



Physician Manual

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Introduction

This manual contains policies and procedures for physicians, physician assistants, assistant physicians, ~~chiropractors~~, nurse practitioners, and doulas providing services to MO HealthNet covered participants.

Section 1: Reimbursement Methodology

1.1 Physician Services

Reimbursement for physician services is made on a Fee for Service (FFS) basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

1.2 Determining a Fee

Under a fee system each procedure, service, medical supply, and equipment covered under a specific program has a maximum allowable fee established.

- In determining what this fee should be, the MO HealthNet Division (MHD) uses the following guidelines: Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable

Charge information is obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.

MHD then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

Fee Schedule

MO HealthNet fee schedules are available online. The [Fee Schedule](#) identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit.

The [Fee Schedule](#) is updated monthly and is intended as a reference not a guarantee for payment.

The [Fee Schedule](#) allows for the downloading of a specific fee schedule. Some procedure codes may be billed by multiple provider types.

Categories within the Fee Schedule are set up by the service rendered and are not necessarily provider specific.

Refer to [Section 2](#) in this manual for program specific benefits and limitations.

1.3 Medicare/MO HealthNet Reimbursement (Crossover Claims)

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. See the [Medicare/Medicaid Claims Processing Provider Manual](#) for a general explanation of these claims.

1.4 Managed Care Program

One method through which MO HealthNet provides services is through a MO HealthNet Managed Care Program. A basic package of services is offered to the participant by the Managed Care health plan; however, some services are not included and are covered by MO HealthNet on a FFS basis.

Physician services are included as a plan benefit in the MO HealthNet Managed Care Program.

Refer to the [General Sections Manual](#) for more information regarding MO HealthNet's Managed Care Program.

The MO HealthNet Program utilizes the managed care delivery system for certain included MO HealthNet eligible participants. Refer to the [General Sections Manual](#) for more information.

Section 2: Benefits and Limitations

This section contains specific information regarding the benefits and limitations of the MO HealthNet Physician Program. Physicians, physician assistants, assistant physicians, ~~chiropractors~~, nurse practitioners, and doulas are subject to the benefit limitations and coverage restrictions set forth in this manual.

Refer to the [General Sections Manual](#) for information regarding provider participation issues, nondiscrimination, retention of records, participant eligibility, non-liability information, third party liability (TPL), and other information relevant to all MO HealthNet enrolled providers.

2.1 Provider Participation

Physicians may participate in the Title XIX Medicaid Program if the following requirements are met:

- The physician holds a valid certificate of registration or licensure within the state of practice
- Enrollment as a MO HealthNet provider is approved by Missouri Medicaid Audit and Compliance (MMAC)

Please review the [General Sections Manual](#) for a discussion of provider participation.

2.2 Lock-In Participants

'Lock-in' is the term used to describe MO HealthNet participants who are restricted, or locked-in, to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. When the participant has an administrative lock-in provider, the provider's name and telephone number are identified on eMOMED when verifying eligibility. Refer to the [General Sections Manual](#) for more information.

In order for outpatient hospital services or physician services to be payable for a participant who is locked-in to a physician or hospital different from the billing provider, one of the following exceptions must apply:

Emergency services. If emergency services are provided, completed progress notes from the participant's medical record explaining the emergency must be attached to the claim when it is submitted for payment. Refer to [Section 2.21](#) in this manual for the definition of emergency services.

Participants locked-in to another provider for administrative purposes, e.g., abuse, overutilization, must be referred by the lock-in provider for services. The [Medical Referral of Restricted Participant \(PI- 118\)](#) form is to be completed and signed by the authorized lock-in provider when a referral to another provider is medically necessary. The referral is valid for a maximum of 30 days. For the performing provider to receive payment the referral form must be submitted with each claim. Provider numbers begin with the provider type of the individual provider, e.g., physician, clinic, pharmacy. For further explanation of the Lock-In Program and a copy and explanation of the PI-118 form, refer to the [General Sections Manual](#).

2.3 Temporary Medicaid During Pregnancy Limitations

The purpose of the Temporary MO HealthNet during Pregnancy (TEMP) Program is to provide pregnant women with access to ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility. Certain qualified providers, as determined by FSD, may issue TEMP cards. A TEMP replacement letter may also be issued when the TEMP individual has formally applied for MO HealthNet and is awaiting eligibility determination.

