Hospital Manual

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Table of Contents

Introduction

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The MO HealthNet Division (MHD) reimburses inpatient and outpatient hospital services for Fee-For-Service (FFS) participants. These services are mandatory Medicaid-covered services and are provided statewide. Inpatient hospital services are medical services provided in a hospital acute or psychiatric care setting for the care and treatment of MO HealthNet participants. Outpatient hospital services include preventive, diagnostic, emergency, therapeutic, rehabilitative, or palliative services provided in an outpatient setting.

Section 1: Reimbursement Methodology

1.1 Hospital Reimbursement Methodology

The reimbursement methodology for hospitals is found in the Code of State Regulations (CSR); see **13 CSR 70-15.010** for Inpatient Hospital Services reimbursement methodology, **13 CSR 70-15.190** for Out-of-State Hospital Services Reimbursement, and **13 CSR 70-15.160** for Outpatient Hospital Services reimbursement methodology.

Inpatient Services

Effective with discharge dates on or after July 1, 2025, hospitals will be reimbursed under an All Patients Refined Diagnosis Related Group (APR-DRG) except the following types of hospitals, which will continue to be reimbursed on a per diem basis.

- In-state specialty pediatric hospitals
- In-state pediatric hospitals licensed for fewer than fifteen (15) beds and specializing in pediatric orthopedic care
- In-state free-standing psychiatric hospitals
- In-state free-standing rehabilitation hospitals
- In-state free-standing long-term acute care (LTAC) hospitals
- In-state hospitals enrolled in MO HealthNet on or after January 1, 2025, that have an eighty percent (80%) or greater patient mix in mental health and substance abuse
- Out-of-state free-standing psychiatric hospitals

If a patient is admitted to a hospital that will be reimbursed under the APR-DRG, prior to July 1, 2025, and discharged after July 1, 2025, the reimbursement will be calculated by APR-DRG, not the per diem rate.

All Patient Refined Diagnosis Related Group

An APR-DRG is a classification system used to group a participant's inpatient stay according to their reason for admission, severity of illness, and risk of mortality. Refer to **13 CSR 70-15.010** for the Inpatient Hospital Services reimbursement methodology and **13 CSR 70-15.190** for the Out-of-State Hospital Services reimbursement methodology. The APR-DRG reimbursement methodology does not pay based on the lower of the providers' billed charges when compared with the APR-DRG. The APR-DRG is paid regardless of the billed charges amount. The APR-DRG is adjusted for any Third Party Liability (TPL).

In-State Per Diem

Inpatient services provided for in-state hospitals are reimbursed by multiplying the per diem times the number of days approved by Conduent, the MO HealthNet Division's (MHD's) review authority. Refer to **Section 2.27** in this manual for more information regarding Conduent.

Out-of-State Per Diem

Inpatient services provided in out-of-state hospitals are reimbursed at the lower of the following options, multiplied by the number of days approved by Conduent, MHD's review authority.

Out-of-state free-standing psychiatric hospitals per diem rate

The amount of total charges billed by the hospital

When applicable, Medicare Part A and Part C's deductibles, coinsurance, or copayment. Refer to the **Medicare/Medicaid Claims Processing Provider Manual** for payment methodology.

Inpatient Per Diem Rate Change

If an MHD per diem rate change occurs during a participant's stay, reimbursement is based on the per diem rate in effect on the day of admission. Refer to **Section 5** of this manual for a list of ancillary service revenue codes included in the inpatient per diem rate.

Outpatient Services

Hospitals must report outpatient services and associated charges at the claim line level using Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes appropriate to the service provided. Payment under the Outpatient Simplified Fee Schedule (OSFS) methodology is final, without cost settlement. Refer to the **MO HealthNet Fee Schedule** for more information. Refer to **13 CSR 70-15.160** for Outpatient Hospital Services reimbursement methodology.

1.2 Medicare/MO HealthNet Reimbursement (Crossover Claims)

When MO HealthNet providers submit claims to Medicare for payment, Medicare will pay the claim, apply a deductible/coinsurance or co-pay amount and then automatically forward the claim to MHD for review of payment. This is referred to as a crossover claim. For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, when appropriate, MHD pays the deductible, and coinsurance amounts otherwise charged to the participant by the provider. Refer to the **Medicare/Medicaid Claims Processing Provider Manual** for a general explanation of these claims.

Limitation on Reimbursement of Medicare Part A Inpatient Hospital Crossover Claims

MHD is responsible for deductible, and coinsurance amounts for Medicare Part A crossover claims only when the MHD applicable payment schedule exceeds the amount paid by Medicare, plus calculated pass-through costs. In those situations where MHD has an obligation to pay a crossover claim, the amount of this payment is limited to the lower of the actual crossover amount or the amount by which the MHD fee exceeds the Medicare payment plus pass-through costs. The provider's Remittance Advice (RA) shows the amount paid for each repriced crossover with a Group and Reason Code CO-45: "Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement."

To ensure the provider is reimbursed at the proper rate, MHD utilizes data from the provider's Medicare cost report to obtain pass-through costs. It is important that the provider promptly notify MHD if their Medicare cost reports are amended or if changes are made in the Notice of Program Reimbursement (NPR). Please send amendments and changes to:

MO HealthNet Division
Clinical Program and Policy Unit
Part A Crossover Repricing
P.O. Box 6500
Jefferson City, MO 65102

Failure to promptly send this data to MHD may result in erroneous MHD payments.

Amounts not reimbursed by MHD for allowable crossover claims may not be billed to the participant.

The following are two (2) examples of repriced crossovers:

Example 1: Inpatient stay of three (3) days.

Item	Cost
Medicare payment plus pass-through costs	$2,000.00
MHD payment schedule for three (3) days	$1,350.00

Item	Cost
Amount exceeding MHD's payment schedule	$650.00

In this example, no amount is due from MHD to the provider, as Medicare's payment exceeds the MHD payment schedule for the services by $650.00.

Example 2: Inpatient stay of six (6) days.

Item	Cost
Medicare payment plus pass-through costs	$1,158.00
MHD payment schedule for six (6) days	$1,950.00
Amount MHD payment exceeds Medicare	($792.00)
Medicare coinsurance	$942.00
Amount of MHD payment for hospital stay	$792.00

In this example, the payment from MHD to the provider would be $792.00 since MHD reimburses the lower of the Medicare coinsurance or the amount that exceeds Medicare's payment.

Application of Part A Medicare Deductible

MHD is responsible for deductible, and coinsurance amounts for Medicare Part A crossover claims only when the MHD applicable payment schedule exceeds the amount paid by Medicare, plus calculated pass-through costs, and the participant has Qualified Medicare Beneficiary (QMB) coverage. The Part A Medicare deductible for inpatient services is always applied to the day of admission or the first day of the hospital stay that the individual becomes Medicare eligible. If the patient is not MO HealthNet eligible on the day the deductible is applied, MHD does not pay the deductible, and it becomes the patient's responsibility to pay the deductible.

For more information on QMB, refer to the **General Sections Manual**.

Reimbursement of Medicare Part A and Medicare Advantage/Part C Inpatient Hospital Crossover Claims

MHD is responsible for deductible, and coinsurance amounts for Medicare Part A and deductible, coinsurance, and copayment amounts for Medicare Advantage/Part C crossover claims only when the MHD applicable payment schedule exceeds the amount paid by Medicare, plus calculated pass-through costs. In those situations where MHD has an obligation to pay a crossover claim, the amount of MHD's payment is limited to the lower of the actual crossover amount or the amount by which the MHD fee exceeds the Medicare payment plus pass-through costs. Medicare/Advantage/Part C primary claims must have been provided to QMB or QMB Plus participants to be considered a Medicare/Medicaid crossover claim.

An example of a repriced crossover is provided below:

Example: Inpatient stay of four (4) days

$470.51 + $1,639.42 = $2,109.93 per day x four (4) Inpatient Hospital stay days = $8,439.72

Item	Cost
Primary Payment	$6,888.00
Patient Responsibility	$1,480.00
MHD allowable	$8,439.72
Part C Payment	$1,551.72

In this example, the balance of $1,551.72 is more than the Patient Responsibility, therefore no additional payment is made by MHD to the provider.

Reimbursement Limitation of Medicare Part B/Part C Outpatient Hospital Crossover Claims

MHD is responsible for deductible, and coinsurance amounts for Medicare Part B crossover claims and copayment amounts for Medicare Advantage/Part C crossover claims for participants with QMB coverage. The reimbursement of Medicare/Medicaid crossover claims for Medicare Part B and Medicare Advantage/Part C outpatient hospital services will be calculated at seventy-five percent (75%) of the allowable coinsurance, deductible, or Part C copayment amount. This methodology results in payment comparable to the Fee-For-Service (FFS) amount MHD would pay for those same services.

This reimbursement methodology does not impact outpatient hospital crossover claims submitted by public hospitals operated by the Department of Mental Health (DMH).

Reporting Medicare's Bad Debt

MHD expects a portion of the cost to the hospitals for nonpayment of the coinsurance, deductible, or Part C copayment amount for Medicare Part B to be recovered through Medicare's bad debt reimbursement policies as set forth in **42 CFR 413.89** and the **Medicare/Medicaid Claims Processing Provider Manual**. Medicare does not reimburse for bad debts associated with services paid under a reasonable charge-based methodology (such as ambulance services) or a fee schedule (such as therapies and laboratory services). The bad debts associated with nonpayment of the coinsurance, deductible, or Part C copayment amount for Medicare Part C claims related to QMB or QMB plus participants are not eligible for reimbursement from Medicare. Hospitals will be responsible for correctly reporting the allowable bad debt pertaining to the coinsurance, deductible, or Part C copayment amount for Medicare Part B not paid by MHD on their Medicare cost report to receive Medicare reimbursement. If the allowable bad debt is not correctly reported on the Medicare cost report, hospitals may not receive reimbursement from Medicare. To assist hospitals with identifying the amounts they can report as bad debt for Medicare reporting purposes, MHD will utilize the following Group and Reason Codes, which will be reflected on the hospital's RA.

Group & Reason Code	Description
OA45	Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement
N59	Refer to the appropriate **provider manual** for additional program and provider information

1.3 MO HealthNet Managed Care

Under MO HealthNet's Managed Care Program, certain eligible individuals are enrolled with a MO HealthNet Managed Care health plan. A basic package of services is offered to the participant by the MO HealthNet Managed Care health plan; however, some services are not included and are covered by MO HealthNet on a FFS basis.

Hospital services are included as a plan benefit in the MO HealthNet Managed Care program.

Refer to the **General Sections Manual** for more information on the Managed Care Program.

1.4 Direct Deposit and Remittance Advice

MO HealthNet providers must complete an **Electronic Funds Transfer (EFT) Authorization Agreement** to receive reimbursement for services through direct deposit into a checking or savings account. This form must be used for initial enrollment, re-enrollment, revalidation, or any update or change needed. All providers are required to complete the **EFT Authorization Agreement** regardless of whether the reimbursement for their services will be going to another provider.

Direct deposit begins following the submission of a properly completed **EFT Authorization Agreement** to the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit, the successful processing of a test transaction through the banking system, and the authorization to make payment using direct deposit. The **EFT Authorization Agreement** and any associated documentation should be submitted by fax to (573) 634-3105. The state uses an originating depository financial institution to conduct direct deposits through the automated clearinghouse system. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply as limited or modified by law.

MMAC will terminate or suspend the direct deposit for administrative or legal actions, including but not limited to ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions to ensure program compliance, death of a provider, and closure or abandonment of an account.

Visit **MMAC Provider Enrollment Applications and Forms** to access all enrollment forms.

For questions regarding direct deposit or provider enrollment issues, please email **MMAC.ProviderEnrollment@dss.mo.gov**.

Once a user ID and password are obtained, **eMOMED** can be accessed to retrieve, view, and print current and aged Remittance Advice (RA). Refer to the **General Sections Manual** for more information on eMOMED.

Updates or changes providers make to their **eMOMED** file will not update their provider master file. Therefore, updates or changes should be requested by completing the **Provider Update Request**. Providers should fax the Provider Update Request to (573) 634-3105.

If providers prefer not to print and scan paper documents, the Provider Update Request and common attachment forms are available with DocuSign. To receive the MMAC DocuSign form menu, send an email to **MMAC.DocuSign-NOREPLY@dss.mo.gov**.

Section 2: Benefits and Limitations

This section contains information common to the policies, benefits, and limitations of the MO HealthNet Inpatient and Outpatient Hospital Programs.

2.1 Provider Participation

To participate in the MO HealthNet Hospital Program, the hospital provider must satisfy the following requirements:

- The provider is licensed by the Missouri Department of Health and Senior Services (DHSS) as an acute care, psychiatric, or rehabilitation hospital unless the facility is exempt from licensure because it is a city or state-operated facility. Out-of-state hospitals must be licensed by the appropriate agency of the state in which the hospital is located.

- DHSS certifies the provider for participation in Title XVIII Medicare Programs. Out-of-state hospitals must be certified by the appropriate agency of the state in which the hospital is located.
- The provider is enrolled as a MO HealthNet provider. Contact **MMAC.ProviderEnrollment@dss.mo.gov** for enrollment information. Refer to the **MMAC Provider Enrollment** for additional information.

Additional information on provider conditions of participation can be found in the **General Sections Manual**.

2.2 Advance Health Care Directives

Advance Health Care Directive Definition

An advance health care directive is a written instruction, such as a health care treatment directive, living will, or durable power of attorney for health care decisions, recognized under state law related to health care provision in the event a person loses decision-making capacity.

An advance health care directive allows an individual to communicate health care treatment preferences when decision-making capacity is lost.

Provider Requirements for Advance Health Care Directives

Federal law (**42 U.S.C. 1396a (w)**, **42 CFR 434.28**, and **42 CFR 489 Subpart I**) requires the following who receive MO HealthNet Division (MHD) payments to maintain written policies and procedures concerning advance health care directives for all adults receiving medical care by or through the provider.

- Hospitals
- Nursing facilities
- Providers of home healthcare services
- Providers of personal care services
- Hospices
- Health plans (prepaid health plans, health maintenance organizations)

Review Missouri Revised Statutes (RSMo) **404.800-404.872** and **459.010-459.250** for Missouri laws concerning advance health care directives.

The above-listed MO HealthNet providers are also required to:

- Provide written information to each adult regarding the individual's right under state law tomake decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance health care directives

- Document in the patient's record that an advance health care directive has or has not been executed. Provide care whether or not the individual has executed an advance health care directive and ensure compliance with state law requirements.
- Provide for, individually or with others, education for staff and the community on issues concerning advance directives

Release for Ethical Reasons

No individual who is a health care provider can be required to provide care that conflicts with an advance health care directive.

No individual who is a health care provider can be required to implement an advance directive if such refusal is based upon the individual's religious beliefs or sincerely held moral convictions.

Each above-listed MO HealthNet provider shall have a process by which the individual who is a health care provider may refer the patient to another health care provider licensed to provide care appropriate to the patient's medical condition and advance health care directives.

When Written Information Is Provided

Written information about advance health care directives must be provided to an adult individual in the following cases:

- Hospital: At the time of the individual's admission as an inpatient
- Nursing facility: At the time of the individual's admission as a resident
- Provider of home health care or personal care services: In advance of theindividual coming under the care of the provider
- Health plan (health maintenance organization, prepaid health plan): At the time of enrollment of the individual with the organization

Admission of an Incapacitated Person

If the provider distributes information about its policies and procedures to the incapacitated person's family, surrogates, or other concerned person, all advance health care directive information normally provided must also be given.

Additional Sources of Information About Advance Health Care Directives

The following are organizations that provide additional information regarding advanced health care directives.

- Center for Practical Bioethics: (816) 221-1100
  Email: **center@practicalbioethics.org**
  Website: **www.practicalbioethics.org/**

- American Health Law Association: (202) 833-1100
  Contact Info: **www.americanhealthlaw.org/about-ahla/contact-us**
  Website: **www.americanhealthlaw.org/**
- Missouri Bar: (573) 635-4128
  Email: **mobar@mobar.org**
  Website: **mobar.org/**
- American Medical Association: (800) 621-8335
  Email: **customer.relations@ama-assn.org**
- AARP: (800) 523-5800
  Contact Info: **help.aarp.org/s/article/contact-aarp**
  Website: **www.aarp.org/homepage/value/**
- Legal Counsel for the Elderly: (202) 434-2120
  Contact Info: **help.aarp.org/s/article/contact-aarp**
  Website: **www.aarp.org/legal-counsel-for-elderly/**
- Commission on Law and Aging: (202) 662-8690
  Email: **mailto:aging@americanbar.org**
  Website: **www.americanbar.org/groups/law_aging/**
- Division Counsel
  MO HealthNet Division
  P.O. Box 6500
  Jefferson City, MO 65102-6500

2.3 Documentation of Physician Orders

Adequate Documentation

All services provided must be adequately documented in the medical record. The Code of State Regulations (CSR), **13 CSR 70-3.030(2)(A)** defines 'adequate documentation' and 'adequate medical records' as follows:

Adequate documentation means documentation from which services are rendered, and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

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

Refer to the **General Sections Manual** for more information.

Inpatient Hospital Services

Inpatient hospital services must have signed and dated physician or other medical professional (authorized by State licensure law to order hospital services for diagnosis or treatment of a patient) orders within the patient's medical record for services billed to MHD.

Outpatient Hospital Services

For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician or other medical professional orders for services billed to the MHD.

Where the hospital acts as an independent laboratory or independent radiology service for persons considered by the provider as 'non-hospital' patients, the hospital must have a written request or requisition slip ordering the tests or procedures. The order does not have to be signed by a physician or other medical professional; however, the request for laboratory/pathology or radiologic procedures must be traceable to a physician or other medical professional, order in the medical record (such as in a nursing home or physician's office). If the request or referral is by telephone, the request must be committed to a written format.

The minimum information required on a written request or referral is as follows:

- Name of patient
- Name of referring entity (such as nursing home, laboratory, physician, or other medical professional)
- Procedure
- Date ordered
- Date received

All records, whether signed orders or written requests for non-hospital patients, must be kept for five (5) years.

Services billed to MHD that are not fully documented in the patient's medical records or for which there is no record that services were performed may be considered false or fraudulent billing and, thus, subject to investigation.

2.4 Participation Eligibility

The participant must be eligible for MO HealthNet services on the day the service is provided, or the provider will not be reimbursed through MHD. This is a requirement even when the service has been prior authorized. The provider is responsible for verifying the participant's MO HealthNet eligibility on the day the service is provided via **eMOMED** or by using the Interactive Voice Response (IVR) system at (573) 751-2896 or toll-free (833) 222-7916.

Additional information about participant eligibility can be found in the **General Sections Manual**.

Administrative Lock-In Participants

Some MO HealthNet participants are restricted or locked-in to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. Refer to the **General Sections Manual** for more information regarding Administrative Participant Lock-In. When the participant has an administrative lock-in provider, the provider's name and telephone number are identified on **eMOMED** when verifying eligibility.

Only providers named in **eMOMED** are authorized to provide services for participants with physician or hospital restrictions. For outpatient hospital services or physician services to be payable for a participant who is locked into a physician or hospital different from the billing provider, one (1) of the following exceptions must apply:

- Emergency services: If emergency services are provided, medical records documenting the emergency circumstances must be attached to the claim when submitted for payment explaining the emergency. Note "EMERGENCY" at the top of the claim. Refer to **Section 3.4** in this manual for more information.
- Referrals made by the authorized provider: When a referral is necessary, the authorized physician must complete a **Medical Referral of Restricted Participant (PI-118)** before providing services. The completed referral form must be attached to the paper claim or submitted through **eMOMED**.

It is the provider's responsibility to determine if a participant has restricted eligibility. Payment is not made if an unauthorized provider provides non-emergency, non-referred services to a lock-in participant.

Hospice

To be eligible to elect hospice care under MO HealthNet, individuals must be certified by a physician as being terminally ill. Refer to the **Hospice Provider Manual** for more information.

Inpatient Services—Respite Care

When necessary to relieve family members or other persons caring for the individual at home, respite care is a covered service under the Hospice Program. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days per calendar month. It may be provided in a nursing home or an acute care hospital (ACH). The hospice reimburses the nursing home or ACH. Claims submitted directly to MHD are denied.

The hospital is not required to obtain admission certification from Conduent, MHD's review authority, for hospice respite care.

Refer to the **Hospice Provider Manual** for more information.

Inpatient Services—Crisis Care

Inpatient hospital services are covered under the Hospice Program for palliative care during a period of an acute medical crisis. The hospice provider is limited to using no more than twenty percent (20%) of its total reimbursed days for inpatient hospital care. The hospice reimburses the hospital. Claims for crisis care by the hospital submitted directly to MHD are denied.

The hospital is not required to obtain admission certification from Conduent, MHD's review authority, for crisis care.

Refer to the **Hospice Provider Manual** for more information.

Temporary Assistance for Needy Families Benefit and Limitations for Hospital

The Temporary Assistance for Needy Families (TEMP) services are limited to ambulatory prenatal services (physician, clinic, nurse midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services). The diagnosis on the claim form must be a pregnancy/prenatal diagnosis.

Inpatient hospital services are not considered ambulatory prenatal services; therefore, inpatient hospital claims billed for participants with only TEMP eligibility are denied.

If the TEMP participant is provided illness care, the illness diagnosis code must appear as the primary diagnosis code on the claim form. However, a pregnancy/prenatal diagnosis code must also appear on the claim form.

A TEMP participant may apply for full MO HealthNet coverage and be determined eligible for the complete range of MO HealthNet covered services. Regular MO HealthNet coverage may be backdated and overlap with a TEMP eligibility period. Approved individuals receive an approval letter that shows their eligibility dates and type of assistance coverage from the Family Support Division (FSD). Services not covered under the TEMP Program may be resubmitted under the new type of assistance using the participant's MO HealthNet Identification Number instead of the TEMP number. The resubmitted claims are then processed without TEMP restrictions.

