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Section 1: Overview

About Missouri Care
Since 1998, Missouri Care, a WellCare Company, has worked with the MO HealthNet Division to improve member access to cost-effective, quality health care for eligible MO HealthNet participants in all MO HealthNet managed care counties in the state of Missouri. 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.

We offer integrated physical and behavioral health (including substance abuse) 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, are extremely successful in increasing access to care, improving clinical outcomes and reducing costs. We are proficient 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.

Missouri Care is accredited by the National Committee for Quality Assurance (NCQA), a private non-profit organization dedicated to improving health care quality.

About WellCare
WellCare Health Plans, Inc., (WellCare) provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans, health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. As of September 2013, WellCare served approximately 2.8 million members. Our experience and commitment to government-sponsored health care programs enable us to serve our members and providers as well as manage our operations effectively and efficiently.

Mission and Vision
WellCare’s vision is to be the leader in government-sponsored health care programs in partnership with the members, providers, governments and communities we serve. WellCare will:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Our Values are:

- Partnership – Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public’s resources and trust. We will deliver excellent service to our partners.
- Integrity – Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.
- Accountability – All associates must be responsible for the commitments we make and the results we deliver.
• **Teamwork** – With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.

**Purpose of this Manual**
This Provider Manual is intended for Missouri Care-contracted (participating) Medicaid providers providing health care service(s) to enrolled Missouri Care members. This manual serves as a guide to the policies and procedures governing the administration of Missouri Care’s Medicaid plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between Missouri Care and health care providers, who include, without limitation: physicians, hospitals and ancillary providers (collectively, providers). This manual replaces and supersedes any previous versions dated prior to July 1, 2014 and is available on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources). A paper copy, at no charge, may be obtained upon request by contacting Customer Service (Provider Services) or your Provider Relations representative.

In accordance with the Policies and Procedures clause of the Agreement, participating Missouri Care Medicaid providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to Missouri Care’s policies and procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other period of time as necessary for Missouri Care to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by Missouri Care in the form of Provider Bulletins and will be incorporated into subsequent versions of this manual. Provider Bulletins that are state-specific may override the policies and procedures in this manual.

Missouri Care provides additional information online via the *Quick Reference Guide*. The *Quick Reference Guide* is a document that lists important addresses, phone and fax numbers, and authorization requirements. The Missouri Care *Quick Reference Guide* is available on the website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

**Missouri Care’s Medicaid Managed Care Plans**
Missouri Care is a managed care organization contracted with the MO HealthNet Division (MHD) which offers products to MO HealthNet participants. These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area.

Missouri Care serves both adults and children eligible to participate in the MO HealthNet program. This plan offers members more benefits and coverage than traditional Medicaid at no additional cost. Members may choose their Primary Care Provider (PCP) from a network of participating providers, including family doctors, pediatricians and internists. Missouri Care members are not required to get a referral from their PCP before requesting care from a provider.

**Covered Services and Benefits**
- **Primary Care Providers** – We have a great selection of PCPs available.
- **Wide selection of specialists** – When you need a specialist, we recommend that the PCP coordinate care with one of many specialists.
- **Quality hospitals** – You can go to any hospital for emergency care, and our health care providers have access to a large number of hospitals.
- **Preventive care services** – Checkups and health screenings to keep you healthy.
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<th>Adults</th>
<th>Pregnant Women</th>
<th>Children</th>
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<tr>
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<tr>
<td>Hearing services (restrictions may apply)</td>
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<tr>
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<td>Kidney Dialysis and Transplants</td>
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<td>Covered by MO HealthNet Fee for Service</td>
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<td>Not covered</td>
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<td>Benefits</td>
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<tr>
<td>Therapy – Physical, Speech, Occupational</td>
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<td>Urgent Care Services (restrictions may apply)</td>
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<td>Vision Services (restrictions may apply)</td>
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**Expanded Benefits**

- Missouri Care knows how important it is for kids to have a safe place to go after school or to join a club to help them build character. We support this by covering the yearly membership cost for your choice of one of the following programs in your area:
  - **Boy Scouts** – The Boy Scouts help build character, train boys to be a better citizen and develop personal fitness.
  - **Girl Scouts** – The Girl Scouts build girls of courage, confidence and character who make the world a better place.
  - **4-H** – Kids in 4-H do well in schools and sciences and are committed to improving their communities.
  - **Boys & Girls Club** – The Boys & Girls Club is a safe place to learn and grow – all while having fun.
- Diabetes Camp – one of the best experiences for a child with diabetes. Kids can learn self-confidence while being with other kids who have diabetes. Best of all, they have a great time.
- Vision Camp – for kids ages 9–14 years who have vision issues. The day camp lets kids try a number of typical outdoor camp activities. Camp helps kids be independent. It also teaches social skills that help them be successful adults.
- Circumcisions – non-medically necessary during the first 28 days with prior authorization. After 28 days, medical necessity is required.
- Maternity support hose and support belts – maternity support hose and support belts are available to all pregnant women. No prior authorization is required.
- Childbirth and breastfeeding classes – members can attend childbirth and breastfeeding education classes at no cost to the member.
- Breast Pumps – Breast pumps are available to members with babies admitted to the NICU as a monthly rental. Prior authorization is required for electric pumps.
- Diabetic Foot Care – includes routine trimming of nails, corns and calluses for adult members with diabetes.
- Peak Flow Meters – includes peak flow meters to asthmatic members without prior authorization.
• Enhanced Transportation Service – includes transportation to WIC, childbirth or breast feeding classes, parents visiting hospitalized children, pharmacy to pick up prescriptions following a doctor appointment, methadone clinic, and transportation to behavioral health inpatient or residential facility for parents to participate in family therapy.

**Provider Services**
The Provider Relations team is responsible for provider education, recruitment, contracting, new provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®), and investigation of member complaints. The Provider Operations team is responsible for contract operations, collection of credentialing and re-credentialing documents and claims research and resolution.

Missouri Care offers an array of provider services that includes initial orientation and education, either one-on one or in a group setting, for all providers. These sessions are hosted by our Provider Relations representatives.

Provider Relations representatives are available to assist in many requests for participating Missouri Care providers. Contact your local market office for assistance or call the Provider Relations number located on your *Quick Reference Guide* to request a Provider Relations representative to contact you.

Providers may contact the appropriate departments at Missouri Care by referring to the *Quick Reference Guide* on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

**Website Resources**
Missouri Care’s website, [www.missouricare.com](http://www.missouricare.com), offers a variety of tools to assist providers and their staff.

Available resources include:

- Provider Manual;
- *Quick Reference Guide*;
- Clinical Practice Guidelines;
- Clinical Coverage Guidelines;
- Provider lookup (directory);
- Authorization lookup tool;
- Training materials and guides or job aids;
- Newsletters;
- Member rights and responsibilities;
- Privacy statement and notice of privacy practices; and
- Additional forms and documents.

**Secure Provider Portal – Benefits of Registering**
Our secure Provider Portal offers immediate access to an assortment of useful online tools.

Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All providers who create a login and password using their assigned Missouri Care Provider Identification (Provider ID) number have access to the following features:
• **Claims submission status and inquiry:** Submit a new claim, check the status of an existing claim, and customize and download reports.

• **Member eligibility and co-payment information:** Verify member eligibility and obtain specific co-payment information.

• **Authorization requests:** Submit authorization requests, attach clinical documentation and check authorization status. You can also print and/or save copies of authorization forms.

• **Training:** Take required training courses and complete attestations online.

• **Reports:** Access reports such as active member rosters, authorization status, claims status, eligibility status, and more.

• **Provider news:** View the latest important announcements and updates.

• **Personal inbox:** Receive notices and key reports regarding your claims, eligibility inquiries and authorization requests.

**How to Register**
Visit [www.missouricare.com/registration/provider](http://www.missouricare.com/registration/provider) and follow the prompts. For additional details, please refer to the *Website Capabilities Guide* found on Missouri Care’s website at [www.missouricare.com/provider](http://www.missouricare.com/provider).

After registering for Missouri Care’s website, providers should retain login and password information for future reference.

For more information about Missouri Care’s web capabilities, please contact Provider Services at 1-800-322-6027 or your Provider Relations representative.

**Additional Resources**
The Provider Resource Guide also contains information about the secure online Provider Portal, member eligibility, authorizations, filing paper and electronic claims, appeals and more. *The Resource Guide* is available on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

Another valuable resource is the *Quick Reference Guide*, which contains important addresses, phone/fax numbers and authorization requirements. The *Quick Reference Guide* is available on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Guidelines

Overview
This section is an overview of guidelines for which all participating Missouri Care Medicaid Managed Care providers are accountable. Please refer to the Provider Participation Agreement (Agreement) or contact your Provider Relations representative for clarification of any of the following.

Participating Missouri Care Medicaid providers, must in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with Missouri Care in its efforts to monitor compliance with its Medicaid contract(s) and/or MO HealthNet Division (MHD) rules and regulations, and assist Missouri Care in complying with corrective action plans necessary for Missouri Care to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to Missouri Care members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii).];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of MHD and Missouri Care guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender title (examples: MD, DO, ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any member in need of health care services;
- Maintain the confidentiality of member information and records;
- Allow Missouri Care to use provider performance data;
- Respond promptly to Missouri Care’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all Missouri Care’s policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Ensure that: (a) all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between provider and Missouri Care; (b) to the extent the physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and (c) the physician maintains
written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state, and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Missouri Care, the member, or the requesting party at no charge, unless otherwise agreed;
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical and medication regimen;
- Not discriminate in any manner between Missouri Care Medicaid members and non-Missouri Care Medicaid members;
- Ensure that the hours of operation offered to Missouri Care members is no less than those offered to commercial members;
- Not deny, limit or condition the furnishing of treatment to any Missouri Care member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on member's behalf for member's health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify members who are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to Missouri Care-sponsored or community-based programs; and
- Document the referral to Missouri Care-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

**Excluded or Prohibited Services**

Providers must verify patient eligibility and enrollment prior to service delivery. Missouri Care is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as non-emergency transportation, are coordinated by Missouri Care although administered outside of the managed care program.

Excluded services are defined as those services that are not considered covered benefits under the MO HealthNet program, and for which Missouri Care is not financially responsible. Providers are required to determine eligibility and covered services prior to rendering services.
Responsibilities of All Providers
The following is a summary of responsibilities specific to all providers who render services to Missouri Care members. These are intended to supplement the terms of the Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

Provider Identifiers
All participating providers are required to have a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims.

Living Will and Advance Directive
Members have the right to control decisions related to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states. Providers must comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care hospices, and HMOs specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each Missouri Care member (age 18 years or older and of sound mind), should receive information regarding living will and advance directives. This allows them to designate another person to make a health care decision should they become mentally or physically unable to do so. Missouri Care provides information on advance directives in the Member Manual.

Information regarding living will and advance directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members’ medical records.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

The above shall not be construed to prohibit the application of any Missouri law which allows for an objection on the basis of conscience for any provider or agent of such provider.

Provider Billing and Address Changes
We rely on our provider network to advise of changes so we can keep our provider information current. Out-of-date provider information causes our provider directory information to be incorrect and can result in claim denials or incorrect payments if the provider information in our system does not match what is submitted on claims.

Prior written notice of the following changes is required:

- 1099 mailing address;
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address;
- Telephone and fax number; and/or
- Panel changes.

30-day advance notice is recommended. Please see our provider newsletters for fax #, email, and physical address that should be used to submit your changes.
Provider Termination
In addition to the provider termination information included in the Agreement, you must adhere to the following terms:

- Any contracted provider must give at least 90 days prior written notice to Missouri Care before terminating your relationship with Missouri Care “without cause,” unless otherwise agreed to in writing. This ensures that adequate notice may be given to Missouri Care members regarding your participation status with Missouri Care. Please refer to your Agreement for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above;
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month; and
- Members in active treatment may continue care when such care is medically necessary, through the completion of treatment of a condition for which the member was receiving at the time of the termination or until the member selects another treating provider, not to exceed 90 days after the provider termination.

Please refer to Section 6: Credentialing of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

Note: Missouri Care will notify, in writing, all appropriate agencies and/or members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary provider within the service area except under the following circumstances:

- A provider becomes physically unable to care for members due to illness;
- The provider is deceased;
- The provider moves outside of the service area and fails to notify Missouri Care; or
- The provider fails credentialing.

Out-of-Area Member Transfers
Providers should assist Missouri Care in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Missouri Care provider and the out-of-network attending physician/provider.

Members with Special Health Care Needs
Individuals with Special Health Care Needs (ISHCN) include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care;
- Related populations eligible for SSI; or
- Individuals who, without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:
  - Individuals with Autism Spectrum Disorder;
• Individuals in foster care or other out-of-home placement;
• Individuals receiving foster care or adoption subsidy; and
• Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the State agency in terms of either program participant or special health care needs.

The following is a summary of responsibilities specific to providers who render services to Missouri Care members who have been identified with special health care needs:

- Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
- Coordinate treatment plans with members, family and/or specialists caring for members;
- Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members’ conditions or needs;
- Coordinate with Missouri Care, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
- Coordinate services with other third party organizations to prevent duplication of services and share results on identification and assessment of the member’s needs; and
- Ensure the member’s privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for ISHCN, refer to Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM).
Access Standards
Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member’s needs. Missouri Care shall monitor providers against these standards to ensure members can obtain needed health services within the acceptable appointment types and in-office waiting times. Providers not in compliance with these standards will be required to implement corrective actions set forth by Missouri Care.

<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>APPOINTMENT TYPE</th>
<th>ACCESS STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Medical - Urgent Care</td>
<td>within 24 hours</td>
</tr>
<tr>
<td>Medical</td>
<td>Medical - Sick</td>
<td>within 7 calendar days or 5 business days (whichever is earlier)</td>
</tr>
<tr>
<td>Medical</td>
<td>Medical - Routine</td>
<td>within 30 calendar days</td>
</tr>
<tr>
<td>Behavioral Health/Substance Abuse</td>
<td>Follow-up to hospital discharge</td>
<td>within 7 calendar days</td>
</tr>
<tr>
<td>Maternity Care - Initial Prenatal Visit</td>
<td>1st trimester initial visit</td>
<td>within 7 calendar days</td>
</tr>
<tr>
<td>Maternity Care - Initial Prenatal Visit</td>
<td>2nd trimester initial visit</td>
<td>within 7 calendar days</td>
</tr>
<tr>
<td>Maternity Care - Initial Prenatal Visit</td>
<td>3rd trimester initial visit</td>
<td>within 3 calendar days</td>
</tr>
<tr>
<td>Maternity Care - Initial Prenatal Visit</td>
<td>High-Risk Pregnancy initial visit</td>
<td>within 3 calendar days</td>
</tr>
</tbody>
</table>

The average waiting times for appointments should not exceed one hour from scheduled appointment times. This includes time spent both in the lobby and in the room before provider examination.

