the original consent will be considered void.

Federal government auditors closely monitor the proper and timely completion of the consent form in relation to the performance of the sterilization procedure. Missouri Care is required to insist on strict adherence to these Federal requirements.

5.7.E Concurrent Review

The facility is required to participate in the timely communication of the acute care admission treatment plan, the member's response to the treatment plan, and any pertinent factors regarding transition of the member's care to the next appropriate level of care with the Missouri Care Concurrent Review Nurse. This communication is required for member's that are inpatient at the time of notification to the health plan and are to continue concurrently for the length of the admission stay.

Missouri Care performs concurrent review telephonically and considers appropriate communication of an acute care inpatient admission to be at a minimum the timely telephonic presentation of the clinical treatment plan, member's response, and anticipated discharge needs. The health plan's concurrent review staff has secured voicemail. Concurrent review updates can be left at these secured voicemail boxes in the event the concurrent review nurse is not immediately available to accept a call.

In the instance where Missouri Care has been afforded access to a facility's medical records via a secured web-portal the health plan's concurrent review staff will, upon notice of an admission, access the medical record to perform the initial admission and concurrent reviews. Missouri Care agrees to comply with the provider's policies and procedures relative to confidentiality of member medical records.

5.7.F Discharge Planning

Missouri Care's philosophy is to initiate discharge planning at time of admission. The health plan will coordinate information with the facility's discharge planning/case management staff to support a timely, appropriate, quality focused discharge plan to promote the best outcome for the member. The health plan reserves the right to participate in family discharge planning conferences. The Missouri Care Concurrent Review Nurse and/or Discharge Planner will coordinate with the health care team, the member, and significant family members discharge care within the Missouri Care provider network as is possible. In the event there is the need to utilize out-of-network providers the health plan will coordinate the authorization of service/treatment as well as reimbursement with the out-of-network provider.

5.8 Transition of Care

Missouri Care supports and actively assists in the transition of medical records and authorized on-going care/treatment for new members who are or have become eligible with Missouri Care and have received authorization for covered services from MO HealthNet or another health plan. The health plan will require the medical necessity documentation for the service/treatment requested and currently authorized to effectively transition the member so he/she will not be without medically necessary medical supplies, nutrition supplements, pharmaceutical products, physical, occupational and/or speech therapy, psychological counseling, home care services, personal care, etc. during the transition period even if those services are provided by an out-of-network provider. Additionally the health plan will actively support the transition of medical records and relevant information to MO HealthNet or another health plan for members losing eligibility with Missouri Care⁶³

⁶³ RFP 2.5.8.a

Continued authorization of the transitional medical supplies or services will be based on a review of the supporting medical necessity documentation presented for the request to extend service. Transition to a participating provider for the services will be required if the out-of-network provider does not seek to contract with Missouri and/or the transitional service is no longer part of an “on-going” treatment plan

Missouri Care is required to cover specific services that were authorized and subsequently delivered and/or placed within six (6) months of approval and after the termination of a member from the health plan. Providers rendering the following services must have obtained prior authorization from the health plan while the member was still an eligible member with Missouri Care.

The listing of service includes:

- Custom or power wheelchair
- Dentures (excluding orthodontic services)
- Augmentative communication devices
- Eyeglasses
- Hearing aids
- Custom HCY equipment⁶⁴

Section 6 Case Management⁶⁵

The Case Management (CM) Department consisting of licensed clinical and non-clinical professionals to assess and provide interventions to members based on identified risks and unmet needs.

Missouri Care has structured the Case Management Department to promote an enhanced level of integration that goes beyond standard case management. We facilitate case management of members identified with co-morbidities, with physical health and/or behavioral health/substance abuse conditions by working together as a team to support the member. The physical health and behavioral health/substance abuse case managers jointly work with the member to develop a plan of care, regularly discuss the member’s needs and coordinate services, discuss progress with the member’s PCP, psychiatrist, substance abuse counselor or other health care team members to evaluate if and when the member no longer needs the intensive oversight case management provides.

Missouri Care’s Case Management Programs include but are not limited to:

- Pregnancy Outreach and High Risk OB
- Special needs
- Elevated lead
- Behavioral Health

⁶⁴ RFP 2.5.4.6.g

⁶⁵ NQCA QI 7B-6

The Case Manager performs a health risk assessment to assess the members' medical, behavioral health, and bio-psychosocial status. Case Managers collaborate with the member, member's family, PCP's and other health care team members to achieve a quality focused cost effective care plan by appropriately utilizing acute inpatient and outpatient levels of care as well as community-based resources

If you would like further information or to refer one of our members to case management, please contact us at 1-800-322-6027 and ask for Case Management. You can also find a Case Management Referral form via our web-based portal at www.missouricare.com under the Provider Manual forms section.

6.1 Prenatal Case Management

The Prenatal Case Manager utilizes the **Pregnancy Notification and Risk Screening** form to identify pregnant members for case management. The case manager works collaboratively with the member, the member's family the primary care obstetrician provider and other stakeholders to develop an individualized plan of care that targets those issues identified on the Pregnancy Notification and Risk Screening form. Members are stratified as high, moderate or low based on their identified risks. Interventions by the Prenatal Case Manager are determined by the member's risk level. The goal of the Prenatal Case Management program is healthy, full term infants and healthy moms. The Prenatal Case Manager works closely with the obstetrical provider to promote access to early and regular prenatal care, and compliance with postpartum follow-up care.

6.2 Lead Case Management

The Lead Case Manager educates families on the effects of lead toxicity and importance of follow-up care for lead screens. The Lead Case Manager collaborates with the member's family, PCP, LPHA and Division of Medical Services to meet CDC's guidelines for screening children for lead poisoning.

6.3 Special Needs Case Management

Special Needs Case Management includes members with Autism Spectrum Disorder. Children with special health care needs are those children that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization. The Special Needs Case Manager facilitates coordination of health care services based on the severity of member's condition. The Special Needs Case Manager provides support to families with children with special needs to ensure compliance with complex specialty medical services.

6.4 Disease Management⁶⁶

Missouri Care's disease management program is available to members with diabetes, asthma, chronic obstructive pulmonary disease (COPD), major depression and congestive heart failure (CHF). Program components include patient education and outreach, physician interaction and support. Members are identified through the use of our proprietary Predictive Modeling tool or can be referred to the program by their primary care physician, health plan staff (i.e. prior authorization, concurrent review, case management), or may refer themselves. Once identified members are assessed for risk based on adherence to standard treatment guidelines, inappropriate use of ER, co-existence of complicating conditions or co morbidities, and life-style issues. Members identified as high-risk are contacted by a program representative to assess the appropriate level of care needed to assist the member in managing their disease. Low-risk members are enrolled in the member education component of the program.

The program utilizes our proven protocols and processes in managing care for participants stratified for disease management. We work with participants who have chronic conditions as identified by clinical data to help them successfully manage their condition. The programs focus on meeting the specific clinical, cultural and social needs of each individual. Our disease management programs also include evidence-based practices for special needs populations. Provider and participant education is a key component in improving clinical outcomes. Proactive outreach and ongoing communication empower participants to take an active role in successfully managing their chronic conditions. The disease management programs also recognize 1) health literacy, 2) ethnic and cultural disparities in care, and 3) linguistic issues that may impede the treatment and management of a participant's medical conditions. Our programs aim to reduce the frequency and severity of exacerbations caused by one or more chronic conditions.

Our disease management programs place a heavy emphasis on ameliorating the course of disease while maintaining the participant's maximum functionality. We send disease appropriate mailings to participants with chronic conditions to remind them about the importance of applicable screenings (e.g., lipid testing, vision screens, Hba1c screening, blood pressure monitoring, etc). When we identify participants who miss scheduled appointments or screenings, our staff performs outreach to engage participants in their own self-management and emphasize the importance of preventive services and assist with scheduling an appointment and arranging transportation, if needed. Participant education includes targeted participant educational mailings, individual participant health profiles and a Web site with access to searchable data for additional information and education. Health education materials are available in English and Spanish. We train our outreach staff in proven engagement techniques and cultural competency and have developed a script to guide their discussions with these participants. We also utilize bilingual staff or provide access to oral translation services as needed.

⁶⁶ NCQA QI 9, Element A4 and QI8, H
Missouri Care Provider Manual
8/1/2010

The following guidelines are utilized within the Disease Management Program in the treatment of the following conditions: Asthma, Congestive Heart Failure, COPD, Diabetes and Depression. They can be accessed on our website at

<http://www.schalleranderson.com/AllPlanDM/providers.aspx>

If you would like to refer a patient for disease management, please call 1-800-322-6027.

SECTION 7 BILLING PROCEDURES

Missouri Care uses the QNXT™ system to process and adjudicate claims. QNXT™ is a client/service-based managed care information system that operates in a Microsoft Windows™ and SQL Server environment. Missouri Care has preloaded all CPT, HCPCS, and revenue codes and identified those codes requiring prior authorization. The claims system is structured so claims are denied if they do not have a prior authorization number for codes requiring authorizations.

7.1 ELECTRONIC SUBMISSION OF CLAIMS

Missouri Care encourages all providers to submit their claims electronically and will work with each interested Provider to assist in setting up this process. Please contact your Provider Relations representative at (800) 322-6027 for additional information.

7.2 NATIONAL PROVIDER IDENTIFER (NPI)

The NPI will soon replace health care provider identifiers in use today in standard health care transactions. It will eliminate the need for providers to track and use multiple identifiers assigned to them by health plans and other payers. Please refer to the website <https://nppes.cms.hhs.gov> for information on how to apply for your NPI.

Missouri Care requires the use of NPI on all electronic and paper claim submissions. Please communicate your NPI directly to the Missouri Care Provider Relations Department as soon as you obtain one. You may mail or fax a copy of the return notification from CMS containing your new NPI to the address or fax number below:

Missouri Care Health Plan
Attention: Provider Relations Department
2404 Forum Boulevard
Columbia, MO 65203
Fax: 866-946-1105

EDI CLAIMS INFO FOR CLEARINGHOUSES

When submitting claims electronically, please work with your vendor to ensure that your NPI is placed in NM109 using the Identification Code Qualifier of 'XX' in NM108, and your state issued Medicaid ID is placed in REF02 using the appropriate Identification Code Qualifier in REF01 within the Secondary Identifier segment.

7.3 ACCEPTABLE CLAIM FORMS

Missouri Care encourages all providers to submit electronic claims. If you are not yet submitting electronic claims, please contact your Provider Relations representative at 800-322-6027 for information.

Missouri Care requires all Providers to use one of the following forms when submitting paper claims:

A 1500 (08-05) billing form is used when submitting claims for all professional services, including ancillary services and professional services billed by a hospital. DME and Home Health Services are also billed on a 1500 (08-05). Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB-04 billing form.

Missouri Care will not process claims received on any other type of claim form.

7.4 COMPLETING A CMS 1500

The CMS 1500 (08-05) form should be typed or legibly printed. If a correction needs to be made on the CMS 1500 (08-05), mark out the change, write the corrected information in or near the mark out and initial the change in the upper right hand corner of the claim form. **DO NOT USE WHITE OUT.** If white out is used, the claim will be returned.

When filing a claim on a CMS 1500 (08-05), there are certain fields on the form that are required to be completed. Listed in this section are the field numbers, along with explanations. The number of the field corresponds with the field number on the CMS 1500 (08-05) claim form.

CMS 1500 (08-05) FORM

The CMS 1500 (08-05) form is used to bill professional services provided to our Members. The following is a field-by-field description of the current form. The items listed below are used for claims processing.