Refer to the **General Sections Manual** for more information on coverage for TEMP participants. Refer to **Section 4** of this manual for billing information on full MO HealthNet Eligibility after TEMP.

2.5 Participant Non-Liability

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

Participant Non-Liability

The participant is liable for inpatient hospital services in the following circumstances:

- When a preadmission request for certification is denied, and the participant is notified in writing of the denial but chooses to be admitted, the participant is liable for all days
- When a post-admission request for certification of an urgent or emergency admission is denied, the participant is liable for those days after notification of the denial
- When the participant's eligibility was not established on or by the date of admission, and the post-admission review request for certification is denied, the participant is liable for all days
- When the participant has signed a written agreement with the provider indicating that MHD is not the intended payer for the specific inpatient service, the participant is liable for all days. The agreement must be signed prior to receiving the services. In this situation, the participant accepts the status and liabilities of a private pay patient in accordance with **13 CSR 70-4.030**.
- When a service is related to non-covered procedures, the service is also non-covered. If any non-covered procedure is the chief reason for hospital services, none of the hospital charges are reimbursable.

The participant is not liable for inpatient hospital services in the following circumstances:

- When a post-admission request for certification is denied, the participant is not liable for any days prior to notification of the denial.
- When Conduent, MHD's review authority, performs a validation review based on medical records and determines a stay was not medically necessary for inpatient services, the participant is not liable for any days.

NOTE: Although Conduent sends the participant a written notification of denial, it is acceptable and may be to the hospital's benefit to advise the participant of the Conduent decision as soon as possible. If the hospital chooses to advise the participant of the decision, the hospital must maintain documentation of the participant's receipt of the notification. Refer to **Section 2.27** in this manual for more information regarding Conduent.

2.6 Out-of-State, Non-Emergency Services

Refer to the **General Sections Manual** for further information.

Definition of Emergency Services

Emergency medical/behavioral health services mean covered inpatient and outpatient services that are furnished by a provider who is qualified to provide these services and are needed to evaluate or stabilize an emergency medical condition.

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

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

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

2.7 Hospitals with Skilled Nursing Facility Units

Hospitals with Skilled Nursing Facility (SNF) units not enrolled as MO HealthNet Nursing Facility providers must not submit crossover claims for their Medicare/MO HealthNet patients using their hospital National Provider Identifier (NPI) and taxonomy number. Billing SNF services with the hospital NPI and taxonomy number is considered fraudulent billing. These SNF units may be enrolled in MO HealthNet as Nursing Facility providers. Then both crossovers and MO HealthNet only long-term care days may be billed. Contact Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment at **MMAC.ProviderEnrollment@dss.mo.gov** to inquire about Nursing Facility enrollment. Refer to **MMAC Provider Enrollment** for additional information.

2.8 Screening Potential Nursing Home Placement

The following information is important when a patient faces a potential nursing home placement from an inpatient setting to inform them of community long-term care options and to identify mentally ill, intellectually disabled (ID), or developmentally disabled (DD) individuals.

Missouri Care Options Philosophy

The main objective of DHSS Missouri Care Options is to make individuals aware of the broad choice of services and settings available in the long-term care system. It is an effort to assist individuals in identifying and accessing services that best meet their needs for long-term care.

This philosophy is not intended to prevent people from entering nursing homes. It is an opportunity to make sure that people are aware of all available care options.

The Missouri Care Options Philosophy is part of a long-range effort to design and develop an adequate continuum of long-term care services. A key to the success of this concept is that home and community-based care options are available and that access to these alternative services is easily arranged.

New referrals for home care services are made by contacting the DHSS Division of Senior and Disability Services (DSDS) at (866) 835-3505. Refer to **Missouri Care Options** for more information.

Preadmission Screening and Resident Review

States are required to have a Preadmission Screening and Resident Review (PASRR) program for individuals with mental illness, ID, DD, or a related condition and who are applying to, or residing in, a MO HealthNet certified nursing facility. Refer to the **Nursing Home Provider Manual** or the **Nursing Home provider page** for information on the PASRR process.

2.9 Clinical Laboratory Improvement Amendments

Under the Clinical Laboratory Improvement Amendments Act of 1988 (CLIA), all laboratory testing sites, as defined in **42 CFR 493.2**, must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States. Claims from laboratories without CLIA numbers are subject to denial.

CLIA applies to any entity that performs laboratory testing of human specimens for the purpose of providing information for the diagnosis, prevention, treatment of disease or impairment, or the assessment of the health of human beings. Every lab that meets the above definitions must apply to the Centers for Medicare & Medicaid Services (CMS) for a CLIA certificate and pay a fee to CMS. The regulations mandate bi-annual onsite surveys.

For information on how to obtain a CLIA Certificate, providers should review the CMS website, **How to Apply for a CLIA Certificate**.

Refer to the **Physician Provider Manual** for more information.

2.10 Participant Copayment

MHD does not require copays for any services.

2.11 Certified Registered Nurse Anesthetists/Anesthesiologist Assistant

Inpatient Hospital

When anesthesiology charges are billed to Medicare on a **CMS-1500 claim form**, they are not included on the Hospital Medicare Cost Report. Therefore, the hospital may not include the anesthesiology charges in their MO HealthNet Cost Reports. Hospitals that include anesthesiology charges on their Medicare Cost Report have those charges recognized on their MO HealthNet Cost Report. For those providers, hospital-based or contractually compensated Certified Registered Nurse Anesthetists/Anesthesiologist Assistant (CRNA/AA) costs for treatment of MO HealthNet participants cannot be separately billed on a **CMS-1500 claim form** but must be shown as ancillary charges on the inpatient claim.

Providers who may have hospital-salaried or contractually compensated CRNA/AA's whose services are billed to Medicare on a **CMS-1500 claim form** should enroll the CRNA/AA's as MO HealthNet providers. The CRNA/AA's charges for MO HealthNet participants can be billed to MHD on a **CMS-1500 claim form** using the CRNA/AA's MO HealthNet provider identifier, assigned by MMAC after enrolled as a MO HealthNet provider. Refer to **MMAC Provider Enrollment** for enrollment information.

Hospitals employing CRNA/AA's with a professional 'group' provider identifier and taxonomy code may bill with those numbers and enter the CRNA/AA MO HealthNet provider identifier in Field 24J of the **CMS-1500 claim form** as the rendering provider. Refer to the **Physician Provider Manual** for CMS-1500 Claim Filing Instructions.

Inpatient services of CRNA/AA's not employed by the hospital may be billed on a **CMS-1500 claim form** by the CRNA/AA or the employer. Charges for those services must not appear on the hospital's inpatient claim.

Outpatient Hospital

All CRNA services provided in the outpatient department of a hospital must be billed on a **CMS-1500 claim form**, regardless of the method of cost reporting. Hospital-based or contractually compensated CRNA's should be enrolled as MO HealthNet providers to bill for their services. Refer to **MMAC Provider Enrollment** for enrollment information. Any CRNA costs incurred by the outpatient hospital are non-allowable on the hospital's MO HealthNet Cost Reports.

The billing provider may be the hospital if the CRNA is hospital-salaried or contractually compensated. Hospitals employing CRNA/AA's and that have professional 'group' provider identifiers and taxonomy codes may bill with those numbers and enter the CRNA MO HealthNet provider identifier in Field 24J of the **CMS-1500 claim form** as the rendering provider. Refer to the **Physician Provider Manual** for CMS-1500 Claim Filing Instructions.

The physician may bill for those services if the physician employs the CRNA. CRNAs who are self-employed and receive no financial compensation from the hospital may bill for outpatient services under their provider number using the **CMS-1500 claim form**. Refer to the **Physician Provider Manual** for more information.

2.12 Therapy Services

Physical therapy is covered in the Hospital Program for adult participants age 21 and over, in the assistance categories for pregnant women, blind, and skilled nursing facility (SNF) residents.

Occupational and speech therapy are covered in the outpatient hospital setting for adult participants age 21 and over, in the assistance categories for pregnant women, blind, and SNF residents when needed for adaptive training to use an orthotic or prosthetic device. Expanded therapy services are covered in a hospital for participants under age 21 if a Healthy Children and Youth (HCY) screening has identified the need for services. The HCY Program is Missouri's Early Periodic, Screening, and Diagnostic Treatment program.

Refer to the **Therapy Provider Manual** for more information on therapy coverage for participants under age 21.

2.13 Habilitative Skilled Therapy Services

Habilitative skilled therapy (physical, occupational, and speech) services are covered for individuals in a category of assistance for the adult expansion group (Medicaid Eligibility (ME) code: E2). Habilitative skilled therapy services are physical, occupational, or speech therapy services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for an individual not walking or talking at the expected age.

Refer to the **General Sections Manual** for more information on ME codes.

2.14 Hearing Aid Services

Hospital-based audiologists must individually enroll as MO HealthNet providers to participate in the MO HealthNet Hearing Aid Program. Under HCY, diagnostic audiological services are covered. The HCY services must be prior authorized. Reimbursement is Fee-For-Service (FFS) based on the submission of a **CMS-1500 claim form**. Refer to the **Hearing Aid Provider Manual** for more information.

2.15 Sterilization

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

For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing. They must always be reported as family planning services.

It is important to correctly identify family planning services by diagnosis and procedure code since the Federal Medical Assistance Percentage (FMAP) for these procedures is ninety percent (90%) (rather than the normal FMAP of approximately sixty percent (60%). The remaining percentage is funded by state general revenue.

In all situations involving voluntary sterilization, it is mandatory that the **Sterilization Consent Form**, used by MO HealthNet, be attached to each paper claim or submitted in **eMOMED**. Any claim for a sterilization procedure performed that does not have a signed, Missouri-approved **Sterilization Consent Form** is denied in accordance with mandated regulations set forth by CMS. All fields must be legible. Each provider involved in the sterilization-related procedure, including inpatient hospital and outpatient hospital, is required to obtain a copy of the **Sterilization Consent Form** from the performing physician.

The use of the **Sterilization Consent Form** is mandatory in all situations involving voluntary sterilization in accordance with **42 CFR 441.250 - 441.259**. If, in these situations, premature delivery or emergency abdominal surgery is necessary, the following special instructions with regard to time requirements apply:

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

Informed consent has been given only if the person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure and if that person provided a copy of the **Sterilization Consent Form** to the individual to be sterilized.

The person obtaining consent has met the informed consent requirement if they orally provided all the following information or advice:

- The individual has been advised that they are free to withhold or withdraw consent to this procedure at any time before the sterilization. This decision does not affect the right to future care or treatment. It does not cause the loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.
- The individual has been given a description of available alternative methods of family planning and birth control

- The individual has been advised that the sterilization procedure is considered permanent and irreversible
- The individual has been given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing
- The individual has been advised of the discomforts and risks accompanying or following the procedure, including explaining any anesthetic type and possible side effects
- The individual has been given a full description of the benefits or advantages that may be expected as a result of the sterilization
- The individual has been advised that the sterilization will not be performed for at least 30 days after the date the **Sterilization Consent Form** is signed, except under the circumstances specified on the form under Premature Delivery or Emergency Abdominal Surgery
- For blind, deaf, or otherwise handicapped participants, suitable arrangements were made to ensure that all the information in this list was effectively communicated
- An interpreter was provided if the individual to be sterilized did not understand the language used on the **Sterilization Consent Form** or the language used by the person obtaining consent. The **Sterilization Consent Form (Spanish)** is also available.
- The individual to be sterilized was permitted to have a witness of their choice present when consent was obtained

Informed consent for a sterilization procedure may not be obtained from a participant under the following conditions:

- The participant is in labor or childbirth
- The participant is seeking to obtain or is obtaining an abortion
- The participant is under the influence of alcohol or other substances that affect the individual's state of awareness

The **Sterilization Consent Form** must be signed and dated at the same time. The form will not be returned to the provider for adding the participant's missing signature or date. The procedure will be denied if either of these requirements is not met. The **Sterilization Consent Form** must be signed and dated by:

- The individual to be sterilized
- The interpreter (if applicable)
- The person who obtained the consent (on or after the date of the participant's signature)
- The physician who performed the sterilization

All applicable items of the **Sterilization Consent Form** must be completely filled out.

The physician's statement on the **Sterilization Consent Form** must be signed and dated by the physician who performed the sterilization on or after the date the sterilization procedure was performed. The date of the sterilization must match the date of service on the claim form.

The participant must:

- Be at least 21 years old at the time consent is obtained. There are no exceptions (**42 CFR 441.253**)
- Not be a mentally incompetent individual or an institutionalized individual (**42 CFR 441.251**)
- Have voluntarily given informed consent in accordance with mandated regulations set forth by CMS and requirements by the Department of Social Services (DSS)

A mentally incompetent individual is an individual who has been declared mentally incompetent for any purpose by a federal, state, or local court of competent jurisdiction unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

An institutionalized individual is an individual who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or another facility, for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

All voluntary sterilization procedures must be identified as family planning procedures.

Refer to the **Fee Schedule** for a list of procedures that require attachments.

2.16 Hysterectomy Procedures

A hysterectomy is covered if:

- The person who secured authorization to perform the hysterectomy has informed the individual and their representative, if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing.
- The individual or their representative has signed the **Acknowledgement of Receipt of Hysterectomy Information**. Refer to the **Fee Schedule** for a list of procedures that require attachments.

A hysterectomy is not covered if:

- The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing

- There was more than one (1) purpose to the procedure, but it would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing

The hospital is required to submit the **Acknowledgement of Receipt of Hysterectomy Information** via **eMOMED** when additional documentation is not required. This form must be completed and kept in the patient's medical file. When submitting via **eMOMED**, the form should not be submitted with the claim.

If additional documentation is required to be submitted with the **Acknowledgement of Receipt of Hysterectomy Information**, it can be mailed separately to:

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

Exceptions to an Acknowledgement of Receipt of Hysterectomy Information Form

Exceptions to the submission of the **Acknowledgement of Receipt of Hysterectomy Information** are as follows:

- The individual was already sterile prior to the hysterectomy. The physician who performs the hysterectomy must certify in writing that the individual 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 attached to the claim for payment.
- The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgment is not possible. The physician must certify in writing to this effect and include a description of the nature of the emergency.
- The participant was not MO HealthNet eligible at the time the hysterectomy was performed, but eligibility was made retroactively. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted along with a completed **Certificate of Medical Necessity** indicating the participant was not eligible at the time of service but has become eligible retroactively to that date. The physician who performed the hysterectomy must certify in writing that the individual was informed before the operation that the hysterectomy would make them permanently incapable of reproducing. Refer to **Section 3.4** in this manual for more information.

The hospital is responsible for obtaining the necessary certification from the performing physician.

Hysterectomies must not be reported as family planning services.

2.17 Concurrent Dates of Service

Any outpatient service performed after a participant has been formally admitted as an inpatient must be shown as ancillary charges on the inpatient claim. Formally admitted refers to the time at which the medical professional ordered the participant into inpatient status. It is an improper billing procedure for a provider to submit an inpatient claim and the same or a different provider to submit an outpatient claim for concurrent dates of service for the same participant. Outpatient services provided on the day of admission, but prior to admission, or on the day of discharge, are not considered concurrent care for the purpose of this policy. Such outpatient services provided on the day of admission, or the day of discharge are reimbursable as outpatient services.

As an example of concurrent dates of service that are not separately reimbursable, consider the following circumstance: A participant receives emergency room services on Monday and is then admitted that day. The participant is discharged on Friday, and the first of a series of outpatient therapy services begins on Friday. The outpatient services received on Monday and Friday are reimbursable as outpatient services. Any services performed in the outpatient department on Tuesday, Wednesday, or Thursday of that inpatient stay are considered concurrent dates of service that are not reimbursable as outpatient services.

When a provider outside the hospital furnishes procedures or services, such as complex laboratory or radiology procedures, the services are to be billed as ancillaries on the inpatient claim. It is the responsibility of the inpatient hospital to make arrangements with the outside provider for payment of those services. Any claim submitted to the fiscal agent for outpatient services will be denied when concurrent inpatient services occur. If an outpatient claim is paid before the inpatient claim is processed, the inpatient claim is paid, and a recoupment of the outpatient claim is made.

2.18 Fetal Monitoring

Internal Fetal Monitoring

Initiation and/or supervision of internal fetal monitoring during labor by a consultant is a MO HealthNet covered service. This procedure may only be performed on an inpatient hospital basis.

External Fetal Monitoring

Fetal contraction stress tests and fetal non-stress tests may be billed on an outpatient claim if the service is physician-ordered based on circumstances that indicate the fetus may be experiencing difficulties.

Routine fetal monitoring, including auscultation of fetal heart tones using Doppler (e.g., doptone), performed as outpatient services, is not separately billable.

2.19 Intraoperative Neurophysiological Monitoring

Intraoperative neurophysiological monitoring may be used to identify and/or prevent complications during surgery on the nervous system, its blood supply, or adjacent tissue. Monitoring can identify new neurologic impairment, identify or separate nervous system structures (e.g., around or in a tumor), and demonstrate which tracts or nerves are still functional. Intraoperative neurophysiological testing may provide relative reassurance to the surgeon that no identifiable complication has been detected up to a certain point, allowing the surgeon to proceed further and provide a more thorough or careful surgical intervention than would have been provided in the absence of monitoring.

Some high-risk patients may be candidates for a surgical procedure only if monitoring is available. Intraoperative testing may be indicated with the following types of surgery:

Surgery to the aortic arch, its branch vessels, or thoracic aorta, including internal carotid artery surgery, when there is the risk of cerebral ischemia.

- Resection of epileptogenic brain tissue or tumor
- Resection of brain tissue close to the primary motor cortex and requiring brain mapping
- Protection of cranial nerves:
    - Tumors that are on optic, trigeminal, facial, or auditory nerves
    - Cavernous sinus tumors
    - Oval or round window graft
    - Endolymphatic shunt for Ménière's disease
    - Vestibular section for vertigo
    - Microvascular decompression of cranial nerves
- Correction of scoliosis or deformity of the spinal cord involving traction on the cord
- Protection of the spinal cord where work is performed in close proximity to the cord, as in the removal of old hardware or where there have been numerous interventions
- Spinal instrumentation requiring pedicle screws or distraction
- Decompressive procedures on the spinal cord or cauda equina carried out for myelopathy or claudication where the function of the spinal cord or spinal nerves is at risk
- Resection of:
    - Spinal cord tumors
    - Neuromas of peripheral nerves or brachial plexus, when there is a risk to major sensory or motor nerves

- Surgery for:
  - Intracranial Arteriovenous (AV) malformations
  - AV malformation of the spinal cord
  - Surgery for intractable movement disorders
  - Cerebral vascular aneurysms
  - Surgery for intractable movement disorders
- Arteriography, during which there is a test occlusion of the carotid artery
- Circulatory arrest with hypothermia
- Distal aortic procedures, where there is a risk of ischemia to the spinal cord
- Leg lengthening procedures, where there is traction on the sciatic nerve or other nerve trunks
- Basil ganglia movement disorders
- Surgery as a result of traumatic injury to the spinal cord/brain
- Deep brain stimulation

Limitations of Intraoperative Neurophysiological Monitoring

The operating surgeon must request intraoperative neurophysiological monitoring, and the monitoring must be performed by a physician other than the operating physician, the technical/surgical assistant, or the anesthesiologist rendering the anesthesia. The monitoring must be performed by a specifically trained technician, preferably registered with one (1) of the credentialing organizations, and in continuous attendance in the operating room, recording and monitoring a single surgical case, with either the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology.

Intraoperative monitoring is not medically necessary in situations where historical data and current practices reveal no potential for damage to neural integrity during surgery. Monitoring under these circumstances will exceed the patient's medical needs.

Undivided attention to a unique patient may be required during some surgeries, such as when responding to acute events or identifying the cerebral cortex to be resected or spared from resection. When monitoring this type of case, the physician must have a plan to transfer care of all other cases to another physician. When paying undivided attention to a unique patient, the physician must code and bill for only that one (1) case during those times. A physician may code and bill for up to three (3) cases simultaneously for other medically necessary intraoperative neurophysiologic monitoring.

MO HealthNet does not cover 'incident to' care in the hospital setting. More than one (1) patient may be monitored at once; however, claims for physician services must be submitted only for the time devoted to monitoring. This time, however, may be cumulative and does not have to be continuous, i.e., 30 minutes of continuous attendance followed by another 30 minutes later in the procedure will constitute one (1) hour of monitoring.

Technical Criteria

Technical criteria include at least eight (8) recording channels be available (16 if Electroencephalogram (EEG) is monitored) for all intraoperative neurophysiological monitoring. The supervising physician may remotely monitor the tracings, but the remote monitoring must include routine real-time auditory or written communication with the operating room and have the capability for telephone communications with the monitoring technologist, operating surgeon, and anesthesiologist.

The equipment must also provide all the monitoring modalities that may be applied, including auditory-evoked response, electroencephalography/electrocorticography, electromyography and nerve conduction, and somatosensory-evoked response.

2.20 Items and Services Not Covered in the Hospital Program

The following is a list of items and services not covered through the MO HealthNet Hospital Program. These items and services may be covered as benefits in another MO HealthNet program, e.g., Physician, Dental, Durable Medical Equipment (DME), Optical, Ambulance, etc. Charges for those items and services can be billed to MHD by an enrolled provider using the claim form and procedures appropriate to that program. Refer to the specific **Provider Manual** for more information.