Responsibilities of Primary Care Physicians (PCP)
The following is a summary of responsibilities specific to PCPs who render services to Missouri Care members. These are intended to supplement the terms of the Agreement, not replace them:

- Coordinate, monitor and supervise the delivery of primary care services to each member;
- See members for an initial office visit and assessment within the first 90 days of enrollment in Missouri Care;
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under the age of 21;
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance;
- Maintain continuity of each member’s health care;
- Make referrals for specialty care and other medically necessary services to both in-network and out-of-network providers;
- Work with health plan case managers in developing plans of care for members receiving case management services;
• Conduct a behavioral health screen to determine whether the member needs behavioral health services;
• Maintain a comprehensive, current medical record for the member, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.
• Provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, 7 days per week. To ensure accessibility and availability, PCPs must provide one of the following:
  o A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
  o An answering system with option to page the physician for a return call within a maximum of 20 minutes if urgent or one hour if non-emergent; or
  o An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes.
• Assure members are aware of the availability of public transportation where available;
• Provide access to Missouri Care or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
• Submit an encounter for each visit where the provider sees the member or the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to Section 5: Claims;
• Ensure members utilize network providers. If unable to locate a participating Missouri Care Medicaid provider for services required, contact Customer Services for assistance. Refer to the Quick Reference Guide which may be found on Missouri Care’s website at www.missouricare.com/provider/resources; and
• Comply with and participate in corrective action and performance improvement plan(s).

Continuity and Coordination of Care between PCPs and Specialists
Continuity and coordination of care between primary care providers and specialists is an important aspect in the delivery of quality health care. Care provided by specialists can affect an individual’s health.

We strongly encourage open communication between PCPs and specialists. If a member’s medical or behavioral condition changes, Missouri Care expects that both PCPs and specialists will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

Communication with the PCP should occur more frequently if clinically indicated. Missouri Care expects PCPs and specialists to respond to routine coordination requests within two business days and one calendar day for urgent requests.

**Continuity and Coordination of Care between PCPs and FQHC/RHC providers**
Continuity and coordination of care between primary care providers and FQHC and RHC providers is an important aspect in the delivery of quality health care. Care provided by FQHC and RHC providers can affect an individual’s health.

We strongly encourage open communication between PCPs and FQHC and RHC providers. If a member’s medical or behavioral condition changes, Missouri Care expects that both PCPs and
FQHC and RHC providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

Communication with the PCP should occur more frequently if clinically indicated. Missouri Care expects PCPs and FQHC and RHC providers to respond to routine coordination requests within two business days and one calendar day for urgent requests.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**

Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services are responsible for:

- Conducting and documenting well-child visits (screenings) using the *State HCY/EPSDT Screening Form* found on the Internet at: [manuals.momed.com](http://manuals.momed.com) (Direct Link: manuals.momed.com/manuals/presentation/forms.jsp)
- Referring the member to an out-of-network provider for treatment if the service is not available within Missouri Care's network;
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Providing vaccinations in conjunction with EPSDT/well-child visits.
- Providers shall enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for WIC site, the health plan shall reimburse only the cost for administration at the current MO HealthNet program rates in effect at the time of the service, unless otherwise negotiated. Members with ME codes 73 through 75 can receive vaccines but are not eligible to receive vaccines through the VFC Program. Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
- Monitoring, tracking and following up with members:
  - Who have not had a health assessment screening; and
  - Who miss appointments to assist them in obtaining an appointment.
- Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with members to ensure they receive the necessary medical services; and
- Assisting members with transition to other appropriate care for children who age-out of EPSDT services.

The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary.

Providers will be sent a monthly membership list which specifies the health assessment-eligible children who have not had an encounter within 120 days of joining Missouri Care or are not in compliance with the EPSDT Program.

Provider compliance with member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the Missouri Care Quality Improvement Department. Corrective action plans will be required for providers who are below 80 percent compliance with all elements of the review.
For more information on EPSDT covered services, refer to Section 1: Overview. For additional information regarding EPSDT requirements, see Section 3: Quality Improvement.

Note: Refer to Section 3: Quality Improvement, to view MO HealthNet’s “Health Screen & Lead Poison Assessment Record” for members.

Primary Care Offices
PCPs provide comprehensive primary care services to Missouri Care members. Primary care offices participating in Missouri Care’s provider network have access to the following services:
- Support of the Provider Relations, Provider Services, Health Services and Marketing and Sales Departments; as well as the tools and resources available on Missouri Care’s website at www.missouricare.com; and
- Information on Missouri Care network providers for the purposes of referral management and discharge planning.

Panel Threshold
Missouri Care requires that all in-network providers give a report detailing the number of members they will accept as patients (in the case of PCPs) or limitations to the number of referrals they will accept (in the case of non-PCPs). This information is to be reported within 30 days of initial contracting and anytime thereafter when panel status changes. In addition, Missouri Care requires that all providers report to the Provider Relations Department as soon as possible when they reach 85 percent of their panel capacity. The Provider Relations Department shall regularly review these reports to identify any changes that may require additional network recruiting.

Closing of Physician Panel
When requesting closure of your panel to new and/or transferring Missouri Care members, PCPs must:
- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all Missouri Care members who were provided services before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

Covering Physicians/Providers
In the event that participating providers are temporarily unavailable to provide care or referral services to Missouri Care members, providers should make arrangements with another Missouri Care-contracted Medicaid (participating) and credentialed provider to provide services on their behalf, unless there is an emergency.

Covering physicians should be credentialed by Missouri Care, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill Missouri Care members. For additional information, please refer to Section 6: Credentialing.

In non-emergency cases, should you have a covering physician/provider who is not contracted and credentialed with Missouri Care, contact Missouri Care for approval. For more information, refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.
Termination of a Member

A Missouri Care provider may not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member’s medical condition, amount or variety of care required, or the cost of covered services required by Missouri Care’s member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should provide adequate documentation in the member’s medical record to support his or her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the Missouri Care member until such time that written notification is received from Missouri Care stating that the member has been transferred from the provider’s practice, and such transfer has occurred.

In the event that a participating provider desires to terminate her or his relationship with a Missouri Care member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member’s non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider should complete a PCP Request for Transfer of a Member Form, attach supporting documentation, and fax the form to Missouri Care’s Provider Relations.

Smoking Cessation

PCPs should direct members who smoke and wish to quit smoking to call Missouri Care’s Provider Services and ask to be directed to the Case Management Department. A case manager will educate the member on state, national and community resources that offer assistance, as well as smoking cessation options available to the member through Missouri Care. Missouri does have a smoking cessation program that includes pharmacological and behavioral health interventions.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of all Missouri Care Medicaid members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

Member Administrative Guidelines

Overview

Missouri Care will make information available to members on the role of the PCP, how to obtain care, what members should do in an emergency or urgent medical situation as well as members’ rights and responsibilities. Missouri Care will convey this information through various methods including a Member Handbook.

Member Handbook

All newly enrolled members will receive a Member Handbook within 10 calendar days of receiving the notice of enrollment from Missouri Care. Missouri Care will mail all newly enrolled members a Member Handbook via U.S. Postal Service.
**Enrollment**

Members must apply for and maintain eligibility for medical assistance through their local Family Support Division (FSD) office. Once determined eligible to participate in the MO HealthNet program, members may elect Missouri Care as their health care plan. Missouri Care must obey laws that protect from discrimination or unfair treatment. Missouri Care does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon assignment to Missouri Care, members are provided the following:

- Terms and conditions of enrollment;
- Description of covered services in-network and out-of-network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding out-of-network emergency services; and
- Grievance and disenrollment procedures.

**Member Identification Cards**

Member identification (ID) cards are intended to identify Missouri Care members, the type of plan they have and to facilitate their interactions with health care providers. Information found on the member ID card may include the member’s name, ID number, plan type, PCP’s name and telephone number, health plan contact information and claims filing address. Possession of the member ID card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

**Eligibility Verification**

A member’s eligibility status can change at any time. Therefore, all providers are encouraged to request and copy a member’s ID card, along with additional proof of ID such as photo identification, and file them in the patient’s medical record. In addition, providers should access the secure portal of Missouri Care’s website at [www.missouricare.com/provider](http://www.missouricare.com/provider) to obtain a member’s current assigned PCP.

Providers must perform the following to verify eligibility:

- Access the secure, online portal of Missouri Care’s website at [www.missouricare.com/provider](http://www.missouricare.com/provider);
- Access the MO HealthNet portal ([www.emomed.com](http://www.emomed.com));
- Access Missouri Care’s Interactive Voice Response (IVR) system; and/or
- Contact Provider Services.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Agreement for additional details.

**Member Rights and Responsibilities**

Missouri Care members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

**Member Rights as a MO HealthNet Managed Care Health Plan Member**

Whether or not a member receives a service from an in-network provider or an out-of-network provider, members have the right to:

- Be treated with respect and dignity;
- Receive needed medical services;
- Privacy and confidentiality (including minors) subject to state and federal laws;
- Select their own PCP
- Refuse treatment
- Receive information about their health care and treatment options
- Participate in decision making about their health care
- Have access to their medical records and to request changes, if necessary
- Have someone act on their behalf if they are unable to do so
- Get information on our Physician Incentive Plan, if any, by calling 1-800-322-6027
- Be free of restraint or seclusion from a provider who wants to:
  - Make them do something they should not do;
  - Punish them;
  - Get back at them; or
  - Make things easier for him or her.
- Be free to exercise these rights without retaliation
- Receive one copy of their medical records once a year at no cost to them

**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

**Members Have a Responsibility To:**
- Read and follow their handbook
- Show their Missouri Care ID card and MO HealthNet red or white card to each health care provider before they get medical services
- Know the name of their PCP
- Get approval from their PCP before they get services from any other provider unless it is an emergency. There are exceptions, like family planning. Call Member Services at 1-800-322-6027 if you have questions.
- Make appointments ahead of time for all PCP visits or transportation
- Be on time for appointments or cancel the day before their appointment
- Give their PCP their past health information. Their PCP needs to see shot (immunization) records for members up to age 21.

**Assignment of Primary Care Physician**
Members enrolled in a Missouri Care Medicaid plan must choose a PCP or they will be assigned to a PCP within Missouri Care’s network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member’s health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

**Changing Primary Care Physicians**
Members may change their PCP selection at any time by calling Member Services. The requested change will be effective the first day of the following month of the request if the request is received after the tenth day of the current month.
**Women’s Health Specialists**
PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women’s health specialist for covered services related to this type of routine and preventive care.

**Hearing-Impaired, Interpreter and Sign Language Services**
Hearing-impaired, interpreter and sign language services are available to Missouri Care members through Missouri Care’s Member Services. Multilingual and TTY services are available. PCPs should coordinate these services for Missouri Care members and contact Provider Services if assistance is needed. Please refer to the *Quick Reference Guide* for the Provider Services telephone numbers on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).
Section 3: Quality Improvement

Overview
Missouri Care’s Quality Improvement (QI) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities are implemented to improve health care outcomes. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas that includes, but is not limited to:

- Quantitative and qualitative improvement in member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Patient safety and confidentiality;
- Preventive health;
- Service utilization;
- Complaints/grievances;
- Appeals;
- Adverse events;
- Disease and case management;
- Behavioral health services;
- Member and provider satisfaction;
- Availability and access to quality providers;
- Tracking and trending of data;
- Identification of issues and outcomes;
- Internal process reviews;
- Evaluation of compliance to policies and procedures related to state, federal, and accreditation standards;
- Member and provider newsletters; and
- Medical record reviews.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS measures, and/or medical record audits. The organization’s Board of Directors has delegated authority to the QI Committee to approve specific QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

The goals of the QI Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate, and evaluates the results of actions taken to improve quality of care outcomes and service levels;
- Ensure availability and access to qualified and competent providers;
- Establish and maintain safeguards for member privacy, including confidentiality of member health information;
• Engage members in managing, maintaining or improving their current states of health through fostering the development of a PCP-patient relationship and participation in care programs;
• Provide a forum for members, providers, various health care associations and community agencies to provide suggestions regarding the implementation of the QI program;
• Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies;
• Identify best practices for performance and QI; and
• Review and revise goals annually.

Provider Participation in the Quality Improvement Program
Network providers are contractually required to cooperate with QI activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) assessments, and feedback/input via satisfaction surveys, grievances, and calls to Provider Services. Missouri Care seeks input from and works with members, providers, and community resources and agencies to actively improve the quality of care provided to members. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report assessing the progress in meeting goals. Missouri Care evaluates the effectiveness of the QI Program on an annual basis. An annual report is summarized detailing a review of completed and continuing QI activities that address the quality of clinical care, trending of measures to assess performance in quality of clinical care and quality, any corrective actions implemented, corrective actions which are recommended or in progress, and any modifications to the program. This report is available as a written document.

Member Satisfaction
On an annual basis, Missouri Care conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality, and access is evaluated. The results are compared to Missouri Care’s performance goals, and improvement action plans are developed to address any areas not meeting the standard.
**EPSDT Screen Periodicity Schedule**
Well-child visits (screenings) should be conducted and documented using the *State HCY/EPSDT Screening Form* found on the internet at: [manuals.momed.com](http://manuals.momed.com) (Direct Link: manuals.momed.com/manuals/presentation/forms.jsp)

**MO HealthNet provides the following Health Screen & Lead Poison Assessment Record for Members:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Date of Health Screen</th>
<th>Date of Lead Poison Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By one month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-5 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-8 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-14 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-17 months</td>
<td></td>
<td>Your child needs a Blood Lead Level at 12 and 24 months</td>
</tr>
<tr>
<td>18-23 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td></td>
<td>Your child needs a Blood Lead Level each year until age 6 if in a high-risk area.</td>
</tr>
<tr>
<td>4 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-7 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8-9 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-13 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-15 years</td>
<td></td>
<td>A Blood Lead Level is recommended for women of child-bearing age.</td>
</tr>
<tr>
<td>16-17 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-19 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 years</td>
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</tbody>
</table>

The MO HealthNet online provider manual references the Childhood Immunization Schedule on the Department of Health and Senior Services’ website at [health.mo.gov](http://health.mo.gov) (Direct Link: health.mo.gov/living/wellness/immunizations/professionals.php).
MO HealthNet provides members with a current, abbreviated CDC immunization schedule.

A full HCY/EPSDT well-child visit includes all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different providers. An interperiodic screen is defined as any encounter with a health care professional acting within his or her scope of practice. (Sect 2.7.5.f.1)

- A comprehensive health and developmental history including assessment of both physical and behavioral health developments;
- A comprehensive unclothed physical exam;
- Health education (including anticipatory guidance);
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
- Appropriate immunizations according to age;
- Annual verbal lead assessment beginning at age 6 months and continuing through age 72 months;
- Blood level testing is mandatory at 12 and 24 months or annually if residing in a high-risk area of Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030;
- Hearing screening;
- Vision screening; and
- Dental screening (oral exam by PCP as part of comprehensive exam). Recommended that preventive dental services begin at age 6 through 12 months and be repeated every 6 months.

If a suspected problem is detected during a well-child visit, the child must be evaluated as necessary using the required assessment protocol for further diagnosis. This diagnosis is used to determine treatment needs. (Sect 2.7.5.f.2)

HCY/EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate (defined as “prevent from worsening”) defects, physical and behavioral health issues, and conditions discovered by the screening services, or correct a problem discovered during an HCY/EPSDT visit. All medically necessary diagnoses and treatment services must be provided as long as they are permitted under the Medicaid statute, whether or not they are covered under the state’s Medicaid plan, and without any regard to any restrictions the state may impose on services for adults. (Sect 2.7.5.f.3)

The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child (Sect 2.7.5.f.1).