- ITEM 1 PROGRAM
This field shows all type(s) of health insurance coverage applicable to this claim.
- ITEM 1a INSURED'S ID NUMBER
This is the patient/Member's Missouri Care Identification number shown on the Member's Missouri Care Identification Card (Same as the MO HealthNet DCN).
- ITEM 2 PATIENT'S NAME
Enter last name, first name, and middle initial as it appears on the Member's Missouri Care Identification Card.
- ITEM 3 PATIENT'S BIRTH DATE, SEX
This is the birth date and sex of the Member. This data is **REQUIRED** to verify that this is in fact a Missouri Care enrolled Member.
- ITEM 4 INSURED'S NAME
If there is individual or group insurance besides Missouri Care, enter the name of the primary policyholder. If this field is completed, you are required to complete fields #6, #7, #11 and #13. If no primary insurance is involved, LEAVE BLANK.
- ITEM 5 PATIENT'S ADDRESS
May be used as verification for patient's name and ID number.
- ITEM 6 PATIENT RELATIONSHIP TO INSURED
Mark appropriate box if there is other insurance. If no primary insurance is involved, LEAVE BLANK.
- ITEM 7 INSURED'S ADDRESS
Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no primary insurance is involved, LEAVE BLANK.
- ITEM 8 PATIENT STATUS
This indicates the patient's marital status and whether employed or a student.

- ITEM 9 OTHER INSURED'S NAME
If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no primary insurance is involved, LEAVE BLANK.
- ITEM 9a OTHER INSURED'S POLICY OR GROUP NUMBER
Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no primary insurance is involved, LEAVE BLANK.
- ITEM 9b OTHER INSURED'S DATE OF BIRTH
Enter the secondary policyholder's date of birth and mark the appropriate box for sex. If no primary insurance is involved, LEAVE BLANK.
- ITEM 9c EMPLOYER'S NAME OR SCHOOL NAME
Enter the secondary policyholder's employer name. If no primary insurance is involved, LEAVE BLANK.
- ITEM 9d INSURANCE PLAN NAME OR PROGRAM NAME
Enter the secondary policyholder's insurance plan name. If no primary insurance is involved, LEAVE BLANK.
- ITEM 10 IS PATIENT'S CONDITION RELATED TO:
This identifies if the claim is work related, due to an auto accident or other type of accident. If services are not accident related, LEAVE BLANK.
- ITEM 11 INSURED'S POLICY GROUP OR FECA NUMBER
Enter the secondary policyholder's insurance policy group number. If no primary insurance is involved, LEAVE BLANK.
- ITEM 11a INSURED'S DATE OF BIRTH
This lists the other insured's date of birth and sex for verification. If no primary insurance is involved, LEAVE BLANK.
- ITEM 11b EMPLOYERS NAME OR SCHOOL NAME
This lists the name of the employer or school that this coverage is provided under. If no primary insurance is involved, LEAVE BLANK.

- ITEM 11c INSURED'S PLAN NAME OR PROGRAM NAME
 Enter primary insurance plan name. If no primary insurance is involved, LEAVE BLANK.
- ITEM 11d IS THERE ANOTHER HEALTH BENEFIT PLAN?
 This is used to identify additional coverage, which will be listed in Item 9.
- ITEM 12 PATIENT'S SIGNATURE
 Leave blank.
- ITEM 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
 This authorizes the insurance carrier to release payment directly to the Provider. **REQUIRED** when primary insurance is involved.
- ITEM 14 DATE OF CURRENT: ILLNESS, INJURY OR PREGNANCY
 This field is required only when billing global obstetric care codes, delivery codes, or initial case management. The date should reflect the initial prenatal visit.
- ITEM 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
 This is the date of onset of same or similar illness, injury, or pregnancy for use in determining pre-existing conditions.
- ITEM 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
 Leave blank.
- ITEM 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE
 This is the name of the referring provider.
- ITEM 17a OTHER ID NUMBER OF REFERRING PROVIDER
 Any other ID number for the referring, ordering, or supervising provider is reported in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
- OB State License Number
 1D Medicaid Provider Number
 ZZ Provider Taxonomy

- ITEM 17b NATIONAL PROVIDER IDENTIFIER (NPI)
Enter the NPI number of the referring, offering, or supervising provider.
- ITEM 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
If the services on the claim were provided in an inpatient hospital setting, enter the admit and discharge dates. This field is required when the place of service is an inpatient setting.
- ITEM 19 RESERVED FOR LOCAL USE
Leave blank.
- ITEM 20 OUTSIDE LAB
This indicates if laboratory services were provided outside of the office but are included in this billing.
- ITEM 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
List the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
- ITEM 22 MEDICAID RESUBMISSION CODE
Leave blank.
- ITEM 23 PRIOR AUTHORIZATION NUMBER
Enter the Missouri Care prior authorization number if applicable.
- ITEM 24a DATE(S) OF SERVICE
Enter the date of service under “from” in month/day/year format (mm/dd/yy). All line items are **REQUIRED** to have a “from” date. A “to” date is required when billing for subsequent physician hospital visits on consecutive days.
- ITEM 24b PLACE OF SERVICE
This code indicates where the service took place (e.g. provider’s office, inpatient hospital, outpatient hospital etc.). For ambulance services, the place of service is the destination of the ambulance trip.
- ITEM 24c EMG
This box is for the emergency code: Y = emergency; leave blank for non-emergency.

- ITEM 24d PROCEDURES, SERVICES, OR SUPPLIES
This indicates the service provided using the appropriate CPT or HCPCS codes and applicable modifiers (including State specific codes and modifiers).
- ITEM 24e DIAGNOSIS POINTER
Enter the line number from Item 21 that relates to the service(s) performed.
- ITEM 24f CHARGES
Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
- ITEM 24g DAYS OR UNITS
If a service is provided over a number of days or in excess of a single unit, the quantity will be listed here. **Note: Anesthesia time must be reported in units (1 unit = 15 minutes).**
- ITEM 24h EPSDT/FAMILY PLANNING
This indicates the services provided were related to the EPSDT or Family Planning programs.
- ITEM 24i ID QUALIFIER
If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area.
- ITEM 24j RENDERING PROVIDER NPI
This is a **REQUIRED** field. The NPI of the individual performing/rendering the service is reported in 24j. Enter the NPI number in the un-shaded area of the field. For services paid at a group or institutional level (e.g., ambulance, DME, home health, public health), the organizational (Type 2) NPI must be entered here and should match the billing NPI in Item 33a.
- ITEM 25 FEDERAL TAX ID NUMBER
This is a **REQUIRED** field. Enter the appropriate EIN or SSN for the billing provider identified in Item 33.
- ITEM 26 PATIENT ACCOUNT NUMBER
This item is for Provider's reference.

- ITEM 27 ACCEPTS ASSIGNMENT
This field is completed if the Provider/supplier accepts assignment of Medicare benefits.
- ITEM 28 TOTAL CHARGE
This is the total amount the Provider is billing for the services provided.
- ITEM 29 AMOUNT PAID
This is the amount paid by any other payer. This amount is documented on the attached Explanation of Benefits.
- ITEM 30 BALANCE DUE (IF DIFFERENT THAN ITEM 28)
This indicates the amount due after any deductions from other payers.
- ITEM 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
This is a **REQUIRED** field and must be indicated. The acceptable signatures are as follows:
- Provider's signature (must be legible), or
 - Provider's signature rubber stamped (on all copies), or
 - Computer generated claim form with the Provider's name in BLOCK LETTERS.
- ITEM 32 SERVICE FACILITY LOCATION INFORMATION
This is the location where the actual services were provided. This may or may not match the billing address listed in item 33.
- ITEM 32a Enter the service facility NPI if applicable.
- ITEM 32b Enter the service facility legacy number if applicable.
- ITEM 33 BILLING PROVIDER INFO & PH #
This information is **REQUIRED** and should include the correct pay-to name and address. This information must be consistent with the owner of the federal tax ID entered in Item 25.
- ITEM 33a This is a **REQUIRED** field. Enter the billing provider NPI.
- ITEM 33b Enter the billing provider legacy number if applicable.

7.5 CMS 1500 DOCUMENTATION

All claims that involve other insurance must be accompanied by an explanation of benefits (EOB) from the primary insurer.

If a referral for services is required, a request should be made for the services being rendered to the Missouri Care Prior Authorization department, and reference the referral/PA number in field 23 of the CMS 1500 form.

7.6 BILLING GUIDELINES FOR OBSTETRICAL SERVICES

COVERED GLOBAL OB SERVICES

Global obstetric services include: initial care, all ante partum care (physical exams, medical history, vital signs, fetal heart tones, fetal monitor strip, maternity counseling, amino-infusion, prostaglandin gel insertion, external version, Pitocin induction), routine laboratory services (if performed in the office as per contract), any false labor including hospitalization, delivery regardless of routine, postpartum care (hospital, office visits, and outpatient care up to six weeks), one ultrasound performed in the office, one non-stress test performed in the office. Additional ultrasounds and non-stress tests may be performed in the office and reimbursed separately.

GLOBAL OB BILLING

Global obstetric services **MUST** be billed using the following CPT codes: 59400, 59510, 59610, and 59618. If you are billing for only ante partum global services, you **MUST** use 59425 or 59426. Global obstetric services **MUST** be billed on the date of delivery and should include the post-partum visit. Appropriate authorizations must be received for the global obstetrical services provided.

ENCOUNTER DATA

Providers must report prenatal and post-partum encounters in an appropriate manner prior to submitting global obstetric service claims to Missouri Care. To do so, provider should submit timely claims for all prenatal and post-partum visits utilizing generic evaluation and management codes (99201-99205, 99211-99215), with the following parameters:

- The beginning Date of Service (Item 14) is equal to the initial prenatal visit.
- A \$.01 charge for the office visit should be entered in the charge column (Item 24f).

7.7 ANESTHESIA GUIDELINES

- A) Claims must be submitted on a CMS 1500 form.
- B) Missouri Care recognizes anesthesia CPT codes (00100-01999) billed in conjunction with the appropriate modifier:
 - AA Anesthesia Service performed personally by anesthesiologist
 - QK Medical direction of two-to-four concurrent procedures involving qualified professionals
 - QX CRNA service with medical direction by physician
 - QZ CRNA service without medical direction
- C) Subject to national coding guidelines (e.g., CMS CCI edits), anesthesia providers may bill separately for insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation and epidurals. These surgical codes should be billed without modifiers.
- D) Bill using **units of time (one unit = 15 minutes)** in Field 24g of the CMS 1500. Bill only for actual anesthesia time; base units for the procedure must **NOT** be included. The actual anesthesia time may be included in procedure field if desired.
- E) If more than 10 units are billed start and stop times must be recorded on the claim.
- F) If an anesthesia claim is billed in minutes instead of units, the claim will be denied.

7.8 COMPLETING THE UB-04

The UB-04 is used to bill facility services provided. The following is a field by field description of the form:

- ITEM 1 PROVIDER NAME, ADDRESS & TELEPHONE NUMBER
The name of the Provider submitting the bill and the complete mailing address to which the Provider wishes payment sent.
- ITEM 2 PAY TO NAME, ADDRESS, CITY, AND STATE
This field is required when the pay to name and address information is different than the billing Provider information.
- ITEM 3 PATIENT CONTROL NUMBER
Patient's unique alphanumeric number assigned by the Provider to facilitate retrieval of individual financial records and posting of payment.