The items and services below are not covered in the **CMS-1450 (UB-04) claim form**. Including these charges in the hospital's facility charge on an outpatient claim is inappropriate. These items and services include:

- Ambulance services
- DME and supplies furnished to the patient to be used post-discharge
- Eyeglasses and any related optical materials, including artificial eyes
- Hearing aids and any related audiological materials
- Prosthetic and orthotic devices which are furnished to the patient to be used post-discharge
- Physician services
- Take home drugs, with the exception of a one (1) day supply of an oral medication due to pharmacy availability at night

- Occupational outpatient therapy—except for participants under the age of 21 or in the assistance categories for pregnant women, blind, and SNF residents when needed for adaptive training to use an orthotic or prosthetic device
- Physical outpatient therapy—except for participants under the age of 21 or in assistance categories for pregnant women, blind, and SNF residents
- Speech outpatient therapy—except for participants under the age of 21 or in the assistance categories for pregnant women, blind, and SNF residents when needed for adaptive training for an artificial larynx

Physician Services

The costs of patient-related physician services must not be included in any ancillary charge of the inpatient claim. Patient-related physician services (as opposed to hospital related, such as a supervisory function) are not an allowable cost on the cost report. Those costs are not included in setting a reimbursement rate. The charges for physician services must be billed on a **CMS-1500 claim form**. The method by which a hospital may bill on a **CMS-1500 claim form** for hospital-salaried or contractually compensated physician services is described in **Section 2.40** of this manual.

Infusion Therapy

The services of the physician supervising infusion therapy in the inpatient or outpatient hospital setting are to be billed using the appropriate Evaluation and Management procedure codes. Refer to **Section 5** in this manual for more information.

Infusion therapy performed by hospital nurses in an inpatient or outpatient setting is included in the inpatient facility charge or the outpatient hospital procedure codes appropriate to the service and is not separately billable on the **CMS-1500 claim form** (e.g., chemotherapy, antibiotic therapy, hydration therapy, immune globulin therapy, intravenous (IV) rate change, Pitocin, etc.). Refer to the Outpatient Simplified Fee Schedule in **Section 2.35** of this manual for more information on billing outpatient services and associated charges using Current Procedure Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes.

2.21 Non-Covered Items and Services

Non-covered services may be billed to the patient. The following is a list of some services, procedures, and items that MO HealthNet does not cover. It is not appropriate to include these charges in the hospital's facility charge on an outpatient claim:

- Autopsy services
- Biofeedback services
- Circumcisions, unless prior authorized as medically necessary. For policy regarding circumcision procedures, refer to the **Physician Provider Manual**.

- Clinical studies, trials, testing, experimental medical procedures, drugs, equipment, etc.
- Cosmetic surgery, unless prior authorized as medically necessary
- Days of a custodial nature pending arrangements for placement
- Leave of absence days
- Non-care items, such as television, telephone, baby pictures, birth certificates, newspapers, guest cots, or guest trays
- Personal comfort items, including barber and beautician charges
- Routine physical examinations requested by third parties, such as insurance companies, unless required under the **Health Insurance Premium Payment (HIPP) Program**
- Psychosexual therapy
- Treatment of infertility
- Tuboplasty, sterilization reversal
- Weight control

Services related to non-covered procedures are also non-covered. If any non-covered procedure is the chief reason for hospital services, none of the hospital charges are reimbursable.

2.22 Services Included in Other Charges

The following services are included in other charges shown on a claim. They are not to be shown as a separate charge and cannot be included in the facility charge. They also cannot be billed to the participant. These services include:

- After-hours services
- Call-back services
- Claim filing fees
- Education/instruction, e.g., colostomy care, cardiac care, etc.
- Handling charge for specimens referred to an independent laboratory
- Late discharge fee
- Preparation of special reports sent to insurance companies
- Psychiatric reports for court evaluation or juvenile court
- Standby equipment
- Stat charges

Services not Separately Billable

Inpatient services deemed not separately billable may be added to the inpatient facility charge. These services include but are not limited to IV infusion services, such as:

- Chemotherapy
- Antibiotic therapy
- Hydration therapy
- Immune globulin therapy
- IV rate change
- Pitocin

Inpatient services performed by hospital staff incidental to physician services may not be separately billed or added to the inpatient facility charge.

2.23 Provider Preventable Conditions

Provider Preventable Conditions (PPC) is an umbrella term established by CMS for hospital and non-hospital acquired conditions identified by the State for nonpayment to ensure the high quality of Medicaid services. PPCs include two (2) distinct parts: Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). CMS has mandated that state Medicaid agencies implement policies and procedures for reporting, reviewing, and, if appropriate, nonpayment or payment recoupments for services designated as a PPC.

Health Care Acquired Conditions

HCACs are conditions that could reasonably have been prevented by the health care establishment and through the implementation of appropriate policies, procedures, and protocols by a hospital. HCAC for state Medicaid agencies apply only to the inpatient hospital setting and are defined as the full list of Medicare's Hospital Acquired Conditions (HAC), with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients. A complete list of diagnosis and diagnosis/procedure combinations currently designated as HAC can be found on the CMS website at International Classification of Diseases (ICD)-10 HAC List.

To meet the CMS-mandated requirements, MO HealthNet providers are required to report all HAC diagnosis codes. Providers will report this information by entering the appropriate Present on Admission (POA) indicator for all diagnosis codes submitted on their claims. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, prior to admission to inpatient, including emergency department, observation, or outpatient surgery, are considered POA.

The POA indicator will be required for all diagnosis codes submitted on claims excluding those diagnosis codes designated under the current version of the ICD Official Guidelines for Coding and Reporting as exempt from the POA requirement. Claims containing an invalid or missing POA indicator will be denied unless the diagnosis is exempt from the POA requirement. Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting for proper assignment of the POA indicator. Valid POA indicator values are:

POA Indicator	Description	Definition
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	Documentation is insufficient to determine if the condition is present on admission
W	Clinically Undetermined	The provider is unable to clinically determine whether the condition was present on admission or not.

As stated above, CMS and state regulations require MHD to capture and review claims data and medical records when appropriate for services billed with a HCAC diagnosis that was not present at the time of admission. The state regulation authorizes MHD to reduce or recoup claim payment if the condition is preventable, resulting in additional hospital services not otherwise needed and/or lengthened hospital stay.

Post-payment Adjustment Process

The post-payment adjustment process applies to hospitals reimbursed on a per diem basis. This process is triggered when the condition is on the list of HCACs, and the condition is acquired during the hospital stay (POA indicator of 'N' or 'U'). Refer to the table above for POA indicator descriptions. If the claim has indicated a HCAC and the POA indicator is a 'N' or 'U', a Diagnosis Related Grouping (DRG) will be assigned to the claim. DRG assignment is used to identify the effect of a HCAC on the resources needed to care for a patient. If removing the HCAC results in a DRG with a lower relative weight, payment on the claim will be affected. Payment will be adjusted by a percentage based on the difference in the DRG weights.

The HCAC will be considered up front during the claim processing for all other hospitals reimbursed by APR-DRG. MHD will not adjust the payment on these claims.

For more information related to the inpatient hospital reimbursement methodology, refer to **Section 1.1** in this manual.

Other Provider Preventable Conditions

MHD follows CMS guidelines regarding OPPC. MHD will not cover a surgical procedure or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- The wrong procedure
- The correct procedure, but on the wrong body part
- The correct procedure, but on the wrong patient

In addition, MHD will not cover hospitalizations and other services related to these non-covered procedures. When an error occurs, all services provided in the operating room are considered related and, therefore, not covered. All providers in the operating room when the OPPC occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. However, related services do not include the performance of the correct procedure.

Services falling in an OPPC category will be denied MHD reimbursement in **eMOMED**. Services must be billed appropriately when the OPPCs listed above occur.

OPPC medical claims (**CMS-1500 claim form** or its electronic equivalent) must be billed with the surgical procedure code and modifier listed below which indicates the type of OPPC and/or the diagnosis code for wrong surgery, wrong patient, or wrong body part must be present as one of the diagnoses codes on the claim.

Modifier	Description
PA	Wrong body part
PB	Wrong patient
PC	Wrong Surgery

OPPC outpatient claims (**CMS-1450 (UB-04) claim form** or its electronic equivalent) must be billed with a diagnosis code for the wrong surgery, wrong patient, or wrong body part within the first five (5) diagnosis codes listed on the claim.

OPPC inpatient claims must be billed with a type of bill 110. If there are covered services or procedures provided during the same stay as the OPPC, then the facility must submit two (2) claims: one (1) claim with covered services unrelated to the OPPC event and one (1) claim for all services related to the OPPC event.

Type of Bill 110 claim should also contain one (1) of the diagnosis codes to indicate the type of OPPC: wrong surgery, wrong patient, or wrong body part within the diagnosis codes listed on the claim.

A participant shall not be liable for payment for an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by MHD.

Medical Record Documentation

As stated in the Introduction to the ICD Official Guidelines for Coding and Reporting, a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term 'provider' means a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

2.24 Inpatient Hospital Stays

An 'inpatient' service, which requires the submission of an inpatient claim, is one in which the hospital expects to provide service to the patient in the hospital for a 24-hour period or longer. The stay is considered inpatient upon issuing a written physician or other medical professional's orders to that effect. A medical professional is a physician or other person authorized by State licensure law to order hospital services for the diagnosis or treatment of a patient.

If a patient dies or is discharged prior to being assigned and/or occupying a room, the hospital may enter an appropriate room and board charge on the claim. The service is still considered an inpatient if the intent is to stay 24 hours or longer even though the patient dies, is discharged, or is transferred to another institution and does not actually stay in the hospital for 24 hours.

Regardless of the length of time, services in an observation status without a written admission order, are not considered inpatient services. Refer to **Section 2.36** of this manual for more information.

Enrollment Cehanges Bbetween Fee-For-Service and Managed Care Health Plans Dduring Inpatient Stay

Participants, including newborn participants, who are hospitalized in an acute setting, will not be disenrolled from FFS or a general Managed Care hHealth pPlan until they are discharged from the inpatient stay, unless one (1) of the following applies:

- Tthey are enrolleding in Show Me Healthy Kids (SMHK), the specialty Managed Care Specialty hHealth pPlan for children in DSS state custody
- They , are no longer eligible for the Managed Care hHealth pPlan
- , or Tthey opt out of participating in the Managed Care hHealth pPlan.

Participants enrolled in FFS at the time of inpatient hospitalization on the effective date of enrollment into any of the Managed Care hHealth pPlans, including the Specialty Health PlanSMHK, will remain in FFS until discharged from the inpatient stay.

Participants enrolled in a general Managed Care hHealth pPlan at the time of acute inpatient hospitalization on the effective date of enrollment in a new general Managed Care hHealth pPlan will remain with the previous general Managed Care hHealth pPlan until discharged from the inpatient stay.

The Managed Care Specialty Health PlanSMHK will assume financial responsibility for enrolled participants enrolled in the Managed Care Specialty Health Plan effective on the first day of the month in which the participant enrolled in the Managed Care Specialty Health PlanSMHK, regardless of whether they were hospitalized on that date. In situations where a participant starts an inpatient hospital stay while enrolled in a general Managed Care hHealth pPlan and transitions to the Managed Care Specialty Health PlanSMHK during the stay, the health plan that the participant was enrolled in at the time of discharge would pay for the entire stay.

Admission Orders

The physician or other medical professional may clarify the admission order at any time prior to the patient's death or discharge as long as this modification only serves to make the physician's or other medical professional's actions more consistent with the initial intent. The initial intent itself cannot be changed. However, if the written order is vague or inconsistent with the hospital's actions, the physician or other medical professional may clarify that order (intention) at any time prior to the hospital's initial claim submission. If the written admission order is completed after the patient has died or been discharged from the hospital, the inpatient stay is not payable, and the participant cannot be held responsible for the charges incurred.

2.25 Maximum Number of Covered Inpatient Hospital Days

The number of inpatient hospital days which are reimbursable by MHD is limited by the number of days certified as medically necessary by the MO HealthNet review authority, Conduent. Refer to **Section 2.27** in this manual for more information regarding Conduent.

2.26 Counting Inpatient Days

For the purpose of administering the number of inpatient hospital days reimbursed by MHD, the counting of days begins with the latest of:

- The day of admission
- The first day certified by Conduent
- The first day MO HealthNet eligibility begins

The counting of days by the hospital's Utilization Review Committee begins with the day of admission. For participants eligible under Medicare Part A and MO HealthNet, counting days begins with the day following the last day of Medicare coverage. A midnight bed count is a common measure to determine a payable day. If a patient is in the hospital at midnight, that day is payable. A new day begins at 12:01 a.m.

Interim Billing

It is usually inappropriate to submit more than one (1) claim for one continuous hospitalization; however, there are some instances where it is required. This is discussed in the **Participant Ineligible During a Stay** section below. The reimbursement of interim billed claims is based on the Milliman Care Guidelines for stays authorized by Conduent, or the Preadmission Screening (PAS) length of stay for certain pregnancy and newborn-related stays, as part of one (1) continuous stay. Interim billed claims represent one (1) continuous stay that exceeds the number of PAS allowed days, and the reimbursement is cut back to the number of approved days versus the number of days billed. The group and reason code on the RA for this situation is CO 198, Precertification/authorization exceeded. Refer to **Section 4** of this manual for more information regarding interim billing.

Providers reimbursed under the APR-DRG reimbursement methodology may submit one (1) interim claim. Providers must void the prior interim claim before submitting another interim claim. When the participant is discharged, the provider must void the interim claim and submit the final claim, which covers the full length of stay.

Participant Ineligibility During a Stay

A participant may become ineligible for MO HealthNet benefits during an inpatient stay.

Example 1: A spend down eligible participant has an inpatient stay from March 28 to April 3. The participant has met their spend down for March but not for April before they are discharged from the hospital. The provider should bill one (1) interim claim with the dates of March 28 to March 31 with a status of '30', reflecting that the participant was still a patient on March 31. If the provider determines the participant has met their spend down for April, the provider would need to void the original interim claim and rebill for the entire stay.

Example 2: A participant's coverage termed during their inpatient stay. In this instance, the provider would only bill one (1) claim for the dates of service the participant was eligible for MO HealthNet.

Refer to **Section 4.18** of this manual for CMS-1450 (UB-04) claim form instructions. Refer to the **Spend Down FAQs** for more information on the Spend Down Program.

Day of Discharge, Death, or Transfer

MHD reimburses a facility for the day of admission. MO HealthNet does not cover the day of discharge, death, or transfer unless it is also the day of admission, and then it is reimbursable. The day of discharge, death, or transfer cannot be billed to the participant.

Private Rooms

MHD covers charges for private room accommodations only if they are medically necessary. Inpatient hospital claims with Revenue Codes 0110—0119 and 0140—0149 must substantiate a medical need. Refer to **Section 5.2** in this manual for more information. The documentation of need must be in the patient's medical records. If a private room is not considered medically necessary, the claim is only processed if the difference between the private room accommodation charge and the semi-private room charge times the number of covered days are shown in the non-covered charge column of the claim form. Hospitals with only private rooms are exempt from this policy.

Transfers Between Hospitals

A transfer from one hospital to another is acceptable only when the transferring hospital cannot provide the services the patient needs. There may be some exceptions to this policy; for ***Example:*** transfer is acceptable if the attending physician feels that the patient needs the support of family members who do not live within visiting distance. This information must be included in the patient's medical chart. Transfers for other reasons are subject to recoupment of payments made to the second hospital.

The hospital where the patient has been transferred is subject to admission certification requirements.

Newborns are considered admitted as inpatient when born in a hospital setting, even if they are transferred and admitted to another facility on the same day, when the transfer is medically necessary. Below is an example of Neonatal Intensive Care Unit (NICU) transfer billing:

- If the ~~baby~~newborn is born/delivered at Hospital A, Hospital A should bill for the delivery date~~.~~
- If the ~~baby~~newborn is transferred to Hospital B for NICU services, Hospital B can admit the newborn on the same date, that Hospital A billed for, and bill for services on that date as well~~.~~
- If the ~~baby~~newborn does not receive care or services in Hospital A's NICU, Hospital A should not bill a NICU revenue code(s). Hospital A should only bill for an inpatient stay and any other critical care codes.

Transfers Within a Hospital

Submitting two (2) claims when a participant is transferred from one part of a hospital to another is improper. The counting of days that are allowable under the Conduent approved days is from the date of initial admission for a continuous period of hospitalization. Only one (1) claim should be submitted covering the full continuous length of stay. This includes the following situations:

- Movement from one level of room accommodation to another level
- Movement from the acute area of the hospital to another area, such as a psychiatric or rehabilitation unit
- Written discharge from one unit and admission to another unit of the hospital

2.27 Inpatient Hospital Admission Certification

Inpatient hospital admissions must be certified as medically necessary and appropriate before MHD reimburses for inpatient services. All MHD-enrolled hospitals in Missouri and bordering states are subject to the admission certification requirement. The state has given authority for Conduent, MHD's review authority, to receive all the appropriate information necessary to review admissions subject to admission certification.

Services Exempt from Admission Certification

Some inpatient stays are exempt from review by Conduent. These exemptions can have certain pregnancy-related, delivery, or newborn diagnosis codes.

When the stay is exempt, the maximum number of days allowed will be identified by the exempt diagnosis code on the **Inpatient Stay Exemption By Diagnosis Code Table**. If the inpatient stay does not exceed the number of days allowed for the exempt diagnosis, the provider is not required to obtain a precertification. However, if the stay exceeds the allowed number of days, the provider must obtain a precertification for the entire inpatient stay; otherwise, payment will only be made for the allowed number of days listed for the exempt diagnosis table.

Admissions of Participants Enrolled in Managed Care Health Plans

The Managed Care health plan is responsible for certifying hospital admissions for Managed Care members. The health plan is responsible for pre-transplant and post-transplant follow-up. Refer to the **General Sections Manual** for information regarding the MO HealthNet Managed Care Program.

Admissions Covered by Medicare Part A

Claims for deductible and coinsurance for MO HealthNet participants with Medicare Part A benefits are exempt from admission certification. However, if Medicare Part A benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. MO HealthNet participants with both Medicare Part C and Qualified Medicaid Beneficiary (QMB) coverage are exempt from admission certification. MO HealthNet participants with Medicare Part B only require admission certification.

Claims with an exempt principal diagnosis code do not require a certification number in Field 63 of the **CMS-1450 (UB-04) claim form**. Refer to **Section 4.18** of this manual for CMS-1450 (UB-04) claim form instructions.

Conduent Review Personnel

The Conduent review staff consists of Utilization Review Assistants (URAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs). The URAs, LPNs, and RNs perform all initial screening reviews for admission certification, continued stay review, and validation review. Conduent Psychiatric Nurse reviewers screen medical records for youth under 21 years of age under the Certification of Need audit program.

Conduent Physician reviewers must be Doctors of Medicine or osteopathy, licensed, and actively practicing medicine in Missouri.

Quality Management Program

The Conduent Quality Management Program (QMP) includes quality assessment and improvement (QA&I), which seeks to ensure that qualified Certification/Review Personnel implement and utilize review policies and procedures in accordance with standards of practice and that such personnel deliver timely, valid, and appropriate determinations.

Criteria Used in Review

Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations, including those for adult and child psychiatric care, alcohol and drug abuse detoxification, and physical rehabilitation. It is important to remember that screening criteria are not standards of care. Failure to meet any particular screen does not mean that the patient does not require an acute hospital level of care but rather that the case requires review by a physician.

Conduent follows the **Criteria for Post-Payment Review of Specialty Pediatric Hospital Discharges** to determine medical necessity for Specialty Pediatric Hospitals.

Conduent Responsibilities

Certification review is performed via **CyberAccess** within Conduent's Inpatient Certification Management System (ICMS), which uses the review criteria Milliman Care Guidelines®. The review is based on pertinent medical information received from the attending physician or hospital regarding the patient's condition and planned services. For certifications meeting criteria, Conduent expects to certify the admission at the time of the initial request when made via **CyberAccess** or telephone. Certifications meeting criteria when submitted by written or fax request will be made by the end of the next working day. Cases meeting criteria are assigned a unique seven (7) digit admission certification number to be entered in Field 63 of the **CMS-1450 (UB-04) claim form** submitted to MHD for payment. Refer to **Section 4** of this manual for further details.

For cases meeting the criteria, the initial length of stay assignment and unique certification number are communicated via **CyberAccess** and/or during the initial telephone conversation. Cases not meeting the criteria are referred to a physician reviewer for a medical necessity determination. A decision is made within two (2) working days after receipt of all required information. Decisions to deny certification are only made by a physician reviewer. The physician reviewer is not bound by any criteria and makes the determination based on medical facts in the case using medical judgment. Prior to a potential denial determination, the physician reviewer contacts the attending physician, who is allowed the opportunity to provide additional information. When Conduent informs a hospital that its admission request is referred to a physician reviewer, it is helpful if the hospital notifies the patient's attending physician. Alerting the attending physician that there may be a call from the Conduent physician reviewer helps facilitate discussion between the attending and reviewing physicians regarding the medical necessity of admission. Any additional information is considered by the physician reviewer prior to a decision to approve or deny admission.

The attending physician, other medical professional, and the hospital can obtain the status of all certification requests, including the certification number, on **CyberAccess**. If inpatient admission is approved and surgery is planned, the nurse reviewer recommends that preadmission testing be accomplished on an outpatient basis to avoid unnecessary preoperative days. The date of surgery is the first date approved for coverage unless the nurse or physician reviewer approves a preoperative day for evaluating concurrent medical conditions or other risk factors.

Daily Discharge/Expired Certification Report

Conduent will provide a daily report by facility on **CyberAccess** reflecting all approved certifications scheduled to expire or have already expired that do not contain a discharge date. This is called the Daily Discharge/Expired Certification Report. Each facility will access the report using the Case Management link in **CyberAccess**. The facility must then add the discharge date to the report and save it. This lets Conduent know the certification is complete and can be closed.

Conduent Notifications

All admission certification decisions are available through the **CyberAccess** web portal. Written notification of approved certifications will not be sent. It is the provider's responsibility to obtain this information from **CyberAccess**. Denial determination notices are sent to the participant, attending physician, and hospital. Certification of admission is not a guarantee of payment by MHD. The participant must be eligible on each date of service, and the provider must comply with other program policies. Reconsideration is available to all parties of a denial determination. It is explained in the **Summary of Certification Requests** section below.

Conduent's determinations regarding MO HealthNet admission certifications are advisory. MHD is the final payment authority.