Each provider office is required to have the following equipment to provide a complete health check:

- Weight scale for infants;
- Weight scale for children and adolescents;
- Measuring board or device for measuring height or length in the recumbent position for infants and children up to age 2;
- Measuring board or device for measuring height in the vertical position for children who are 2 years old or older;
- Blood pressure apparatus with infant, child and adult cuffs;
- Eye charts appropriate to children by age;
• Developmental and behavioral screening tools; and
• Ophthalmoscope and otoscope.

120-day Non-Compliant Report
Missouri Care will send providers a monthly membership list of EPSDT-eligible children who have not had a screen within 120 days of enrolling with Missouri Care. Missouri Care shall provide written notification to its families with eligible children when appropriate well-child visits are due. The health plan shall follow up with families that have failed to access well-child visits after 120 calendar days of when the well-child visit was due. The health plan shall provide to each PCP, on a monthly basis, a list of the eligible children who are not in compliance with the periodicity schedule. The PCP shall contact these members’ parents or guardians to schedule an appointment.

Clinical Practice Guidelines (CPGs)
Missouri Care adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede CPGs, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Corporate Medical Policy Committee (MPC) and the Market Utilization Management Medical Advisory Committee (UMAC), which reports to the QI Committee. CPGs, to include preventive health guidelines, are on our corporate website at www.wellcare.com/provider/CPGs.

HEDIS
The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. The tool comprises 71 measures across 8 domains of care, including:
• Effectiveness of care;
• Access and availability of care;
• Satisfaction with the care experience;
• Use of services;
• Cost of care;
• Health plan descriptive information;
• Health plan stability; and
• Informal health care choices.

HEDIS is a mandatory process that occurs annually. It is an opportunity for Missouri Care and providers to demonstrate the quality and consistency of care that is available to members. Medical records and claims data are reviewed to capture required data. Compliance with HEDIS standards is reported on an annual basis with results available to providers upon request. Through compliance with HEDIS standards, members benefit from the quality and effectiveness of care received and providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Medical Records
Medical records should be comprehensive and reflect all aspects of care for each member. Records are to be maintained in a secure, timely, legible, current, detailed and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up.
treatment. Complete medical records shall include, but are not limited to: medical charts, health status screens, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of service provided. Medical records must be signed and dated.

To comply with regulatory and accreditation requirements, the QI Department may conduct annual medical record audits in physician offices. A patient’s record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Physicians will be given results and a corrective action plan will be required if the score is lower than 80 percent.

The goal of conducting medical record reviews is multifold, including the ability of Missouri Care to assess the level of provider compliance to documentation standards and clinical guidelines (disease and preventive, etc.), and to gauge quality of care and patient safety practices.

In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, physicians shall maintain an adequate and complete medical record for each member and may maintain electronic records provided the record keeping format is capable of being printed for review. An adequate and complete medical record shall include documentation of the following information:

- Identification of the member, including name, birth date, address and telephone number;
- The date(s) the member was seen;
- The current status of the member, including the reason for the visit;
- Observation of pertinent physical findings;
- Assessment and clinical impression of diagnosis;
- Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed or administered; and
- Any informed consent for office procedures.

In addition, Missouri Care requires all medical records, including all entries in the medical record:

- Be organized in a manner to enable easy access to its content and be neat, complete, clear, concise, detailed, comprehensive and timely and include all recommendations and essential findings in accordance with good professional practice;
- Be maintained in a manner that permits effective professional medical review and medical audit processes;
- Be maintained in a manner that facilitates an adequate system for follow-up treatment;
- Be signed;
- Include the name and profession of the practitioner rendering services, for example, RN, MD, DO, including signature or initials of practitioner;
- Be legible to readers and reviewing parties and maintained in an orderly and detailed manner;
- Be dated and recorded in a timely manner. Late entries should include date and time of occurrence and date and time of documentation;
• Not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed.
• Any correction, addition, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and 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;
• Only include standard abbreviations and symbols;
• Include the patient’s name (first and last name) or ID number on each page of the electronic or paper record;
• Include the following personal and biographical data in the record:
  o Name;
  o Member ID;
  o Age;
  o Date of birth;
  o Sex;
  o Address;
  o Home and work telephone numbers;
  o Emergency contact;
  o Legal guardianship;
  o Marital status;
  o Name of spouse;
  o Next of kin or closest relative;
  o Employer; and
  o Insurance information or family history as applicable.
• Reflect the primary language spoken by the member and translation or communication needs of the member. Translation or communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate;
• Prominently note any adverse drug reactions and/or food allergies or “no known allergies” and known reactions to drugs. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record;
• Easily identify the past medical history, including serious accidents, hospitalizations, operations, illness, prenatal care and birth as appropriate. As appropriate, medical records from previous providers should be obtained and easily accessible. Old records including past medical history, physical examinations, necessary tests and possible risk factors for the member relevant to treatment should be used to assess the periodicity schedule and maintain continuity of care;
• Maintain a current immunization record;
• Provide a current medication list. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications;
• Provide a problem list, with past and current diagnoses and procedures and be used to provide continuity of care. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, etc.;
• Present health history/past medical history and physical examination as related to the visit, chief complaint or purpose of the visit and objective findings of the practitioner, diagnosis or medical impression;
• Include plan of treatment, referrals, disposition, recommendations and instructions, diagnostic testing, studies ordered, therapies administered and prescribed regimens;
• Contain information about consultations, referrals and specialist reports;
• Include notations on all forms or notes regarding follow-up care, calls or visits, when indicated;
• Studies/tests ordered (e.g., laboratory, X-ray, EKG) are reviewed;
• Follow-up plans for abnormal testing/consultation reports and referrals. Documentation that the abnormal results or consultation reports were reviewed by the practitioner and the follow-up care to be done is also documented;
• Age appropriate life-style and risk counseling is documented;
• Patient education and instruction, whether verbal, written or by telephone;
• Dispositions, recommendations and instructions to the member;
• Must include a screening for substance abuse of tobacco, alcohol and drugs, and documentation of appropriate counseling/referrals if needed and follow-up;
• If applicable, include a screening for domestic violence and documentation of appropriate counseling/referrals and follow-up;
• For all members older than 18, must provide evidence that the member was asked about or executed an advance directive, including a mental health directive, and documentation of acceptance or refusal. **Note:** The record must contain evidence that the member was provided written information concerning his or her rights regarding advance directives and whether or not he or she has executed an advance directive. The member does not have to have an advance directive completed. A signed statement that the member has been asked if he or she has one and if not, offering one will suffice. A stamp may be used. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive;
• Must detail informed consent discussions, where appropriate.
• If surgery is proposed, there is documentation of informed consent including discussion with the member of the medical necessity of the procedure, the risks and any alternative treatment options available; and
• Documentation that the member has received the provider’s policy regarding office practices compliant with the Health Insurance Portability and Accountability Act (HIPAA).

The record shall contain evidence of the practitioner’s knowledge of the member’s course of care and adherence to continuity of care requirements and
• Documentation and reports of consultations and referrals to specialty practitioners, if indicated. Continuity between PCP and specialists/consultant note/referral reports in chart.
• Reports of diagnostic testing – the medical record must show documentation of results for reports for diagnostic testing that were ordered.
• There is documentation in the record if a member was seen in the emergency room and appropriate medically indicated follow-up after ER visits
• There is documentation in the medical record of the plan for hospital discharge.

For members 21 years and older, the following adult preventive requirements from the US Preventive Task Force and the Missouri Care CPGs are required:
• Nutritional assessment
• Blood pressure, height and BMI checked every 1-2 years
• Vision and hearing screening annually if age 65+
• Pneumococcal vaccine, 1 dose if ages 65+
• Influenza vaccine annually
• Tetanus and diphtheria booster every 10 years
• Screening for cholesterol and dyslipidemia – at a minimum every 5 years – ages 35-65 for males and 45-65 for females
• Mammogram screening – every 1-2 years after age 40
• Colorectal cancer screening-age 50 and older
• Pap smear and chlamydia screening for females – every 1-3 years

For pregnant members the following OB preventive screenings are required:
• Physical assessment that includes weight, blood pressure, fundal height and fetal heart tones
• Nutritional assessment and counseling
• Blood typing and antibody screening
• Rubella anti-titer
• Urinalysis
• Pap smear
• STD testing
• Hemoglobin and hematocrit tests
• HIV counseling and HIV testing
• HBsAG testing at the initial prenatal visit
• Depression screening
• Pre-term delivery risk assessment
• Alpha Fetal Protein screening
• Diabetes screening
• Group B Strep screening
• Postpartum exam

Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.

A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Missouri Care, or its representatives, without a fee to the extent permitted by state and federal law. The member’s medical record is the property of the provider who generates the record. Upon the written request of a member, guardian, or legally authorized representative of a member, a copy of the medical records of the member’s health history and treatment rendered shall be furnished. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each member is entitled to 1 free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

Providers shall cooperate with the health plan to provide the state agency with access to all members’ medical records, whether electronic or paper, within 30 calendar days of receipt of written request at no charge. The provider shall cooperate with the health plan to provide the state agency with access to a single or small volume of medical records within 5 calendar days of receipt of written request at no charge. The provider and health plan shall provide the state agency with immediate access for on-site review of medical records. For on-site review of
medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. The provider shall cooperate with the health plan to fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all providers.

The state agency is not required to obtain written approval from a member before requesting the member’s record from the provider. If the state agency requests, the provider shall cooperate with the health plan to gather all medical records from providers.

When a member changes PCPs, upon request, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

Records remaining under the care, custody, and control of the physician or health care provider shall be maintained for a minimum of 10 years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to Missouri Care upon request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

Providers must follow “Provider Conditions of Participation” section of the MO HealthNet provider manual, which defines “adequate documentation” and “adequate medical records” under 13 CSR 70-3.030, Section(2)(A). The MO HealthNet provider manual is located on the web at: manuals.momed.com (Direct Link: manuals.momed.com/manuals/hyperlinkPage.render?idLinkParmName=phy)

For more information on medical records compliance, including confidentiality of member information and release of records, refer to Section 8: Compliance.

**Website Resources**
Missouri Care periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the Missouri Care website. Please check frequently for the latest news and updated documents at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

**Patient Safety Plan**

**Overview**
Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all inpatient and outpatient providers, Missouri Care supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, use of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues, and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:
- Regular checkups for adults and children;
- Prenatal care for pregnant women;
- Well-baby care;
- Immunizations for children, adolescents, and adults; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, pap smears, and mammograms.

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating providers and the QI Committee. Activities include distribution of information, encouragement to use screening tools, and ongoing monitoring and measuring of outcomes. While Missouri Care can and does implement activities to identify interventions, the support and activities of families, friends, providers, and the community have a significant impact on prevention.

**Quality of Care Issues**

Quality of care referrals may be generated by the Complaints, Grievance and Appeals, Case Management and/or Utilization Management Departments, or may be identified through routine record review. Quality of care issue types include unplanned readmissions for a same or similar diagnosis in less than 30 days, patient falls, serious complications from anesthesia, transfusion errors, medication errors, serious disabilities, post-operative complications, lack of care which could have resulted in a potentially serious complication, etc.

Record reviews identifying possible quality of care issues may be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Peer review is categorized in the following manners:
- Substantiated – there is evidence of a deviation in the standard of care; or
- Unsubstantiated – there is no evidence of a deviation from the standard of care.

Once that determination is made, the outcome is classified as either “adverse event” or “no adverse event.” Results of peer review activity may be reported to state and regulatory agencies as appropriate.

**Incident Reporting**

Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a provider or member should be reported to Missouri Care.

*Incidents* are statutorily defined as any untoward or adverse event that results in death, serious impairment of bodily function or any other result that requires medical intervention other than minimal first aid treatment. Serious incidents involving Missouri Care members shall be reported to Missouri Care’s QI Department at **1-573-441-2110** immediately as these incidents must be reported within 48 hours.

Examples of such incidents are death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong patient or wrong site, or wrong surgical procedure performed.
Other incidents involving Missouri Care members which are required to be communicated include, but are not limited to:

- A slip or fall;
- Medication error;
- Reaction requiring treatment;
- Abusive patient or family member;
- A theft or loss from provider’s office;
- Malfunction or damage of equipment during treatment;
- Accusations of malpractice by a patient or family member; and/or
- Non-compliance which may potentially be considered life-threatening.

Physicians are reminded that serious negative events or incidents which occur in a provider’s office or facility must be reported to the appropriate regulatory agency directly by the provider.

**Hospital Patient Safety**

Missouri Care is committed to offering services that ensure the safe delivery of clinical care to its members. Missouri Care’s Patient Safety Plan exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of hospitals, Missouri Care’s active patient safety plan goal includes fostering a supportive environment to provide improved patient health care and safety through reduction in avoidable medical errors. Some objectives of Missouri Care’s Patient Safety Plan include, but are not limited to:

- Support of and ongoing collaboration with participating hospitals to encourage and endorse patient safety activities;
- Continual monitoring of performance against national patient safety benchmarks; and
- Educating hospitals about safe practices.

In support of safe clinical practices, Missouri Care’s policies and procedures define and also provide for the monitoring of nationally accepted quality of care indicators.

Through tracking and trending of relevant plan metrics, Missouri Care can identify opportunities for improvement and facilitate education of a specific practitioner and/or the hospital community at large in order to reduce the potential for patient safety incidents.

Missouri Care addresses key elements of patient safety, such as coordination of care between hospitals, medical record review findings, adverse event and quality of care grievance tracking/trending and electronic medical records implementation. Annually, Missouri Care will define the specific areas of patient safety to be monitored, which may include but are not limited to, the following metrics as indicators of safe clinical care:

- Number of quality of care complaints; and
- Number of adverse events reported per quarter.

Following the objectives as outlined in the plan, Missouri Care may use newsletters, provider relations representatives, and tailored education to periodically communicate the key activities of patient safety initiative, such as network patient safety performance data and survey results. Missouri Care is dedicated to improving safety and reducing medical errors for patients within hospitals. Participating hospitals are required to have a Patient Safety Plan to identify and resolve, through process improvement, situations that could jeopardize patient safety.
Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)

Utilization Management

Overview
Missouri Care’s Utilization Management (UM) Program is designed to meet contractual requirements with state and federal regulations while providing members access to high quality, cost-effective, medically necessary care. For purposes of this section, terms and definitions may be contained in this section, in Section 13: Definitions of this Manual, or both.

The goal of the UM Program is to achieve the best outcomes while providing quality health care at the most appropriate setting and the most appropriate time for the members. The UM Program:

- Ensures culturally sensitive delivery of services that are medically necessary, appropriate and are consistent with the member's diagnosis and level of care required;
- Provides access to the most appropriate and cost efficient health care services. Ongoing monitoring, tracking and trending of care rendered to Missouri Care’s members in order to ensure that quality health care is provided;
- Works collaboratively with the CM, DM, and QI Departments by identifying and referring potential quality of care issues for review and implementation of intervention plans, as indicated;
- Monitors over- and under-utilization, continuity and coordination of care and implements corrective action intervention plans, as needed;
- Works collaboratively with the Provider Services Department and the Appeals and Grievance Committees with timely review and response to member or provider grievances/appeals relating to UM decisions;
- Facilitates communication and partnerships among participants, physician providers, facility providers, delegated entities and Missouri Care in an effort to enhance cooperation and appropriate utilization of health care services; and
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of UM processes.