- ITEM 4 TYPE OF BILL
A code indicating the specific type of bill (inpatient, outpatient, etc.).
- ITEM 5 FEDERAL TAX NUMBER
The number assigned to the provider by the federal government for tax reporting purposes.
- ITEM 6 STATEMENT COVERS PERIOD
The beginning and ending service dates of the period included on this claim.
- ITEM 7 NOT USED
- ITEM 8 PATIENT NAME
The provider enters the patient's last name, first name, and if any, middle initial, along with patient ID (if different than the subscriber insured's ID).
- ITEM 9 PATIENT ADDRESS
The Provider enters the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and Zip code.
- ITEM 10 BIRTHDATE
The provider enters the month, day and year of birth (MMDDCCYY) of patient.
- ITEM 11 PATIENT'S SEX
The provider enters an "M" (male) or an "F" (female).
- ITEM 12 ADMISSION DATE
Required for Inpatient and Home Health. The hospital enters the date the patient was admitted for inpatient care (MMDDYY).
- ITEM 13 ADMISSION HOUR
The hour during which the patient was admitted for inpatient or outpatient care.
- ITEM 14 TYPE OF ADMISSION/VISIT
Required on inpatient bills only. This is the code indicating priority of this admission.

- ITEM 15 SOURCE OF ADMISSION
The code indicating the source of this admission.
- ITEM 16 DISCHARGE HOUR
Hour that the patient was discharged from inpatient care.
- ITEM 17 PATIENT STATUS
A code indicating patient status as of the ending service date of the period covered on this claim, as reported in ITEM 6.
- ITEM 18-28 CONDITION CODES
Code(s) used to identify conditions relating to this claim that may affect payer processing. For all claims subject to an outlier provision defined in the provider contract, condition code 61 MUST be billed.
- ITEM 29 ACCIDENT STATE
Not Used.
- ITEM 30 UNLABELED FIELD
This field is reserved for National use.
- ITEM 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this claim that may affect payer processing.
- ITEM 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.
- ITEM 37 UNTITLED
- ITEM 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the claim.
- ITEM 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified elements necessary to process this claim as qualified by the payer organization.

- ITEM 42 REVENUE CODE
A code which identifies a specific accommodation, ancillary service or billing calculation. Use the most recent codes established.
- ITEM 43 REVENUE DESCRIPTION
A narrative description of the related revenue categories included in this claim.
- ITEM 44 HCPCS/RATES
The accommodation rate for inpatient claims and the Health Care Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient claims.
- ITEM 45 SERVICE DATE
The date the indicated service was provided.
- ITEM 46 UNITS OF SERVICE
A quantitative measure of services rendered by revenue category to or for the patient to include such items as number of accommodation days, miles, pints of blood, treatments, etc.
- ITEM 47 TOTAL CHARGES (BY REVENUE CODE CATEGORY)
Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
- ITEM 48 NON-COVERED CHARGES
To reflect non-covered charges for the primary payer pertaining to the related revenue code.
- ITEM 49 UNLABELED FIELD
This field is reserved for National use.
- ITEM 50 PAYER IDENTIFICATION
Names and, if required, number identifying each payer organization from which the Provider might expect some payment for the claim.
- ITEM 51 PROVIDER NUMBER
The number assigned to the Provider by the payer indicated in ITEM 50.

- ITEM 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the Provider has on file a signed statement permitting the Provider to release data to other organizations in order to adjudicate the claim.
- ITEM 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the Provider has a signed form authorizing the third party payer to pay the Provider.
- ITEM 54 PRIOR PAYMENTS - PAYERS AND PATIENT
The amount the hospital has received toward payment of this claim prior to the billing date by the indicated payer.
- ITEM 55 ESTIMATED AMOUNT DUE
The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
- ITEM 56 NATIONAL PROVIDER IDENTIFIER
Provider's NPI number.
- ITEM 57 OTHER PROVIDER ID
Not required.
- ITEM 58 INSURED'S NAME
The name of the individual in whose name the insurance is carried.
- ITEM 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.
- ITEM 60 INSURED'S UNIQUE ID
Insured's unique identification number assigned by the payer organization (i.e., the Member's Missouri Care/MO HealthNet Identification Number.)
- ITEM 61 INSURED GROUP NAME
Name of the group or plan through which the insurance is provided to the insured.

- ITEM 62 INSURANCE GROUP NUMBER
The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
- ITEM 63 TREATMENT AUTHORIZATION CODE
A number or other indicator that designates that the treatment covered by this claim has been authorized by the payer.
- ITEM 64 DOCUMENT CONTROL NUMBER (DCN)
The number issued by the health plan's fiscal agent as part of their internal control.
- ITEM 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in ITEM 58.
- ITEM 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER
The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
- ITEM 67 PRINCIPAL DIAGNOSIS CODE
The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).
- ITEM 67A-Q OTHER DIAGNOSIS CODES
The ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.
- ITEM 68 NOT USED
- ITEM 69 NOT USED
- ITEM 70A-C NOT USED
- ITEM 71 NOT USED
- ITEM 72 NOT USED.
- ITEM 73 NOT USED

- ITEM 74 PRINCIPAL PROCEDURE CODE AND DATE**
The CPT code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.
- ITEM 74A-E OTHER PROCEDURE CODES AND DATES**
The codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.
- ITEM 75 NOT USED**
- ITEM 76 ATTENDING PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)**
The name and/or number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
- ITEM 77 OPERATING PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)**
The name and ID number of the individual with the primary responsibility for performing the surgical procedure.
- ITEM 78-79 OTHER PROVIDER NAME AND IDENTIFIERS (INCLUDING NPI)**
The name and/or number of the licensed provider other than the attending provider as defined by the payer organization.
- ITEM 80 REMARKS**
Notations relating specific State and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill State reporting requirements.
- ITEM 81 CODE – CODE FIELD**
To report additional codes related to a form locator or to report external code list approved by the NUBC for inclusion to the institutional data set.

7.9 TIMELY CLAIM SUBMISSION REQUIREMENTS

Missouri Care as Primary Payer: Missouri Care requires that you initially submit your claim within 180 days from the date of service. Providers have 365 days from the date of service to correct and resubmit claims if the initial submission time period has been met.

Missouri Care as Secondary Payer: Claims must be received within 365 days from the date of service or 90 days from the date of the EOB, whichever time period is longer.

Out of network providers have 365 days to submit a claim.

A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the Provider of service or from a third party. If any corrections are made on an original claim, the correction must be initiated to ensure the integrity of the claim. Failure to adhere to this requirement may result in the denial of your claims.

For paper submission, please mail all claims and encounter information to:

Missouri Care Health Plan
Attn: Claims Submission
P.O. Box 61625
Phoenix, Arizona 85082-1625

7.10 RESUBMITTING A CLAIM

If a provider believes a claim has not been properly processed, the following procedure can be used to help resolve issues and resubmit the claim.

Once the initial one hundred eighty (180) day submission requirement has been met, a provider has up to 365 days from the date of service to resubmit the claim for adjustment. Missouri Care will readjudicate claims resubmitted by the Provider only if the initial claim had been filed within the prescribed submission deadline.

If resubmitting a claim electronically, the provider must do the following:

1. Utilize Loop 2300 Segment & Element CLM05-3 ("Claim Frequency Code") of an 837 Professional or Institutional claim.
2. Providers should use either a claim frequency code of "7" to replace a prior claim or "8" to void/cancel a prior claim.

If the provider wants to resubmit a claim on paper, the following process is required:

1. Make a copy of the claim and mark clearly as a resubmission.
2. Mail the claim and all attachments to:

**Missouri Care Health Plan
Attn: Claims Resubmission
P.O. Box 61625
Phoenix, Arizona 85082-1625**

7.11 INQUIRING ABOUT A CLAIM

Missouri Care has staff to help with inquiries the provider may have about claims. The claims staff will take telephone inquiries from Providers concerning claims issues. By following a few guidelines, you can help Missouri Care provide you with prompt, efficient service. Please have all of the information ready before you call.

1. Please limit telephone inquiries to check on claim status to a maximum of three (3) claims per call.
2. Please provide the Member's Missouri Care ID Number, date of service, procedure code, Provider's name and claim number (if known).
3. To check on claims status, call (800) 322-6027.
4. If you have questions about a specific remittance advice or a denial please call (800) 322-6027 and select Claims Research Dept.

7.12 THIRD PARTY RESOURCES

Missouri Care is, by law, the payer of last resort for MO HealthNet Managed Care Program members. Therefore, the provider must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing Missouri Care, as required in the provider contract. Once the provider has billed the other carrier and received an Explanation of Benefits (EOB), the provider may submit the claim to Missouri Care. Attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason. The provider has 90 days from the date of the primary EOB to submit the claim and the EOB to Missouri Care, or within 365 days from the date of service, whichever is longer.

Claims submitted without an EOB will be denied for lack of the EOB. Claims may also be denied if the other insurance carriers' requirements are not met.

7.13 TECHNICAL ASSISTANCE

If Providers need technical assistance related to encounter/claims submissions, please contact your assigned Provider Relations Representative. Technical assistance sessions can be scheduled to discuss areas of difficulty.

7.14 REFUNDS / REVERSALS AND VOIDS

A claim adjustment form is required when filing a refund, reversal or void. For claims adjustment forms please copy (Attach J), please visit the provider forms section of our website at www.MissouriCare.com, [→ Providers → Provider Resources](#) or contact your Provider Relations Representative.

To send a Refund Check:

- Include copy of remit page
- Copy of primary EOB (if applicable)
- Detailed explanation of why the refund is being sent
- New claim form (if applicable)

To submit a Claim Reversal (Does not include a Check)

- Include copy of remit page
- Copy of primary EOB (if applicable)
- Detailed explanation of why the reversal is being requested
- New claim form (if applicable)

To submit request for Check Void:

- Include original health plan check
- Copy of entire remit
- Explanation of why the check needs to be voided
- Copy of primary EOB (If Applicable)
- New claim form (If Applicable)

The following is a list of why a provider might send a reversal, refund or void to Missouri Care:

- Provider did not render services to member; claim billed in error
- Both primary insurance and Missouri Care paid
- Entire remit was paid incorrectly
- Provider was partially paid and wishes to rebill unpaid portion of claim
- Co-pay was not deducted from provider's payment

Claim adjustments forms and required documentation should be sent to:

**Missouri Care Health Plan
Attn: Claims Adjustments
PO Box 61625
Phoenix, AZ 85082-1625**

7.15 MEMBER BILLING

It is against the law for a provider to bill a MO HealthNet beneficiary for services included in their benefit package. In accordance with Title 13 CSR 70-030, when an enrolled MO HealthNet provider provides an item or service to a MO HealthNet recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient's MO HealthNet benefits and seeks reimbursement from the MO HealthNet agency in accordance with all the applicable MO HealthNet rules.

The Code of Federal Regulations Title 42 CFR 447.15 requires that,

[a] State plan must provide that the MO HealthNet agency must limit participation in the MO HealthNet program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan.

The Code of Federal Regulations Title 42 CFR 447 also states that providers must accept, as payment in full, the amounts paid by the agency. The provider may not deny services to any eligible individual on account of the individual's inability to pay. Furthermore, if a provider seeks to collect from an individual the amount that exceeds an amount specified, the MO HealthNet agency may provide for a reduction of any payment amount other wise due to the provider in addition to any other sanction available to the agency. The reduction may be equal to up to three times the amount that the provider sought to collect.

PRIVATE PAY AGREEMENT

In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs. This agreement shall only be overcome by written evidence of an agreement between the provider and the member indicating the member accepts the status and liabilities of a private pay patient. The health plan shall make it clear to members that all covered services are available to the member at no cost subject to any applicable co-pays. **The private pay agreement shall only be for services not included in the comprehensive benefit package.**

If a provider has questions regarding billing or the benefits covered by Missouri Care, please contact the Missouri Care Provider Relations Department at (800) 322-6027.

SECTION 8 Clinical Programs

8.1 EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) Program

Background

Since 1989, the federal government has required state Medicaid programs to cover **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment (EPSDT) services for categorically eligible Medicaid recipients under age 21. It is the responsibility of Missouri Care Health Plan and the network of PCPs to ensure that these services are provided to all eligible children. The State of Missouri also refers to this program as Healthy Children and Youth (HCY).