If Conduent denies a provider's request for admission certification after the patient has formally been admitted, charges for those inpatient services cannot be billed on an outpatient claim. Claims are monitored post-payment to ensure compliance with this policy.

Insufficient Information

Certification requests submitted via **CyberAccess**, fax, or mail must have all information necessary for Conduent to review and complete the certification of the inpatient stay. If Conduent does not receive all necessary information, the certification request will be closed, and the physician and hospital will receive a letter requesting all medically necessary information to complete the certification. This is not a denial of the certification. The certification request will be considered closed, so the reconsideration and appeal rights awarded to each certification remain intact. The provider must then resubmit all information pertaining to the inpatient stay. Conduent will review the information again to determine a benchmark length of stay and issue a certification number if the stay is approved. If the original request was submitted prior to discharge but did not contain sufficient information and a new complete request is not received by Conduent prior to discharge, the request will be considered retrospective and restricted to the retrospective certification guidelines. These guidelines are explained in the **Summary of Certification Requests** section below.

Procedures for Requesting Conduent Certification

The physician or the hospital must contact Conduent to provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in **13 CSR 70-15.020**. Providers may submit inpatient certification requests at **CyberAccess**. Submission via **CyberAccess** is the preferred method. **CyberAccess** is available 24 hours a day, seven (7) days a week for admission certification prior to admission, on the day of admission, prior to discharge, or within 14 days calendar days after discharge for continued stay reviews.

Other methods of submission include calling (800) 766-0686, Option 0, faxing to (866) 629-0737, or by mail to:

United States Postal Service (USPS) Mail	Fed Ex/UPS
Conduent P.O. Box 105110 Jefferson City, MO 65110	Conduent 3425 West Truman Jefferson City, MO 65109

Providers must use the **Inpatient Certification Request Form** when a certification is faxed or mailed.

For retrospective requests and/or reconsiderations, please mail the entire medical record with a completed **Inpatient Certification Request Form** to the appropriate address above.

The Conduent office is open from 7:30 a.m. to 4:30 p.m. Central Standard Time (CST), Monday through Friday, except for established **state holidays**.

The certification request can be made by hospital staff, physicians, or other medical professionals authorized by state law to order hospital services for the diagnosis or treatment of a patient. The hospital staff, physician, or other medical professional requesting inpatient certification must provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in **13 CSR 70-15.020**. The physician or other medical professional is not required to be a MO HealthNet provider to request a certification.

Summary of Certification Requests

There are six (6) types of certification requests, each with a specific purpose and detailed below.

Prospective (Preadmission)

A prospective certification request is a physician-ordered inpatient stay that should be requested at least two (2) days prior to the participant's scheduled admission date. Requests are usually for elective surgery cases when hospitalization admission is planned. This request can be submitted online using **CyberAccess**, by telephone at (800) 766-0686, Option 0, or by fax. Submit the completed **Inpatient Certification Request Form** when submitting by fax to (866) 629-0737.

Admission (Initial)

The admission certification request is the initial request for an inpatient stay after the patient has already been admitted. This type of request should be submitted by the end of the first full working day after the date of admission or prior to discharge, whichever comes first. This type of request is for urgent or emergency admissions while the patient is still in the hospital. The request should be submitted online using **CyberAccess**, by telephone at (800) 766-0686, Option 0, or by fax to (866) 629-0737. Submit the completed **Inpatient Certification Request Form** when submitting by fax. Refer to **Section 2.6** of this manual for the definition of emergency services.

Other potentially serious medical conditions, less severe than those meeting the definition of an emergency medical condition, may be classified as urgent. Prompt admission to the hospital is required to prevent the deterioration of a medical condition from an urgent to an emergency situation. Refer to **Section 2.6** of this manual for the definition of an emergency medical condition.

Continued Stay Review

The Continued Stay Review (CSR) certification request requests additional days required beyond what was initially certified due to unforeseen complications in the participant's condition. The hospital or attending physician must contact Conduent prior to the last approved day or within 14 calendar days after discharge, at which time a CSR is conducted. Extensions are granted based on the medical necessity of the inpatient setting for care delivery. The approval process for a CSR is the same as mentioned in the **Conduent Responsibilities** section above. This request should be submitted online using **CyberAccess**, by telephone at (800) 766-0686, Option 0, or by fax to (866) 629-0737. Submit the completed **Inpatient Certification Request Form** and any additional supporting documentation when submitting by fax. Payment for the hospital stay is made according to the lesser of the actual discharge date or the cease payment date assigned by Conduent. CSRs submitted after 14 days post-discharge are considered retrospective reviews, as described below.

Retrospective (Post Discharge)

The retrospective certification request is used after the participant has been discharged from the hospital. A prior certification would not have been completed for this type of request. Retrospective certification requests are only accepted when the participant has retroactive eligibility, or the hospital provider has a retroactive enrollment date. All other retrospective certifications will only be accepted on a case-by-case basis. The **Inpatient Certification Request Form** must be mailed with a copy of the patient's medical record for days of the inpatient stay requiring review. The request must be mailed to:

USPS Mail	Fed Ex/UPS
Conduent P.O. Box 105110 Jefferson City, MO 65110	Conduent 3425 West Truman Jefferson City, MO 65109

When mailing the retrospective certification request, indicate on the **Inpatient Certification Request Form** if the participant is "incarcerated, involuntarily confined to a state or federal prison, jail, detention facility, or other penal facility" and attach (if applicable) the recoupment letter from Centurion.

Providers are encouraged to make their certification requests in a timely manner to reduce their liability for denied cases. If a certification request is made after the date of discharge or after 14 days post-discharge for a CSR, Conduent's time for responding differs from their response time for timely requests. For retrospective reviews, Conduent must make the determination within 20 working days of receiving all necessary information.

Validation Review

A validation review certification request is a quarterly review that confirms that the information provided at the time of the certification request is consistent with the documentation and clinical findings in the medical record. Conduent will choose a statistically valid sampling of certifications from each hospital, including certified admissions and CSRs. Denied and exempt cases are excluded from the Conduent sample. Conduent will perform utilization and quality of care reviews on those admissions chosen in the sampling. All admissions may be subject to focused validation if the nurse reviewer identified a potential quality of care issue. Cases are flagged in the Conduent's ICMS system for identification. Selection occurs quarterly even if the corresponding claim has not been paid.

For admissions subject to review, Conduent requests medical records. Providers have 30 calendar days from the date of request to submit documentation. Records not received within the 30 calendar days result in the admission being denied. Conduent reimburses for copies of the medical record for validation review cases at a rate determined by Conduent. The mailing costs are also paid. Conduent includes an invoice with the request for records, which is to be submitted at the same time the records are mailed to Conduent.

Admission certification is not a guarantee of payment. If the information provided during the certification process cannot be validated in the medical record by the nurse reviewer or is false, misleading, or incomplete, the case is referred to a physician reviewer for a medical necessity determination. As in the admission certification process, the attending physician and hospital are allowed to respond to a proposed denial before issuing a final denial notice. If the physician reviewer determines the admission was not medically necessary, a denial notice is issued to the attending physician and the hospital. Reconsideration and appeal procedures also apply to this element of the review procedure.

A validation review determination that an inpatient stay was not medically necessary results in the recoupment of MHD payments in accordance with state regulation **13 CSR 70-3.030**. Overpayment determinations may be appealed to the Administrative Hearing Commission (AHC).

Request for Reconsideration

An attending physician, hospital, or participant dissatisfied with a Conduent initial denial determination is entitled to reconsideration by Conduent. The reconsideration may be requested before or after discharge. However, the request must be made within three (3) working days of receipt of the denial letter if the participant is still inpatient or within 60 calendar days if the participant has already been discharged. Requests for reconsideration must be mailed using the **Inpatient Certification Request Form** and all pertinent medical documentation. The request and documentation must be mailed to:

USPS Mail	Fed Ex/UPS
Conduent P.O. Box 105110 Jefferson City, MO 65110	Conduent 3425 West Truman Jefferson City, MO 65109

The request for reconsideration is conducted by a Conduent physician reviewer who has had no previous involvement in the case. The physician is board certified or board eligible in the specialty that matches the care under review except in cases where meeting this requirement compromises the efficiency and effectiveness of the review. The reconsideration process consists of reviewing all medical records, including information used to make the initial determination. Conduent also considers any additional information submitted by a party to the reconsideration. Conduent reconsideration is the final level of review. Providers may not appeal this decision through Conduent but can appeal to the AHC.

Prior to Admission/Prior to Discharge

To request an expedited reconsideration for a patient prior to admission or for a patient still in the hospital, the provider should request a reconsideration to Conduent by calling (800) 766-0686, Option 0. To expedite the process, the provider must indicate that this is a request for reconsideration. Conduent will complete the reconsideration review and issue a determination within one (1) working day of Conduent receipt of the request and all pertinent information. Pertinent information is defined as any information that the attending physician, hospital, or participant feels may justify or qualify the hospitalization.

Post Discharge

If the patient has been discharged from the hospital, the provider must submit a request for reconsideration by mail at the address above or by fax to (866) 629-0737. This request may be initiated by telephone but must be followed by a written request. The request must be made within 60 calendar days of receipt of the written denial notice. Conduent will complete the reconsideration review within 30 days after receipt of the request for reconsideration, medical records, and all pertinent information submitted by parties to the denial notice. A written notice will be issued to the participant, attending physician, and hospital within three (3) days after the reconsideration is completed.

Participant Liability

In some instances, the participant may be held financially responsible for all or part of an inpatient stay when an inpatient certification request is denied. The participant can be held responsible in the following circumstances:

- When the prospective request for certification is denied, the participant is notified of the denial but chooses to be admitted anyway

- When an admission request for certification is denied, the participant is liable for those days of inpatient hospital service provided after the date of the denial notification if they choose to remain in the hospital
- When the participant's eligibility was not established on or by the date of admission, and the request for certification is denied, the participant is liable for all days
- When the participant has signed a written agreement with the provider indicating that MHD is not the intended payer for the specific item or service, they are liable for all days. The agreement must be signed prior to receiving the services. In this situation, the participant accepts the status and liabilities of a private pay patient in accordance with **13 CSR 70-4.030**.

The participant cannot be held financially responsible under the following conditions:

- When the provider fails to comply with prospective certification requirements, the participant is not liable for any days
- When an admission request for certification is denied, the participant is not liable for those inpatient hospital services provided prior to and including the date of the notification of the denial to the participant
- When the medical review agent performs a validation review and determines an admission was not medically necessary for inpatient services, the participant is not liable for any days

Participant Right to Hearing

If the participant disagrees with Conduent's reconsideration decision, the participant has the right to a fair hearing. The participant has 90 days from the date of the denial to request a hearing. The participant must make this request by calling MHD at (800) 392-2161 or (573) 751-6527 or by submitting a request in writing to the Constituent Services Unit at P.O. Box 6500, Jefferson City, MO 65102.

2.28 Continued Length of Stay for Children in State Custody

MO HealthNet Managed Care health plans and MO HealthNet FFS do not pay for days beyond those medically necessary. The following information is to clarify the policy for reimbursement of continued stay days beyond those determined to be medically necessary for children in state custody.

Hospital stays beyond those determined to be medically necessary can occur when the hospital personnel are concerned about discharge plans for a child and continued days are no longer medically necessary. As mandated reporters, when hospital personnel have concerns about the parent/caretaker's ability to care for the child, they must notify the **Child Abuse and Neglect Hotline** at (800) 392-3738. It is the hospital's responsibility to do appropriate discharge planning prior to the occurrence of non-medically necessary days. Early notification allows the appropriate services to be in place prior to the child's discharge. Notification should be done immediately, as the child needs to be discharged as planned when services are no longer medically necessary.

For children in state custody, hospital discharge planners must coordinate the discharge in advance with the DSS Children's Division (CD) regardless of the payment source for the medically necessary days. It is the hospital's responsibility to notify CD staff of the medically necessary length of stay days. Information regarding the child's discharge date must be relayed to CD staff as soon as the medically necessary length of stay is determined. In accordance with FSD policy, it is the CD worker's responsibility to secure a placement for the child upon discharge from the hospital. Also, in accordance with CD policy, CD is mandated to find the least restrictive environment to meet a child's needs. Therefore, hospitals are not an appropriate placement when the child's medical condition no longer warrants such.

Hospitals should only allow children in CD custody to remain in the hospital beyond the medically necessary length of stay days if they have written authorization from CD staff that clearly states that CD is responsible for payment beyond the medically necessary length of stay days. This is the only way CD becomes financially responsible for the days beyond the medically necessary length of stay.

If CD authorizes hospital days that are not medically necessary, they instruct the hospital on how to bill CD for authorized days beyond the medically necessary length of stay.

Services for children not in state custody are not paid by CD, MHD, or MO HealthNet Managed Care health plans when the hospital keeps the child longer than the medically necessary length of stay days.

If the child is in the custody of the Department of Mental Health (DMH) or DSS Division of Youth Services (DYS), the hospital should communicate the discharge plans for the child with the appropriate case manager.

2.29 Institutions for Mental Diseases

Institutions for Mental Diseases (IMD) are those facilities maintained primarily for the care and treatment of patients with mental illness. According to CMS, a facility is considered an IMD if the reason for admission of fifty percent (50%) or more of all patients in the facility was due to a mental disorder. The facility must have 17 or more beds primarily engaged in diagnosing, treating, or caring for persons with mental diseases. CMS also states that alcohol and other substance use disorders are classified as a mental disorder according to the ICD system.

Two (2) federal programs permit MHD reimbursement to an IMD. One (1) program authorizes services to individuals aged 65 years or older. The other provides services to individuals under age 21, or if the individuals were receiving services immediately before they reached age 21, services may continue until they reach age 22. This age limitation applies to Medicare Part A and Part C deductible/coinsurance/copayment claims unless the participant is a QMB.

For payment purposes, an IMD discharge occurs when Medicare benefits are exhausted, and the date benefits exhaust (if present) will substitute for the 'actual' discharge date. The claim is paid based on the benefits exhaust date (if present) rather than the discharge date. Hospitals should consider the Medicare benefits exhaust date as the discharge date and bill MHD from that point forward if the participant is MO HealthNet eligible.

Psychiatric Services for Participants Between the Ages of 21 and 64

CMS approved Missouri's Serious Mental Illness (SMI) 1115(a) Medicaid Demonstration effective December 6, 2023. Reimbursement to MO HealthNet enrolled providers for participants between the ages of 21 and 64 in psychiatric hospitals greater than 16 beds is available during the demonstration period of December 6, 2023, through December 31, 2028. As a condition of this demonstration, MHD has implemented the following requirements.

- Psychiatric hospitals must screen participants for co-morbid physical health, substance use disorder (SUD), and suicidal ideation and facilitate access to treatment for those conditions
- Psychiatric hospitals must assess participants' housing situations and coordinate with housing service providers when needed and available
- Psychiatric hospitals must contact participants and community-based providers through the most effective means possible, e.g., email, text, or phone call, within 72 hours post-discharge
- Psychiatric hospitals must utilize the Level of Care Utilization System (LOCUS) to determine the appropriate level of care when admitting adults ages 21 to 64
- The LOCUS is an evidence-based, publicly available patient assessment tool developed by the American Association of Community Psychiatrists (AACP). MHD recommends training approved by the AACP. Review **AACP Education and Training** for more information.
- Psychiatric hospitals that meet the definition of an IMD must comply with this requirement to participate in the 1115 SMI Demonstration as this is part of Missouri's Special Terms and Conditions (STCs) agreement with CMS. Refer to STC 5.6.3.3.4. within **Missouri's 1115 waiver approval document**.

2.30 Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Hospital

Federal regulations at **42 CFR 441 Subpart D** and **42 CFR Part 456 Subparts D and G** provide requirements for psychiatric services for participants under age 21 in psychiatric facilities. Audits are performed by state and federal personnel to monitor hospital compliance with this program. MHD payments are recouped for cases that do not have documentation that indicates compliance.

Requirements for Psychiatric Services for Individuals Under 21 in Psychiatric Facilities

The following four (4) requirements are specific to psychiatric services for children and youth and must be documented. Each requirement is described below.

Medical, Psychiatric, and Social Evaluation

Before admission to a psychiatric hospital, the physician member of the team responsible for the certification of need for services must make a medical evaluation of the child or youth's need for care in the hospital. The team responsible for certification of need for services must make a psychiatric and social evaluation.

The medical evaluation must include:

- Diagnoses
- Summary of present medical findings
- Medical history
- Mental and physical functional capacity
- Prognoses
- A recommendation by a physician concerning:
    - Admission to the mental hospital
    - Continued care in the mental hospital for individuals who apply for MO HealthNet

Admission Status

The status of the child or youth at the time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for the certification of need for inpatient care.

It is important for psychiatric hospitals serving children and youth under age 21 to determine whether an admission is a psychiatric emergency. The type of admission determines if the certification for the need for inpatient services and the medical/psychiatric/social evaluation must be made by an independent team or the hospital's interdisciplinary team.

A psychiatric emergency is a condition requiring immediate psychiatric intervention as evidenced by:

- Impairment of mental capacity whereby the person is unable to act in their own best interest
- Behavior that is by intent an action dangerous to others
- Behavior and action that is dangerous to self

Independent Review Team

If the admission is not an emergency and the individual is an eligible MO HealthNet participant at the time of admission, the **Certification of Need for Private PRTF Services** shall be completed by an independent team of healthcare professionals that meet the following criteria:

- Includes a physician and a licensed behavioral health clinician
- Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry
- Has knowledge of the participant's situation

Ideally, the certification of need should be completed by the physician and behavioral health clinician treating the participant in the community. However, if the participant has been unable to establish care in the community, other options are allowed as long as the team includes at least two qualified healthcare professionals that meet the criteria above and they are not the same providers as the hospital that is admitting them.

Acceptable examples include the following:

- Inpatient hospitals and outpatient clinics that may be affiliated with the Psychiatric Residential Treatment Facility (PRTF)
- Contracted providers
- MO HealthNet Managed Care health plan representatives may be an option in specific circumstances. Providers should contact the Managed Care health plan for further guidance.

Interdisciplinary Review Team

If the admission is an emergency or the individual applies and is approved for MO HealthNet while in the facility, the facility's interdisciplinary team is responsible for the certification of need for inpatient care. The interdisciplinary team is responsible for the plan of care. For emergency admissions, certification of need must be made within 14 days of admission. Certification of need for individuals who become MO HealthNet eligible while in the hospital must be made before submitting a claim for payment and must cover any period for which MHD claims are made. Emergency admission to a private PRTF is allowed for MO HealthNet participants, if warranted.

The required composition of the treatment facility's interdisciplinary team is in **13 CSR 70-15.070**. The team should include, as a minimum, at least one (1) of the below:

- A board-eligible or board-certified psychiatrist who is a licensed physician
- A clinical psychologist who has a doctoral degree is licensed, and a physician licensed to practice medicine or osteopathy
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of behavioral health disorders and a licensed psychologist who has a master's degree or doctorate in clinical psychology

The team must include at least one (1) other individual or professional from the list below:

- A licensed psychiatric social worker
- A licensed RN with specialized training or one (1) year of experience in treating behavioral health disorders
- A licensed occupational therapist with specialized training or one (1) year of experience in treating behavioral health disorders
- A licensed psychologist who has a master's degree or doctorate in clinical psychology

Certification of Need for Psychiatric Services

For inpatient psychiatric services provided in a psychiatric facility, an appropriate team must certify that:

- Ambulatory care resources in the community do not meet the needs of the youth
- Proper treatment of the individual's condition requires inpatient services under the direction of a physician
- The services can reasonably be expected to improve the patient's condition or prevent further regression so that services are no longer needed.

A **Certification of Need for Private PRTF Services** documents and certifies the need for inpatient psychiatric service. The form must be signed and dated by two (2) team members as well as the physician. A copy of a completed **Certification of Need for Private PRTF Services** should be sent to FSD in the participant's county of residence. Use **Find an Office** to locate the address for an FSD office.

Plan of Care

An individual plan of care must be developed and implemented within 14 days of admission and reviewed every 30 days by the facility's interdisciplinary team.

The plan of care must be:

- Based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the participant's situation and reflects the need for inpatient psychiatric care

- Developed by a team of professionals in consultation with the participant, the parents, legal guardians, or others to whose care the participant will be released after discharge
- State treatment objectives
- Prescribe an integrated program of therapies, activities, and experiences to meet the objectives
- At an appropriate time, include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the participant's family, school, and community upon discharge

Active Treatment

Inpatient psychiatric services must involve active treatment, which means the implementation of a professionally developed and supervised individual plan of care. Refer to **42 CFR 441.154** for more information.

Certification of inpatient admission by Conduent, MHD's review authority, is required for claims payment purposes for this program, as with all hospital admissions except deliveries, newborns, and certain pregnancy-related cases.

The requirements of inpatient psychiatric services are in lieu of many of the utilization control requirements. However, DHSS continues to perform annual on-site inspections of care reviews. It is important that all MO HealthNet participants in-house at the time of the inspection are identified for review.

2.31 Utilization Review Plans

Federal regulation **42 CFR 456, Subparts C, D, and F**, prescribes the requirements for control of utilization of inpatient hospital services for acute care hospitals, intermediate care facilities, and mental hospitals. These requirements include certification of need for care, plan of care, and utilization review plans.

All in-state and out-of-state MO HealthNet inpatient providers must have a current utilization review (UR) plan made available to MMAC upon request. The UR plans must be signed and dated by a hospital representative. A list of current hospital UR committee members and their professional status is to be included with the UR plan.

Each ACH, Intermediate Care Facility (ICF), and mental hospital furnishing inpatient services to MO HealthNet participants must have a written UR plan that provides a review of each participant's need for services.