Medically Necessary Services
The determination of whether a covered benefit or service is medically necessary complies with the requirements established in Missouri Care’s contract with MO HealthNet. Please refer to Section 11: Definitions for the definition of medical necessity.

Missouri Care provides covered services to members, sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting.

Missouri Care’s UM Program includes components of prior authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on Missouri Care members’ coverage, and the
appropriateness of such care and services, and to determine the extent of coverage and payment to providers of care.

Missouri Care does not reward practitioners, providers or associates who perform utilization reviews, including those of the delegated entities, for denials. No one is compensated or otherwise given incentives to encourage denials that result in under-utilization. Utilization reviews are based on appropriateness of care and existence of coverage. Utilization denials (adverse determinations) are based on lack of medical necessity or lack of covered benefits.

**Criteria for UM Decisions**

Missouri Care’s UM Program uses nationally recognized review criteria based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Missouri and professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

The UM Program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- InterQual™;
- Missouri Care Clinical Coverage Guidelines;
- Medical necessity;
- Member benefits;
- State Medicaid Contract;
- State Provider Manuals, as appropriate;
- Local and federal statutes and laws;
- Medicaid and Medicare guidelines; and
- Hayes Health Technology Assessment.

The nurse reviewer and/or Medical Director involved in the UM process applies medical necessity criteria in context with the member’s individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the UM Department via Provider Services. The phone number is listed on the Quick Reference Guide on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

**Utilization Management Process**

The UM process is comprehensive and includes the following review processes:

- Notifications;
- Referrals;
- Prior Authorizations/Pre-certification (Prospective Review);
- Concurrent Review;
- Discharge Planning; and
- Retrospective Review.

The UM Department adheres to state, federal, and accreditation standards for service authorization decisions and adverse determinations, which include notification time frames.
These standards are applied to urgent/expedited and routine requests for prospective, concurrent and retrospective services.

Missouri Care’s forms for the submission of notifications and authorization requests are on Missouri Care’s website at [www.missouricare.com/provider/forms](http://www.missouricare.com/provider/forms)

**Notification**
Notifications are communications to Missouri Care with information related to a service rendered to a member or a member’s admission to a facility. Notification is required for:

- Prenatal services. This enables Missouri Care to identify pregnant members for inclusion into the Prenatal Program and identify members who may benefit from the High Risk Pregnancy Program. Obstetrical providers are required to notify Missouri Care of pregnant members via fax using the *Pregnancy Risk Screening Form* within two business days of the initial visit. This process will expedite case management and claims reimbursement;
- A member’s admission to a hospital. This enables Missouri Care to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include member demographics, facility name, and admitting diagnosis; and
- Observation stays. The short stay or observation unit is identified as a clinical unit where the member’s condition does not meet acute care criteria nor warrant an inpatient stay. Missouri Care adheres to the MO HealthNet policy that observation services will not exceed a maximum of 24 hours.

**Referrals**
For an initial referral, Missouri Care does not require authorization as a condition of payment if the service is done in the Missouri Care network. Certain diagnostic tests and procedures considered by Missouri Care to be routinely part of an office visit may be conducted as part of the initial visit without an authorization if the services are done in network. Referrals may be made to an out-of-network provider and may be authorized by Missouri Care if the covered services are not available in network. All out of network referrals require prior authorization by Missouri Care.

**Prior Authorization**
Prior authorization allows for efficient use of covered services and ensures that members receive the most appropriate level of care, in the most appropriate setting. Prior authorization may be obtained by the member’s PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity;
- Appropriateness of rendering provider;
- Appropriateness of setting; and/or
- Case and disease management considerations.

Prior authorization is **required** for elective or non-emergency services as designated by Missouri Care. Prior authorization requirements by service type may be found on the *Quick Reference Guide* on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources)
Providers can also use the searchable Authorization Lookup Tool at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources). Providers will need to register and log in to use this secure tool.
Requests for prior authorization can be submitted to Missouri Care by:
1. Contacting Provider Services directly at 1-800-322-6027;
2. Submitting via fax the required supporting documentation to fax number 1-866-946-2052; or
3. Submitting the required supporting documentation via Missouri Care’s web-based prior authorization portal at [www.missouricare.com](http://www.missouricare.com).

Some prior authorization guidelines to note are:
- The prior authorization request should include the diagnosis to be treated and the *Current Procedural Terminology* (CPT) code describing the anticipated procedure. The authorization request should outline the plan of care, including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission.

**Authorization Request Forms**
Missouri Care requests providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request, including:
- *Inpatient Log Sheet* is used to submit notification of an inpatient admission: elective, acute, skilled nursing facility, rehabilitation, long-term and sub-acute admissions;
- *Prior Authorization Request Form* is used to submit authorization requests for select outpatient surgical, diagnostic, and therapeutic services including transition-of-care and out-of-network requests;
- *Therapy Services Request Form* is used to submit authorization requests for Occupational, Physical and Speech Therapy services;
- *Home Health Services Request Form* is used to submit authorization requests for home health services including skilled nursing;
- *Durable Medical Equipment Request Form* is used to request all equipment including orthotics and prosthetics;
- *Enteral Formula Request Form* is used to request enteral nutrition, formula and supplies.
- *A Pregnancy Risk Screening Form* should be completed by the obstetrician/gynecologist (OB/GYN) during the first visit and faxed to Missouri Care within 2 business days of the initial visit. Notification of obstetric services enables Missouri Care to identify members for inclusion into the Prenatal Program and/or members who might benefit from Missouri Care’s High Risk Pregnancy Program.

To ensure timely and appropriate claims payment, all forms must:
- Have all required fields completed; to include member name, date of birth, MO HealthNet or Missouri Care identification number, diagnosis and *Current Procedural Terminology* (CPT) codes/description
- Be typed or printed in black ink for ease of review; and
- Contain a clinical summary or have supporting clinical information attached.

Prior authorization requirements by service type are in the *Quick Reference Guide* on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources). Providers can also use the searchable Authorization Lookup Tool located on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources). Providers will need to register and log in to use this secure tool.
Forms are located on Missouri Care’s website at [www.missouricare.com/provider/forms](http://www.missouricare.com/provider/forms). All forms should be submitted via fax to the number listed on the form.

**Exceptions**

Requests for exceptions to non-covered benefits must demonstrate at least one of the following:

- Item or service required to sustain life
- Item or service would substantially improve the quality of life for a terminally ill patient
- Item or service is necessary as a replacement due to a violence of nature
- Item or service is necessary to prevent a higher level of care

Any procedure must be listed in the current CPT code book. The member must be eligible on the dates of service and the physician or provider of service must be enrolled in the Medicaid program on the date the item or service is provided. The item or service must not depart from accepted medical standards. Reimbursement will be made in accordance with the Medicaid established fee schedule.

The services requested must meet medical necessity criteria and must be prior authorized by the Medical Director. These exceptions will be time-limited, and will be made on a case-by-case basis. In no event will the decision on an individual case be construed to set precedent for future cases. Since these decisions are exceptions to the standard benefits, no appeal process is available.

Member’s PCP must inform the company of their desire for an exception. Any requests that do not meet the policy guidelines listed above will be denied.

The request must be accompanied by medical records documenting the current status and treatment outcomes, the two proposed treatment plans if appropriate, (one through covered benefits available and one through non-covered benefits available) and the time frames and outcomes expected for the different options.

Both options will be evaluated for cost-benefit and a final exception decision will be made by the Medical Director based on the specifics of the individual case.

Since these decisions are exceptions to the coverage standards, no appeal process is available.

The exceptions request form can be found on Missouri Care’s website at [www.missouricare.com/provider/forms](http://www.missouricare.com/provider/forms).

**Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic, fax or chart review and communication with the attending physician, hospital utilization manager, CM staff or hospital clinical staff involved in the member’s care.

Concurrent review is initiated as soon as Missouri Care is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity,
treatment plan, and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;
- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning; and
- Identify cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Missouri Care Medical Director.

To ensure the review is completed in a timely manner, providers must submit notification and clinical information the next business day after the admission, as well as upon request of the Missouri Care review nurse. Failure to submit necessary documentation for concurrent review may result in a denial for continued services and non-payment.

- Hospitals must notify Missouri Care by phone or via the inpatient notification by fax by the next business day following the admission. No medical authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next business day if not already presented at the time of notification.
- Missouri Care has staff available 24 hours a day, 7 days a week. If a hospital would like to have an immediate authorization decision rendered, and is able to provide clinical information at the time of notification, the call will be transferred to the nurse review staff (or on-call nurse) to provide a response within 1 hour.
- A Missouri Care nurse will review the clinical information, and will respond to the facility with an authorization status decision within 1 day after receipt of the information.
- If a member is admitted, and subsequently discharged before the next business day (i.e., over a weekend) the facility must still notify Missouri Care, and provide clinical information so that an authorization decision can be made.
- Facilities must notify Missouri Care of admissions for the delivery of newborn or stillborn babies. Notification should be by fax, using the Birth Notification Form, by the next business day following the birth. Baby clinical information (gender, weight, date of birth) must be provided no later than the next business day, if not included in the initial notification. Missouri Care will respond to the facility with an authorization number within 2 business days of the receipt of complete information.
- Failure of a hospital(s) to notify Missouri Care of a member’s inpatient admission by the next business day, or failure to communicate information related to service(s) rendered to a member will result in the denial of the submitted claim(s) associated with the said admission or service(s).

Based on professionally generated criteria, Missouri Care will review all admissions to and services provided in an acute care setting. All participating hospital reviews must comply with procedures outlined in the hospital’s utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer. This entry must also indicate the severity of illness/intensity of service (SI/IS) criteria that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of reimbursement of your claim.
If the hospital uses an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

**Discharge Planning**
Discharge planning begins upon admission and is an essential part of the concurrent review process. It is designed to quickly identify medical and/or psychosocial issues that will need post-hospital intervention. It may include coordinating services required to assist in arranging for and implementing a member’s transition to a more appropriate or lower level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician, and/or the discharge planning personnel at the hospital.

The Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary providers, and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care. An Inpatient Review Nurse may refer an inpatient member with identified complex discharge needs to CM for post-discharge follow up.

When a covered member is hospitalized, and is disenrolled from Missouri Care during the hospital stay, Missouri Care shall maintain responsibility for the coordination of care, and discharge planning for that member.

When a covered newborn remains hospitalized, and is disenrolled from Missouri Care during the hospitalization, Missouri Care shall remain responsible for the coordination of care and discharge planning, until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

**Retrospective Review**
A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews, which Missouri Care may perform:

- Retrospective Review initiated by Missouri Care: It is the policy of Missouri Care to assure, through Retrospective Review, the compliance by providers to generally acceptable coding guidelines. Retrospective Review will request specific medical records from the provider in order to conduct this review to determine if coding compliance is accurate and appropriate.
- Retrospective Review initiated by Providers: Retrospective review is performed when a service has been provided and no authorization has been given. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the members' needs at the time of service. Post-service authorization requests are also reviewed to determine if any of the following circumstances exist:
  - The provider was not able to determine the member’s eligibility;
  - The service was urgent in nature and there was not time to submit a request prior to service delivery;
  - The service is part of an ongoing plan of treatment for a newly eligible member; or
  - Extenuating circumstances existed that precluded the provider from submitting a timely pre-service or concurrent review authorization request.
Providers are expected to adhere to the business rules for submission of service authorization requests. Post-service requests that do not meet one of the above conditions may be administratively denied. Exceptions may be granted if specifically addressed through contract language. Retrospective review requests must be submitted in writing within 90 days of the member’s discharge date. Missouri Care will communicate decisions to the requesting practitioners/provider and the member, if applicable, within 30 calendar days of receipt of the request.

The member or provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the UM Department via Provider Services. Refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.

### Service Authorization Decisions

<table>
<thead>
<tr>
<th>Type of Authorization</th>
<th>Decision</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Pre-service</td>
<td>2 business days</td>
<td>Not to exceed 14 calendar days from receipt of request</td>
</tr>
<tr>
<td>Expedited (Urgent) Pre-service</td>
<td>24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Post service</td>
<td>30 calendar days</td>
<td>Not to exceed 14 calendar days</td>
</tr>
</tbody>
</table>

**Standard Service Authorization**

Missouri Care will provide a service authorization decision as expeditiously as the member’s health condition requires and within state-established time frames which will not exceed 2 business days following receipt of the request for service. In no case shall the health plan exceed 14 calendar days following the receipt of the request of service to provide approval or denial.

The decision time frame may be extended beyond 14 days if:

- The member, or the provider, requests an extension; or
- Missouri Care justifies (to the state agency upon request) a need for additional information and how the extension is in the member’s best interest.

Missouri Care will fax an authorization response to the provider fax number(s) included on the authorization request form.

**Expedited Service Authorization**

If a provider indicates, or Missouri Care determines, that following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, Missouri Care must make an expedited authorization decision and provide notice within 24 hours after receipt of the request for service.

**Requests for expedited decisions for prior authorization should be requested by telephone,** not fax or Missouri Care’s secure, online Provider Portal.

Please refer to the Quick Reference Guide to contact the UM Department via Provider Services, which may be found on Missouri Care’s website at www.missouricare.com/provider/resources.
Members and providers may file a verbal request for an expedited decision.

**Urgent Concurrent Authorization**
An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within 24 hours of receipt of the request. An extension may be granted for an additional 48 hours if:
- The request to extend urgent concurrent care is not received at least 24 hours prior to the expiration of the previous authorization or
- Previous care was not authorized, and Missouri Care was not able to obtain needed clinical information within the initial 24 hours after the request, with at least one documented request for the clinical information.

**Services Requiring No Authorization**
In order to facilitate timely and effective treatment of members, Missouri Care has determined that many routine procedures and diagnostic tests are allowable without medical review, including:
- Certain diagnostic tests and procedures considered by Missouri Care to routinely be part of an office visit. Routine clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require prior authorization. The exceptions to this rule are:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests.
- Certain tests described as CLIA-waived may be conducted in the physician’s office if the provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to Missouri Care.

All services performed without prior authorization are subject to retrospective review by Missouri Care. Prior authorization requirements by service type may be found on the Quick Reference Guide on Missouri Care’s website or on the searchable Authorization Lookup Tool, both at www.missouricare.com/provider/resources. Providers will need to register and log in to use this secure tool.

**Peer-to-Peer Reconsideration of Adverse Determination**
In the event of an adverse determination following a medical necessity review, peer-to-peer reconsideration is offered to the treating physician on the Notice of Action (NOA) communication. The treating physician is provided the toll-free number to the health plan to request a discussion with the Missouri Care Medical Director who made the denial determination. Peer-to-peer reconsideration is offered when requested within 3 business days of the denial determination. The health plan medical director will make 2 attempts to contact the treating practitioner and conduct the review. The physician will have the opportunity to discuss the decision with the peer clinical reviewer making the determination or with a different clinical peer if the original reviewer is not available. The peer-to-peer dialogue must be completed within 5 business days of the denial determination. The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process. In the event the peer-to-peer dialogue does not occur during the specified timeframes, the provider will have the opportunity to use the standard provider appeals process.
Missouri Care Proposed Actions
A proposed action is an action taken by Missouri Care to deny a request for services. In the event of a proposed action, Missouri Care will notify the member and the requesting provider in writing of the proposed action. The notice will contain the following:
- The action Missouri Care has taken or intends to take;
- The reason(s) for the action;
- The member’s or provider’s right to appeal;
- The member’s right to request a state fair hearing;
- Procedures for exercising the member’s rights to appeal or file a grievance;
- The member’s right to represent himself or use legal counsel, a relative, or a friend;
- The specific regulations that support or the change in federal or state law that requires the action;
- The member’s right to request a state agency hearing, or in cases of an action based on change in law, the circumstance under which a hearing will be granted;
- Circumstances under which expedited resolution is available and how to request it; and
- The member’s rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued.