Periodicity Schedule

The State of Missouri follows the American Academy of Pediatrics schedule for preventive pediatric health care as a minimum standard for screening frequency (see schedule below). Missouri Care Health Plan strongly recommends annual exams for all children over the age of two and will reimburse PCPs for annual screening.

To avoid missed opportunities for EPSDT screenings, Missouri Care encourages providers to assess a child's need for an EPSDT screening at every clinical encounter in case the EPSDT interval has inadvertently lapsed. Providers may offer an EPSDT screening to eligible children when they present for:

- Other preventive care (e.g., sports physical).
- A prescription refill
- A sick visit

American Academy of Pediatrics EPSDT Periodicity Schedule

<u>Well-Child Checkups Schedule</u>	
Newborn	7 years
By one month	8 years
2 – 3 months	9 years
4 – 5 months	10 years
6 – 8 months	11 years
9 – 11 months	12 years
12 – 14 months	13 years
15 – 17 months	14 years
18 – 23 months	15 years
24 months	16 years
30 months	17 years
3 years	18 years
4 years	19 years
5 years	20 years
6 years	

MO HealthNet EPSDT Periodicity Schedule

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

Components of a Full Screening

Interval History	
<ul style="list-style-type: none"> - Interval Health and Developmental History (both physical and mental health) - Missouri Care recommends that providers include a growth chart in the records of children up to age 18 - Height, weight and head circumference must be plotted on children twelve (12) months and under - Height and weight must be plotted on children over twelve (12) months. - Missouri Care also recommends that providers plot body mass index (BMI) beginning at age two (2) 	
Unclothed Physical Exam	Fine Motor/ Gross Motor Skills
Developmental Screening	Hearing
Anticipatory Guidance	Vision
Lab/Immunizations (when indicated)	Dental
Lead Assessment and Testing	

Billing

To bill for a full EPSDT screening, the above components must be met.

Full EPSDT Screenings must be billed with V20.2 as the primary diagnosis for children over 28 days old, V20.31 for a newborn fewer than 8 days old, and V20.32 for a newborn 8 to 28 days old. The following code set must be used for full or partial EPSDT screenings:

Full Screening Procedure Codes (New or Established Patient)

Procedure Code (use age appropriate code*)	Modifier
99381, 99391	EP
99382, 99392	EP
99383, 99393	EP
99384, 99394	EP
99385, 99395	EP

***Modifier UC should be used if child was referred for further care as a result of screening. UC must always appear as the last modifier.**

Partial Screenings (New or Established Patient)
Unclothed Physical and History

Procedure Code (use age appropriate code*)	Modifier 1	Modifier 2
99381, 99391	52	EP
99382, 99392	52	EP
99383, 99393	52	EP
99384, 99394	52	EP
99385, 99395	52	EP

***Modifier UC should be used if child was referred for further care as a result of screening. UC must always appear as the last modifier.**

Partial Screening - Dental

Procedure Code (use age appropriate code)	Modifier 1	Modifier 2
99429	N/A	N/A
99429	UC	N/A

Partial Screening - Developmental/ Mental Health

Procedure Code (use age appropriate code)	Modifier 1	Modifier 2
99429	59	N/A
99429	59	UC

Partial Screening - Hearing

Procedure Code (use age appropriate code)	Modifier 1	Modifier 2
99429	EP	N/A
99429	EP	UC

Partial Screening - Vision

Procedure Code (use age appropriate code)	Modifier 1	Modifier 2
99429	52	N/A
99429	52	UC

School Physicals

A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis V20.2 should be used with the billing codes for an EPSDT screen with 52 EP as the

modifiers. This also applies for other school physicals when required as conditions for entry into or continuation of education. Use the appropriate Preventative Medicine codes and modifiers as listed in the tables above.

Missouri Care encourages providers to offer a full EPSDT exam when a Member has not had a full EPSDT exam in the last 12 months.

Well Woman Exams

A well woman exam for Members 18-20 years of age can be billed using the age appropriate preventative medicine code (99381-99385; 99391-99395) with a diagnosis code V72.31.

Lead Screening and Testing

Lead Screening is a mandatory component of a full EPSDT exam. The State of Missouri has developed a mandatory HCY Lead Screening Guide to be used by providers for all children between the ages of 6 months and 72 months (6 years) of age. In addition, blood lead testing must be done at 12 months, 24 months, and when indicated from the lead screening assessment. Screening is mandatory for refugee's ages 6 months to 16 years at entry into the United States.

For questions regarding childhood lead poisoning prevention and treatment, please contact Missouri Care Lead Case Manager at 1-800-322-6027 or the Department of Health and Senior Services at 573-751-6102.

Screening Forms

The Healthy Children and Youth [HCY Screening] and the HCY Lead Risk Assessment Guide are both mandatory screening tools. Both forms must be signed and dated by the screener and retained in the medical record. For providers who use electronic medical records (EMRs), the HCY Screening Guides are not required, but all components of the Guides must be captured and easily accessible in the medical record. The State of Missouri supplies the tools at no cost to the provider. The forms can be downloaded from the Division of Medical Services web site at <http://manuals.momed.com/manuals/presentation/forms.jsp>. In addition, the forms can be ordered from Infocrossing HealthCare Services, PO Box 5600, Jefferson City, MO 65102.

Immunizations

MO HealthNet providers must enroll in the Vaccines for Children (VFC) program, which is administered by the Department of Health and Senior Services. The program provides vaccine at no charge to public and private providers for MO HealthNet eligible children. To enroll in the VFC program, please contact the Department of Health and Senior Services at 1-800-219-3224. When an appropriate immunization is not provided, the patient's medical record must document why the appropriate immunization was not provided (i.e. Refused by the parent or guardian of the patient).

2010 Updated Immunization Schedules

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years United States • 2010

For those who fall behind or start late, see the catch-up schedule

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations:

<http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, **800-822-7967**.

EPSDT COMPONENTS

IMMUNIZATIONS:

Immunization status must be addressed at each EPSDT visit. If a child's immunization status is not up to date, appropriate immunizations must be given at the time of visit unless contraindicated. Immunizations must be administered according to the current immunization schedule recommended by The Advisory Council on Immunization Practices (ACIP) and/or the Centers for Disease Control (CDC) and documented on the HCY Screening Form. An immunization history must be maintained in the child's medical record for easy referral. Reasons or problems related to not giving immunizations must be recorded in the progress notes and on the Screening Form. Providers should familiarize themselves with the valid and invalid contraindications to immunize to avoid missed opportunities.

LABORATORY TESTS:

BLOOD LEAD SCREENING: All children age six (6) months through six (6) years **must** be screened for lead toxicity. A verbal risk assessment is required at each EPSDT visit to determine risk category. Children determined to be at high risk must receive a blood lead level at that visit or referred to a contracted lab. For all children, a blood level is **required** at twelve (12) months and twenty-four (24) months. For children who have not previously received a screening blood lead test and are between twelve (12) and seventy-two (72) months of age, a blood lead test is required immediately.

TUBERCULOSIS SCREENING:

TB testing is required at twelve (12) months, four (4)- five (5) years and between fourteen (14) – seventeen (17) years. The Mantoux Test (PPD) is the recommended test for all ages. The Tine Test may be used for children up to age five (5). Any positive Tine Test must be followed up by a PPD. Annual testing is recommended for children in high-risk populations, or at the discretion of the Provider if health history indicates otherwise. High risk populations include: children born outside the U.S. in developing countries; any resident of a long-term care facility; any child with a medical condition which places him/her at increased risk for TB infection (e.g. HIV infection, chemotherapy treatment, diabetes, renal disease, or other conditions which suppress the immune system); and any child living in a household with anyone who has active TB, has tested positive with a PPD test, has HIV infection, or is an identified alcoholic or IV drug abuser. **ANEMIA TESTING (Hgb/Hct)/SICKLE CELL:** Anemia testing is required at fifteen (15) months and four (4) – five (5) years. Microhematocrit or measurements of hemoglobin concentration are acceptable methods. Sickle Cell, U/A, and other appropriate lab testing is to be done as indicated.

INITIAL HISTORY:

A comprehensive history is required in all charts and must be obtained at the first office or clinic visit. A comprehensive history includes documentation of medical, familial, developmental, nutritional, social and current health status. Documentation should include disease history (i.e. Varicella).

INTERVAL HISTORY:

Health status since last visit or reason for current visit must be indicated on the HCY Screening Form.

GROWTH CHARTS:

Assessment of growth pattern is required at each EPSDT visit. Results are to be documented on the HCY Screening Form and recorded on the growth chart for graphic display. Height, weight and head circumference must be plotted on children twelve (12) months and under; height and weight on children over twelve (12) months. Growth charts must be maintained in the medical record until eighteen (18) years of age.

NUTRITIONAL ASSESSMENT:

A nutritional assessment is required at each EPSDT visit. Assessment is based on the child's history, physical exam including oral dental exam, growth pattern and appropriate blood work. Results must be documented on the HCY Screening Form. Missouri Care also recommends that providers plot body mass index (BMI) beginning at age two (2)

VISION TESTING:

Vision testing is required at each EPSDT visit. Guidelines for performing vision testing on infants and small children are indicated on the age appropriate HCY Screening Forms. Vision screening using a Snellen Eye Chart is to be done on all children four (4) years and older. A preschool or Snellen "E" Chart may be necessary for the younger child. If a child is uncooperative during the eye exam and the screen can not be performed, please document "uncooperative" on the HCY Screening Form.

HEARING TESTING:

Hearing testing is required at each EPSDT visit. Guidelines for performing hearing testing on infants and small children are indicated on the age appropriate HCY Screening Form. It is extremely important to initiate hearing screening during infancy. Hearing screening should consist of history, risk factors, parental questions, otoscopic examination and appropriate hearing test according to age. Pure tone and impedance testing should be done when indicated and/or when medically necessary.

SPEECH SCREENING:

Speech screening is done to identify children in need of referral. There is no specific speech assessment tool required. Refer to the guidelines on the age appropriate HCY Screening Form.

BLOOD PRESSURES:

Blood pressures are to be taken on all children three (3) years of age and older at each EPSDT visit. If a child is uncooperative and the blood pressure can not be obtained, please document such on the HCY Screening Form.

DEVELOPMENTAL ASSESSMENT:

A developmental assessment is required at each EPSDT visit and must be documented on the HCY Screening Form. Components of a developmental assessment include: obtaining a relevant developmental history, making accurate and informative observations and attending to parental concerns. Findings must be reviewed in conjunction with other information obtained during the physical exam. Developmental progress must be reviewed as a component of overall health and well being, given the child's age and culture. An objective developmental test must be administered as a "second stage" screening tool when the history and/or physical exam is suspicious.

BEHAVIORAL HEALTH SCREENING:

Screening for mental health and substance abuse must be done at each EPSDT visit beginning at age three (3). All eligible children in need of mental health and/or substance abuse services must be referred for evaluation and treatment.

PHYSICAL EXAM:

A comprehensive unclothed physical examination is required at each EPSDT visit. Guidelines for evaluating the general physical and mental health status of infants, children, and youth to age twenty-one (21) are on the age appropriate HCY Screening Forms.

DENTAL REFERRALS:

It is recommended that assessment preventative dental services and oral treatments for children begin at age 6-12 months and be repeated every 6 months or as medically indicated. PCPs are to perform oral dental examinations as part of the medical examination to identify children who require further evaluation and treatment. PCPs should observe closely for and educate parents about baby bottle tooth decay. The referral must be documented on the HCY Screening form.