The UR plan must meet the certification of need, plan of care, and utilization review requirements listed for each below:

Entity	Requirements
ACH	**42 CFR 456.101 - 456.145 (Subpart C)** **42 CFR 482.30 (Subpart C)**
ICF	**42 CFR 456 (Subpart F)**
Mental Hospital	**42 CFR 456.201 - 456.245 (Subpart D)** **42 CFR 482.30 (Subpart C)**

2.32 Inpatient Medically Managed Treatment

Under the Hospital Program, MO HealthNet covers Medically Managed Inpatient Treatment services that align with the American Society of Addiction Medicine (ASAM) Criteria, 4th edition (or the most current ASAM edition after the 4th edition). Within the 4th edition, this service is referred to as ASAM Level of Care 4. These services are delivered in a specialized acute care setting that provides 24-hour medically directed evaluation and treatment of intoxication, withdrawal, and biomedical and psychiatric comorbidities. This level of care is intended for patients whose signs and symptoms are severe enough to require primary medical and nursing care.

Key Service Functions of Inpatient Medically Managed Treatment

- Full medical acute care services
- Intensive care unit (ICU) services, as needed
- Psychiatric services
- Nursing assessments conducted at admission and regular intervals throughout care
- Hourly or more frequent nurse monitoring of member progress and medication administration as needed
- Clinical services
- Care coordination
- Communication with external addiction or mental health providers at admission and during transitions
- Coordination of referrals to support transition to other levels of care (e.g., CSTAR services)
- Psychosocial services available at least eight (8) hours per day
- Health education
- Recovery support services

- Services integrating family and significant others
- Laboratory services
- Toxicology services

Additionally, Inpatient Medically Managed Treatment pharmacies should include all Food and Drug Administration (FDA) approved treatments for substance use disorders (SUD) on their formularies, including all medications to treat opioid use disorder, alcohol use disorder, and tobacco use disorder.

ASAM guidance also outlines the following expectations related to Specialty Assessment and Treatment Planning:

- A treatment planning assessment that includes a history and physical examination is performed within 24 hours of admission.
- An ASAM level of care assessment, addressing dimensions one (1) through six (6) is completed as part of the biopsychosocial assessment process.
- An individualized treatment plan should be completed that includes problem identification, treatment goals and objectives, and activities to meet those goals in ASAM dimensions one (1) through six (6).

Qualified Providers of Inpatient Medically Managed Treatment

- A medical director
- Physicians with controlled substance prescribing authority. At least one prescriber authorized to prescribe buprenorphine should be available on-site or via telemedicine 24 hours a day, seven (7) days a week
- Nurses, including registered nurses or other appropriately licensed and credentialed nurses must be available 24 hours a day. A nursing supervisor should be available 24 hours a day, seven (7) days a week to respond to urgent situations
- Clinical staff (i.e., psychologists, clinical social workers, SUD and mental health counselors) available on-site or via telemedicine at least eight (8) hours a day
- Allied health staff (i.e., certified peer specialists, patient navigators, health educators, counselor aides, group living workers)

All medical practitioners on the team may provide medically supervised monitoring of health status and withdrawal symptoms.

Service Limitations

When Conduent is contacted to perform required admission certification for these cases, an initial length of stay is assigned. The nurse reviewer assigns a unique certification number with the length of stay based upon the number of days the attending physician or hospital requests, up to a maximum of three (3) days. To extend the length of stay beyond the initially assigned days, either the attending physician or hospital must call Conduent. The nurse will review the medical information to determine if continued stay criteria are met. If criteria are met, the nurse reviewer may extend the hospital stay to a maximum of five (5) days. If the screening criteria are not met or the provider requests more than five (5) days, the case is referred to a physician reviewer for a medical necessity determination. The physician reviewer is not bound by the screening criteria and will make a determination based on medical facts in the case, using the physician reviewer's medical judgment.

Procedures for decision notification, reconsideration process, validation review, and participant liability remain the same as for admission certification. Refer to **Section 2.27** of this manual.

2.33 Community Psychiatric Rehabilitation Program

Participants with serious and persistent mental illnesses may be eligible to receive Community Psychiatric Rehabilitation (CPR) program services following discharge from inpatient hospital care. Refer to the **Community Psychiatric Rehabilitation Provider Manual** for additional information.

2.34 Evaluation of Inpatient Hospital Admissions and Continued Days of Stay

Per **13 CSR 70-15.020**, the basis on which hospitals providing inpatient care to MO HealthNet participants are audited to determine that admissions/lengths of stay were medically necessary, that duration and setting were appropriate, and that MHD rules and policies were followed. This audit rule is for review of the continued days of stay of certified admissions and of admissions/continued days of stay for cases exempt from the admission certification procedure. MO HealthNet participating hospitals in Missouri and bordering states are subject to desk or on-site audit procedures performed by MMAC.

A notice letter of an audit is sent to the hospital administrator 15 calendar days prior to the date upon which an on-site audit is to begin.

The hospital has 30 calendar days from the date of notice to furnish medical records for the desk audits.

Refer to **MMAC Provider Reviews** for more information.

Payment for requested copies is reimbursed by MHD in accordance with state statute **RSMo 191.227**. Copies must be legible.

The Milliman Care Guidelines® are used as screening criteria for medical, adult, and pediatric generic and body systems, adult and adolescent/child psychiatric care, rehabilitation care, and alcohol/drug abuse treatment. If the medical record documentation regarding the patient's condition and planned services meets the applicable criteria, the services are approved as medically necessary. If the criteria are not met, the nurse reviewer refers the case to a physician reviewer to determine the medical necessity and appropriateness of the setting. The physician reviewer uses their medical judgment to make a determination based on the documented medical facts in the record. Medically necessary inpatient services mean medical treatment for health reasons requiring continuous direction by a physician in an acute care setting.

If the physician reviewer denies the admission or continued days of stay, a preliminary denial notice is mailed to the attending physician and hospital. The attending physician and hospital have 15 working days from the date of notice to send in additional documentation. The physician reviewer examines the medical record and additional documentation prior to a determination to approve or deny the admission or continued days of stay. The determination made by the physician reviewer completes the final level of review. A written report of the physician reviewer's determination, as approved by MHD, is issued.

A policy compliance audit can be performed to determine conformity with written and published policies and procedures of the MO HealthNet Hospital Program.

A UR audit can be performed to determine compliance with the hospital's UR plan as it applies to the MO HealthNet program and is defined in federal regulation **42 CFR 456, Subparts C and D**, and **42 CFR 482.30**.

All pertinent and adequate hospital inpatient medical record documentation and UR records must be available to MHD at the time of the review, and copies must be provided by the hospital if requested. Adequate hospital inpatient medical records are records that are of the type and in a form required of good medical practice and contain:

- Patient identification data
- Medical history of the patient:
  - Chief complaint
  - Details of present illness, including assessment of the patient's emotional, behavioral, and social status
  - Relevant past, social, and family histories
  - Inventory by body systems where necessary for diagnosis and treatment
- Report of a relevant physical examination
- Diagnostic and therapeutic orders

- Evidence of appropriate informed consent. When consent is unavailable, the reason shall be entered in the record.
- Clinical observations, including results of therapy
- Reports of procedures, tests, and their results
- Conclusions at termination of hospitalization or evaluation/treatment

The audit and decision are based on the medical record documentation provided at the time of review for the specific date of admission. MMAC notifies hospitals if an adjustment of MHD payment is required due to audit findings. The following MHD policies apply for the calculation of payment:

- MHD shall reimburse at a hospital per diem rate when that level of service is provided in the inpatient hospital setting in accordance with **13 CSR 70-15.010** for:
  - In-state specialty pediatric hospitals
  - In-state pediatric hospitals licensed for fewer than fifteen (15) beds and specializes in pediatric orthopedic care
  - In-state free-standing psychiatric hospitals
  - In-state free-standing rehabilitation hospitals
  - In-state free-standing LTAC hospitals
  - In-state hospitals enrolled in MO HealthNet on or after January 1, 2025, that have eighty percent (80%) or greater patient mix in mental health and substance abuse
  - Out-of-state free-standing psychiatric hospitals
- MHD shall reimburse all other hospitals by APR-DRG
- No MHD payment is made on behalf of any participant who has received inpatient hospital care and did not need inpatient care
- No payment is made for outpatient services rendered on an inpatient basis
- MHD does not pay for admissions or continued days of stay for social situations, placement problems, court commitments, or abuse/neglect without medical risk

In accordance with the provisions of **RSMo 208.156** and **RSMo 621.055**, overpayment determinations may be appealed to the AHC.

2.35 Outpatient

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

Outpatient hospitals may be organized as clinics and/or emergency room departments. Outpatient clinics are established to provide services on a scheduled basis. Outpatient emergency rooms are established to provide services on an unscheduled basis as a response to treatment of an imminently life-threatening condition, traumatizing injury, illness, or when a delay in treatment may permanently impair the individual's health. When non-emergent services are provided in the emergency room, they should be considered clinic services for billing purposes. Refer to **Section 2.6** of this manual for more information.

Outpatient Hospital Services

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

Subject to the limitations given in this manual, the following types of treatment and services are covered when provided in the outpatient hospital clinic or emergency room and under the direct supervision of a medical professional. These treatments and services include:

- Preventive
- Diagnostic
- Therapeutic
- Palliative
- Therapies including:
  - Chemotherapy
  - Radiation therapy
  - Physical therapy
  - Routine dialysis treatment
- Medical and surgical supplies
- Medications that are administered on-site
- Injections and immunizations
- Observation

Direct supervision of a nurse practitioner in the hospital setting means the supervising physician must be on the grounds and immediately available to provide assistance and direction throughout the time the nurse practitioner performs the service. Direct supervision of a physician assistant means the supervising physician must be in the same facility sixty six percent (66%) of the time for practice supervision and collaboration. Physician assistants must practice within 30 miles of the supervising physician. The supervising physician must be readily available in person or via telecommunication when the physician assistant is providing patient care.

Outpatient Simplified Fee Schedule

All outpatient hospital services are reimbursed based on the OSFS. Hospitals must report all outpatient services and associated charges at the claim line level using CPT/HCPCS procedure codes appropriate to the services rendered. Reimbursement for the procedure codes billed by the hospital represents the facility charges.

Payment for covered services will be the lower of the provider's charge or the payment as calculated under the OSFS methodology. Payment under the OSFS methodology is final, without cost settlement.

Refer to the **Fee Schedule** for a complete list of outpatient hospital procedure codes with the MHD allowed amount under the OSFS methodology.

Hospitals may bill for services on an outpatient claim when the hospital provides services to a person registered on the hospital records as outpatient. An outpatient facility charge should be shown on the outpatient claim if the patient sees a medical professional. A medical professional is considered a physician or other person authorized by State licensure law to order hospital services for diagnosis or treatment of the patient, for evaluation, or treatment of the condition that caused the need for hospital services.

The charge for a facility procedure should include the following hospital operational cost elements:

- Administrative costs
- Basic floor stock supplies
- Durable, reusable items or medical equipment
- Fixed building costs
- Furnishings
- Insurance
- Laundry
- Maintenance
- Nursing salaries

- Paramedical salaries
- Records maintenance
- Utilities

Services performed by hospital staff that are incidental to physician services must not be separately billed or added to the outpatient facility charge. An outpatient facility charge includes services such as venipuncture, specimen collection, taking and monitoring vitals, prepping, positioning, injecting, call back, STAT charges, and routine fetal monitoring. Including non-covered and non-allowed charges in the outpatient facility charge is inappropriate.

Services provided by a physician assistant (PA) are payable when provided under the physician supervision guidelines as mentioned in this section. An outpatient facility charge may be billed when a PA provides services in the hospital setting, including those provided in an outpatient hospital-owned clinic.

The costs of diagnostic testing and treatment-type equipment should be included in the charge for the specific service provided to the patient. The cost of hospital staff necessary to provide the specific service should be included in the charge. Examples are radiology procedures, renal dialysis, and physical therapy.

Dental Procedures Performed in the Outpatient Setting

MHD reimburses for dental procedures performed in their facilities. Providers should bill using the Current Dental Terminology© (CDT) codes included on the **Fee Schedule** under Outpatient Hospital to receive maximum reimbursement for services.

Procedure code 41899 (Unlisted Procedure, Dentoalveolar Structures) should only be billed when there is no specific CDT code available for the dental procedure performed in the hospital.

Example: Anesthesia services should not be billed to code 41899 but instead should be billed utilizing the appropriate CDT code:

CDT Code	Description	Time
D9222	Deep Anesthesia	First 15 minutes
D9223	Deep Sedation/General Anesthesia	Each additional 15 minutes

Discounting Multiple Procedures

Effective July 1, 2024, MHD applies multiple procedure discounting when two (2) or more services are billed on the same date of service. Procedure codes considered for discounting are identified as 'Procedure or Service, Multiple Procedure Reduction Applies' under Medicare Outpatient Prospective Payment System (OPPS) Addendum D1. Multiple procedure reduction under the OSFS excludes CDT dental procedures.

If the multiple procedure claim line with the highest allowed amount has more than one (1) unit, the first unit is priced at one hundred percent (100%) of the maximum allowed, with all other units on the line priced at fifty percent (50%) of the maximum allowed amount. If the multiple procedure claim line with the highest allowed amount has only one (1) unit, it is priced at one hundred percent (100%) of the maximum allowed amount. The second and subsequent covered procedures are priced at fifty percent (50%) of the maximum allowed amount.

Modifier 50 Bilateral Procedure Billing

Hospitals are instructed to bill the bilateral procedure only once with modifier 50. Bill the procedure/modifier on one (1) line for one (1) unit of service. MHD recognizes modifier 50 for procedure codes on the Medicare National Physician Fee Schedule Relative Value File (PFS RVU) with a '1' in the BILAT SURG column.

Effective July 1, 2024, these procedures may be subject to a payment adjustment when billed with modifier 50 and performed bilaterally on both sides of the body at the same operative session. Claim lines appropriately billed with these bilateral procedures and modifier 50 are priced at one hundred and fifty percent (150%) of the maximum allowed amount for the single code.

Clinical Diagnostic Laboratory Services

Outside Laboratory Reimbursement

MO HealthNet enrolled hospitals may bill for outpatient laboratory services if the services are performed:

- In the hospital's laboratory
- By an independent laboratory enrolled as a MO HealthNet provider under an arrangement that documents that the hospital is responsible for billing the services provided by the independent laboratory
- By an independent laboratory not enrolled as a MO HealthNet provider under an arrangement that documents that the hospital is responsible for billing the services provided by the independent laboratory. Providers must keep a copy of this documentation on file and be able to provide it upon request.

Providers need to keep a copy of the appropriate CLIA certification on file and be able to provide the certification upon request.

Additionally, MO HealthNet enrolled independent laboratories also have the choice to bill for outpatient laboratory services. However, laboratory services that the hospital bills cannot be billed by the independent laboratory and vice versa. This is considered duplicate billing, and these claims are subject to recoupment.

MHD payments made to the hospital for outpatient services under the OSFS cover management and supervision services performed by the pathologist. Hospitals are responsible for paying the pathologist for their professional services. Facility charges cannot be billed if laboratory services are the only services provided during a visit.

Multi-Test Laboratory Panels

Current Procedural Terminology (CPT) coding logic has determined specific tests that must be provided when billing certain Multi-Test Laboratory Panels. Tests included in these specific panels should be billed using the appropriate panel code instead of individually billing each code. It is possible that tests in addition to those in the panel may also be necessary, and those tests may be billed in addition to the panel test.

Corneal Transplants

Corneal transplants are covered for eligible MO HealthNet participants and do not require prior authorization. Corneal transplants are among those procedures that may be denied for admission certification as inpatient services by MHD's review authority, Conduent. The services are restricted to an outpatient or Ambulatory Surgical Center (ASC) place of service (POS) unless the provider is able to justify inpatient admission for the performance of the procedure.

Refer to the **Physician Provider Manual** for more POS information.

2.36 Observation Room Services

Observation care is a well-defined set of specific, clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. Observation services are only covered when provided by order of a physician or another medical professional authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

General standing orders for observation services following outpatient surgery are not recognized. Hospitals should not report as observation care services that are part of another covered outpatient service, such as postoperative monitoring during a standard recovery period (e.g., four (4) to six (6) hours). Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterward are included in the payments for those diagnostic services. The participant must have been seen and/or received a service/procedure and had a complication arise, or the participant is not recovering as quickly as expected and requires additional hospital care for observation until stabilized or formally admitted as an inpatient. Documentation in the participant's medical record must record this complication or the need for the observation services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals should record for each period of observation services, the beginning and end times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services.

Observation Time

Observation time begins at the clock time documented in the participant's medical record, which coincides with the time that observation care is initiated in accordance with a physician's or other medical professional's order. Charges for observation time must be submitted using revenue code 0762 with procedure code G0378 and the actual number of hours the participant was in observation as units billed. Hospitals should round to the nearest hour.

Observation time ends when all medically necessary services related to observation care are completed. For ***Example***, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit as appropriate). Alternatively, the end time of observation services may coincide with the time the participant is discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the physician writes the discharge order but before the participant is discharged. However, reported observation time would not include the time participants remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

Under the OSFS methodology, direct admit to observation (HCPCS G0379) is not separately payable and pays zero (0) as it is considered included in the payment for G0378 (hospital observation per hour).

Refer to **Section 5** of this manual for more information on procedure codes.

Outpatient Hospital Services Exceeding 24 Hours

MO HealthNet covers up to 24 hours of observation time. Only one (1) observation code per stay may be billed. If the hospital has a patient in an observation room for more than 24 hours, the charges beyond that time must be absorbed as an expense to the hospital. Those charges cannot be billed to MHD or the participant. If the stay spans past midnight, only one (1) date of service is billed, which is the date the patient was placed in observation status. Diagnostic and procedural services performed after the initial 24-hour period has expired may be billed to MHD. The date of service is the date the services were provided. Outpatient hospital services beyond 24 hours must not be billed as inpatient services. If a patient was never formally admitted into inpatient status, the services must be billed as outpatient services.

Under the OSFS methodology, diagnostic and procedural services provided to participants who remain in observation status after the 24-hour period of observation has expired must not be submitted on the same claim with the observation of up to 24 hours. A separate claim must be submitted for diagnostic and procedural services provided after the initial 24 hours of observation and all necessary authorizations attained for those services. If the participant was not formally admitted into inpatient status, observation services beyond the 24-hour period are not covered as inpatient services and are subject to post-payment review and recoupment.

Facility Charges

There are circumstances in which a hospital may bill for services on a claim in addition to the observation room service. An example is emergency or operating room services provided prior to observation status.

2.37 Hospital-Based Dialysis Clinics

Under the OSFS methodology, hospitals must report the technical component of dialysis provided in a hospital-based dialysis clinic using procedure code 90999 (Other Dialysis Procedure).

Refer to **Section 5** of this manual for more information on procedure codes.

2.38 Outpatient Claim for an Inpatient Admission

If Conduent denies a provider's request for inpatient admission certification and the patient is or has been formally admitted, charges for those inpatient services cannot be billed on an outpatient claim. Outpatient claims are monitored post-payment to ensure compliance with this policy.

2.39 Physician, Anesthesiologist Assistant, and Certified Registered Nurse Anesthetist Services

Services provided by hospital salaried physicians, Anesthesiologist Assistants (AA), CRNAs, or other medical professionals able to individually enroll as MO HealthNet providers in the inpatient or outpatient hospital setting, including those provided in a clinic or emergency room must be billed on a **CMS-1500 claim form** or an electronic equivalent. This policy includes the professional components of radiology and pathology services. Physician benefits and **CMS-1500 claim form** instructions are in the **Physician Provider Manual**.

The following information is provided for hospitals billing for hospital-salaried or contractually compensated physicians or other medical professionals. Reimbursement for professional services is based on the lesser of billed charges or an established fee schedule. The cost of these services must not be included in the MHD cost reporting data for hospital cost settlement purposes.

Individual departments within a hospital must enroll in the MO HealthNet Physician Program. Each physician or other medical professional with a valid NPI and performing services in that department must also enroll as a rendering/performing provider. When billing for hospital department professional charges, a rendering provider's NPI must be shown in the Rendering (or Performing) Provider field. Using the department-specific NPI and taxonomy, the hospital bills each department's services on a separate **CMS-1500 claim form** or electronic equivalent and shows the appropriate medical professional's NPI number as the rendering provider. When billing, if physicians from two (2) or more different departments provide professional services for one (1) participant, then a **CMS-1500 claim form** or electronic equivalent needs to be submitted for each professional service.

Refer to **MMAC Provider Enrollment** for more information on enrolling as a MO HealthNet provider.

2.40 Reporting Child Abuse Cases

Per **RSMo 210.115**, hospitals and other specified personnel are required to report possible child abuse cases to the **Child Abuse and Neglect Hotline** at (800) 392-3738. For questions, contact Provider Communications at (573) 751-2896 or toll-free (833) 222-7916.

2.41 Sexual Assault Findings Examination and Child Abuse Resources Examination Network

The **Sexual Assault Findings Examination-Child Abuse Resources Examination (SAFE-CARE) Network** is a group of physicians throughout the state who are committed to a comprehensive and competent examination of child victims of sexual abuse. The SAFE-CARE Network was developed in response to a number of concerns about sexually abused children. Physicians in the SAFE-CARE Network have participated in a DHSS training session where topics such as sexual abuse examinations, court testimony, and child interview techniques were discussed. Physicians interested in joining the SAFE-CARE Network should call (573) 751-6261 or email **info@health.mo.gov**.

MO HealthNet Managed Care enrolled children receive SAFE-CARE services as a benefit outside of the MO HealthNet Managed Care health plan on a FFS basis. Refer to **Section 5** of this manual for a list of acceptable procedure codes to bill SAFE-CARE examinations in the outpatient hospital or emergency room setting.

2.42 Poison Control Hotline

The Missouri poison control hotline number is (800) 222-1222 or visit **Missouri Poison Center**. To report suspected lead poisoning call DHSS at (573) 751-6102 or (866) 628-9891 or email **info@health.mo.gov**.

2.43 Therapeutic Apheresis (Plasma and/or Cell Exchange)

Apheresis is a medical procedure utilizing specialized equipment to remove selected blood components (plasma or cells) from whole blood and return the remaining components to the person from whom the blood was taken.