Second Medical Opinion
A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team, including a member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified health care professional within network, or Missouri Care shall arrange for the member to obtain one outside the network if there is not a participating provider with the expertise required for the condition. The second opinion shall be provided at no cost to the member. Certain elective surgical procedures, pursuant to Missouri Law require a second medical opinion be provided prior to surgery.

A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

Missouri Care’s prior authorization department can assist in coordinating the second or third opinion with an in-network or out-of-network provider by calling Provider Services at 1-800-322-6027.

Emergency/Urgent Care and Post-Stabilization Services
Emergency services are not subject to prior authorization requirements and are available to members 24 hours a day, 7 days a week. See Section 13: Definitions for definitions of “emergency” and “urgent”. Urgent care services are provided as necessary and are not subject to prior authorization or pre-certification.

Post-stabilization services are services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve, or resolve the member’s condition. Post-stabilization services are covered without prior authorization up to the point Missouri Care is notified that the member’s condition has stabilized.
Continuation of Care
In the event that a physician should terminate his or her contract with Missouri Care, members in active treatment may continue to receive care from the terminated provider in the following circumstances:

- Pregnancy;
- A disability, life-threatening illness;
- Active stage of an illness; or
- Serious medical condition.

If a member is receiving treatment from the terminated provider and the 90-day transition period has expired, Missouri Care will consider whether an in-network provider could provide the medically necessary services or if continued care with the terminated provider must be continued.

For continued care under this provision, the terminated provider accepts the following:

- Reimbursement rate of 100 percent of the Medicaid fee schedule
- Payment from Missouri Care as payment in full (no balance billing) and shall not collect payment from members except for:
  - Applicable MO HealthNet cost-sharing amounts.

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 the 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.

Transition of Care
The health plan shall provide continuation of medically necessary covered services for the lesser of 90 calendar days or until the member has transferred, without disruption of care, to an in-network provider. Missouri Care will continue to be responsible for the costs of continuation of such medically necessary covered services, without any form of prior approval and without regard to whether such services are being provided within or outside Missouri Care’s network until such time as Missouri Care can reasonably transfer the member to a service and/or network provider without impeding service delivery that might be harmful to the member’s health. However, notification to Missouri Care is necessary to properly document these services and determine any necessary follow-up care.

After the initial 90 days providers are required to follow Missouri Care’s prior authorization or concurrent review requirements.

When relinquishing members, Missouri Care will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other provider.

When Missouri Care becomes aware that a covered member will be disenrolled from Missouri Care and will transition to another health plan or to a fee-for-service Missouri Medicaid program a Case Manager who is familiar with that member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.
Missouri Care must identify and facilitate coordination of care for members during changes or transitions between plans. Members with special circumstances may require additional and/or distinctive assistance during the transition period. Special circumstances include members designated as having "special health care needs".

If a provider receives an adverse claim determination which they believe was a transition of care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation for reconsideration. Refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources for the Appeals Department contact information.

**Limits to Abortion, Sterilization, and Hysterectomy Coverage**
The following services have special requirements from the State of Missouri.

**Abortion**
Prior authorization is not required for abortion procedures. However, Missouri Care will deny any provider claims submitted without the required abortion certification form or with an incomplete or inaccurate abortion certification form.

Abortions are covered for eligible Missouri Care members if the provider certifies that the abortion is medically necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

Abortions are not covered if used for family planning purposes. A Certification Of Medical Necessity For Abortion Form [MO886-3255 (10-07)] must be properly executed and submitted to Missouri Care with the provider’s claim. This form may be filled out and signed by the physician and is located at manuals.momed.com/forms/Certificate_of_Medical_Necessity_for_Abortion.pdf. Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition, Missouri Care also requires the submission of the History, Physical and Operative Report and the Pathology Report with all claims that have the following ICD-9-CM procedure codes to ensure that abortions are not being billed through the use of other procedure codes:

- 69.0 Dilation and curettage of uterus;
- 69.02 Dilation and curettage following delivery or abortion;
- 69.09 Other dilation and curettage;
- 69.5 Aspiration curettage of uterus;
- 69.52 Aspiration curettage following delivery or abortion;
- 69.59 Other aspiration curettage of uterus;
- 69.6 Menstrual extraction or regulation;
- 69.93 Insertion of Laminaria;
- 70.0 Culdocentesis;
- 72.7 Vacuum extraction;
- 72.71 Vacuum extraction with episiotomy;
- 72.79 Other vacuum extraction;
- 74.99 Other cesarean section of unspecified type; and
• 96.49 Genitourinary installation.

The following procedure codes require abortion certifications:
• 69.01 Dilation and curettage for termination of pregnancy;
• 69.51 Aspiration curettage of uterus for termination of pregnancy;
• 74.91 Hysterectomy to terminate pregnancy; and
• 75.0 Intra-amniotic injection for abortion.

Sterilizations
Missouri Care will not and is prohibited from making payment for sterilizations performed on any person who:
• Is under 21 years of age at the time he or she signs the consent; or
• Is not mentally competent.

The Sterilization Consent Form (PSFL-200) form is required for sterilizations. This form can be found at manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf. Prior authorization is not required for sterilization procedures. However, Missouri Care will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days. The signed consent form expires 180 calendar days from the date of the member’s signature. The day after the signing is considered the first day when counting the 30 days.

In the case of premature delivery, the consent form must be completed and signed by the member at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. For emergency abdominal surgery, the consent form must be completed and signed by the member at least 72 hours prior to the sterilization procedure. Although these exceptions are provided, the conditions of the waiver will be subject to review.

A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to Missouri Care. The member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

The following is a list of ICD-9-CM procedure codes associated with sterilization. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

ICD-9-CM codes that always require a Sterilization Consent Form:
• 63.70 Male sterilization procedure, not otherwise specified; and
• 66.39 Other bilateral destruction or occlusion of fallopian tubes.

ICD-9-CM codes that require a Sterilization Consent Form if done for sterilization purposes:
• 63.71 Other ligation of vas deferens;
• 63.73 Vasectomy;
• 65.6 Bilateral Salpingo-oophorectomy;
65.61 Other removal of both ovaries and tubes at same operative episode;
65.62 Other removal of remaining ovary and tube;
66.99 Other operations on fallopian tubes;
66.02 Salpingostomy;
66.21 Bilateral endoscopic ligation and crushing of fallopian tubes;
66.22 Bilateral endoscopic ligation and division of fallopian tubes;
66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes;
66.31 Other bilateral ligation and crushing of fallopian tubes;
66.32 Other bilateral ligation and division of fallopian tubes;
66.4 Total unilateral salpingectomy;
66.51 Removal of both fallopian tubes at same operative episode;
66.52 Removal of remaining fallopian tube;
66.63 Bilateral partial salpingectomy, not otherwise specified; and
66.69 Other partial salpingectomy.

**Hysterectomy**

Prior authorization is required for the administration of a hysterectomy to validate medical necessity when performed in an inpatient setting. Missouri Care reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual and her representative (e.g., legal guardian, husband, etc.) was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member and the attending physician must sign and date the *Acknowledgement of Receipt of Hysterectomy Information Form* [MO886-3280 (9-95)]. The form can be found at [207.15.48.5/collections/collection_phy/Physician_Section14.pdf](207.15.48.5/collections/collection_phy/Physician_Section14.pdf). Exceptions to the requirement for an *Acknowledgement of Receipt of Hysterectomy Information Form* may be made in the following situations:
  - The member was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the member was already sterile at the time of the hysterectomy and state the cause of the sterility. This must be documented by an operative report or admit and discharge summary;
  - The member requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgement is not possible. The physician must certify in writing to this effect, and include a description of the nature of the emergency; or
  - The member was not MO HealthNet eligible at the time the hysterectomy was performed but eligibility was made retroactive to this time. The physician who performed the hysterectomy must certify in writing to one of the following situations:
    1. The member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;
    2. The member was already sterile before the hysterectomy; or
    3. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible.
A hysterectomy is not covered when:
- The hysterectomy was performed solely for the purpose of rendering a member permanently incapable of reproducing; or
- There was more than one purpose to the procedure. The hysterectomy would not have been performed but for the purpose of rendering the member permanently incapable of reproducing.

Missouri Care will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. Missouri Care does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

The following is a list of ICD-9-CM procedure codes associated with hysterectomies. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy acknowledgement form is attached. All hysterectomy codes listed require the Acknowledgement of Receipt of Hysterectomy Information Form [MO886-3280 (9-95)]:
- 68.31 Laparoscopic supracervical hysterectomy (LSH);
- 68.39 Other and unspecified subtotal abdominal hysterectomy;
- 68.41 Laparoscopic total abdominal hysterectomy;
- 68.49 Other and unspecified total abdominal hysterectomy;
- 68.51 Laparoscopically assisted vaginal hysterectomy (LAVH);
- 68.59 Other and unspecified vaginal hysterectomy;
- 68.61 Laparoscopic radical abdominal hysterectomy;
- 68.69 Other and unspecified radical abdominal hysterectomy;
- 68.71 Laparoscopic radical vaginal hysterectomy (LRVH);
- 68.79 Other and unspecified radical vaginal hysterectomy;
- 68.8 Pelvic evisceration; and
- 68.9 Other and unspecified hysterectomy.

**Delegated Entities**

Missouri Care delegates some UM activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for UM activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required UM standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Missouri Care and the delegated entities. Agreement must be approved by MO HealthNet prior to implementation.

Delegation of select functions may occur only after an initial audit of the UM activities has been completed and there is evidence that Missouri Care’s delegation requirements are met. These requirements include:
- A written description of the specific UM delegated activities;
- Semi-annual reporting requirements;
- Evaluation mechanisms; and
Remedies available to Missouri Care if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently as needed, audits of the delegated entity are performed to ensure compliance with Missouri Care’s delegation requirements. For more information on delegated entities, refer to Section 9: Delegated Entities.

Case Management Program

Overview
Missouri Care offers comprehensive integrated Case Management (CM) services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. Missouri Care trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Missouri Care CM Programs.

Missouri Care’s multidisciplinary CM teams are led by specially trained Registered Nurses (RN) or Licensed Behavioral Health Case Managers who perform a comprehensive assessment of the member’s clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The case managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

Missouri Care’s CM teams also serve in a supportive capacity to the PCP and assist in actively linking the member to providers, medical and behavioral services, residential, social and other support services, as needed. A provider may request case management services for any Missouri Care member.

The CM process begins with member identification and follows the member until discharge from the program. Members may be identified for CM by:
- Referral from a member’s PCP or specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- Completion of a Health Risk Assessment (HRA);
- DM Program referral; and/or
- Data mining for members with high utilization.

Missouri Care’s philosophy is that the CM Program is an integral management tool in providing a continuum of care for Missouri Care members. Key elements of the CM process include:
- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where he or she is in the health continuum. This assessment gauges the member’s support systems and resources and seeks to align them with appropriate clinical needs;
- **Care Planning** – collaboration with the member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the plan of care;
- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up; and
• **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Case managers assist members with seeking the services to optimize their health. CM emphasizes continuity of care for members through the coordination of care among physicians, Community Mental Health Centers, and other providers.

Members with the following concerns are commonly included in the CM Program:

- **Catastrophic** – Traumatic injuries, e.g., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas;
- **Multiple Chronic Conditions** – multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), hypertension, cancer, cardiac disease or multiple intricate barriers to quality health care, e.g., acquired immune deficiency syndrome (AIDS); and chronic pain;
- **Transplantation** – organ failure, donor matching, post-transplant follow-up;
- **Complex Discharge Needs** – members discharged home from an acute inpatient stay or Skilled Nursing Facility (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health), complicated, non-healing wounds, advanced illness, etc.;
- **Special Health Care Needs** – Children or adults who have serious medical or chronic conditions with severe physical, mental or developmental disabilities; sickle cell, hepatitis, pervasive development disorder, anxiety disorders;
- **Pregnant Members**
- **Members with Elevated Lead Levels** – Any member with a lead level greater than 10 ug/dl must be referred for case management; and
- **Members with co-occurring behavioral health and substance abuse.**

**Disease Management Program**

**Overview**

Disease management (DM) is a population-based strategy that involves consistent care across the continuum for members with certain disease states. Elements of the program include education of the member about the particular disease and self-management techniques, monitoring of the member for adherence to the treatment plan and the consistent use of validated, industry-recognized evidence-based CPGs) by the treatment team as well as the Disease Manager.

The Disease Management Program targets the following conditions:

- Asthma – adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes – adult and pediatric;
- HIV/AIDS;
- Hypertension;
- Depression.

Missouri Care’s DM Program educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating providers regarding the standards of specific disease states...
and current treatment recommendations. Intervention and education can improve the quality of life of members, improve health outcomes and decrease medical costs. In addition, Missouri Care makes general information available to providers and members regarding health conditions on Missouri Care’s website at www.wellcare.com/provider/CPGs.

**Candidates for Disease Management**

Missouri Care encourages referrals from providers, members, hospital discharge planners and others in the health care community.

Interventions for members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized CPGs. Members identified at the highest stratification levels receive a comprehensive assessment by a DM nurse, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals.

Each PCP will receive a list of their members enrolled in each DM Program upon the member’s initial enrollment and at least yearly thereafter. Disease-specific CPGs adopted by Missouri Care may be found on Missouri Care’s website at www.wellcare.com/provider/CPGs.

**Access to Case and Disease Management Programs**

If you would like to refer a Missouri Care member as a potential candidate to the CM or DM Programs, or would like more information about one of the programs, you may call the Missouri Care Case Management Referral Line. Members may self-refer by calling the Case Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Case Management Referral Line, refer to the *Quick Reference Guide* on Missouri Care’s website at www.missouricare.com/provider/resources.
Section 5: Claims

Overview
The focus of Missouri Care’s Claims department is to process claims in a timely manner. Missouri Care has established toll-free telephone numbers for providers to access a representative in our Provider Services Department.

For more information, refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.

Timely Claims Submission
Providers have 365 days from the date of service to correct and resubmit claims if the initial submission time period has been met. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims. For coordination of benefits, providers have 365 days from date of service or 90 days from the date of the primary Explanation of Benefits (EOB); whichever time frame is longer to submit. Unless prohibited by federal law or CMS, Missouri Care may deny payment for any claims that fail to meet Missouri Care’s submission requirements for clean claims or that are received after the time limit in the Agreement for filing clean claims.

The following items can be accepted as proof that a claim was submitted timely:
- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Missouri Care; and
- A provider’s electronic submission sheet with all the following identifiers:
  - patient name;
  - provider name;
  - date of service to match Explanation of Benefits (EOB)/claim(s) in question;
  - prior submission bill dates; and
  - Missouri Care product name or line of business.

The following items are not acceptable as evidence of timely submission:
- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the provider’s billing screen.