HEALTH EDUCATION:

The PCP is responsible for assuring that health education is provided at each EPSDT visit. This includes providing assistance to parents or guardians in terms of development, healthy lifestyle choices, and accident and disease prevention. In accordance with MC+ policy and Missouri Care's Family Planning Guidelines, PCPs shall inform and counsel all Members beginning at age twelve (12) or earlier if indicated on the prevention of STDs, pregnancy and the availability of family planning services.

REFERRALS:

Any problems identified must be followed up with diagnosis and treatment. This will assist Missouri Care in tracking and following up on these children to ensure that they are receiving the needed care.

RECOMMENDATIONS:

To avoid missed opportunities for EPSDT and immunizations, Missouri Care encourages all PCPs to assess a child's need for an EPSDT exam and immunizations at every clinical encounter and provide these services whenever possible, unless contraindicated. Missouri Care recommends that annual EPSDT exams continue after age two.

8.2 FAMILY PLANNING

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

Billing guidelines for family planning services:

- Use the appropriate office visit code
- Use a DX code in the range of V25 through V25.9

Family planning includes one or more of the following services:

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
Note: Obtaining a specimen of a Pap Smear is included in the office visit. Screening and interpretation of a Pap Smear can be reimbursed only to a clinic or certified independent laboratory.
- A breast examination

Providers may bill the following family planning services in addition to the office visit:

- All laboratory and x-ray services provided as part of the family planning encounter.
- A pregnancy test if provided at the time at which family planning services are initiated.
- HIV blood screening testing performed as part of a package of screening testing and counseling in conjunction with family planning encounter.

PARAGARD

The IUD is defined as an “Intrauterine Copper Contraceptive”. Missouri Care sets reimbursement for this device. Payment is based on the usual and customary fee

- HCPCS Code J7300 – IUD. This code is now carved out to the State.
- CPT Code 58300 - Insertion of the IUD
- No invoice is required when submitting claims on a HCFA 1500 form

Note: The appropriate office visit procedure code may be billed for the removal of the IUD. CPT code 58301 is not a billable procedure as payment for this service is included in the office visit procedure code.

MIRENA

The IUD is defined as a “Levonorgestrel-releasing Intrauterine Contraceptive System”. Reimbursement for this device is set by the Health Plan. Payment is based on the usual and customary fee

- HCPCS Code J7302 – IUD- This code is now carved out to the State.
- CPT Code 58300 - Insertion of the IUD
- No invoice is required when submitting claims on a HCFA 1500 form

Note: The appropriate office visit procedure code may be billed for the removal of the IUD. CPT code 58301 is not a billable procedure as payment for this service is included in the office visit procedure code.

DIAPHRAGMS OR CERVICAL CAPS

The fitting for the diaphragm or cervical cap is included in the fee for an office visit procedure code.

- Procedure Code A4266 – Diaphragm for contraceptive use
- Procedure Code A4261 – Cervical cap for contraceptive use

Reimburse for each item is based on the MO HealthNet Fee Schedule pricing. No invoice is required for claims submission.

NORPLANT SYSTEM

The insertion and device are reimbursed separately. An office visit code may not be billed in addition to any of the Norplant procedure codes. The charge for the office visit is assumed to be covered in the reimbursement of the procedure.

- Procedure Code J7306 – Levonorgestrel (contraceptive) implant system, including implants and supplies. This code is now carved out to the State.
- CPT Code 11975 – Insertion, implantable contraceptive capsules
- CPT Code 11976 – Removal, implantable contraceptive capsules
- CPT Code 11977 – Removal with reinsertion, implantable contraceptive capsules

Reimburse for each item is based on the MO HealthNet Fee Schedule pricing. No invoice is required for claims submission

DEPO-PROVERA

The appropriate office visit code may be billed in addition to this service.

- HCPCS Code J1051 – Injection, medroxyprogesterone acetate, 50mg. This code is now carved out to the State.
- HCPCS Code J1055 – Injection, medroxyprogesterone acetate for contraceptive use, 150 mg. This code is now carved out to the State.

Reimburse for each item is based on the MO HealthNet Fee Schedule pricing. No invoice is required for claims submission

ORAL CONTRACEPTIVES

A provider should refer to Missouri Care Health Plan's Preferred Drug List for approved contraceptives. www.missouricare.com

STERILIZATIONS

Sterilization is defined as any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

A MO HealthNet Recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent. All sterilization procedures require a prior authorization.

Guidelines for consent form:

- The recipient must give an informed consent voluntarily in accordance with Federal and State requirements.
- Form must be completed and signed by the recipient at least 31 days, but not more than 180 days, prior to the date of the sterilization procedure.
- There must be 30 days between the date of signing and the surgery date.
- The day after the signing is considered the first day when counting the 30 days.
- The form must be completed and forwarded to Missouri Care Health Plan when requesting authorization prior to services rendered.
- The completed consent form is reviewed to ensure compliance with State and Federal guidelines prior to issuing an authorization number.

EXCEPTIONS

The only exceptions to the time requirements are for situations involving premature delivery or emergency abdominal surgery

- **Premature delivery:** The Sterilization Consent Form must be completed and signed by the recipient at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. Expected date of delivery is required on the Sterilization Consent Form. (This also applies to consent forms used in lieu of the Missouri- approved Sterilization Consent Form for services provided in non-bordering states.)
- **Emergency abdominal surgery:** The Sterilization Consent Form must be completed and signed by the recipient at least 72 hours prior to sterilization. The nature of the emergency abdominal surgery must be documented on the Sterilization Consent Form. (This also applies to consent forms used in lieu of the Missouri- approved Sterilization Consent Form for services provided in non-bordering states.)

BILLING

Claims should be billed with the appropriate procedure code. The sterilization form is not a required attachment when submitting claims.

CPT Code – 58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

CPT Code – 58605 Ligation or transection of fallopian tubes(s), abdominal or vaginal Approach, postpartum, unilateral or bilateral, during same hospitalization

CPT Code – 58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery

CPT Code – 58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring)
Vaginal or suprapubic approach

CPT Code – 58671 Occlusion of fallopian tube(s) by laparoscopic approach

HYSTERECTOMY

A hysterectomy is not a covered benefit if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

A Hysterectomy is a covered service if the following guidelines are met:

- The individual or her representative, if any, has signed a written Acknowledgment of Receipt of Hysterectomy Information form
- The person who secured authorization to perform the hysterectomy has informed the individual orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing

SERVICES NOT COVERED UNDER FAMILY PLANNING

- Condoms and devices or supplies available as non-prescribed, over-the-counter products
- Reversal of sterilization procedure
- Abortions performed as family planning
- Hysterectomies for the purpose of family planning

SECTION 9 APPEALS, COMPLAINTS & GRIEVANCES

9.1 PROVIDER COMPLAINTS AND APPEALS ⁶⁷

Missouri Care evaluates and processes complaints and appeals filed by participating and non-participating health professionals according to applicable State of Missouri and federal statutes, regulations, contract and policies. All medical issues are reviewed by the Chief Medical Officer or his designee.

An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for services; or the failure of the health plan to act within the timeframes specified⁶⁸.

A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with health plan policy, procedure, claims (reimbursement amount, processing time, procedures, etc.) or any aspect of health plan functions other than an action⁶⁹. All complaints will be logged and tracked whether received by phone, in person or in writing

An appeal is the mechanism which allows providers the right to appeal actions of the health plan⁷⁰. Appeals must be submitted in writing. All expressions of dissatisfaction resulting from receipt of a claim or authorization denial are automatically classified as an appeal.

9.2 PROVIDER COMPLAINTS AND APPEALS PROCEDURES:⁷¹

- All complaints and appeals will be filed directly with the Missouri Care Complaints and Appeals Analyst at 2404 Forum Boulevard, Columbia, MO 65203.
- Providers may file a verbal or written complaint or a written appeal within ninety (90) days, or within a contractually specified timeframe, of the incident or action/denial that resulted in the complaint or appeal.
- Complaints will be resolved within thirty (30) calendar days of receipt of the complaint at the health plan. At the time of the complaint decision the provider will receive written notification of their right to file an appeal.
- If the provider is dissatisfied with the complaint resolution, the provider or provider's representative may file an appeal in writing within ninety (90) calendar days of the complaint resolution.

⁶⁷ See NCQA CR10, A-4

⁶⁸ RFP 2.15.1

⁶⁹ RFP 2.17.1

⁷⁰ RFP 2.17.1

⁷¹ See NCQA CR10, A-4

- The appeal process will include an opportunity for the provider or their representative to present their case in person⁷².
- Missouri Care will reach a final decision on an appeal within thirty (30) calendar days of receipt of the appeal, with extensions possible if approved by the state agency.
- The provider may request an expedited review of the appeal if the standard time frame could seriously jeopardize the member's life, physical or mental health or the member's ability to regain maximum function⁷³. All expedited appeals are treated as member appeals.
- The expedited review will be resolved no later than 72 hours after the request or as expeditiously as the member's physical or mental health requires.

9.3 MEMBER GRIEVANCES AND APPEALS

Missouri Care evaluates and processes grievances and appeals filed by members according to applicable State of Missouri and federal statutes, regulations, contracts and policies. Members can file grievances in regard to any aspect of service including those related to cultural sensitivity or sexual harassment. In no instance will a member be subject to any punitive action, including charges, for utilizing the grievance and appeal process.

A grievance is an expression of dissatisfaction about any matter other than an action as defined above⁷⁴. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights.

An appeal is a request for review of an action⁷⁵.

9.4 MEMBER GRIEVANCE PROCEDURE:

All grievances directed at a provider for the following issues related to the office / location are reported to Missouri Care's Provider Relations Department: physical accessibility, physical appearance, adequacy of waiting / examination room space, availability of appointments, adequacy of treatment record keeping. Any such grievance will be followed by a site visit to the provider's office for review.⁷⁶ An action plan will be implemented if deficiencies are noted.

⁷² RFP 2.17.2.b.5

⁷³ RFP 2.15.6.n

⁷⁴ RFP 2.15.1

⁷⁵ RFP 2.15.1

⁷⁶ See NCQA CR6, A-1

- A member may file a grievance either verbally or in writing⁷⁷.
- All grievances will be acknowledged in writing within ten (10) business days of filing⁷⁸.
- Written notification of the disposition of the grievance will not exceed thirty (30) calendar days from the filing date or as expeditiously as the member's health condition requires⁷⁹.

9.5 MEMBER APPEAL PROCEDURE

- A member may file an appeal and may request a State fair hearing within 90 calendar days from the date on the health plan's notice of action. With the member's written consent, a provider may file an appeal on behalf of a member⁸⁰.
- A member may file an appeal either verbally or in writing. Verbal requests must be followed by a written, signed appeal, unless expedited review is requested⁸¹. For expedited appeals, providers may act as the member's authorized representative without written consent by the member.
- All appeals will be acknowledged in writing within ten (10) business days after receiving the appeal⁸².
- The timeframe for resolution of the appeal and written notification of the resolution will not exceed 45 calendar days from the date of the receipt of the appeal or will be as expeditious as the member's health condition requires⁸³.