The TEMP card and letter may only be used to obtain ambulatory prenatal services. The diagnosis on the claim form must be a pregnancy/prenatal diagnosis. If the TEMP participant is provided illness care, the illness diagnosis code must appear as the primary diagnosis code and the pregnancy/prenatal diagnosis code must also appear on the claim form.

Refer to the [General Sections Manual](#) for more information on TEMP and MO HealthNet eligibility after TEMP.

2.4 Automatic MO Healthnet Eligibility for Newborn Children

A child born to a woman who is eligible for and receiving MO HealthNet benefits on the date of birth is automatically eligible for MO HealthNet. Coverage begins with the date of birth and extends until the child's first birthday. Reference the [General Sections Manual](#) for detailed information regarding automatic newborn eligibility.

2.5 Qualified Medicare Beneficiaries Program

Section 301 of the [Medicare Catastrophic Coverage Act of 1988](#) makes individuals who are Qualified Medicare Beneficiaries (QMB) a mandatory coverage group under MO HealthNet for the purpose of paying Medicare deductible and coinsurance amounts on their behalf. Refer to the [General Sections Manual](#) for detailed information on QMB participants.

How the Quality Medicare Beneficiaries Program Affects Providers

It is important for providers to understand the difference between the services MHD reimburses for those individuals with QMB only and for those with QMB and MO HealthNet eligibility.

- For a QMB only participant (Medicaid Eligibility (ME) code 55), MHD only reimburses providers for Medicare deductible and coinsurance amounts as well as Medicare Part C deductible, coinsurance, and copayment amounts for services covered by Medicare, including providers of services not currently covered by MO HealthNet such as independent therapists. MHD does not reimburse for non-Medicare services, such as prescription drugs, eyeglasses, most dental services, adult day health care, personal care services, most eye exams performed by an optometrist or nursing care services not covered by Medicare.
- A QMB and MO HealthNet eligible participant may receive all services (within limitations) covered by MO HealthNet and provided by enrolled providers. MO HealthNet also covers all Medicare deductible, and coinsurance amounts as well as Medicare Part C Deductible, coinsurance, and copayment amounts for services provided by providers who may or may not be enrolled as a MO HealthNet provider. Refer to the [General Sections Manual](#) for further information.

2.6 Third Party Liability

It is a federal requirement that MHD be the payer of last resort for medical services covered under the state plan. Any insurance or other source that is liable for payment of services provided to a participant must be utilized before MHD reimburses for that service.

The purpose of administering a TPL program is to ensure that federal and state funds are not misspent for covered services to MO HealthNet participants when third parties exist who may be legally liable for those services. A claims processing edit denies a claim when no TPL information is shown on the claim, but the participant file indicates other insurance.

Federal regulations at [42 CFR 447.20](#) prohibit a provider from refusing to furnish services covered by MO HealthNet to an individual who is eligible for MO HealthNet because of a third party's potential liability for the service.

Providers should complete the [Insurance Resource Report \(TPL-4\)](#) to report changes to MHD in insurance coverage when they learn of them from the participant or the insurance company with the MO HealthNet.

Refer to the [General Sections Manual](#) for more information on TPL.

2.7 Service Modifiers

Claims submitted to MHD must reflect the appropriate modifier with a procedure code when billing for the services defined below.

Modifier	Description
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia Service Performed Personally by Anesthesiologist
QK	Medical Direction of Two (2), Three (3), or Four (4) Concurrent Anesthesia Procedures Involving Qualified Individuals
QX	Certified Registered Nurse Anesthetist (CRNA)/ Anesthesiologist Assistant (AA) Service; with Medical Direction by a Physician
QZ	CRNA Service; Without Medical Direction by a Physician
TC	Technical Component
UC	Early Periodic Screening, Diagnostics, and Treatment (EPSDT) Referral for Follow-Up Care (Required if EPSDT Referral is Made)