Tax Identification (TIN) and National Provider Identifier (NPI) Requirements
Missouri Care requires the payer-issued Tax Identification (Tax ID/TIN) and National Provider Identifier (NPI) on all claims submissions. Missouri Care will reject claims without the Tax ID and/or NPI. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov.

Preauthorization Number
If a preauthorization number was obtained, it is recommended that providers include this number in the appropriate data field on the claim to reduce processing errors.
National Drug Codes (NDC)
Missouri Care follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process (SNIP)
All claims and encounter transactions submitted via paper, Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.

If a claim is rejected for lack of compliance with Missouri Care’s claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information, see the Encounters Data section below.

Claims Submission Requirements
When presenting a claim for payment to Missouri Care, the provider is indicating an understanding that:

- The provider has an affirmative duty to supervise the provision of, and be responsible for, the covered services claimed to have been provided;
- To supervise and be responsible for preparation and submission of the claim; and
- To present a claims that is true and accurate and is for health plan covered services that:
  - Have actually been furnished to the member by the provider prior to submitting the claims; and
  - Are medically necessary.

Providers using electronic submission shall submit all claims to Missouri Care or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or an original (red and white) CMS 1500 and/or UB-04, or their successors. Claims shall include the provider’s NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member’s medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses and/or non-covered services. For more information on paper submission of claims, refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.

Electronic Claims Submissions
Missouri Care accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Missouri Care must be in the ANSI ASC X12N format, version 5010. For more information on EDI implementation with Missouri Care, refer to the Missouri Care Companion Guides which may be found on Missouri Care’s website at www.missouricare.com/provider/claims_updates.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or with Missouri Care’s contracted clearinghouse, to establish EDI with Missouri Care. For information on the unique Missouri Care Payer Identification (Payer ID) numbers used to identify Missouri Care on electronic claims submissions, or to contact Missouri Care’s EDI team, refer to the Provider Resource Guide on Missouri Care’s website at www.missouricare.com/provider/resources.
To Submit Coordination of Benefits (COB) Electronically
To submit COB claims, your practice management system/data entry process and your clearinghouse must be able to:

- Create or forward claims in the full HIPAA standard form at (837) or in a format that contains equivalent information and includes necessary COB fields; and
- Include payment information received from the primary payer’s HIPAA standard electronic remittance advice (ERA) or by converting the primary payer’s paper Explanation of Benefits (EOB) into the standard coding used in an ERA (see section on Converting Information for more details).

Types of COB claims that can be sent electronically:

- Commercial insurance claims where another payer is primary and Missouri Care is secondary; and
- Medicare primary claims when Medicare hasn’t already forwarded us their claim and payment information.

Payment information required for commercial electronic COB claims:

- Adjustment amounts – at both claim level and service line level (if available);
- Adjustment reasons – contractual obligation, deductible, coinsurance, etc.; and
- Primary payer paid amount – at both claim level and service line level (if available)

Payment information required for Medicare primary electronic COB claims:

- Adjustment amounts – at both claim level and service line level (if available)
- Adjustment reasons – contractual obligation, deductible, coinsurance, etc.
- Medicare paid amount – at both claim level and service line level (if available)
- Medicare acceptance of assignment

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as Missouri Care, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format. To promote consistency and efficiency for all claims and encounter submissions to Missouri Care, it is Missouri Care’s policy that these requirements also apply to all paper and DDE transactions.

On October 1, 2015, Missouri Care will no longer accept ICD-9 codes due to the CMS ICD-10 mandate. Missouri Care will accept only ICD-10 codes on all claim submissions with dates of service on or after October 1, 2015. Missouri Care will reject any claim submissions that have ICD-9 and ICD-10 codes in the same claim. Please refer to CMS website for more information about ICD-10 and split claim guidance at www.cms.gov. Please see the NUCC and NUCB guides for billing details. Please see 837 Implementation Guides (IG) for EDI for correct qualifier to use with the ICD-10 codes.
All providers must submit HIPAA compliant diagnoses codes, ICD-9-CM or its successor, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) or their successors, and current Revenue Codes and UB Bill Types. Missouri Care will follow all CMS mandates for any future ICD, CPT, HCPCS, Revenue Code or Bill Type changes.

Specific Missouri Care requirements for claims and encounter transactions, code sets and SNIP validation are described below. To promote consistency and efficiency for all claims and encounter submissions to Missouri Care, it is Missouri Care’s policy that these requirements also apply to all paper and DDE transactions.

Specific Missouri Care requirements for claims and encounter transactions, code sets and SNIP validation are described below. For more information on EDI implementation with Missouri Care, refer to the Missouri Care Companion Guides which may be found on Missouri Care’s website at [www.missouricare.com/provider/claims_updates](http://www.missouricare.com/provider/claims_updates).

Paper Claims Submissions
For a more timely processing of claims, providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties in the Agreement. For assistance in creating an EDI process, contact Missouri Care’s EDI team by referring to the Quick Reference Guide on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

If permitted under the Agreement, and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the elements and formatting described below:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for clean claims submission:
  - The information must be aligned within the data fields and must be:
    - On an original red ink on white paper claim forms;
    - Typed. Do not print, hand-write, or stamp any extraneous data on the form;
    - In black ink;
    - In large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - The typed information must not have:
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

**CMS Fact Sheet about UB-04:**

**CMS Fact Sheet about CMS-1500:**
Claims Processing

Readmission
Missouri Care may choose to review claims if data analysis deems it appropriate. Missouri Care may review hospital admissions on a specific member if it appears that 2 or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider), Missouri Care will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by Missouri Care, may be subject to a recoupment.

Disclosure of Coding Edits
Missouri Care uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to Missouri Care. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Prompt Payment
By contract with the State of Missouri, Missouri Care follows Missouri State statutes 376.383 and 384 regarding prompt payment.

Coordination of Benefits (COB)
As a Medicaid payer, Missouri Care is considered the payer of last resort.

Missouri Care shall coordinate payment for covered services in accordance with the terms of a member’s benefit plan, MO HealthNet rules and regulations, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Missouri Care. Missouri Care will coordinate up to the Medicaid allowable, so if there is any balance due after receipt of payment from the primary payer, all charges should be submitted to Missouri Care for consideration. The claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits (EOB). Missouri Care may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Missouri Care policies and procedures regarding subrogation activity.

Balance Billing Prohibited
Providers shall accept payment from Missouri Care for covered services provided to Missouri Care members in accordance with the reimbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by Missouri Care for covered benefits, with the exception of member expenses. For covered services, providers shall not balance bill members any amount in excess of the contracted amount in the Agreement. An adjustment in
payment as a result of Missouri Care’s claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for covered services.

Missouri Code of State Regulations Title 13 CSR 70-4.030 states in part, “When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient’s Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules.”

Missouri Care members should not be billed or reported to a collection agency for any covered services your office provides.

Providers may not bill Missouri Care members for:
- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow plan procedures;
- Covered services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where a contracted provider fails to notify the plan of a service that required prior authorization. Payment for that service will be denied;
- Covered services that were not medically necessary, in the judgment of Missouri Care, unless prior to rendering the service, the provider obtains the member’s informed written consent and the member receives information regarding the member’s financial responsibility for the specific services.

Providers may bill Missouri Care members only:
- When prior to services being rendered to the member, the member and provider enter into a written agreement indicating that neither Missouri Care nor MO HealthNet are the intended payers for the specific item or service but rather the member accepts the status and liabilities of a private pay patient in accordance with Missouri Code of State Regulations Title 13 CSR 70-4.030. The statement should also include the cost of the non-covered service and an assurance that there are no other covered services available to the member. In addition, the disclosure statement must contain the payment arrangements. If the member will be subject to collection action upon failure to make the required payment, the terms of said action must be included in the disclosure document. A copy of the disclosure form must be kept in the member’s treatment record; or
- When the requirement for written evidence of an agreement between the member and provider is not applicable to services provided to a member who is dually eligible and entitled to both Missouri Care and Medicare Part B medical insurance benefits.

Provider-Preventable Conditions (PPCs)
Missouri Care follows CMS guidelines regarding “Hospital Acquired Conditions,” “Never Events,” and other “Provider-Preventable Conditions (PPCs).” Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

A Never Event is defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:
- a different procedure altogether;
- the correct procedure but on the wrong body part; or
- the correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html) and include such events as an air embolism, falls, and catheter-associated urinary tract infection.

Health care providers may not bill, attempt to collect from, or accept any payment from Missouri Care or the member for PPCs or hospitalizations and other services related to these non-covered procedures.

**Claims Disputes**

The claims dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Missouri Care in writing within 365 days of the date of denial of the Explanation of Payment (EOP).

The following documentation is required:
- Date(s) of service;
- Member name;
- Member Missouri Care ID number (or MO HealthNet DCN) and/or date of birth;
- Provider name;
- Provider Tax ID/TIN;
- Total billed charges;
- The provider’s statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical records).

To initiate the process, please mail to the address, or fax to the fax number, listed in the Quick Reference Guide on Missouri Care’s website [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

Following the outcome of payment determination, providers may be afforded further appeal rights. For more information, please refer to Section 7: Appeals and Grievances.

**Corrected Claims or Voided Claims**

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

To submit a corrected or voided claim electronically:
- For Institutional claims, the provider must include the original Missouri Care claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, the provider must have the frequency code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

These codes are not intended for use for original claim submission or rejected claims.

To submit a corrected or voided claim via paper:
• For Institutional claims, the provider must include the original Missouri Care claim number and bill frequency code per industry standards.

Example:

Box 4 – Type of Bill: the third character represents the “Frequency Code”

<table>
<thead>
<tr>
<th>TYPE OF BILL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>B</td>
<td>117</td>
</tr>
</tbody>
</table>

Box 64 – Place the claim number of the prior claim in Box 64

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL NUMBER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>298370064</td>
<td></td>
</tr>
</tbody>
</table>

• For Professional claims, the provider must include the original Missouri Care claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 OR 8</td>
<td>123456789012A33456</td>
</tr>
</tbody>
</table>

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible) – and noted “Payment lost/voided/missed.” This process will deduct the payment for this claim, or zero net amount if applicable.

2. The corrected or voided claim will be processed with the newly submitted information and noted “Adjusted per corrected bill.” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

**Surgical Payments**

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

• **Incidental Surgeries/Complications** – A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a Missouri Care Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- **Follow-up Surgery Charges** – Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

### Multiple Procedures

Payment for multiple procedures is based on:

- 100% of maximum allowable fee for primary surgical procedure;
- 50% of maximum allowable fee for second through the fifth surgical procedure; and
- 25% of maximum allowable fee for all subsequent surgical procedures.

The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

### Modifier 51

When multiple procedures are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or services(s) shall be identified by appending modifier 51 to the additional procedure or service codes(s).

Modifier 51 should not be appended to designated “add-on” codes.

### Assistant Surgeon

Assistant Surgeons (modifier 80) are reimbursed consistent with the MO Medicaid Physician Fee Schedule effective on the date the service is provided and consistent with multiple procedure reduction.

### Co-Surgeon

Each provider will be reimbursed consistent with the MO Medicaid Physician Fee Schedule effective on the date the service is provided. In these cases, each surgeon should report his or her distinct operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier ‘62’ added.

### Overpayment Recovery

Missouri Care strives for 100% payment quality but recognizes that a small percentage of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s), and other reasons.

Missouri Care will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Missouri Care will adhere to requirements defined by MO HealthNet and State statute.
In all cases, Missouri Care, or its designee, will provide a written notice to the provider explaining the reason for the overpayment and amount, contact information, and instructions on how to send the refund. The standard request notification provides 60 days for the provider to send in the refund, request further information, appeal or dispute the retroactive denial.

Failure of the provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The provider will receive an Explanation of Payment (EOP) indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the provider may be contacted by Missouri Care, or its designee, to arrange payment.

If the provider independently identifies an overpayment, it can either a) send a corrected claim, b) contact Missouri Care Provider Services to arrange an off-set against future payments, or c) send a refund and explanation of the overpayment to:

Missouri Care Health Plans, Inc.
P.O. Box 31584
Tampa, FL 33631-3584

For more information on contacting Provider Services, refer to the Quick Reference Guide which may be found on the Missouri Care website at: www.missouricare.com/provider/resources.
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate Missouri Care peer review bodies evaluate the credentials and training qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

This review includes (as applicable to practitioner type):
- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care;
- Accreditation status, as applicable to non-individuals; and
- Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver.

Practitioners are required to be credentialed prior to being listed as participating network providers of care or services to Missouri Care members.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:
- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and Missouri Care policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to Missouri Care members.
- Satisfactory site inspection evaluations may be required periodically in accordance with state, federal, and accreditation requirements.
- After the provider enrollment process has been completed, a timely notification of the credentialing decision is forwarded to the provider.
Credentialing may be performed directly by Missouri Care or by an entity approved by Missouri Care for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet Missouri Care’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Missouri Care requirements.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

**Practitioner Rights**

Practitioner Rights are listed below and included in the application/re-application cover letter.

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**

Written requests for information may be emailed to missouriproviderrelations@wellcare.com. Upon receipt of a written request, Missouri Care will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/Re-Credentialing Application**

The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies and certification boards, subject to any Missouri Care restrictions. Missouri Care, or its designee, will review the corrected information and explanation at the time of considering the practitioner’s credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by Missouri Care or its designee.

**Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame**

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Missouri Care, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Missouri Care will provide written notification to the practitioner of the discrepant information.

Missouri Care’s written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
• The addressee in Credentialing to whom corrections must be sent;
• Missouri Care’s documentation process for receiving the correction information from the provider; and
• Missouri Care’s review process.

Baseline Criteria
The baseline criteria for practitioners to qualify for provider network participation are as follows:

• **License to Practice** – Practitioners must have a current, valid, unrestricted license to practice (as applicable to practitioner type).
• **Drug Enforcement Administration Certificate** – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD).
• **Work History** – Practitioners must provide a minimum of five (5) years’ relevant work history as a health professional.
• **Board Certification** – Physicians (MD, DO, DPM) must maintain Board Certification in the specialty being practiced as a provider for Missouri Care or must have verifiable educational/training from an accredited training program in the specialty requested.
• **Hospital-Admitting Privileges** – Specialist practitioners shall have hospital-admitting privileges at a Missouri Care-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Missouri Care-participating provider who has admitting privileges at a Missouri Care-participating hospital for the admission of members.
• **Ability to Participate in Medicaid and Medicare** – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Missouri Care Company Plan. Providers are not eligible for participation if such provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the provider. Existing providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with Missouri Care policy and procedure.
• **New Providers** – All health care providers that are covered entities under HIPAA must obtain a National Provider Identifier (NPI) to participate in Missouri Care’s network.

Liability Insurance
Missouri Care Plan providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits as indicated below, unless otherwise agreed by Missouri Care in writing:
• $1,000,000/$3,000,000 per provider.

Providers must furnish copies of current professional liability insurance certificate to Missouri Care, concurrent with expiration.

Site Inspection Evaluation (SIE)
Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds have been established for:
• Office-site criteria:
  o Physical accessibility;
Physical appearance; and
Adequacy of waiting room and examination room space;
- Medical/treatment record keeping criteria;
- Evidence that the health plan has determined that the following documents are posted in the provider's waiting room/reception area:
  - Office Hours; and
  - Member Rights and Responsibilities.