9.6 FRAUD AND ABUSE

Fraud and Abuse

Missouri Care is committed to promoting integrity and ethical behavior. As part of its compliance program activities, we encourage every practitioner, provider and member to report any suspected cases of MO HealthNet fraud or abuse to Missouri Care. Please note the following definitions of fraud and abuse:

- FRAUD - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 CFR § 455.2]

⁷⁷ RFP 2.15.5.a

⁷⁸ RFP 2.15.5.c

⁷⁹ FRP 2.15.5.e

⁸⁰ RFP 2.15.6.a

⁸¹ RFP 2.15.6.b

⁸² RFP 2.15.6.e

⁸³ RFP 2.15.6.k

- ABUSE - means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the MO HealthNet program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the MO HealthNet program. [42 CFR § 455.2]

Fraud and Abuse Involving Members

- Through its Member Handbook, Missouri Care instructs members to safeguard their Medicaid identification cards as they would any other private and personal identification information, such as a driver's license or checkbook.
- If a provider has any concerns regarding a member's enrollment with Missouri Care when he/she presents for non-emergent or non-urgent services, 1) ask for another form of identification, preferably one with a photograph, 2) use the Interactive Voice Response (IVR) System at [573-635-8908](tel:573-635-8908) to confirm enrollment, or 3) contact the Missouri Care Member Services Department for verification.

Fraud and Abuse Involving Practitioners or Providers

- If a provider believes they have information about potential fraud and abuse by a practitioner or provider, such as inappropriate billing, inappropriate denial, or delivery of services, please notify either the Missouri Care Compliance Officer or the Division of Medical Services using the contact information listed below.

Reporting Fraud and Abuse

To report fraud and abuse, please contact the Missouri Care Compliance Officer at (573) 441-2100 or 1 (800) 322-6027. Information about fraud and abuse can be reported to:

Missouri Care Health Plan
Attn: Compliance Officer
2404 Forum Boulevard
Columbia, MO 65203

Please report any incidents involving non-Missouri Care members to the Division of Medical Services Provider Communications unit at (573) 751-2896.

All information provided to Missouri Care regarding a potential fraud and abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions of Missouri Care compliance program policies and procedures. Any information developed, obtained or shared among participants

in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns you may have regarding confidentiality should be addressed to the attention of the Missouri Care Compliance Officer.

Missouri Care takes compliance seriously and appreciates your cooperation in helping us detect, report and prevent fraud and abuse.

Provider Responsibilities:

- Report fraud and abuse to the Missouri Care Compliance Officer at (573) 441-2100 or (800) 322-6027.
- Report any incidents involving non-Missouri Care members to the Division of Medical Services Provider Communications unit at (573) 751-2896.

9.7 COORDINATION AND COOPERATION WITH GOVERNMENTAL AGENCIES

Missouri Care and its subcontractors shall cooperate fully with DMS and other governmental agencies in their efforts to prevent, detect, review and report potential fraud and abuse incidents by employees, providers, subcontractors, agents and members relating to the services coordinated by and administration of the MC+ managed care program. Missouri Care's fraud and abuse activities will be coordinated with these agencies to the maximum extent practicable.

9.8 GOVERNING SOURCES

- MO HealthNet RFP # **B3Z09135**, Section 2.32
- Social Security Act Section 1903 (q)
- 42 CFR Sections 455.10-455.23 and 1007.5-1007.11

SECTION 10 QUALITY MANAGEMENT (QM) PROGRAM

The Quality Program is a comprehensive program that outlines the monitoring, evaluation, and improvement Missouri Care undertakes in the realm of continuity, quality, safety, accessibility and availability of health care and services that are provided to Missouri Care's members.

Components of the QM Program are comprehensive in that it touches confidentiality, committee structure, quality management programs and staffing, credentialing, quality review of complaints, provider and member, monitoring of medical records, member services, provider and network services, health information systems, records management, data collection with analysis, as well as review and monitoring of clinical and medical operations.

Purpose and goals of the QM Program are defined as promotion and monitoring of cultural competency concerning members, providers, and employees; improvement in the quality of care by monitoring the service delivery system and provider network, written policies and procedures for quality assessment and analysis, and initiation of performance improvement projects to address trends noted through reviews of complaints, provider credentialing, prevention and wellness and utilization management.

Structure of the Quality Management Program is comprised of the QM Work Plan, QM Annual Evaluation, and the QM Oversight Bodies.

Quality Management (QM) Program operates under the leadership of the Chief Medical Officer (CMO). The purpose of the program is to assure a strong monitoring and evaluation process designed to focus on quality of care issues and serve as a part of an ongoing continuous quality improvement initiative. The CMO is responsible for directing, developing, and overseeing the quality programs established by Missouri Care. As an integrated model of behavioral and physical health, the CMO delegates the administration of the behavioral health quality components of the organization to the Behavioral Health Medical Director. The CMO also delegates the day to day operations of the quality program to the Quality and Accreditation Manager.

Health care delivery methods are monitored and evaluated to continuously improve and resolve identified MQM and quality improvement (QI) issues, ensuring compliance with all quality assessment and improvement procedural requirements of the MO HealthNet program.

Major components of the Program include:

- Adverse outcomes/quality issues
- Special medical practice studies
- Pharmacy/drug utilization
- Ancillary Provider review
- Review of Member/Provider internal Missouri Care and MC+ Program complaints related to delivery of care or service
- Physician office onsite medical record reviews and office evaluations
- Physician profiling
- Peer review
- Credentialing/Recredentialing Program
- Risk management
- EPSDT/maternal-child health
- MQM committee
- Women's health
- Member & Provider surveys

Medical Quality Management is a cooperative effort involving Missouri Care staff, Missouri Care health care professionals and Providers. If you would like further information on our Quality Management Program contact us at 1-800-322-6027.

10.1 CREDENTIALING

All contracted health professionals are required to be credentialed by Missouri Care in accordance with NCQA guidelines. Health professionals are responsible for completion of the standardized State Credential Form and Missouri Care's release of information form and for providing all supplemental documentation requested. Providers are recertified at least every three (3) years.

Completed initial Credential Forms are forwarded to Missouri Care's Medical Quality Management Department for internal processing. Completed, verified credentials are reviewed by the medical directors, the MQM Committee, and may be reviewed by the Quality Management Oversight Committee.

Missouri Care's policies and procedures include the right to:

- Review information submitted to support their credentialing application.
- Correct erroneous information.
- Receive the status of their credentialing or recertification application, upon request.
- Receive notification of these rights.⁸⁴

10.2 PROVIDER PROFILES

Missouri Care evaluates the practice patterns of contracted Providers through a review of claims and encounter data, pharmacy data, surveys, quality issues/adverse outcomes, medical record review, complaints and grievance activity. Data is used to create a profile of the Provider's practice patterns as compared to other Providers with the same specialty in similar geographic settings, with industry norms and plan experience. The Provider then receives feedback on a regular basis as to how he/she compares to other Providers within his/her specialty and geographic area, and how well they follow Missouri Care's managed care philosophy.

10.3 PEER REVIEW

The Missouri Care MQM Committee under the direction of the CMO conducts peer review activities. Health professionals who are reviewed and not satisfied with the results are provided an opportunity to appeal the MQM Committee's recommendation. If a decision is upheld following a peer-to-peer review, a formal appeal in writing may be submitted. Appeals may be submitted to the MQM Committee via a written request stating the reasons the Provider does not agree. The Provider may request to present his/her case in person at an MQM Committee meeting.

10.4 QUALITY MANAGEMENT COMMITTEES

The program's committee structure is comprised of the following committees:

- Quality Management Oversight Committee (QMOC)
 - Missouri Care Medical Quality Management Committee (MQM)
 - Missouri Care Service Improvement Committee (SIC)
 - Missouri Care Cultural Competency Committee (CCC)
 - Missouri Care Compliance Committee
 - Missouri Care Policy Committee
 - Delegation Oversight Committee (DOC)

Quality Management Oversight Committee

- The Quality Management Oversight Committee (QMOC), which is chaired by the CEO or designee, integrates quality management activities throughout the health plan and provider network. The QMOC provides executive oversight of quality activities across Missouri Care. All other committees report into the QMOC.

In this capacity, the committee will:

- Evaluate efforts to integrate quality management activities throughout the organization, including service and clinical issues;
- Review special cases (such as trends of complaints and specific grievance issues);
- Evaluate credentialing activities;
- Advise and submit to the CEO and the MQM Committee recommendations for needed follow-up actions when appropriate.

The committee reviews minutes and issues from the other quality committees each meeting, receives regular reports from all departments and committees and monitors the status of special projects.

The QMOC is made up of Missouri Care's management team which include. Missouri Care's CEO, CMO, CFO/COO, Director of Operations, Director of Health Services, Medical Management Managers; which include Case Management Manager and Utilization Management Manager, Accreditation and Quality Management Manager, Outreach and Member Advocacy Manager and Provider Relations. The QMOC committee meets on a quarterly basis. Minutes are recorded for all meetings and provided to the Missouri Care Operating Board for review.

Medical Quality Management Committee

The Medical Quality Management (MQM) Committee advises and makes recommendations to the Senior Medical Director and to the QMOC on matters pertaining to the quality of care and services provided to members. The committee is made up of a diverse body of providers from the Missouri Care network. The Committee uses the peer review process to evaluate and address specified care, service, or utilization issues arising from the activities of health care professionals or providers in order to improve the quality and appropriate utilization of health care available to members. The MQM committee also advised Missouri Care on HEDIS performance measure improvement initiatives and Performance Improvement Projects.

Service Improvement Committee (SIC)

The Service Improvement Committee (SIC) is designated to review comments and complaints related to access of care and quality of care issues in order to facilitate referrals to appropriate Missouri Care departments and subcontractors for proper action and resolution. The committee will also review the required quarterly cumulative complaint and grievance reports submitted to the State to ensure that all complaints and grievances have been acted on and resolved. Reports will be provided to the SIC by the departments or subcontractors assigned by the committee to investigate and develop action plans. The SIC will meet at least monthly and consist of representatives from Member Services, Medical Quality Management, and Provider Relations. Minutes of the meetings will be reported to the QMOC and any other appropriate committee.

Cultural Competency Committee

The Cultural Competency Committee meets quarterly. This committee advises & makes recommendations to the Quality Management Oversight Committee regarding community cultural competency & health issues, needs, partnerships, outreach activities as well as educating network practitioners & internal staff w/ regards to cultural & linguistic needs of its membership.

Compliance Committee

The Missouri Care Compliance and Privacy Committee meet in conjunction with the QMOC, and is comprised of the same voting members of the QMOC. During these meetings, Compliance issues are discussed that include, but are not limited to, policies and procedures, state notifications, state reporting requirements, and fraud and abuse; privacy issues include member requests and possible HIPAA disclosures or other issues.

Policy Committee

The Policy Committee meets at least ten times per year. The Policy Committee is a subcommittee of Quality Management Oversight Committee and provides a forum for consistent development, review, implementation, approval & communication of policies

Delegation Oversight Committee

The Delegation Oversight Committee advises & makes recommendations to the Quality Management Oversight Committee & health plan management about issues related to delegated entities.

- Key responsibilities of this committee include:
- Reviewing adherence to RFP & NCQA required standards
- Reviewing UM structure, QI plans, and appeal administration
- Performing quarterly operations reviews
- Evaluating, reviewing, and analyzing reports
- Conducting audits and evaluations of policies and procedures
- Monitoring adequacy of provider network and credentialing policies
- Reviewing marketing practices and quality of members services
- Implementing Corrective Action Plans (CAPs) as necessary

SECTION 11 GLOSSARY OF TERMS

AFDC - Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended - a mandatory Medicaid population.

Ancillary and Allied Provider Services - refers to supplemental health care services such as; pharmacy, home health, dental, vision, medical supplies, durable medical equipment, transportation, laboratory.

Appeal - The formal mechanism which allows a member or a Provider the right to question a grievance decision.

Authorization - An administrative procedure whereby Missouri Care gives approval of medical services rendered to members, such as outpatient procedures, hospitalization, referrals to a physician specialist, etc.

Auto Assignment - An automated method of enrolling MO HealthNet eligible persons with a health plan.

Billed Charges - Charges billed by a Provider rendering service to a Missouri Care member.

Board Certified - A physician who has successfully completed a required residency in an approved training facility, meets the experience requirements and has passed the examination of the respective board.