Plasma exchange for eligible MO HealthNet participants is allowed without prior authorization.

Therapeutic apheresis is covered for the following indications:

- Leukapheresis in the treatment of leukemia
- Plasma exchange for acquired myasthenia gravis
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom)
- Plasmapheresis or plasma exchange as a last resort treatment of thrombotic thrombocytopenic purpura (TTP)
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis
- Plasma perfusion of charcoal filters for treatment of pruritus of cholestatic liver disease
- Plasma exchange in the treatment of Goodpasture's Syndrome
- Plasma exchange in the treatment of glomerulonephritis associated with anti-glomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage
- Treatment of chronic relapsing polyneuropathy for patients with severe or life-threatening symptoms who have failed to respond to conventional therapy
- Treatment of life-threatening scleroderma and polymyositis when the patient is unresponsive to conventional therapy
- Treatment of Guillain-Barre Syndrome
- Treatment of last resort for life-threatening systemic lupus erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration
- Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndrome

2.44 Sleep Studies

The criteria that must be met for unattended sleep studies to be a covered service are:

- A home sleep apnea test must be used, with technically adequate devices, to diagnose Obstructive Sleep Apnea (OSA) in uncomplicated adult patients presenting with signs and symptoms that indicate an increased risk of moderate to severe OSA

- A home sleep apnea test must not be used for general screening of asymptomatic populations
- A home sleep apnea test must not be used for the diagnosis of OSA in patients with significant cardiorespiratory disease, potential respiratory muscle weakness due to neuromuscular condition, awake hypoventilation, or suspicion of sleep-related hypoventilation, chronic opioid medication use, history of stroke or severe insomnia
- A home sleep apnea test must not be used to diagnose OSA in children
- When an initial polysomnogram is negative and clinical suspicion for OSA remains, a second polysomnogram must be considered to diagnose OSA

2.45 Take-Home Drugs and Supplies

Only drugs and items used at the hospital are covered services. MO HealthNet does not cover take-home medications and supplies through the Hospital Program. These items may be billed to the participant. The participant should be made aware by the provider that take-home medications may be reimbursable by MHD when a prescription is filled by an enrolled pharmacy provider.

When a patient is seen during the night, and a pharmacy will not be open until morning to dispense a prescription, sending a one (1) day supply of oral medication with the patient is permissible. The billing of this is subject to scrutiny by MMAC.

2.46 Diabetes Self-Management Training

Diabetes self-management training services are used in the management and treatment of type 1, type 2, and gestational diabetes. These services are covered for participants under 21 or adults in the categories of assistance for pregnant women, blind, and SNF residents when prescribed by a physician or a health care professional with the prescribing authority and may be provided by a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Registered Pharmacist (RPh).

Diabetes education services provided on an inpatient basis by hospital staff are included in the hospital's reimbursement.

When diabetes education services are provided in an outpatient setting by hospital staff, the CDE, RD, or RPh must enroll as a diabetes self-management training provider with payment designated to the hospital on the provider enrollment forms. Refer to **MMAC Provider Enrollment** for MO HealthNet enrollment information. Refer to the **Physician Provider Manual** for limitations and billing procedures.

2.47 Chimeric Antigen Receptor T-Cell Therapy

Chimeric Antigen Receptor T-Cell (CAR-T) therapy is a cell-based gene therapy in which T-cells are collected and genetically engineered to express a chimeric antigen receptor that binds to a certain protein on a patient's cancerous cells. The T-cells are then administered to the beneficiary to attack certain cancerous cells, and the individual is observed for potentially serious side effects that may require medical intervention.

MHD will allow separate reimbursement for CAR-T therapy during an inpatient hospital stay or when administered in the outpatient setting. The treating prescriber/facility may choose the method of administration most appropriate for the participant. Providers are responsible for obtaining prior authorization for CAR-T therapy prior to administration. The MHD Pharmacy FFS program processes the CAR-T ingredient cost for all MHD participants. The criteria for CAR-T products are available at **Pharmacy Clinical Edits and Preferred Drug Lists**.

Providers should submit an outpatient or pharmacy claim with the most appropriate National Drug Code (NDC) to receive separate reimbursement for CAR-T therapy ingredient costs during an inpatient hospital stay. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital reimbursement, if the product is administered in the inpatient setting. Providers will receive their inpatient reimbursement in addition to reimbursement for the CAR-T therapy.

To receive separate reimbursement for CAR-T therapy ingredient costs during an outpatient hospital visit, providers should submit an outpatient or pharmacy claim with the most appropriate NDC. To receive reimbursement for the administration of CAR-T therapy in the hospital outpatient setting, providers must submit an outpatient claim with revenue code 0874 and CPT code 0540T. The revenue and procedure codes cover the equipment and personnel needed to administer CAR-T therapy in the hospital outpatient setting. The hospital may not bill an outpatient hospital facility charge on the same date of service unless a medical professional provides services on that day. A medical professional is a physician or other person authorized by State licensure law to order hospital services for the diagnosis or treatment of the patient.

Section 3: Special Documentation Requirements

Program limits may require prior authorization or medical necessity. Refer to the **General Sections Manual** for forms and general instructions.

Please be aware that when a specific five (5) digit procedure code requires an attachment, and that same procedure code exists with a modifier, such as 50 - bilateral, any attachment requirements applicable to the five (5) digit code remain a requirement for the code with the modifier. Refer to the **Fee Schedule** for the required attachment(s) for surgical procedures.

3.1 Required Attachments

Refer to the **General Sections Manual** for specific information on required attachments for claims submitted to the MO HealthNet Division (MHD).

How to Obtain Attachment Forms

Forms necessary for claims processing are available at **Provider Forms**.

3.2 Acknowledgement of Receipt of Hysterectomy Information

The **Acknowledgement of Receipt of Hysterectomy Information** is required when a hysterectomy procedure is performed. This form is required regardless of the age of the woman. Information regarding hysterectomies is provided in **Section 2.16** of this manual. Refer to the **Fee Schedule** for the procedures that require attachments. The hospital is responsible for obtaining the necessary certification from the performing physician. The hospital must also submit the **Acknowledgement of Receipt of Hysterectomy Information** via **eMOMED** when additional documentation is not required. This form must be completed and kept in the patient's file. The form should not be submitted with the claim via **eMOMED** when additional information is not required. If additional documentation is required to be submitted, with the **Acknowledgement of Receipt of Hysterectomy Information**, it can be mailed separately to:

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

Refer to the **General Sections Manual** for specific instructions.

Hysterectomies are not to be reported as family planning services.

The **Sterilization Consent Form** may not be used instead of the **Acknowledgement of Receipt of Hysterectomy Information**.

The paragraph at the bottom of the **Acknowledgement of Receipt of Hysterectomy Information** indicates that the individual or their representative must sign the form before the surgery; there are no time limits. The Centers for Medicare & Medicaid Services (CMS) has given guidelines on this policy that in exceptional cases, the individual or their representative may sign the form after surgery if the patient or representative was informed of the hysterectomy procedure prior to the surgery.

There are exceptions in which the **Acknowledgement of Receipt of Hysterectomy Information** is not required; however, other physician certification is required in these situations. For information regarding these exceptions, refer to **Section 2.16** of this manual.

3.3 Invoice for Manually Priced Procedures

An invoice should be attached to the claim for payment of certain procedures, supplies, and tests that must be manually priced by the State Medical Consultant. As some procedures involve up-front costs to the provider for some materials/supplies, it is helpful if an invoice is attached outlining pertinent information regarding the material/supply.

Refer to the **Fee Schedule** for a list of procedures that require attachments.

3.4 Certificate of Medical Necessity

Certain services, procedures, or circumstances require a **Certificate of Medical Necessity** to be attached to a claim when it is submitted for payment. The service may be payable if the **Certificate of Medical Necessity** supports the need for the service or why another policy could not be followed. For further details, refer to the **General Sections Manual**.

Certificate of Medical Necessity Required

The following circumstances require a **Certificate of Medical Necessity**, each detailed below. Refer to the **Fee Schedule** for procedures that require attachments.

Private Hospital Room

A private room in the hospital is covered if there is a medical justification (e.g., infection control). Proof of medical necessity explaining why a private room was necessary must be retained in the patient's medical file and be available upon request by MHD.

A private room is also covered if all patient rooms in a facility are private. Proof of medical necessity retained in the patient's file is not required in this circumstance.

A private room is not covered if requested by the patient solely for the patient's convenience. When billing for a non-covered private room, the difference between the private and semi-private room charges must be shown on the claim form in the non-covered column. It is the participant's responsibility to pay the difference between the semi-private and the private room rate.

Sonograms

When obstetrical sonograms exceed three (3) per participant per rolling year, a properly completed **Certificate of Medical Necessity** documenting the need for the additional procedures must be submitted with the electronic claim on **eMOMED** or on paper attached to the original claim.

Certificate of Medical Necessity Instead of the Required Attachment

There are situations that normally require specific policy documentation; if there is an unusual or emergency situation, a form may not be completed or is inappropriate for the situation. Refer to **Section 2.6** in this manual for more information. In these instances, a **Certificate of Medical Necessity** must be completed, fully describing the circumstances. The different types of circumstances are described below.

Lock-In Participants

Services provided to participants who are locked-in to a physician or hospital require a **Medical Referral of Restricted Participants (PI-118)** form from the lock-in physician or hospital unless the services are provided in response to an emergency situation. If emergency services are provided, medical records that detail the nature of the emergency must be attached to the claim when it is submitted for payment. Note "EMERGENCY" at the top of the claim for these emergency situations.

Refer to **Section 2.4** in this manual for more information on lock-in.

Procedures That Require Prior Authorization

When procedures that require prior authorization are performed on an emergency basis, a **Certificate of Medical Necessity** fully explaining the emergency situation must be attached to the claim.

Certificate of Medical Necessity Not Used

A **Certificate of Medical Necessity** cannot be used for procedures that require the **Sterilization Consent Form** or **Acknowledgement of Receipt of Hysterectomy Information** when performed as an emergency procedure. Other documentation is required in this situation. Refer to **Sections 2.15** and **Section 2.16** of this manual for specific information.

3.5 Sterilization Consent Form

A **Sterilization Consent Form** must be submitted in conjunction with the hospital claim whenever a voluntary sterilization procedure is performed. The **Sterilization Consent Form** is separately processed from the claim form. Refer to the **Fee Schedule** for the procedures that require this attachment. This attachment can be submitted through **eMOMED** or mailed to:

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

Refer to the **General Sections Manual** for specific information regarding the **Sterilization Consent Form**. Refer to **Section 2.15** of this manual for further information on sterilizations.

3.6 Admission Certification Forms

All inpatient hospital admissions require admission certification except for participants enrolled in a MO HealthNet Managed Care health plan, enrolled in Medicare Part A, pregnancy-related cases, deliveries, and newborns. Refer to **Section 2.27** of this manual for more information.

3.7 Certification of Need for Psychiatric Services

Certification of need for inpatient psychiatric services is one (1) of the requirements for the Inpatient Psychiatric Services for Individuals Under Age 21 Program. The **Certification of Need for Psychiatric Services (IM-71)** form was developed to assist providers in complying with this requirement. This form or a similar one developed by the hospital must be in the participant's medical record and a copy mailed to the Family Support Division (FSD) office in the participant's county of residence. Use **Find an Office** to locate the address for an FSD office.

This certification is required for psychiatric hospitals providing services to participants under 21 years of age. This certification is not required for acute care hospitals providing psychiatric care to participants under 21 years of age, even though the hospital may have a psychiatric unit exempt from Medicare Prospective Payment Systems (PPS).

The status of the child or youth at the time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for certifying need for inpatient care.

Refer to **Section 2** of this manual for a detailed explanation of this and other requirements for psychiatric services to children and youth under age 21 in a psychiatric hospital.

Instructions for Completion of Certification of Need for Psychiatric Services

Below are instructions to complete the **Certification of Need for Psychiatric Services (IM-71)** form.

Field Name	Instructions for Completion
Name of Patient	Enter the name of the MO HealthNet participant
Case Number (DCN)	Enter the participant's MO HealthNet Identification Number (Department Client Number (DCN)
Date of Admittance	Enter the date the individual was admitted to the facility
Name of JCAHO Certified Facility	Enter the name of the Joint Commission on Accreditation of Healthcare Organizations certified facility (hospital)
Physician Team Member/ Date	The physician must each sign and date the certification. The signature must be original.
Team Member/Title/ Date	An independent or interdisciplinary team member must sign and date the certification. The signatures must be original. Include the title of the non-physician team member.
Participant's Name or "Myself"	Enter the participant's name if a parent or guardian signs the form; enter "myself" if the participant signs the authorization to release information
Authorize	Enter the name of the facility
Month/Day/Year	Enter the date of expiration of the authorization, normally not to exceed 30 days from the date of signature
Participant, Parent, Guardian/ Date	The participant, parent, or guardian must sign and date the form. If the participant is unable to sign their name, the signature may be made by a mark.
Relationship	The relationship of the person that signed the form to the participant

Field Name	Instructions for Completion
Witness/Date/Address	The signature, date, and address of the two (2) witnesses is required

Section 4: Billing Instructions

This section has detailed instructions for completing the billing claim form for inpatient and outpatient services. To make this section as instructive for billing purposes as possible, we have presented information on a number of specific services.

4.1 Electronic Data Interchange

Providers exchanging electronic transactions with the MO HealthNet Division (MHD) should access the **ASC X12 Implementation Guides**, adopted under the Health Insurance Portability and Accountability Act (HIPAA). For Missouri-specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the **X12 Version v5010** and **NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides**.

4.2 Electronic Claim Submission

Providers may submit claims via **eMOMED**. Providers are required to register in **eMOMED**. Providers are unable to access **eMOMED** without proper authorization. Authorization is required for each individual user. For more information, refer to the **General Sections Manual**.

The features of **eMOMED** include claim submissions, claim credits, claim attachment submissions, remittance advice retrieval, claim confirmation records, claim status inquiry, and eligibility verification. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

4.3 CMS-1450 (UB-04) Claim Form

The **CMS-1450 (UB-04) claim form** is always used for inpatient and outpatient hospital services unless a provider bills those services electronically.

4.4 Resubmission of Claims

Any line item on a claim that resulted in a zero (0) payment can be resubmitted if it is denied due to a correctable error. The error that caused the claim to be denied must be corrected before resubmitting the claim. The provider may resubmit electronically or on a **CMS-1450 (UB-04) claim form**. A claim that denied appropriately for failing timely filing should not be resubmitted.

If a line item on a claim was paid but the payment was incorrect, do not resubmit that line item. For instance, a claim indicates two (2) units instead of three (3). If everything else on the claim is correct, the provider is paid the maximum amount allowed for two (2) units. That claim cannot be resubmitted. It will be denied as a duplicate. The provider must submit a 'replacement' claim via **eMOMED** to correct that payment. A replacement claim will recoup the incorrect payment received and replace that claim with a corrected one through real-time adjudication so that proper payment can be received. Refer to the **General Sections Manual** for information about the adjustment request process.

4.5 Diagnosis Codes

The diagnosis code is required and must be entered on the claim form exactly as it appears in the most current version of the International Classification of Diseases-Clinical Modification (ICD-CM) code book. Note that the appropriate code(s) must be coded to the highest level of specificity and used as applicable to the patient's diagnosis(es). Claims may be denied if the diagnosis(es) is not coded to the highest level of specificity. The ICD Tabular List should be used as a guide in selecting the specificity of the appropriate diagnosis code. Diagnosis codes are not included in this section.

837I Claim Form: Inpatient, Outpatient, and Institutional Crossover Claims

Effective for dates of service on or after July 1, 2025, MHD's claims processing system will accept and store the following batch X12 837I (inpatient, outpatient, home health, nursing home, and institutional crossover claim) Diagnosis (Dx) information:

- Up to 41 claim header Dx occurrences
- Dx type associated with each Dx occurrence and Dx type sequence in the order submitted
- Dx qualifier associated with each Dx occurrence
- Present on Admission (POA) indicator associated with each principal, other, and external cause of injury (ECI) Dx occurrence

Dx type, Dx type sequence, and Dx qualifier values associated with each Dx occurrence will be derived and stored in the hierarchy described below.

Hierarchy	Dx Type	Dx Type Sequence (In Order Submitted)	Qualifier (ICD-10)
1	P - Principal	1	ABK
2	O - Other	1 - 24	ABF
3	E - ECI	1 - 12	ABN

Hierarchy	Dx Type	Dx Type Sequence (In Order Submitted)	Qualifier (ICD-10)
4	A - Admitting	1	ABJ
5	R - Reason for Visit	1 - 3	APR

4.6 Mailing Addresses

Providers should use the below mailing addresses when sending paper claims to MHD.

Document	Address
Inpatient and Outpatient Claims	Wipro Infocrossing P.O. Box 5600 Jefferson City, MO 65102
Prior Authorization Requests	Wipro Infocrossing P.O. Box 5700 Jefferson City, MO 65102
CMS-1500 Claims	Wipro Infocrossing P.O. Box 5600 Jefferson City, MO 65102
Claim Attachment Submissions not Submitted with Claims	Wipro Infocrossing P.O. Box 5900 Jefferson City, MO 65102
Sending claims by an express delivery service (i.e., Fed Ex, UPS)	Wipro Infocrossing 3600 Country Club Drive, Suite 2002 Jefferson City, MO 65109

Refer to the **General Sections Manual** for more information.

4.7 Billing for Services from the Copayment Requirement

Inpatient

MHD does not require copays for any services.

Outpatient

While MHD does not require copays for any services, the following condition codes must continue to be used to identify emergency or family planning services on outpatient claims:

Services	Condition Code	Admission Type
Emergency Services	AJ	1
Family Planning Services	A4	N/A

When emergency or family planning services are provided in an outpatient setting, only one (1) date of service may be shown on the claim. Claims are denied if multiple dates are shown with the condition codes above.

When billing MHD, indicate the usual and customary charge for the service as the billed amount in the charge column. Do not deduct the participant's copayment amount from the billed charge, and do not show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the copayment amount, thus determining the correct payable amount.

4.8 Billing for Temporary MO HealthNet During Pregnancy

Providers must verify the participant has a Temporary MO HealthNet during Pregnancy (TEMP) card or a TEMP letter each time services are rendered to pregnant women receiving services through the TEMP program. Refer to the **General Sections Manual** for information on TEMP participants.

A pregnancy/prenatal diagnosis code is required on the claim form in one (1) of the diagnosis fields.

Inpatient Hospital Services

Inpatient hospital services are not considered ambulatory prenatal services; therefore, inpatient hospital claims billed for participants with only TEMP eligibility are denied.

An individual who has been TEMP eligible may be determined eligible for full MO HealthNet benefits; however, the eligibility period may not always go back to the beginning date of TEMP eligibility. In this situation, a participant may be TEMP eligible for a portion of an inpatient hospitalization stay and also eligible for regular MO HealthNet for a portion of the hospital stay. The hospital must only bill the dates when the participant was eligible for regular MO HealthNet as covered days. The claim denies if the hospital bills the entire stay as covered days. Hospital providers of inpatient hospital services should show all TEMP-only days as non-covered days. Field 6, Statement Covers Period, on the **CMS-1450 (UB-04) claim form**, should show the first date of regular MO HealthNet eligibility during the hospital stay. This is the first 'covered' day of the hospital stay. If a provider is uncertain about the dates of the participant's regular MO HealthNet coverage, they may call Provider Communications at (573) 751-2896 or toll-free (833) 222-7916 to verify this information. Field 12, Admission/Start of Care Date, on the **CMS-1450 (UB-04) claim form** must reflect the actual date the admission occurred. Refer to **Section 4.18** of this manual for instructions to complete the **CMS-1450 (UB-04) claim form**.

4.9 Third Party Liability

Providers must bill any health insurance a participant has before billing MHD. All third-party resource benefits the provider receives for MHD-covered services must be shown on the **CMS-1450 (UB-04) claim form** in Field 54, Prior Payments. Include the insurance resource name and address in Fields 50, Payer Name, and Field 61, Group Name, on the **CMS-1450 (UB-04) claim form**. Refer to the **Section 4.18** of this manual for instructions to complete the **CMS-1450 (UB-04) claim form**.

Third-Party Liability Edit

When processing MHD claims, the Third Party Liability (TPL) edit compares a claim to the participant's eligibility file for third-party resources. If the eligibility file indicates there is applicable insurance coverage, but there is no TPL amount shown on the claim or no attachment showing denial of payment by the insurance company, the claim will deny. If an insurance carrier denies payment, the information from that denial letter must be submitted with the claim. If submitting a paper **CMS-1450 (UB-04) claim form**, enter in Field 80, Remarks, that insurance denied the claim and that a copy of the denial letter is attached.

If the provider believes the insurance coverage shown on the MO HealthNet participant file is incorrect, the MO HealthNet **Insurance Resource Report (TPL-4)** form should be completed. Refer to the **General Sections Manual** for more information. The **Insurance Resource Report (TPL-4)** form must not be submitted with claims. Send the completed form to **TPL.Database@dss.mo.gov** or fax it to (573) 526-1162.

4.10 Billing for Inpatient Services That Follow Outpatient Services

Outpatient Surgery

The surgery and related services must be billed on the outpatient claim when admission is necessary following outpatient surgery. The surgical procedure cannot be shown on the inpatient claim. Information given to Conduent, MHD's review authority, for admission certification must be clear that the surgery was performed prior to admission. If a second surgery is performed following admission, that surgery code should be entered on the inpatient claim.

Observation Room

When admission is necessary following observation, the date of admission on the inpatient claim must be the date the hospital formally admits the patient. Services provided in the observation room must be billed on an outpatient claim.

4.11 Billing for Physician and Certified Registered Nurse Anesthetist

Hospital providers may bill services of hospital-salaried or contractually compensated physicians and Certified Registered Nurse Anesthetists (CRNAs) on the **CMS-1500 claim form**. Refer to **Section 2** of this manual for more information.