SIEs are conducted for:
- Unaccredited facilities who cannot provide a state or CMS review or certification;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When a complaint is received relative to office site criteria.

Although CMS or State review or certification does not serve as accreditation of an institution, in the case of non-accredited institutions, a CMS or State review may be substituted in lieu of the required site visit. The institution/facility may provide evidence in the form of a report from the state or CMS confirming the review was performed and indicating that the institution/facility met standards; however, a letter from CMS showing that the facility was reviewed and indicating that it passed inspection may also be used in lieu of the survey report. Review of the criteria used by the state or CMS will be made to ensure the criteria used by CMS or the state is acceptable to meet all elements of the plan’s initial assessment criteria.

In states where initial SIEs are not required for credentialing, there is ongoing monitoring of member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

**Covering Physicians**
PCPs in a solo practice must have a covering physician who also participates with or is credentialed with Missouri Care.

**Allied Health Professionals**
Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Missouri Care.

Dependent AHPs include the following, and are required to provide collaborative practice information to Missouri Care that includes a supervising/collaborating physician who also participates with or is credentialed with Missouri Care:
- Advanced Registered Nurse Practitioners (ARNP);
- Certified Nurse Midwife (CNM);
- Physician Assistant (PA);
- Osteopathic Assistant (OA); and
- Anesthesia Assistant (AA)

Independent AHPs include, but are not limited to the following:
- Licensed clinical social worker;
- Licensed master social worker;
- Licensed professional counselor;
- Licensed marriage and family therapist;
• Physical therapist;
• Occupational therapist;
• Audiologist; and
• Speech/language therapist/pathologist.

**Ancillary Health Care Delivery Organizations**
Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE (as applicable). Missouri Care is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a Missouri Care provider.

**Re-Credentialing**
In accordance with regulatory, accreditation and Missouri Care policy and procedure, re-credentialing is required at least once every 3 years.

**Updated Documentation**
In accordance with contractual requirements, providers should furnish copies of current professional or general liability insurance, license, DEA certificate, and accreditation information (as applicable to provider type) to Missouri Care prior to or concurrent with expiration.

**Office of Inspector General Medicare/Medicaid Sanctions Report**
On a regular and ongoing basis, Missouri Care or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most currently available information. This information is cross-checked against the network of providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination and notification of termination of contract, in accordance with Missouri Care policies and procedures.

**Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials**
On a regular and ongoing basis, Missouri Care or its designee contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of Missouri Care providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Missouri Care policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Missouri Care policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

**Participating Provider Appeal through the Dispute Resolution Peer Review Process**
Missouri Care may immediately suspend, pending investigation, the participation status of a participating provider who, in the sole discretion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of members. In such instances, the Medical Director investigates on an expedited basis.
Missouri Care has a Participating Provider Dispute Resolution Peer Review Panel process in the event Missouri Care chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has 2 levels. All disputes in connection with the actions listed below are referred to a first-level Peer Review Panel consisting of at least 3 qualified individuals, of whom at least 1 is a participating provider and a clinical peer of the practitioner who filed the dispute.

The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least 3 qualified individuals of which at least 1 is a participating provider and a clinical peer of the practitioner that filed the dispute and the second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by Missouri Care entitle the affected practitioner to the Provider Dispute Resolution Peer Review Panel Process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct; service or excessive claims and/or sanction history.

Notification of the adverse recommendation, together with reasons for the action, and the practitioner’s rights and process for obtaining the first and/or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or his or her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing.

The practitioner and Missouri Care are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within 5 business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first-level Panel hearing. In the event the findings are positive for the practitioner, the second-level review shall be waived.

In the event the findings of the first-level Panel hearing are adverse to the practitioner, the practitioner may access the second-level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level Peer Review Panel.
Within 10 calendar days of the request for a second-level Peer Review Panel hearing, the Medical Director or his or her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

The second-level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within 5 business days after final adjournment of the second-level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second-level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second-level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives any right to such review to which he or she might otherwise have been entitled. Missouri Care may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

**Delegated Entities**
All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to *Section 9: Delegated Entities* in this Provider Manual for further details.
Section 7: Complaints, Appeals and Grievances

Provider Complaints and Appeals
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 or her 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 Missouri Care to act within the time frames specified.

A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Missouri Care policy, procedure, claims (reimbursement amount, processing time, procedures, etc.) or any aspect of Missouri Care functions other than an action. 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 Missouri Care. Appeals must be submitted in writing. All expressions of dissatisfaction resulting from receipt of a claim or authorization denial or a claims dispute resolution are automatically classified as an appeal.

Provider Complaints and Appeals Procedures
All complaints and appeals will be filed directly by mailing the information to:

Missouri Care
Complaints and Appeals Analyst
2404 Forum Blvd.
Columbia, MO 65203

Providers may file a verbal or written complaint or a written appeal within 90 days, or within a contractually specified time frame, of the incident or action/denial that resulted in the complaint or appeal. Complaints will be resolved within 45 calendar days of receipt of the complaint at Missouri Care. 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 90 calendar days of the complaint resolution. The appeal process will include an opportunity for the provider or their representative to present their case in person.

Missouri Care will reach a final decision on an appeal within 45 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

1 See NCQA CR10, A-4
2 RFP 2.15.1
3 RFP 2.17.1
4 RFP 2.17.1
5 See NCQA CR10, A-4
6 RFP 2.17.2.b.5
member’s life, physical or mental health or the member’s ability to regain maximum function. 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.

**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 using the grievance and appeal process.

A grievance is an expression of dissatisfaction about any matter other than an action as defined above. 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 action.

**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 Services Department: physical accessibility, physical appearance, adequacy of waiting/examination room space, availability of appointments and adequacy of treatment recordkeeping. Any such grievance can be followed by a site visit to the provider’s office for review. An action plan will be implemented if deficiencies are noted.

• A member may file a grievance either verbally or in writing.
• All grievances will be acknowledged in writing within 10 business days of filing.
• Written notification of the disposition of the grievance will not exceed 30 calendar days from the filing date or as expeditiously as the member’s health condition requires.

To file a grievance, a member can call Missouri Care at 1-800-322-6027 and tell them they want to file a grievance. TTY users can call 1-800-735-2966. If the member speaks another language they can ask for an interpreter at no cost to the member.

**Member Appeal Procedure and Rights to a State Fair Hearing**

**Member Appeal Procedure**

A member may file an appeal and/or may request a state fair hearing within 90 calendar days from the date on Missouri Care’s notice of action. With the member’s written consent, a provider or other authorized representative may file an appeal on behalf of a member. The member can

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7 RFP 2.15.6.n
8 RFP 2.15.1
9 RFP 2.15.1
10 See NCQA CR6, A-1
11 RFP 2.15.5.a
12 RFP 2.15.5.c
13 RFP 2.15.5.e
14 RFP 2.15.6.a
present their case in person. The member can represent themselves, or a relative, a friend, or anyone else they want can help them appeal. They can also be represented by an attorney.

A member can also file an appeal in writing with Missouri Care if:

- Missouri Care fails to act within required time frames for getting a service;
- Missouri Care fails to make a grievance decision within 30 days of receipt of request;
- Missouri Care fails to make an expedited decision within 3 days of receipt of request; or
- Missouri Care fails to make an appeal decision within 45 days of receipt of request.

To file an appeal, a member can call Missouri Care at 1-800-322-6027 and tell them they want to file an appeal. TTY users can call 1-800-735-2966. If the member speaks another language they can ask for an interpreter at no cost to the member.

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 requested. 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 10 business days after receiving the appeal.

The time frame 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 requires. MO HealthNet allows 45 days for Missouri Care to make an appeal decision. Missouri Care will make the decision within 30 days of receipt of the request.

*Member Rights to a State Fair Hearing*

To ask for a state fair hearing, a member can call 1-800-392-2161. TTY users, call 1-800-735-2966. If the member speaks another language they can ask for an interpreter at no cost to the member. Or they can write to:

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

The hearing is informal. The member can represent themselves, or a relative, a friend, or anyone else they want can help them request a hearing. They can also be represented by an attorney. The member has 90 days from the date of the notice of action to do this.

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15 RFP 2.15.6.b  
16 RFP 2.15.6.e  
17 RFP 2.15.6.k
The state agency must reach its decisions within the specified time frames:
- For standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a state fair hearing) or the date the member filed for direct access to a state fair hearing.
- For expedited resolution (if the appeal was heard first through the health plan appeal process): within 3 working days from the state agency’s receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using the health plan’s expedited appeal time frames, or was resolved wholly or partially adversely to the member using the health plan’s expedited appeal time frames.
- For expedited resolution (if the appeal was made directly to the state fair hearing process without accessing the health plan appeal process): within 3 working days from the state agency’s receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

A member may continue to receive services during the appeals/hearing process under the following circumstances:
- As used in this section, “timely” filing means filing in writing on or before the latter of the following:
  - Within 10 calendar days of the mailing of the notice of action; or
  - The intended effective date of the proposed action.
- The member’s benefits shall be continued if the member or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits.
- If the member requests benefits to be continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:
  - The member withdraws the appeal.
  - 10 calendar days pass after Missouri Care mails the notice, providing the resolution of the appeal against the member, unless the member, within the 10 calendar day time frame, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
  - A state fair hearing officer issues a hearing decision adverse to the member.
  - The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, that is, upholds Missouri Care’s action, Missouri Care may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. The member is informed that he/she can be financially liable for the services that were rendered during this process.
Section 8: Compliance

Missouri Care Compliance Program

Overview
Missouri Care’s corporate ethics and compliance program, as may be amended from time to time, includes information regarding Missouri Care’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Missouri Care, Missouri Care employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and sub-contractors and their employees, are required to comply with Missouri Care compliance program requirements. Missouri Care’s compliance-related training requirements include, but are not limited to, the following initiatives:

- **Corporate Integrity Agreement (CIA) Training:**
  - Effective April 26, 2011, Missouri Care’s Corporate Integrity Agreement (CIA) with the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS) requires that Missouri Care maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at Missouri Care.

- **HIPAA Privacy and Security Training:**
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA.
  - Training includes, but is not limited to, discussion on:
    - Proper uses and Disclosures of PHI;
    - Member Rights; and
    - Physical and technical safeguards.

- **Fraud, Waste and Abuse (FWA) Training:**
  - Must include, but is not limited to:
    - Laws and regulations related to FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the provider, including provider employees and provider sub-contractors and their employees, to have appropriate policies and procedures to address FWA;
    - Process for reporting suspected FWA;
    - Protections for employees and subcontractors who report suspected FWA; and
    - Types of FWA that can occur.

- **Cultural Competency Training:**
  - Develop programs to educate and identify the diverse cultural and linguistic needs of the members providers serve.

- **Disaster Recovery and Business Continuity:**
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short term or long term interruption of services.

Providers, including provider employees and/or provider sub-contractors, must report to
Missouri Care any suspected fraud, waste or abuse, misconduct or criminal acts by Missouri Care, or any provider, including provider employees and/or provider sub-contractors, or by Missouri Care members. Reports may be made anonymously through the Missouri Care FWA Hotline at 1-866-678-8355.

Details of the corporate ethics and compliance program may be found on Missouri Care’s website at www.wellcare.com/aboutus/default.

Provider Education and Outreach
Providers may:
- Display state-approved health-plan specific materials in-office;
- Announce a new affiliation with a health plan; and
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement.

Providers are prohibited from:
- Orally, or in writing, comparing benefits or provider networks among health plans, other than to confirm their participation in a health plan’s network;
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;
- Furnishing health plans’ membership lists to the health plan, including Missouri Care, or any other entity; and
- Assisting with health plan enrollment.

Code of Conduct and Business Ethics

Overview
Missouri Care has established a Code of Conduct and Business Ethics (the Code) that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Missouri Care’s Code of Conduct and Business Ethics policy can be found at www.wellcare.com/aboutus/default.

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, Missouri Care’s Corporate Ethics and Compliance Program. It describes Missouri Care’s firm commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity. All providers should familiarize themselves with Missouri Care’s Code of Conduct and Business Ethics. Participating providers and other contractors of Missouri Care are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspected fraud, waste and/or abuse by calling the Missouri Care FWA Hotline at 1-866-678-8355.

Fraud, Waste and Abuse (FWA)
Missouri Care is committed to the prevention, detection, and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory, and contractual requirements. Missouri Care has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers, and other common schemes.
Federal and state regulatory agencies, law enforcement, and Missouri Care vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians’ Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), providers and their employees must complete an annual FWA training program.

To report suspected fraud, waste and abuse, please refer to your Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources or call our confidential and toll-free Missouri Care compliance hotline at 1-866-678-8355. Details of the corporate ethics and compliance program, and how to contact the Missouri Care fraud hotline, may be found on Missouri Care’s website at www.wellcare.com/aboutus/default.

Confidentiality of Member Information and Release of Records
Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA Privacy and Security Rules and regulations, as may be amended. All provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members’ medical records and other Protected Health Information (PHI), and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/ inadvertent disclosure of all confidential medical information, including PHI.

Every provider practice is required to provide members with a Notice of Privacy Practices (NPP). The NPP advises members how the provider practice may use and share a member’s PHI and how a member can exercise his or her health privacy rights. Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:
- Medical records;
- Communication between a member and a provider regarding the member’s medical care and treatment;
• All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
• Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.);
• Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
• Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The NPP informs the member of her or his rights under HIPAA and how the provider and/or Missouri Care may use or disclose the member’s PHI. HIPAA regulations require each covered entity, such as health care providers, to provide a NPP to each new patient or member.

Written consent of the member is required for the transmission of the clinical and medical record information of a former enrolled member to any physician not connected with Missouri Care. The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.

**Disclosure of Information**

Periodically, members may inquire as to the operational and financial nature of their health plan. Missouri Care will provide that information to any member upon request. Members can request the above information verbally or in writing.

For more information on how to request this information, members may contact Missouri Care’s Provider Services using the toll-free telephone number found on the member’s ID card. Providers may contact Missouri Care’s Provider Services by referring to the *Quick Reference Guide* on Missouri Care’s website at [www.missouricare.com/provider/resources](http://www.missouricare.com/provider/resources).

**Cultural Competency Program and Plan**

The purpose of the Cultural Competency Program is to ensure that Missouri Care meets the unique, diverse needs of our members, values diversity within the organization and the members that we serve. It also identifies members in need of linguistic services and has adequate communication support for such members. Providers shall recognize and make arrangements to care for the culturally diverse needs of our members they serve.

The objectives of the Cultural Competency Program are to:

• Identify members who have potential cultural or linguistic barriers for which alternative communication methods are needed;
• Use culturally sensitive and appropriate educational materials based on the member’s race, ethnicity, condition of disability, and/or primary language spoken;
• Ensure that resources are available to overcome the language and communication barriers that exist in the member population. Make sure providers care for and recognize the culturally diverse needs of the population; and
• Teach staff to value the diversity of both their co-workers inside the organization and the population served, and behave accordingly. Decrease health care disparities in the minority populations Missouri Care serves.
Culturally and linguistically appropriate services (CLAS) are health care services that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires health care providers and/or their staff to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of Missouri Care’s Cultural Competency Program include:

- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of member data on race, ethnicity and language spoken.

- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled, ensuring that the existing resources for members are being utilized to their full potential.