Capitation Payment - refers to a predetermined periodic payment, based upon the number of assigned members, paid to a Contracted Provider by Missouri Care for providing Covered Services for a specific period.

Clean Claim - Refers to a claim that may be processed without obtaining additional information from the Provider of service or from a third party.

Complaint - A verbal or written expression by a member or Provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. All complaints will be logged whether received by phone, in person or in writing.

Concurrent Review - A type of patient/medical care evaluation study performed while a patient is still hospitalized, that may involve process or intermediate outcome criteria and regular data collection.

Contract - Refers to the present and future Agreement between Missouri Care and the State of Missouri for the purpose of providing health care services under the MC+ Program.

Contractor - Refers to Missouri Care

Co-Payment - Refers to a monetary amount, specified by the State Agency, which the member may be responsible to pay directly to the participating health Provider at the time Covered Services are provided.

Covered Services - Refers to those specific services and goods available to members pursuant to the Missouri MC+ program, statute, and rules and regulations, the Provider contract, Missouri Care medical policies and procedures, and the Provider Manual.

CQI - Continuous Quality Improvement

C-STAR - Comprehensive Substance Abuse and Rehabilitation Programs.

Discharge Planning - Identification of the need and provision for a member's health care requirements after discharge from the hospital.

Disenrollment - The discontinuance of a member's entitlement to receive Covered Services from a Contractor. The member's name is deleted from the approved list of members furnished by the State to the Contractor.

DME - Durable Medical Equipment - includes wheelchairs, oxygen equipment, hospital beds, walkers, etc.

Elective - Usually refers to medical procedures, particularly surgery, not immediately necessary to maintain life or health – procedures, which can often be scheduled weeks or months in advance.

Emergency Dental Services - Those services and operational procedures required to eliminate acute infection, prevent pulpal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

Emergency Medical Services - Refers to those health care services and/or goods provided or required to evaluate and treat an unexpected onset of a medical or mental health condition that manifests itself by acute symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of health and medicine, to believe that immediate medical care is required for such condition which may include, but shall not be limited to:

- A. Placing the member's physical or mental health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- B. serious impairment to a bodily function; or
- C. serious dysfunction of any body organ or part; or
- D. serious harm to a member or others due to an alcohol or drug abuse emergency; or
- E. injury to member or bodily harm to others; or
- F. with respect to a pregnant member who is having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the member or the unborn.

Encounter - A record of medical services provided to a member.

Enrollment - The process by which a person who has been determined eligible becomes a member in a contractor's plan under the Missouri MC+ program. During the enrollment process, the person often has more than one plan from which to choose.

EPSDT Services - Providers are required to participate in the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Program (see also "HCY") for all assigned members under the age of twenty-one (21) years in accordance with the EPSDT Periodicity schedule. Please refer to your EPSDT Provider Manual for more details.

Fee-For-Service Payment (FFS) - Refers to a payment to a Provider by Missouri Care for certain Covered Services that is the lower of the Provider billed and usual charge or Missouri Care's fee schedule.

FQHC/RHC - Federally Qualified Health Centers/Rural Health Centers

Grievance - A written request for further review of a member's or a Provider's complaint that remains unresolved after completion of the complaint process.

HCY - Healthy Children and Youth Program which provides EPSDT services to individuals under the age of twenty-one (21).

HIPAA – The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), as codified at 42 U.S.C. §§ 1320d through 1320d-8 and as further delineated in regulations within Parts 142, 160 and 164 of 45 C.F.R. The Administrative Simplification provisions under HIPAA impose standards for the electronic exchange and protection of private health information to make financial and administrative healthcare transactions more efficient and secure. "HIPAA Privacy Standards" means the portion of HIPAA that covers standards for the privacy of individually identifiable health information. "HIPAA Transaction Standards" means the portion of HIPAA that covers standards for electronic transactions and code sets. "HIPAA Identifier Standards" means the portion of HIPAA that covers national standard identifiers for health care providers, health plans, employers and individuals (if any). "HIPAA Security Standards" means the portion of HIPAA that covers security and electronic signature standards.

Home Health Care (Home Health Services) - Medical care services provided in the home, often by a visiting nurse, usually for patients with chronic disease or disability, recovering patients, or aged homebound patients.

Hospital - A health care institution which is:

- a. Licensed by the State of Missouri as a hospital, and
- b. certified as a provider under Title XVIII of the Social Security Act, as
- c. amended, or is currently determined to meet the requirements of such certification.

Inpatient - A patient admitted to an overnight medical facility such as a hospital.

Inquiry - A request from a member or Provider for information that would clarify health plan policy benefits, procedures, or any aspect of health plan function that may be in question. Inquiries will be investigated to validate the possibility of an inquiry actually being a complaint.

Length Of Stay - The number of days a patient is an inpatient, per episode. The length of time a patient is hospitalized. Total number of days for which a patient is hospitalized, either totally or in a particular unit or level of care; abbreviated as LOS.

Local Health Agencies - Administer public health programs that provide “core services” such as immunizations, family planning, and screening, diagnosis, and treatment for sexually transmitted disease, HIV, tuberculosis, and lead poisoning. These services will be reimbursed by Missouri Care.

MC+ for Adults – Health care coverage that has been extended to low-income parents who do not have access to health insurance.

MC+ for Kids – Missouri’s health insurance program for uninsured children. Part of the federal Children’s Health Insurance Program, is a health insurance program for low-income families who do not have access to affordable health insurance.

Medicaid - A federal/state program under Title XIX of the Social Security Act providing federal matching grants, at State's option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and the medically indigent. Certain minimal programs and services must be included to receive federal matching funds, however, states may optionally include any additional services at state expense.

Medical Director - Refers to a Missouri-licensed physician who is designated by Missouri Care to have overall administrative responsibility for the direction of Missouri Care’s medical delivery system.

Medically Necessary - Refers to those Covered Services provided or furnished, which:

- A. are reasonably and clinically required for the diagnosis or treatment of illness or injury to improve the function of a malformed body member or to minimize the progression of disability; and
- B. could not have been omitted without adversely affecting the member’s
- C. condition or the quality of medical care rendered; and
- D. are furnished in accordance with accepted standards of practice in the medical community of the area in which health services are rendered; and
- E. are furnished in the most appropriate setting

Medically Necessary behavioral health services - refers to those Covered Services:

- A. which have been determined to be appropriate by process of behavioral health assessment that determines the clinical condition of the member and;
- B. meet acceptable standards of practice for such clinical conditions among the community of qualified mental health and substance abuse Providers of the area in which services are provided.

Medically Necessary Dentures - Partial or full dentures and services that are determined to be the primary treatment of choice or an essential part of an overall treatment plan designed to alleviate a medical condition as determined by the Primary Care Provider in consultation with a dentist.

Medicare - A federal program under Title XVIII of the Social Security Act which provides health insurance for persons age sixty-five (65) and older and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

Member - Refers to an individual who has been determined MC+ eligible and enrolled with Missouri Care to receive services.

MO HealthNet - Missouri Medicaid program

NCQA - National Committee for Quality Assurance - an independent external review association for health care quality management.

Non-Participating (non-PAR) Provider-A provider that does not have an executed contract or agreement with Missouri Care.

NPI - National Provider Indicator – a standard, unique identifier for all health care providers.

Occupational Therapy - Medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

Out-Of-Area-Care - Care received by a Missouri Care enrollee when they are outside of their geographic territory.

Outpatient - A member who goes to a licensed health care institution or a facility for care and services, but who does not occupy an inpatient bed.

Participating Health Professionals (PHP) - Refers to those Primary Care Providers, Provider specialists, medical facilities, allied health professionals and ancillary service Providers, under contract with Missouri Care to provide specific Covered Services to members, and represent those individuals and entities to be utilized through the Missouri Care Prior Authorization and Referral Policies and Procedures.

PCO - Primary Care Obstetrician - a physician, nurse practitioner, or certified nurse midwife, licensed to practice in the field of obstetrics/gynecology, which provides obstetrical and primary care to assigned pregnant members during the course of the pregnancy and sixty (60) days postpartum.

PCP - Primary Care Provider - is a Provider who serves as the gatekeeper to supervise, coordinate and provide initial, primary and preventive care to members, initiate referrals for specialty care, follow specialty care and maintain continuity of care. May be a: a) licensed resident specializing in family and general practice, pediatrics, or internal medicine; b) registered nurse who is an advanced practice nurse specializing in family and general practice, pediatrics, or internal medicine; or c) licensed physician in the following specialty: family and general practice, pediatrics, or internal medicine.

Pharmaceutical Services - Medically Necessary drugs prescribed by a Primary Care Provider or other Provider or dentist upon referral by a Primary Care Provider and dispensed in accordance with Missouri Law.

Physician Services - Services provided within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of an individual licensed under State law to practice allopathic medicine or osteopathy.

Preventive Health Care - Those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

Prior Authorization - a unit under the direction of the Medical/Quality Management Department, which is an essential component of any managed care organization. Prior Authorization is the process where health care Providers seek approval prior to rendering specific services as required by Missouri Care policy.

Provider - generally used to identify physicians, hospitals, etc., who provide medical services to Missouri Care members.

Provider Manual - the collection of policies and procedures, as revised from time to time, that may be established and communicate to PHP by Missouri Care including without limitation credentialing, prior authorization, utilization review, quality management programs and administrative and grievance procedures. Missouri Care may revise the Provider Manual by issuing updates, provider newsletters, or bulletins.

Provider Network – all of Missouri Care’s Participating Health Providers.

PSP - Participating specialist physician

Quality Management (QM) - A methodology used by professional health personnel that reviews the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Records - refers to a medical record and other reports, documents or statements relating to the delivery of services under the MC+ program, e.g., financial statements, prescription files, statistical reports

Retrospective Review – To look over after the fact. Used often with respect to utilization management - as with retrospective review and approval or denial of emergency room use.

SAFE-CARE - Sexual Assault Forensic Examination (SAFE) and Child Abuse Resource Education (CARE) exams. These exams are reimbursed by the State on a fee-for-service basis to Providers certified by the Missouri Department of Health to perform the exams.

Short Stay/Observation Unit - A clinical unit which provides Medically Necessary Covered Services to a member whose condition does not meet acute care criteria nor warrant an inpatient stay, yet, observation or other outpatient services are required.

SOBRA - refers to a special membership classification of pregnant women, mothers and babies, who are members of Missouri Care.

Specialist - A physician duly licensed in the State of Missouri and has completed a residency or fellowship in his/her specialty and has been approved to sit for the board examination for the specialty.

SSI - Supplemental Security Income under Title XVI of the Social Security Act, as amended.

TANF - Temporary Assistance for Needy Families (Transitional Medical Assistance.)

Third Party Recoveries - A general term applied to healthcare benefit payments. It derives from the fact that under normal market transactions, there are only two (2) parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, an employer etc.) is ultimately responsible to pay the costs of services provided to covered person.

Title XIX - Section of Social Security Act which describes the Medicaid program's coverage for eligible persons

Uninsured – To be considered uninsured, a child must have been without access to health care insurance for six (6) months prior to application to Medicaid. Adults may apply if they had not had health insurance for six (6) months. If they dropped health insurance, they must wait for six (6) months after dropping the insurance to apply for the MC+ program unless they lost a job but did not quit the job; got a new job that does not have insurance; or COBRA insurance ends.

Utilization Management (Utilization Review, Utilization Control) - Systematic means for reviewing and controlling members' use of medical care services, and Providers' use of medical care resources. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use and particularly costly services such as hospitalization. System of review conducted by professional health personnel, of the appropriateness, quality of and need for health care services rendered to patients covered by Medicare or other third party payers, including MC+.