4.12 Admission Certification Information

A detailed explanation of the policy on admission certification is provided in **Section 2.27** of this manual. The following information is provided to assist in completing the **CMS-1450 (UB-04) claim form**. The admission certification contains critical information a provider must enter on the claim to satisfy the claims processing edits for admission certification.

Conduent will post the status of all certification requests on **CyberAccess**. The certification information reflected in **CyberAccess** confirms the information previously given by either telephone, fax, or during the online submission of the certification request. It is important that the information provided be verified for accuracy. It is suggested that the billing department staff be given access to the **CyberAccess** to compare the information on the claim submitted to MHD. If any information reflected in **CyberAccess** differs from the hospital's records, Conduent must be contacted to correct the certification. The data entered on the **CMS-1450 (UB-04) claim form** discussed below must match the Conduent file, or payment is not made.

NOTE: If Conduent denies a provider's request for admission certification after the patient has formally been admitted, charges for those inpatient services cannot be billed on an outpatient claim. Claims are monitored post-payment to ensure compliance with this policy.

Treatment Authorization Codes

Conduent gives providers a unique seven (7) digit certification number for approved admissions. Providers should enter this number in Field 63, Treatment Authorization Codes of the **CMS-1450 (UB-04) claim form**. Treatment Authorization are required for all claims except those for Medicare Part A, Medicare Part C with Qualified Medicare Beneficiary (QMB) coverage, certain pregnancy-related conditions, newborns, and deliveries. Refer to **Section 2** of this manual for complete information regarding services exempt from certification.

Admission Date

Admission Date (Field 12) is a required field on the **CMS-1450 (UB-04) claim form**. The admission date on the **CMS-1450 (UB-04) claim form** must match the admission date on the Conduent file, or the claim will be denied. If the Conduent reviewer approves an inpatient service but denies a preoperative or weekend day, the provider may still admit for a preoperative or weekend, but MHD does not pay that day(s). In this situation, the provider can receive payment for covered days by entering the first-day Conduent approves for coverage as the 'from date' in Field 6, Statement Covers Period.

Example: The provider plans to admit a patient on Tuesday for surgery on Friday. Conduent approves the surgery but says admission should be Thursday for Friday surgery. If the provider admits the patient on Tuesday, enter that date in Field 12, Admission/Start of Care Date, and enter Thursday's date in Field 6, Statement Covers Period, as the 'from' day. This will "match" the Conduent file, and the claim can be reimbursed. In this situation, the inpatient preoperative days are not payable by MHD as Conduent denied them.

Principal Procedure

Principal Procedure (Field 74) of the **CMS-1450 (UB-04) claim form** is not a required field but may be important for payment if surgery applies to the hospitalization. This only applies if the Current Procedural Terminology (CPT) procedure code, equivalent to the International Classification of Diseases (ICD) Surgical Procedure being used on the claim, is in the range of 10000 to 69999. If the information given by the provider in the request for admission certification includes a date of surgery, this information is entered in the Conduent file. Therefore, the claim is edited to have that identical date. MHD realizes changes in scheduling occur, especially with surgery or when the preadmission request is two (2) weeks ahead of the planned date. If an admission is certified with surgery anticipated but not performed or the date of surgery changes, then Conduent must be contacted with updated information. Refer to **Section 2.27** for Conduent information.

If an admission is certified with no surgery indicated at the time of request, it is not required to contact Conduent if surgery is performed during the inpatient stay.

Leave of Absence Days

MHD does not reimburse for any day the patient is not in the facility.

The 'from' and 'through' dates in Field 6, Statement Covers Period, of the **CMS-1450 (UB-04) claim form** must be for continuous stay days and represent only days the patient was in the hospital. The midnight bed count is a guideline for this.

Example: If a patient takes a temporary leave of absence and is gone overnight or on a weekend pass, the provider must submit two (2) interim claims. The first claim must indicate a patient status of "30, Still a Patient" in Field 17, Patient Discharge Status. The through date entered in Field 6, Statement Covers Period, should be the last date the patient was in the facility at midnight. The second claim should show the same admission date and certification numbers as the first claim, but the "from" date in Field 6, Statement Covers Period, is the date the patient returned to the hospital.

4.13 Diagnoses on the Inpatient Claim

Providers should code the first diagnosis, Field 67, Principal Diagnosis Code and Present on Admission (POA) Indicator, of the **CMS-1450 (UB-04) claim form** based on the primary diagnosis. This is the diagnosis that, after study, explains why the patient was admitted to the hospital. The primary diagnosis is the condition chiefly responsible for the admission, even though another diagnosis may be more severe.

A claim is denied if a diagnosis code considered invalid in the current ICD code book is used in the primary diagnosis field. However, if an invalid diagnosis code is shown in the secondary diagnosis field, the code is changed to zeros when processing the claim. This can reduce the number of Preadmission Screening (PAS) days a secondary diagnosis allows for inpatient days exempt from Conduent certification.

Present on Admission

In accordance with Section 5001(c) of the Deficit Reduction Act of 2005 and state regulation **13 CSR 70-3.230**, MHD requires the POA indicator for all diagnosis codes submitted on inpatient hospital claims. Some diagnosis codes are exempt from the POA requirement and can be found in the ICD Official Guidelines for Coding and Reporting. Claims containing an invalid or missing POA indicator will be denied unless the diagnosis is exempt from the POA requirement. When appropriate, the POA indicator must be present for all diagnosis codes reflected in the Principal and Other diagnosis code fields, including 'External Causes' reported on claim forms **CMS-1450 (UB-04) claim form** and 837 Institutional.

Present on admission is defined as a condition present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter prior to admission to inpatient, including emergency department, observation, or outpatient surgery, are considered present on admission. Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting for proper assignment of the POA indicator. The POA guidelines are not intended to provide guidance on when a condition should be coded but rather on how to apply the POA indicator to the final set of diagnosis codes that have been assigned.

Present On Admission Values

As taken from the General Reporting Requirements in the ICD Official Guidelines for Coding and Reporting, the following values are to be used when assigning the POA indicator:

Value	Definition	Description
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	Documentation is insufficient to determine if condition is present on admission
W	Clinically Undetermined	The provider is unable to clinically determine whether the condition was present on admission
Blank	Unreported/Not Used	Exempt from POA reporting (See the ICD Official Guidelines for Coding and Reporting for a list of exempt diagnosis codes)

Medical Documentation

As stated in the Introduction to the ICD Official Guidelines for Coding and Reporting, a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term provider means a physician or qualified health care practitioner legally accountable for establishing the patient's diagnosis.

4.14 Accommodation Revenue Code

An accommodation revenue code is required on an inpatient claim. Accommodation codes are those numbered from 0110 to 0219. Ancillary codes are those from 0250 to 0949.

An ancillary code, for example, 0720, Delivery/Labor Room, can never be considered an accommodation code, even if the provider shows a rate and number of units (days). A claim is denied if no valid, covered accommodation code is shown.

The number of covered and non-covered days is shown in Field 39-41, Value Codes and Amounts of the **CMS-1450 (UB-04) claim form**. Code 80 reflects the number of covered days, and code 81 reflects any applicable non-covered days. The total number of covered and non-covered days must equal the number of units shown in Field 46, Service Units. The number of covered days must equal the number of days in Field 6, Statement Covers Period.

It is important that the revenue code used corresponds with the diagnosis code on the claim. For ***Example***, a diagnosis code of F43.0, Acute stress reaction, should be billed with a revenue code of 0114, Psychiatric. More than one (1) revenue code may be used to reflect multiple accommodations.

Refer to **Section 5** of this manual for a complete list of covered revenue codes for inpatient claims. Transplant facilities must refer to the **Transplant Provider Manual** for billing transplant revenue codes.

4.15 Interim Billing

It is usually inappropriate to submit more than one (1) claim for one (1) continuous hospitalization. A patient should be discharged from the hospital before a claim is submitted to the fiscal agent. A Patient Discharge Status code 30, which means "Still a patient," in Field 17 of the claim form, should only be used in a minimal number of circumstances, such as the following:

- The patient becomes ineligible for MO HealthNet benefits during the stay
- The hospital's utilization review committee does not certify as medically necessary all days of the stay

- The allowable number of days is unusually long, and to ease the cash flow, the provider interim bills
- The claim is for days prior to the date of an authorized transplant
- The participant has spend-down eligibility, which requires the hospital to bill each calendar month of the inpatient stay individually, or else the claim will deny

If a provider does bill a second (or third) claim for the same hospitalization period, the certification information in Field 63, Treatment Authorization Codes, should be the same as the first claim. The claims processing system suspends interim billed claims to determine the correct number of allowed days under PAS for certification-exempt inpatient stays and Medicare/MO HealthNet Part A crossover claims. Interim billed claims representing one (1) continuous stay that exceeds the PAS allowed number of days or Conduent approved days are cut back to the allowed days. Refer to **Section 2** of this manual for more information.

Providers reimbursed under the APR-DRG reimbursement methodology may submit one (1) interim claim. Providers must void the prior interim claim before submitting another interim claim. When the participant is discharged, the provider must void the interim claim and submit the final claim, which covers the full length of stay.

4.16 Prorating Third-Party Liability on an Inpatient Claim

Insurance benefits to which a participant is entitled must be utilized as the first source of payment for hospital and medical expenses. Refer to the **General Sections Manual** for TPL information. When it has been established that the number of inpatient hospital days reimbursed by a third-party insurer exceeds the number of MO HealthNet allowed days, the TPL amount needs to be prorated. It is the provider's responsibility to determine when this billing method is necessary.

Field 54, Prior Payments, of the **CMS-1450 (UB-04) claim form** should be completed as follows:

If the private insurance company payment includes days that are in excess of PAS or Conduent approved days (non-reimbursable days or other non-covered services), prorate the reimbursement to coincide with the number of days MHD pays per PAS or Conduent limitations.

Example: The total number of days of confinement on a claim is 15 days, and PAS/Conduent limitation allows 10 days, five (5) days non-reimbursable by MHD. The private insurance payment amount is $10,000.00 for 15 days of confinement. The prorated insurance amount is $666.67 ($10,000.00 / 15) per day x 10 days (PAS/Conduent) = $6,666.70. $6,666.70 must be entered in Field 54, Prior Payments.

The provider may wish to show in Field 80, Remarks, the prorated TPL calculation to substantiate the dollar amount entered in Field 54, Prior Payments.

4.17 Surgical Procedure

The below is to clarify situations in which Fields 74, Principal Procedure Code and Date, and 74 A-E, Other Procedure Codes and Dates, are to be completed on the **CMS-1450 (UB-04) claim form**.

If it is necessary to use the operating room to perform a procedure, then the principal procedure Field 74, Principal Procedure Code and Date, on the claim should be completed. If more than one (1) procedure was performed, identify and date any others in Field 74 A-E, Other Procedure Codes and Dates, using ICD Surgical Procedure Codes.

If a procedure is performed in the patient's room, a treatment room, or another area of the hospital that is not an operating room, do not complete the surgical procedure code fields of the claim form. If a procedure is entered in this field, a revenue code must be shown for the operating or labor/delivery room. A claims processing edit monitors for compliance.

4.18 CMS-1450 (UB-04) Inpatient Hospital Claim Filing Instructions

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed, or the claim is denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicate that a field is required in specific situations.

Field Number	Field Name	Instructions for Completion
1*	Provider Name, Address, Telephone Number	Enter the provider's name and address
2	Unlabeled Field	Leave blank
3a	Patient Control Number	A maximum of 20 alpha/numeric characters may be entered here for the provider's information
3b	Med Rec #	Not required

Field Number	Field Name	Instructions for Completion
4*	Type of Bill	The required three (3) digits in this code identify the following: 1st digit: Type of facility 2nd digit: Bill classification 3rd digit: Frequency The allowed values for each of the digits found in the type of bill are listed below: Type of Facility: 1st digit: (1) Hospital Bill Classification: 2nd digit: (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit: (1) Admit thru Discharge Claim (2) Interim Bill—First Claim (3) Interim Bill—Continuing Claim (4) Interim Bill—Last Claim
5	Federal Tax Number	Enter the provider's federal tax number
6	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format. It should include the discharge date as the through date when billing for the entire stay. Unless noted below, it should reflect all days of the hospitalization, including any non-covered days. It should not include the date(s) of patient ineligibility. It should not include inpatient days not certified by Conduent, such as preoperative days or days beyond the cease payment date.
7	Unlabeled Field	Leave blank

Field Number	Field Name	Instructions for Completion
8a	Patient's Name - ID	Enter the patient's eight (8) digit MO HealthNet Identification (ID) Number or MO HealthNet Managed Care Plan ID number. NOTE: The MO HealthNet Department Client Number (DCN)/MO HealthNet ID number or MO HealthNet Managed Care Plan ID number is required in Field 60, Insured's Unique Identifier.
8b*	Patient Name	Enter the patient's name in the following format: last name, first name, middle initial
9	Patient Address	Enter the patient's complete mailing address, including street number and name, post office box number or Rural Free Delivery (RFD), city, state, and zip code
10	Patient Birth Date	Enter the patient's date of birth in MMDDYY format
11	Patient Sex	Enter the patient's sex, 'M' (male) or 'F' (female)
12*	Admission/Start of Care Date	Enter the date the patient was admitted for inpatient care in MMDDYY format. This should be the actual date of admission regardless of the patient's eligibility status on that date or Conduent certification/denial of the admission date.
13	Admission Hour	Not required
14*	Priority (Type) of Admission or Visit	Enter the appropriate type of admission; the allowed values are: 1: Emergency 2: Urgent 3: Elective 4: Newborn 5: Trauma 9: Information not available

Field Number	Field Name	Instructions for Completion
15**	Point of Origin of Admission or Visit	If this is a transfer admission, complete this field. The allowed values are: 1: Non-Health Care Facility Point of Origin 2: Clinic or Physician's Office 4: Transfer from a hospital 5: Transfer from a skilled nursing facility 6: Transfer from another health care facility 8: Court/Law Enforcement 9: Information Not Available D: Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital, Resulting in a Separate Claim to the Payer E: Transfer from Ambulatory Surgery Center F: Transfer from a Hospice Facility Newborn Codes
16	Discharge Hour	Not required

17*	Patient Discharge Status	Enter the two (2) digit patient status code that best describes the patient's discharge status. Common values are: 01: Discharged to home or self-care (routine discharge) 02: Discharged/transferred to a short-term general hospital for inpatient care 03: Discharged/transferred to a skilled nursing facility with Medicare certification in anticipation of skilled care 04: Discharged/transferred to a facility that provides custodial or supportive care 05: Discharged/transferred to a designated cancer center or children's hospital 06: Discharged/transferred to home under the care of an organized home health service organization in anticipation of covered skilled care 07: Left against medical advice or discontinued care 20: Expired 21: Discharge/transferred to Court/Law Enforcement 30: Still a patient 43: Discharged/transferred to a federal health care facility 62: Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63: Discharged/transferred to a Medicare-certified long-term care hospital (LTCH) 64: Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66: Discharged/transferred to a critical-access hospital 70: Discharged/transferred to another type of health care institution not defined elsewhere in this code list.

Field Number	Field Name	Instructions for Completion
18-24*	Condition Codes	Enter the appropriate two (2) character condition code(s). The Official UB-04 Data Specifications Manual contains a complete list of values. The values applicable to MHD are: C1: Approved as billed Indicates the facility's Utilization Review authority has certified all days billed C3: Partial Approval The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. If C3 is entered, Field 35 must be completed. NOTE: Code C1 or C3 is required A1: EPSDT/ CHAP If this hospital stay results from an Early Periodic, Screening, and Diagnostic Treatment (EPSDT) referral or is an EPSDT-related stay, this condition code must be entered on the claim A4: Family Planning This condition code must be entered if family planning services occurred during the inpatient stay
25-28	Condition Codes	Not required
29	Accident State	Not required
30	Unlabeled Field	Leave blank

Field Number	Field Name	Instructions for Completion
31-34**	Occurrence Code and Date	If one (1) or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. The Official UB-04 Data Specifications Manual contains a complete list of values. The values applicable to MHD are: 01: Accident/Medical Coverage 02: No-Fault Insurance Involved – Including Auto Accident/other 03: Accident/Tort Liability 04: Accident/Employment Related 05: Accident/No Medical or Liability Coverage 06: Crime Victim 42: Date of Discharge -- This is to be entered when the 'through' date in Field 6, Statement Covers Period, is not equal to the discharge date. The frequency code in Field 4, Type of Bill, indicates that this is the final bill.
35**	Occurrence Span Codes and Dates (from and through)	Required if C3 is entered in Fields 18-24, Condition Codes. Enter code 'M0' and the first and last days that were approved by Utilization Review
36	Occurrence Span Codes and Dates	Not required
37	Unlabeled Field	Leave blank
38	Responsible Party Name and Address	Not required

Field Number	Field Name	Instructions for Completion
39-41*	Value Codes and Amounts	Enter the appropriate code(s) and unit amount(s) to identify the information necessary for processing the claim 80: Covered Days Enter the number of covered days shown in Field 6, Statement Covers Period, minus the date of discharge. The discharge date is not a covered day and should not be included in the calculation of this field. The through date of service in Field 6, Statement Covers Period, is included in the covered days if the patient status code in Field 17, Patient Discharge Status, equals '30—still a patient.' NOTE: The units entered in this field must equal the number of days in the Statement Covers Period less the day of discharge. If the patient status is 'still a patient,' units entered include the through day. 81: Non-covered Days If applicable, enter the number of non-covered days. NOTE: The total units entered in this field for covered and non-covered days must equal the total accommodation units listed in Field 46, Service Units. The Official UB-04 Data Specifications Manual contains a complete list of values.

Field Number	Field Name	Instructions for Completion
42*	Revenue Code	List appropriate accommodation codes first in chronological order. Ancillary codes should be shown in numerical order. Show duplicate revenue codes for accommodations when the rate differs or when transfers are made back and forth, e.g., general to Intensive Care Unit (ICU) to general. A private room must be medically necessary, and the medical need must be documented in the patient's medical records unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge. If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in Field 47, Total Charges. Enter the difference between the private room total charge and the semi-private room total charge in Field 48, Non-covered Charges, non-covered charges. Revenue codes for the non-covered day(s) must have the corresponding room rate and ancillary charges reported in Field 48, Non-covered Charges. After all revenue codes are shown, skip a line and list revenue code 0001, which represents total charges.
43	Revenue Description	Not required
44*	Healthcare Common Procedure Coding (HCPCS)/Rates/Health Insurance Premium Payments (HIPPS) Code	Enter the daily room and board rate to coincide with the accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use a separate line to report each rate.
45	Service Date	Not required

Field Number	Field Name	Instructions for Completion
46*	Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days. NOTE: The number of units in Fields 39-41, Value Codes and Amounts, must equal the number of units in this field.
47*	Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one (1) line and state the total of these charges to correspond with revenue code 0001. NOTE: The room rate multiplied by the number of units must equal the charge entered for room accommodation(s).
48**	Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in Fields 39-41, Value Codes, and Amounts. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was not medically necessary should be shown as non-covered in this field.
49	Unlabeled Field	Leave blank
50*	Payer Name	The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer, and MHD is listed last.
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Not required
53	Assignment of Benefits Certification of Indicator	Not required

Field Number	Field Name	Instructions for Completion
54**	Prior Payments	Enter the amount the hospital received toward payment of this bill from all other health insurance companies. Payments must correspond with the appropriate payer entered in Field 50, Payer Name. Do not enter a previous MHD payment, Medicare payment, or copayment amount received from the patient in this field.
55	Estimated Amount Due	Not required
56*	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number. If applicable: Enter the corresponding ten 10-digit provider taxonomy code in Field 81CCa, Code-Code Field.
57	Other Provider ID	Not required
58**	Insured's Name	Complete if the insured's name is different from the patient's name
59	Patient's Relationship to Insured	Not required
60*	Insured's Unique ID	Enter the patient's eight (8) digit MO HealthNet ID number or MO HealthNet Managed Care health plan ID number. If insurance was indicated in Field 50, Payer Name, enter the insurance number to correspond to the order shown in Field 50, Payer Name.
61**	Insurance Group Name	If insurance is shown in Field 50, Payer Name, state the name of the group or plan through which the insurance is provided to the insured
62**	Insurance Group Number	If insurance is shown in Field 50, Payer Name, state the number assigned by the insurance company to identify the group under which the individual is covered
63**	Treatment Authorization Codes	For claims requiring certification, enter the unique seven (7) digit certification number supplied by Conduent

Field Number	Field Name	Instructions for Completion
64**	Document Control Number	If the current claim exceeds the timely filing limit of one (1) year from the 'through' date but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one (1) year limit
65	Employer Name	If the patient is employed, enter the employer's name
66	Diagnosis & Procedure Code Qualifier	Enter the appropriate three (3) digit qualifier
67*	Primary Diagnosis Code	Enter the complete International Classification of Diseases (ICD) diagnosis code for the condition established after the study to be chiefly responsible for the admission. Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book. The Present On Admission (POA) Indicator is reported in this field's eighth digit (shaded area). Values are listed in **section 4.13** of this manual. See the ICD Official Guidelines for Coding and Reporting for a list of exempt diagnosis codes.
67a-q**	Other Diagnosis Codes	Enter any additional diagnosis codes that affect the treatment received or the length of stay. POA Indicator is reported in this field's eighth digit (shaded area). Values are listed above.
68	Unlabeled Field	Leave blank
69	Admitting Diagnosis	Enter the diagnosis code that reflects the participant's diagnosis/condition at the time of admission to the hospital
70	Patient's Reason for Visit	Not required
71	Prospective Payment system (PPS) Code	Not required

Field Number	Field Name	Instructions for Completion
72	External Cause of Injury Code (E Code)	Enter the appropriate ICD-10 CM external cause of injury code when the principal or secondary diagnosis reflects an injury, poisoning, or other condition due to an external cause
73	Unlabeled Field	Leave blank
74**	Principal Procedure Code and Date	Enter the complete ICD procedure code of the principal surgical procedure. The date on which the procedure was performed must be shown. Only month and day are required.
74a-e**	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed
75	Unlabeled Field	Leave blank
76*	Attending Provider Name and Identifiers	Enter the attending provider's 10-digit NPI number. Enter the attending provider's last name/first name. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCb, Code-Code Field.
77**	Operating Provider Name and Identifiers	Enter the operating provider's 10-digit NPI number. Enter the operating provider's last name/first name. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCc, Code-Code Field.
78-79**	Other Provider Name and Identifiers	Enter the other provider's 10-digit NPI number. Enter the other provider's last name/first name. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCd, Code-Code Field.
80**	Remarks	Use this field to draw attention to attachments such as operative notes, Third Party Liability (TPL) denial, Medicare Part B only, etc.