- **Diversity and Language Abilities of Health Plan Staff**
  - Non-Discriminating – Missouri Care may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – Missouri Care recruits diverse talented associates in all levels of management; and
  - Multilingual – Missouri Care recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.

- **Diversity of Provider Network**
  - Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that members can choose a provider who speaks their primary language; and
  - Providers are recruited to ensure a diverse selection is available to care for the population served.

- **Linguistic Services**
  - Providers will identify members who have potential linguistic barriers for which alternative communication methods are needed and will contact Missouri Care to arrange appropriate assistance;
  - Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Provider Services Department;
  - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing-impaired. These services will be provided by vendors with such expertise and are coordinated by Missouri Care’s Provider Services Department; and
  - Written materials are available for members in large print format, and certain non-English languages prevalent in Missouri Care’s service areas.

- **Electronic Media**
  - Telephone system adaptations - members have access to the TTY line for hearing impaired services. Missouri Care’s Provider Services Department is responsible for any necessary follow-up calls to the member. The toll-free TTY number can be found on the member ID card.

- **Provider Education**
  - Missouri Care’s Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office’s Cultural Competency;
- For more information on the Cultural Competency Program, contact Provider Services or your Provider Relations representative,
- Providers must adhere to the Cultural Competency Program as set forth by the plan.
Section 9: Delegated Entities

Overview
Missouri Care may, by written contract, delegate certain functions under Missouri Care’s contracts with CMS and/or applicable state governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, case management, disease management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing and sales, adjudicating Medicare organization determinations, and appeals and grievances (the Delegated Services). Missouri Care may delegate all or a portion of these activities to another entity (a Delegated Entity).

Missouri Care oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of Missouri Care to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Missouri Care policies and procedures.

Compliance
The Delegation Oversight Department is charged with the administrative oversight authority and coordination of all delegated activities. The Delegation Oversight Committee (DOC) is chaired by the Director of Delegation Oversight. Committee members include QI Directors, contract owners, subject matter experts (SME) legal and compliance associates, and representatives from each line of business. Other areas of representation include Utilization Management, Claims, Customer Service, Billing, Credentialing, Provider Relations, Corporate Compliance, Medicare Compliance, Medicaid Compliance, Regulatory Affairs, Medical Economics, Quality Management and Appeals & Grievance. In addition to the monthly scheduled meetings, the DOC may conduct weekly ad hoc online meetings as needed. The DOC is the final approval authority for delegation activity. Recommendations for vendor/entity de-delegation are submitted to the Corporate Compliance Committee for final approval. The Delegation Oversight department participates in all internal compliance programs as directed by the organization. The department also contributes but is not limited to, external market and accreditation audits such as NCQA and External Quality Review Organization (EQRO).

Refer to Section 8: Compliance for additional information on compliance requirements.

Missouri Care ensures compliance through the delegation oversight process and the DOC. The DOC and its committee representatives:

- Verify eligibility of all delegated entities for participation in the Medicaid and Medicare programs;
- Review findings of the pre-delegation audit to evaluate the entity’s ability to perform the delegated function;
- Review and approve entities for delegation of functions;
- Ensure written agreements with each delegated entity clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties;
• Conduct formal, ongoing evaluation of the entity’s performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual on-site audit;
• Impose sanctions if the delegated entity’s performance is substandard or terms of the agreement violated;
• Review and initiate recommendations such as termination of delegation, to the Corporate Compliance Committee for unresolved issues of compliance;
• Maintain central database of all pending, active and terminated delegated vendors/entities to monitor and track functions, performance, and audit schedules;
• Identify and implement an escalation process for compliance/performance issues;
• Conduct annual integrity reviews for all delegation auditors;
• Identify and implement a process for validation of audit tools;
• Implement a process for notifying contract owners of corrective action plans;
• Track and trend internal compliance with oversight standards, entity performance, and outcomes;
• Identify and implement an annual training program for internal staff regarding delegation standards, auditing, and monitoring delegated entity/vendor performance; and
• Implement a process for dissemination of regulatory changes to include Medicaid and Medicare lines of business.
Section 10: Behavioral Health

Overview
Missouri Care provides a behavioral health benefit for Medicaid plans. All provisions contained within the Provider Manual are applicable to medical and behavioral health providers unless otherwise noted in this section.

Members may refer themselves for behavioral health services and do not require a referral from their PCP.

Some behavioral health services may require prior authorization, including all services provided by non-participating providers. Missouri Care uses LOCUS/CASII criteria for mental health and substance abuse. The criteria are well-known and nationally-accepted guidelines for assessing level of care.

For information regarding benefits, exclusions and authorization requirements, or in the event you need to contact Missouri Care’s Provider Services for a referral to a behavioral health provider, refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.

Behavioral Health Program
Missouri Care does not require prior authorization for standard outpatient services. We encourage community-based services and member treatment at the least restrictive level of care whenever possible.

Prior authorization is required for intensive outpatient programs, partial hospitalization programs, residential treatment programs and inpatient hospital services. For psychiatric/behavioral emergency stabilization services, notification must be made within 24 hours or, on weekends or holidays, the next business day. For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, Missouri Care uses LOCUS/CASII. If the member scores less than an inpatient level of care on the LOCUS/CASII but the services recommended are not available, Missouri Care will continue to authorize inpatient care. In the event of disagreement, Missouri Care will provide full detail of its scoring of the LOCUS/CASII to the provider of service.

Inpatient reviews will be conducted telephonically. Prior authorization request forms for all other levels of care are made available to providers online or upon request. For information regarding authorization requirements please refer to the Quick Reference Guide on Missouri Care’s website at www.missouricare.com/provider/resources.

For children within the COA 4 group, Missouri Care isn’t responsible for the following medically necessary behavioral health and substance abuse services:

- Inpatient Behavioral Health and Substance Abuse Services
- Outpatient Behavioral Health and Substance Abuse Services
- Comprehensive Community Support Services
**Clinical Practice Guidelines**
Missouri Care adopts validated evidence-based CPGs and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede CPGs, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the QI Committee. CPGs, to include Preventive Health guidelines, may be found on Missouri Care’s website at [www.wellcare.com/provider/cpgs](http://www.wellcare.com/provider/cpgs).

**Continuity and Coordination of Care between Medical and Behavioral Health Care Providers**

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. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice.

Behavioral 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 a member’s treatment plan or medications. The completed form should be sent to the member’s PCP for inclusion in the medical record. Behavioral providers are required to use the DSM-IV multi-axial classification when assessing the member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member’s medical record.

Communication with the PCP should occur more frequently if clinically indicated. Missouri Care encourages behavioral health providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization. Missouri Care recommends faxing discharge information, or a letter summarizing the hospital stay, to the PCP.

We strongly encourage open communication between PCPs and behavioral health providers. If a member’s medical or behavioral condition changes, Missouri Care expects that both PCPs and behavioral health providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

To maintain continuity of care, patient safety, and member well-being, communication between behavioral health care providers and medical care providers is critical, especially for members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and will positively impact member outcomes.

**Responsibilities of Behavioral Health Providers**
Missouri Care monitors providers against access standards to ensure members can obtain needed health services within the acceptable appointment waiting times. The provisions below are applicable only to behavioral health providers and do not replace the provisions set forth in Section 2: *Provider and Member Administrative Guidelines* for medical providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by Missouri Care.
<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Provider – Urgent</td>
<td>24 hours</td>
</tr>
<tr>
<td>BH Provider – Post-inpatient</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>discharge</td>
<td></td>
</tr>
<tr>
<td>BH Provider – Routine</td>
<td>One week or 5 business days</td>
</tr>
</tbody>
</table>

All members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place and name of the provider to be seen. The outpatient treatment must occur within 7 calendar days from the date of discharge.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member’s condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed twenty-four (24) hours per day. The behavioral crisis phone number is printed on the member’s card and is available on our website.

Behavioral health and substance abuse providers are required to complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. Members with physical health conditions (as indicated by the screen) should be referred to their PCP for evaluation and treatment of the physical health condition.

For information about Missouri Care’s CM and DM programs, including how to refer a member for these services, please see *Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)*.

**Community Outreach Advisory Council on Health (COACH)**

Missouri Care values the input of our behavioral health members, advocates, and providers. The COACH council has been established in order to assist with ensuring Missouri Care’s services and programs meet the needs and expectations of the member and provider community. The COACH meets on a quarterly basis and provides recommendations to the QI Committee. We encourage our behavioral health providers to participate in the council. Contact the Manager of Community Relations at 1-800-322-6027 if you are interested in participating in the council.
Section 11: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation agreement you have with Missouri Care.

“Action” means, pursuant to 42 CFR 438.400(b),
- 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 a service;
- the failure to provide services in a timely manner, as defined by the state;
- the failure of Missouri Care to act within the time frames provided in §438.408(b); or
- for a resident of a rural area with only one managed care entity, the denial of a Medicaid enrollee’s request to exercise his or her right under §438.52(b)(2)(ii) to obtain services outside the network.

“Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

“Appeal” means a formal request from an enrollee to seek a review of an action taken by Missouri Care.

“Appeals Process” means the overall process that includes appeals at the contractor level and access to the State Fair Hearing process (the State’s Administrative Law Hearing).

“Authorization” means an approval request for payment of services. An authorization is provided only after Missouri Care agrees the treatment is necessary.

“Benefits” or “Benefit Plan” means the health care services for which Missouri Care has agreed to provide, arrange, and be held fiscally responsible.

“Business Days” means Monday through Friday (8 a.m. to 5 p.m., excluding state holidays).

“Calendar Days” means all 7 days of the week.

“Centers for Medicare & Medicaid Services (CMS)” means the agency within the United States Department of Health and Human Services with responsibility for the Medicare, Medicaid and the State Children’s Health Insurance Program.

“Claim” means a bill for services, a line item of services, or all services for one recipient within a bill.

“Claim Adjustment” means a claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, the payment amount can be changed.

“Clean Claim” means a claim received by Missouri Care for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further
information, adjustment, or alteration by the provider of the services in order to be processed and paid by Missouri Care. The following exceptions apply to this definition:

- A claim for payment of expenses incurred during a period of time for which premiums are delinquent;
- A claim for which fraud is suspected; and
- A claim for which a third party resource should be responsible.

“Clinical Laboratories Improvement Amendments (CLIA) of 1988” means the federal legislation as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

“Co-payment or Co-pay” means the part of the cost-sharing requirement for members in which a fixed monetary amount is paid for certain services/items received from the contractor’s providers.

“Co-Surgeon” means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

“Covered Services” means those medically necessary health care services provided to members, the payment or indemnification of which is covered by Missouri Care or those demonstration services provided to P4HB™ participants, the payment or indemnification of which is covered by Missouri Care.

“Disenrollment” means the removal of a member from participation in Missouri Care’s plan but not necessarily from the Medicaid Program.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program” means a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental deficiencies in members less than 21 years of age, and health care, treatment, and other measures to correct or ameliorate any deficiencies and chronic conditions discovered.

“Emergency Medical Condition” means a medical 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 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 of bodily functions; or
- Serious dysfunction of any bodily organ or part.

An emergency medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

In addition to the conditions identified under federal law and the state of Missouri, Missouri Care considers the following symptoms to also be emergent in nature:

- 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:
  - that there is not adequate time to effect a safe transfer to another hospital before delivery; or
that transfer may pose a threat to the health or safety of the woman or the unborn child.

“Emergency Services and Care” means covered inpatient and outpatient services furnished by a qualified provider needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

“Encounter” means a distinct set of health care services provided to a Medicaid member enrolled with Missouri Care on the dates that the services were delivered.

“Encounter Data” means:
- All data captured during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter;
- The identification of the member receiving and the provider(s) delivering the health care services during the single encounter; and
- A unique, i.e., unduplicated, identifier for the single encounter.

“Grievance” means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to:
- the quality of care or services provided,
- aspects of interpersonal relationships such as rudeness of a provider or employee; or
- failure to respect the member’s rights.

“Health Care” means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:
- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“Ineligible Person” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration; (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs; or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

“Long-Term Acute Care (LTAC) Hospital” means care facilities include nursing homes, skilled nursing facilities, psychiatric residential treatment facilities and other facilities that provide long-term non-acute care.
“Medical Necessity” or “Medically Necessary” means services that are sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community in which the services are rendered. Services shall be furnished in the most appropriate setting. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age-appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity.

“Member” means a Medicaid recipient who is currently enrolled in an MCO plan.

“Member Expenses” means co-payments, coinsurance, deductibles or other cost share amounts, if any, that a member is required to pay for covered services under a benefit plan.

“Members/Individuals with Special Health Care Needs” means adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“Periodicity” means the frequency with which an individual may be screened or re-screened.

“Periodicity Schedule” means the schedule which defines age-appropriate services and timeframes for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Program.

“Post-Stabilization Services” means covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member’s condition.

“Preventive Services” means services provided by a physician or other licensed health practitioner within the scope of his or her practice under state law to:

- prevent disease, disability, and other health conditions or their progression;
- treat potential secondary conditions before they happen or at an early remediable stage;
- prolong life; and
- promote physical and mental health and efficiency.

“Primary Care” means all health care services and laboratory services, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers, required for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

“Primary Care Provider (PCP)” means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to members or P4HBSM participants. A PCP shall include general/family practitioners, pediatricians, internists,
physician’s assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

“Prior Authorization” means the act of authorizing specific services before they are rendered. (Also known as “pre-authorization” or “prior approval”.)

“Proposed Action” means the proposal of an action for 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 part of payment for a service; the failure to provide services in a timely manner; or the failure of Missouri Care to act within the specified time frames.

“Provider” means any person (including physicians or other health care professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Missouri to provide health care services that has contracted with a Care Management Organization to provide health care services to members.

“Provider Complaint” means a written expression by a provider which indicates dissatisfaction or dispute with the contractor's policies, procedures, or any aspect of a contractor's administrative functions.

“Provider Contract” means any written contract between the contractor and a provider that requires the provider to perform specific parts of the contractor's obligations for the provision of health care services under this contract.

“Referral” means a request by a PCP for a member to be evaluated and/or treated by a specialty physician.

“(Claims) Reprocessing” means upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

“Routine Care” means that treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician’s office) or by the patient.

“Service” means health care, treatment, a procedure, supply, item or equipment.

“Urgent Care” means medically necessary treatment for an injury, illness, or another type of condition (usually not life-threatening) which should be treated within 24 hours.

“Missouri Care Companion Guide” means the transaction guide that sets forth data requirements and electronic transaction requirements for clean claims and encounter data submitted to Missouri Care or its affiliates, as amended from time to time. The Missouri Care Claims/Encounter Companion Guides are part of the Provider Manual.
Section 12: Missouri Care Resources

Missouri Care’s Home Page
www.missouricare.com

Provider Home Page
www.missouricare.com/provider

Quick Reference Guide
www.missouricare.com/provider/resources

Provider Orientation
www.missouricare.com/provider
You must be a registered user of Missouri Care’s secure Provider Portal to access.

Forms and Documents
www.missouricare.com/provider/forms

Clinical Practice Guidelines
www.wellcare.com/provider/cpgs

Clinical Coverage Guidelines
www.wellcare.com/provider/ccgs

Claims Information
www.missouricare.com/provider/claims_updates

Job Aids and Resource Guides
www.missouricare.com/provider/resources