WIC - Women, Infants and Children Supplemental Food Program.

Attachment A

 Missouri Care [™] AN AETNA HEALTH PLAN										
<p>NAME JOHN SMITH HEALTH INS. ID# 222666726 BIRTHDATE 12/12/1992 SEX MALE PCP KATHLEEN DORSLEY PCP PHONE# 480-555-1212</p>	<p>Member Services: 1-800-322-6027</p> <p><i>See reverse side before you get care. This card is issued for identification purposes only and is not a guarantee of eligibility, enrollment or payment.</i></p>									
<p>MEMBERS: In an emergency, call 911 or go to the nearest hospital.</p> <p>HOSPITALS/PHYSICIANS/OTHER PROVIDERS:</p> <table><tr><td>• <i>Member Services</i> 1-800-322-6027</td><td>• <i>Prior Authorization</i> 1-800-322-6027</td><td>• <i>Pharmacy Services</i> 1-800-392-2161</td></tr><tr><td>• <i>Behavioral Health Services</i> 1-800-889-4073</td><td>• <i>Case Management</i> 1-800-322-6027</td><td>• <i>Dental Services</i> 1-888-696-9533</td></tr><tr><td>• <i>Behavioral Health Crisis Line</i> 1-800-889-4073</td><td>• <i>Nurse Advice Line</i> 1-800-556-1555</td><td>• <i>Transportation</i> 1-800-695-5791</td></tr></table> <p><i>Benefits may be limited based on your eligibility group.</i></p> <p>SUBMIT CLAIMS TO: Missouri Care Claims Submission P.O. Box 61625 Phoenix, AZ 85082-1625</p> <p> Missouri Care[™] AN AETNA HEALTH PLAN</p>		• <i>Member Services</i> 1-800-322-6027	• <i>Prior Authorization</i> 1-800-322-6027	• <i>Pharmacy Services</i> 1-800-392-2161	• <i>Behavioral Health Services</i> 1-800-889-4073	• <i>Case Management</i> 1-800-322-6027	• <i>Dental Services</i> 1-888-696-9533	• <i>Behavioral Health Crisis Line</i> 1-800-889-4073	• <i>Nurse Advice Line</i> 1-800-556-1555	• <i>Transportation</i> 1-800-695-5791
• <i>Member Services</i> 1-800-322-6027	• <i>Prior Authorization</i> 1-800-322-6027	• <i>Pharmacy Services</i> 1-800-392-2161								
• <i>Behavioral Health Services</i> 1-800-889-4073	• <i>Case Management</i> 1-800-322-6027	• <i>Dental Services</i> 1-888-696-9533								
• <i>Behavioral Health Crisis Line</i> 1-800-889-4073	• <i>Nurse Advice Line</i> 1-800-556-1555	• <i>Transportation</i> 1-800-695-5791								
<p>CARRY THIS CARD WITH YOU AT ALL TIMES</p>										

Attachment B



Continuation of Care Form

Date of Request: _____

This form is used to request ongoing care from your provider. Your provider is no longer working with Missouri Care. You may keep your provider if you are:

- receiving care for an active stage of an illness or a serious medical condition, or
- in your second or third trimester of pregnancy

1. Please fill out page one (for you).
2. The second page is for your provider to fill out.
3. Bring both pages of this form to your provider.
4. Ask your provider to fill out the second page. Send in both pages to Missouri Care.

Please fill out the following:

ID Number:		
Name:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		Phone Number:
City/State/Zip:		
PCP Name:		Specialist Name:
PCP Phone:		Specialist Phone:
Medical Conditions (list all):		
1. List all surgeries you have had in the past six months		
Surgery:	Provider:	Date:
2. List all surgeries that you plan to have in the next six months		
Surgery:	Provider:	Date:
3. Have you visited an ER in the past six months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for Visit:	Name of Hospital:	Date:
4. Do you have any Specialist visits planned in the next six months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Specialist Name:	Reason for visit:	Date of appointment:
5. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Due Date:	OB Name:	OB Phone:
6. Are you currently receiving behavioral health or alcohol and drug abuse services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Provider Name:	Provider Phone:	Date of next visit:
7. Are you currently receiving any of the following services? (Mark all that apply and enter provider name/phone)		
<input type="checkbox"/> Home Health Nursing <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Case Management <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy		
Provider Name:		Phone:
Provider Name:		Phone:

8. Are you currently using any of the following equipment or supplies? (Mark all that apply and enter provider name/phone)	
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Oxygen <input type="checkbox"/> Nebulizer <input type="checkbox"/> IV/Feeding pump <input type="checkbox"/> IV/Feeding Tubes <input type="checkbox"/> Ostomy supplies <input type="checkbox"/> Catheter <input type="checkbox"/> Other _____	
Provider Name: _____	Phone: _____

Your patient is requesting continuity of treatment with you despite discontinuation of your contract for either:

- A) an active course of treatment for an acute episode of chronic illness or an acute medical condition, or
- B) second or third trimester pregnancy despite discontinuation of your contract.

Please enter the requested information below and fax back to Missouri Care Prior Authorizations **866-946-2052**.

By submission of this document you acknowledge and accept:

- A) The reimbursement rate of 100% of the Medicaid fee schedule.
- B) Provider shall accept payment from Missouri Care as payment in full (no balance billing) and shall not collect payment from Members except for:
 - 1) Applicable MO HealthNet cost sharing amounts; and
 - 2) When services are not in the comprehensive benefit package and, prior to providing the services, Provider informed the Member that the services were not covered. Provider shall inform the Member of the non-covered service and have the member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing (a private pay agreement) prior to rendering the service. Regardless of any understanding worked out between Provider and the Member about private payment, once Provider bills Missouri Care for the service that has been provided, the prior arrangement with the Member becomes null and void.

A Missouri Care medical director will review this request and you will be notified promptly after a determination is made.

Requesting Provider:		Contact Person:	
Address:		Phone:	Fax:
Date of Appointment/Service:		Number of Visits Required:	
Problem/Diagnosis (ICD-9 Code(s) Required *see below):			
Service(s) Requested (CPT Code(s) Required *see below):			
Clinical Rationale (Please attach Clinical Notes, Lab reports, X-ray reports, etc.):			
Justification of why this cannot be done by a Missouri Care participating provider:			
Signature of Requesting Provider:		Date:	

***NOTE: FAILURE TO INCLUDE CORRECT CPT AND ICD-9 CODES WILL RESULT IN DENIAL OF REQUESTED SERVICES**

PLEASE SEND COMPLETED FORM TO:
Missouri Care Health Plan
2404 Forum Blvd.
Columbia, MO. 65203
Fax 866-946-2052

Attachment C



PREGNANCY RISK SCREENING AND NOTIFICATION

Name: First _____ Middle _____ Last _____	
DCN or Temp #: _____ Birthdate: month _____ day _____ year _____	
Address: Street _____ Apt _____ City _____ State _____ Zip Code _____	
Telephone: () _____ Alternative Telephone: () _____ County _____	
Current Martial Status: Single__ Married__ Widowed__ Divorced__ Separated__	
Ethnicity: Hispanic__ Non-Hispanic__	
Race: Black__ White__ Am. Indian__ Hawaiian Pacific Islander__ Asian__ Other _____	
English as a second language: Yes__ No__ Language(s) Spoken _____	
Interpreter needed Yes__ No__ Deaf/Hard of Hearing: Yes__ No__	
Interpreter needed: Yes__ No__	
Gravida _____ Para _____ Aborta _____ Anticipated Delivery: Vaginal__ C-Section__ VBAC__	
LMP: month__ day__ year__ EDC: month__ day__ year__ 1 st Prenatal Visit: month__ day__ year__	
Anticipated Delivering Hospital: _____ Anticipated Delivering City: _____	
Check all risk factors below that apply/Circle if current/history-client/partner (Any risk checked qualifies client for prenatal case management)	
1. Pre-pregnant weight <100 lb	13. Preterm Labor – history/current
2. Pre-pregnant weight >200 lbs	14. Previous C-section
3. Diabetes Gestational Type 1 Type 2	15. Previous Fetal Death/Stillborn (20 wks or >)
4. Vaginosis-history/current Syphilis-history/current	16. Previous Infant Death
Gonorrhea-history/current Chlamydia-history/current	17. Prior Low Birthweight infant(<2500 gms)
5. HIV	18. Smoking-history/current
6. Hepatitis B-history/current	19. Domestic Violence-history/current
7. Hepatitis C-history/current	20. Alcohol use-client/partner
8. Hypertension, Hx of 140/90 or >	21. Drug use-client/partner
9. Pregnancy Induced Hypertension	22. Mental Illness-history/current
10. Incompetent cervix or cerclage	23. Lack of family/friends who provide support
11. Interconceptional Spacing < 1 year	24. Homeless
12. Multiple gestation- history/current	25. Other (must be prior authorized by DHSS)
(Fee for Service Providers only)	
Other medical or social concerns _____	
Did the provider counsel on smoking? Yes__ No__	Was client directed to smoking cessation resource? Yes__ No__
Did the provider counsel on alcohol use? Yes__ No__	Was client directed to alcohol/substance abuse resource? Yes__ No__
Did the provider counsel on substance use? Yes__ No__	Was client directed to domestic violence resource? Yes__ No__
Enrolled in WIC @ time of risk screening? Yes__ No__	Was client directed to WIC? Yes__ No__
Blood test for lead level performed? Yes__ No__	
Authorization Number: _____	
Notify Health Plan of new medical risks identified during pregnancy _____	
Provider Name: _____	
Provider Phone: _____	
Provider Fax #: _____	
Performing Provider #: _____	
Name of person completing form: _____ Title: _____ Date: _____	
<i>Providers must notify Missouri Care of all members receiving prenatal care by completing and faxing this form within two (2) business days of the initial prenatal visit. Once the completed form is received by Missouri Care an authorization number for global obstetrical care will be faxed to the provider. The authorization number is required for your reimbursement.</i>	
Fax to Missouri Care Health Plan @ (866) 946-2052	

Updated 10-30-08

Attachment D



**MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
CONSENT FORM**

MO-8612

NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

CONSENT TO STERILIZATION	STATEMENT OF PERSON OBTAINING CONSENT
--------------------------	---------------------------------------

I have asked for and received information about sterilization from _____ (DOCTOR OR CLINIC). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____.

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ MONTH DAY YEAR. I, _____, hereby consent of my own free will to be sterilized by _____ (DOCTOR) by a method called _____ (DOCTOR). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

SIGNATURE _____ DATE (MONTH, DAY, YEAR) _____

You are requested to supply the following information, but it is not required:

- RACE AND ETHNICITY DESIGNATION (PLEASE CHECK)
- AMERICAN INDIAN OR ALASKA NATIVE ASIAN OR PACIFIC ISLANDER
- BLACK (NOT OF HISPANIC ORIGIN) HISPANIC
- WHITE (NOT OF HISPANIC ORIGIN)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

INTERPRETER _____ DATE (MONTH, DAY, YEAR) _____

Before _____ (NAME OF INDIVIDUAL) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that he/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

SIGNATURE OF PERSON OBTAINING CONSENT _____ DATE (MONTH, DAY, YEAR) _____

FACILITY _____

ADDRESS _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (NAME OF INDIVIDUAL) ON _____ (DATE OF STERILIZATION), I explained to him/her the nature of the sterilization operation _____ (SPECIFY TYPE OF OPERATION), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that he/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

PHYSICIAN _____ DATE _____

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- Premature delivery
- Individual's expected date of delivery:
- Emergency abdominal surgery:
- (describe circumstances): _____

PHYSICIAN _____ DATE _____

MO HEALTHNET PROVIDER IDENTIFIER _____ PROVIDER TAXONOMY CODE _____