Field Number	Field Name	Instructions for Completion
81CCa**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 56, National Provider Identifier – Billing Provider: 1st Box: B3 Qualifier 2nd Box: Provider taxonomy code
81CCb**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 76, Attending Provider Name and Identifiers: 1st Box: B3 Qualifier 2nd Box: Provider taxonomy code
81CCc**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 77, Operating Physician Name and Identifiers: 1st Box: B3 Qualifier 2nd Box: Provider taxonomy code
81CCd**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Fields 78-79, Other Provider (Individual) Names and Identifiers: 1st Box: B3 Qualifier 2nd Box: Provider taxonomy code

4.19 Outpatient

All outpatient hospital services are reimbursed based on the Outpatient Simplified Fee Schedule (OSFS). Payment under the OSFS methodology is final, without cost settlement. Payment for covered services will be the lower of the provider's charge or the payment as calculated under the OSFS methodology.

It is acceptable to bill a line with only a revenue code when there is no Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code for the service. No payment will be made for that line, and it is considered packaged, i.e., the services are part of another procedure and are not paid separately. Hospitals must report all outpatient services and associated charges at the claim line level using CPT/HCPCS procedure codes appropriate to the service provided. Reimbursement for the procedure codes billed by the hospital represents the facility charges.

Refer to the **Fee Schedule** for a complete list of outpatient hospital procedure codes with the MHD allowed amount under the OSFS methodology.

Hospitals may bill for services on the outpatient claim when the hospital provides services to a person registered on the hospital records as an outpatient. A medical professional must have provided services. A medical professional is considered a physician or other person authorized by State licensure law to order hospital services for the diagnosis or treatment of the patient.

4.20 Outpatient Supply Charges

Supplies that can be billed on the claim form should be those that are consumed or disposed of after using for one (1) patient.

4.21 Outpatient Observation Services

Observation service charges may be shown separately on an outpatient claim. The revenue code below represents the number of hours in an observation room. If the provider has a patient in an observation room for more than 24 hours, the charges beyond that time must be absorbed as an expense to the provider. Those charges cannot be billed to MHD or the participant. If the patient stays past midnight, the date of service is the date the patient came in. Only one (1) observation code per stay may be billed. Refer to **Section 2** of this manual for more detailed information regarding observation services.

Charges for diagnostic and procedural services that occur after the initial 24 hours have expired may be billed to MHD.

All outpatient hospital services, including observation room services, are reimbursed based on the OSFS. Hospitals must report outpatient services and associated charges at the claim line level using CPT/HCPCS procedure codes appropriate to the service provided. Payment under the OSFS methodology is final, without cost settlement.

Refer to **Section 2.36** of this manual for additional information.

Outpatient Observation Codes

Revenue Code	Procedure Code	Quantity	Description
0762	G0378	24	Hospital Observation Per Hour: Maximum Units is 24. Hospitals should round to the nearest hour.

There are circumstances where a facility charge may be shown on a claim in addition to the observation room charge. An example is when emergency or operating room services are provided in addition to observation.

Under the OSFS methodology, direct admit to observation (HCPCS G0379) is not separately payable as it is considered included in the payment for observation procedure G0378.

4.22 CMS-1450 (UB-04) Outpatient Hospital Claim Filing Instructions

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed, or the claim is denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicate that a field is required in specific situations.

Field Number	Field Name	Instructions for Completion
1*	Billing Provider Name, Address and Telephone Number	Enter the provider name and address
2	Unlabeled Field	Leave blank
3a	Patient Control Number	A maximum of 20 alpha/numeric characters may be entered here for the provider's information
3b	Med Rec #	Not required
4*	Type of Bill	The required three (3) digits in this code identify the following: 1st digit: Type of facility 2nd digit: Bill classification 3rd digit: Frequency The valid type of bill is "131"
5	Federal Tax Number	Enter the provider's federal tax number or leave it blank

Field Number	Field Name	Instructions for Completion
6**	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY or MMDDYYYY numeric format or leave blank.
7	Unlabeled Field	Leave blank
8a	Patient's Name - ID	Enter the patient's eight (8) digit MO HealthNet identification (ID) number or MO HealthNet Managed Care Plan ID number. NOTE: The MO HealthNet Designated Client Number (DCN) MO HealthNet ID number or MO HealthNet Managed Care Plan ID number is required in Field 60, Insured's Unique Identifier.
8b*	Patient Name	Enter the patient's name in the following format: last name, first name, and middle initial
9	Patient Address	Enter the patient's complete mailing address, including street number and name, post office box number or RFD, city, state, and zip code
10	Patient Birth Date	Enter the patient's date of birth in MMDDYY format
11	Patient Sex	Enter the patient's sex, 'M' (male) or 'F' (female)
12	Admission Date	Not required
13	Admission Hour	Not required
14**	Admission Type	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type '1' and Condition code AJ.
15	Source of Admission (SRC)	Not required
16	Discharge Hour	Not required
17	Patient Discharge Status	Not required

Field Number	Field Name	Instructions for Completion
18-24**	Condition Codes	Enter the applicable two (2) character condition code. The Official UB-04 Data Specifications Manual contains a complete list of values. The values applicable to MHD are: AJ: Payer Not Responsible for Co-Payment: While MHD does not require copays for any services, condition code AJ must continue to be used to identify emergency services on outpatient claims correctly. A1: Healthy Children and Youth (HCY)//EPSDT Enter this condition code if this service results from an HCY referral or is an HCY-related visit. A4: Family Planning Enter this condition code if the family planning service occurred during the visit. Do not bill family planning services on the same claim as non-family planning services.
25-28	Condition Codes	Not required
29	Accident State	Not required
30	Unlabeled Field	Leave blank

Field Number	Field Name	Instructions for Completion
31-34**	Occurrence Code and Dates	If one (1) or more of the following occurrence codes apply, enter the appropriate code(s) on the claim. The Official UB-04 Data Specifications Manual contains a complete list of values. The values applicable to MHD are: 01: Accident/Medical Coverage 02: No-Fault Insurance Involved – Including Auto Accident/Other 03: Accident/Tort Liability 04: Accident/Employment Related 05: Accident/No Medical or Liability Coverage 06: Crime Victim
35-36	Occurrence Span Codes and Dates	Not required
37	Unlabeled Field	Leave blank
38	Responsible Party Name and Address	Not required
39-41	Value Code and Amounts	Not required
42*	Revenue Code	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies, and/or on-site medications, enter only the appropriate four (4) digit revenue code(s) for the hospital's outpatient facility charge(s). Enter the appropriate four (4) digit revenue code(s) for the hospital's outpatient service. For an all-inclusive list of revenue codes, see the Uniform Billing Manual.
43	Revenue Description	Not required

Field Number	Field Name	Instructions for Completion
44*	HCPCS/Rates/HIPPS Code	Enter the CPT or HCPCS procedure code(s) and any applicable modifier. Enter the appropriate CPT or HCPCS procedure code and any applicable modifier for all outpatient hospital services.
45*	Service Date	Enter the date of service on each line billed in MMDDYY format
46*	Service Units	Enter the number of units for each procedure or revenue code. NOTE: The system automatically plugs a '1' unit if no entry is made. Facility codes 0450, 0459, 0490, 0510, and 0943; supply codes 0260, 0270, and 0274 should always be billed with a unit of '1.' The outpatient observation code 0762 should be billed with the appropriate number of hours the participant was in observation status.
47*	Total Charges	Enter the total charge for each line item. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001. NOTE: When two (2) encounters occur on the same patient, a completed **Certificate of Medical Necessity** detailing the need for each visit must be submitted with the claim.
48	Non-covered Charges	Not required
49	Unlabeled Field	Leave blank
50*	Payer Name	The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer, and 'MO HealthNet' is listed last.
51	Health Plan ID	Not required
52	Release of Information Certification Indicator	Not required

Field Number	Field Name	Instructions for Completion
53	Assignment of Benefits Certification of Indicator	Not required
54**	Prior Payments	Indicate the amount the provider received toward payment of this bill from all other health insurance companies. Payments must correspond with the appropriate payer entered in Field 50, Payer Name. Do not enter a previous MHD payment, Medicare payment, or copayment amount received from the patient in this field.
55	Estimated Amount Due	Not required
56*	National Provider Identifier (NPI)	Enter the hospital's 10-digit NPI number If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCa, Code-Code Field.
57	Other Provider ID	Leave blank
58**	Insured's Name	Complete if the insured's name is different from the patient's name
59	Patient's Relationship to Insured	Not required
60*	Insured's Unique ID	Enter the patient's eight (8) digit MO HealthNet identification number or MO HealthNet Managed Care Plan identification number. If insurance was indicated in Field 50, Payer Name, enter the insurance number to correspond to the order shown in Field 50, Payer Name.
61**	Insurance Group Name	If insurance is shown in Field 50, Payer Name, state the name of the group or plan through which the insurance is provided to the insured.
62**	Insurance Group Number	If insurance is shown in Field 50, state the number assigned by the insurance company to identify the group under which the individual is covered.

Field Number	Field Name	Instructions for Completion
63	Treatment Authorization Codes	Not required
64**	Document Control Number	If the current claim exceeds the timely filing limit of one (1) year from the 'through' date but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one (1) year limit.
65	Employer Name	If the patient is employed, enter the employer's name
66	Diagnosis & Procedure Code Qualifier	Enter the appropriate three (3) digit qualifier
67*	Primary Diagnosis Code	Enter the complete ICD diagnosis code for the condition in which the service was provided. Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book.
67a-q**	Other Diagnosis Codes	Enter any additional diagnoses that affect the treatment received
68	Unlabeled Field	Leave blank
69	Admitting Diagnosis	Not required
70	Patient's Reason for Visit	Not required
71	Prospective Payment System (PPS) Code	Not required
72	External Cause of Injury Code (E-Code)	Enter the appropriate ICD-10 CM external cause of injury code when the principal or secondary diagnosis reflects an injury, poisoning, or other condition due to an external cause
73	Unlabeled Field	Leave blank

Field Number	Field Name	Instructions for Completion
74**	Principal Procedure Code and Date	Enter the complete ICD surgical procedure code. The date on which the procedure was performed must be stated. Only month and day are required.
74a-e**	Other Procedure Codes and Dates	Identify and date any other procedures that may have been performed
75	Unlabeled Field	Leave blank
76**	Attending Provider Name and Identifiers	Enter the attending provider's 10-digit National Provider Identifier (NPI) number. Enter the attending provider's last name/first name. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCb, Code-Code Field.
77	Operating Provider Name and Identifiers	Enter the operating provider's 10-digit NPI number Enter the operating provider's last name/first name. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCc, Code-Code Field.
78-79**	Other Provider Name and Identifiers	Enter the other provider's 10-digit NPI number Enter the other provider's last name/first name. Administrative Lock-in: If the participant's services are restricted due to administrative lock-in, enter the lock-in provider's number in this field and attach the **Medical Referral Form of Restricted Participant (PI-118)** Emergency services are only considered for payment if the claim is supported by medical records documenting the emergency circumstances. Note "EMERGENCY" at the top of the claim. If applicable: Enter the corresponding 10-digit provider taxonomy code in Field 81CCd, Code-Code Field.

Field Number	Field Name	Instructions for Completion
80	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
81CCa**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 56, National Provider Identifier – Billing Provider 1st Box: B3 qualifier 2nd Box: Provider taxonomy code
81CCb**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 76, Attending Provider Name and Identifiers 1st Box: B3 qualifier 2nd Box: Provider taxonomy code
81CCc**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Field 77, Operating Provider Name and Identifiers 1st Box: B3 qualifier 2nd Box: Provider taxonomy code
81CCd**	Code-Code Field	Enter the B3 provider taxonomy qualifier and corresponding 10-digit provider taxonomy code for the NPI number reported in Fields 78-79, Other Provider Name and Identifiers 1st Box: B3 qualifier 2nd Box: Provider taxonomy code

Section 5: Procedure Codes

Procedure codes used by the MO HealthNet Division (MHD) are identified as Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS are divided into two (2) subsystems, referred to as Level I and Level II. Level I is comprised of Current Procedural Terminology (CPT) codes used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes used primarily to identify products, supplies, and services not included in the CPT codes.

5.1 Current Procedural Terminology/Healthcare Common Procedure Coding System

All outpatient hospital services are reimbursed based on the Outpatient Simplified Fee Schedule (OSFS). Hospitals must report all outpatient services and associated charges at the claim line level using CPT/HCPCS procedure codes appropriate to the services rendered. Payment under the OSFS methodology is final, without cost settlement.

Refer to the **Fee Schedule** for a complete list of outpatient hospital procedure codes with the MHD allowed amount under the OSFS methodology. Payment will be the lower of the provider's charge or the OSFS allowed amount.

Except for those circumstances wherein specific reference is made to certain CPT/HCPCS procedure codes throughout this manual, this section does not list CPT/HCPCS procedure codes.

The professional services of physicians, anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs), etc., are not to be billed on the **CMS-1450 (UB-04) claim form** but instead are to be billed by the physician or other medical professional on the **CMS-1500 claim form**.

Reference materials regarding the CPT/HCPCS may be obtained through the **American Medical Association**.

Sexual Assault Findings Examination and Child Abuse Resource Education Examinations

Laboratory studies for sexual or physical abuse, when requested or ordered by a MO HealthNet enrolled Sexual Assault Findings Examination (SAFE) trained provider, for all MO HealthNet Fee-For-Service (FFS) and MO HealthNet Managed Care enrolled children, must be billed using the following procedure code(s):

Procedure Code	Modifier	Description
57452	U7	Colposcopy
81025	U7	Urine pregnancy test

Procedure Code	Modifier	Description
86317	U7	Chlamydia
86631	U7	Chlamydia
86632	U7	Chlamydia, IgM
87110	U7	Chlamydia, culture
86592	U7	RPR
87076	U7	Culture, bacterial, any source definitive identification, each anaerobic organism
87077	U7	Culture, bacterial, aerobic isolate, additional methods required for definitive identification
87210	U7	Wet mount
86687	U7	HIV
86688	U7	HIV
86689	U7	HIV, Western Blot
87390	U7	HIV-1
87391	U7	HIV-2
87534	U7	HIV-1, direct probe technique
87535	U7	HIV-1, amplified probe technique
87536	U7	HIV-1, quantification
87537	U7	HIV-2, direct probe technique
87538	U7	HIV-2, amplified probe technique
87539	U7	HIV-2, quantification

Habilitative Services Procedure Codes

The following codes are covered for individuals in a category of assistance for the adult expansion group (Medicaid Eligibility (ME) code E2). The combination of habilitative skilled therapy services for the adult expansion group is limited to a total of 20 visits inclusive of services from all MO HealthNet providers. Refer to the **General Sections Manual** for more information on ME codes.

Procedure Code	Modifier	Description
92507	96	Speech/Hearing Therapy
92508	96	Speech/Hearing Therapy
92521	96	Evaluation of Speech Fluency
92522	96	Evaluate Speech Production
92523	96	Speech Sound Lang Comprehen
92524	96	Behavral Qualit Analys Voice
92526	96	Oral Function Therapy
92610	96	Evaluate Swallowing Function
92611	96	Motion Fluoroscopy/Swallow
92612	96	Endoscopy Swallow (Fees) VID
92613	96	Endoscopy Swallow (Fees) I&R
92614	96	Laryngoscopic Sensory VID
92615	96	Laryngoscopic Sensory I&R
92616	96	Fees W/Laryngeal Sense Test
92617	96	Fees W/Laryngeal Sense I&R
92626	96	Eval Aud Funcj 1st Hour
92627	96	Eval Aud Funcj Ea Addl 15
96105	96	Assessment of Aphasia

Procedure Code	Modifier	Description
96112	96	Devel Tst Phys/Qhp 1st Hr
96113	96	Devel Tst Phys/Qhp Ea Addl
97012	96	Mechanical Traction Therapy
97014	96	Electric Stimulation Therapy
97016	96	Vasopneumatic Device Therapy
97018	96	Paraffin Bath Therapy
97022	96	Whirlpool Therapy
97024	96	Diathermy Eg Microwave
97026	96	Infrared Therapy
97028	96	Ultraviolet Therapy
97032	96	Electrical Stimulation
97033	96	Electric Current Therapy
97034	96	Contrast Bath Therapy
97035	96	Ultrasound Therapy
97036	96	Hydrotherapy
97039	96	Physical Therapy Treatment
97110	96	Therapeutic Exercises
97112	96	Neuromuscular Reeducation
97113	96	Aquatic Therapy/Exercises
97116	96	Gait Training Therapy
97124	96	Massage Therapy

Procedure Code	Modifier	Description
97139	96	Physical Medicine Procedure
97140	96	Manual Therapy 1/> Regions
97161	96	Pt Eval Low Complex 20 Min
97162	96	Pt Eval Mod Complex 30 Min
97163	96	Pt Eval High Complex 4 Min
97164	96	Pt Re-eval Est Plan Care
97165	96	Ot Eval Low Complex 30 Min
97166	96	Ot Eval Mod Complex 45 Min
97167	96	Ot Eval High Complex 60 Min
97168	96	Ot Re-eval Est Plan Care
97530	96	Therapeutic Activities
97535	96	Self Care Mngment Training
97750	96	Physical Performance Test
97755	96	Assistive Technology Assess
97760	96	Orthotic Mgmt & Traing 1st Enc
97761	96	Prosthetic Traing 1st Enc
97763	96	Orthc/Prostc Mgmt Sbsq Enc

5.2 Inpatient Hospital Revenue Codes

Accommodations

MHD covers the following categories of accommodation revenue codes. If a revenue code category is not listed, it is not covered under the MO HealthNet Hospital Program. Some revenue codes within the below categories may not be covered. Refer to **Non-Covered Revenue Codes** in this section for a list of individual non-covered revenue codes. Refer to the current version of the Official UB-04 Data Specifications Manual for a complete list of revenue codes and descriptions.

Revenue Code	Description
0001	Total Charge
011x	Room & Board – Private (One Bed)
012x	Room & Board – Semi-Private (Two Beds)
013x	Room & Board – Three and Four Beds
014x	Room & Board – Deluxe Private
015x	Room & Board – Ward
016x	Room & Board – Other
017x	Nursery
020x	Intensive Care Unit
021x	Coronary Care Unit

Ancillaries

The following categories of ancillary revenue codes are covered by MHD and are included in the inpatient reimbursement rate. Charges for the ancillary service revenue codes listed below cannot be billed separately unless specified in **Section 2** of this manual. If a revenue code category is not listed, it is not covered under the MO HealthNet Hospital Program. Some revenue codes within the below categories may not be covered. Refer to **Non-Covered Revenue Codes** in this section for a list of individual non-covered revenue codes. Refer to the current version of the Official UB-04 Data Specifications Manual for a complete list of revenue codes and descriptions.

Revenue Code	Description
025x	Pharmacy (also see 063x, an extension of 025x)

Revenue Code	Description
026x	IV Therapy
027x	Medical/Surgical Supplies and Devices (also see 062x, an extension of 027x)
028x	Oncology
030x	Laboratory
031x	Laboratory Pathology
032x	Radiology – Diagnostic
033x	Radiology – Therapeutic and/or Chemotherapy Administration
034x	Nuclear Medicine
035x	CT Scan
036x	Operating Room Services
037x	Anesthesia
038x	Blood and Blood Components
039x	Administration, Processing, and Storage for Blood and Blood Components
040x	Other Imaging Services
041x	Respiratory Services
042x	Physical Therapy
043x	Occupational Therapy
044x	Speech Therapy – Language Pathology
046x	Pulmonary Function
048x	Cardiology
061x	Magnetic Resonance Technology (MRT)

Revenue Code	Description
062x	Medical Surgical Supplies – Extension of 027x
063x	Pharmacy – Extension of 025x
071x	Recovery Room
072x	Labor Room/Delivery
073x	EKG/ECG (Electrocardiogram)
074x	EEG (Electroencephelogram)
075x	Gastro-Intestinal (GI) Series
079x	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)
080x	Inpatient Renal Dialysis
081x	Acquisition of Body Components (see **Transplant Provider Manual** for instructions to prevent claim denials)
086x	Magnetocencephalography (MEG
088x	Miscellaneous Dialysis
090x	Behavioral Health Treatment/Services (also see 091x, an extension of 090x)
091x	Behavioral Health Treatment/Services – Extension of 090x
092x	Other Diagnostic Services
091x	Other Therapeutic Services

Non-Covered Revenue Codes

The following revenue codes are not covered within the categories shown in the **Accommodations** and **Ancillaries** sections above. If a category of revenue codes is not listed above, it is not covered under the MO HealthNet Hospital Program.

Revenue Code	Revenue Code	Revenue Code
0115	0277	0900
0125	0303	0902
0135	0362	0903
0145	0367	0904
0155	0374	0905
0160	0421	0906
0167	0431	0907
0169	0441	0912
0253	0624	0913
0256	0723	0916
0273	0732	0917
0274	0882	0942

NOTE: Any service for which there is no assigned revenue code is considered non-covered.

Transplant Revenue Codes

Refer to the **Transplant Provider Manual** for revenue codes and proper billing procedures for transplant services.