2.8 Healthy Children and Youth Program

Missouri's Early Periodic Screening, Diagnostic and Treatment (EPSDT) program is called the Healthy Children and Youth (HCY) Program. HCY is a comprehensive, primary, and preventive health care program for MO HealthNet eligible children and youth under the age of 21. HCY is designed to link the child and family to an ongoing health care delivery system. The Social Security Act authorizes Medicaid coverage of medical and dental services necessary to treat or improve defects and physical and mental/behavioral health conditions identified by an HCY screen. These services are covered by MO HealthNet regardless of whether the services are covered under the state Medicaid plan. Services identified by an HCY screening that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope, and prognosis. Prior authorization (PA) of services may be required for service needs and for services of extended duration. Refer to the program specific [Provider Manual](#) for a description of requirements regarding the provision of services.

Some services that are normally non-covered may be covered under the HCY Program and some services require [prior authorization](#) (PA). Information regarding therapy services, surgeries, and psychiatric services for HCY are listed below. Refer to the [HCY Provider Manual](#) and other applicable [provider manuals](#) for additional HCY information.

When requesting a [PA](#) of a non-covered procedure for an HCY participant under the age of 21, add the modifier EP to the existing five (5)-digit code and identify the request as an 'HCY Request.' These requests should be directed to:

Wipro Infocrossing Healthcare Services
PO Box 5700
Jefferson City, MO 65102

2.9 Preventive Medicine Services

Vaccines for Children Program

Through the Vaccines for Children (VFC) Program, federally provided vaccines are available at no cost to public and private providers for eligible children ages 0 through 18 years of age. Children that meet at least one (1) of the following criteria are eligible for VFC vaccine:

- MO HealthNet enrolled: A child enrolled in the MO HealthNet Program
- Uninsured: A child with no health insurance coverage
- Native American/Alaskan: Children as defined in the Indian Health Services Act
- Underinsured: The child has some type of health insurance, but the benefit plan does not include vaccinations. The child must be vaccinated in a Federally Qualified Health Clinic (FQHC) or a Rural Health Clinic (RHC).

MO HealthNet enrolled providers must participate in the VFC Program administered by the Missouri Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified MO HealthNet eligible children. Providers may bill for the administration of the free vaccine by using the appropriate VFC Administration Codes. Refer to [Section 6.8](#) in this manual for a list of VFC procedure codes. Providers must not use any additional administration procedure codes. The administration fee(s) may be billed in addition to a HCY screen, a preventive medicine service, or in addition to an office visit if a service other than administration of a vaccine was provided to the child. Providers enrolled as RHCs or FQHCs must not bill an additional administration fee for any vaccine.

For more information regarding the specific guidelines of the VFC program, refer to [VFC Program – Information for Providers](#), contact DHSS at (800) 219-3224, Fax: (573) 526-0238, or contact the [VFC Regional Contact](#).

Immunizations Outside Vaccines for Children Guidelines

If an immunization is given to a MO HealthNet participant who does not meet the VFC guidelines, use the standard procedure for billing injections. Providers should bill on the pharmacy claim form using the national drug code (NDC). Refer to the [Pharmacy Provider Manual](#) for more information.

Vaccine Shortages

In cases of vaccine shortages, providers are notified by a posted MO HealthNet Bulletin and given further instructions. [Subscribe](#) to [MO HealthNet News](#) to receive Bulletins and other important updates.

Illness Care

If an abnormality is detected during a preventive medicine examination and follow-up care or treatment is required, diagnosis codes should reflect the abnormality or condition for which the follow-up care or treatment is indicated, such as anemia, respiratory problems, heart murmur, underweight, overweight, infections, etc. In these situations, the appropriate Office/Outpatient procedure code found in the Current Procedural Terminology (CPT) book should be used, rather than the Preventive Medicine procedure codes.

School/Athletic Physicals

A physical examination may be necessary to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis code Z00.121 (Encounter for routine child health examination with abnormal findings) or Z00.129 (Encounter for routine child health examination without abnormal findings), should be used. This also applies for other school physicals when required as conditions for entry into or continuance in the educational process. Use the appropriate Preventive Medicine code found in the CPT book with the appropriate modifiers. Refer to the [HCY Provider Manual](#) for the appropriate modifiers.

Women, Infants and Children Services

Women, Infants and Children (WIC) agencies enrolled as MO HealthNet providers, and the performing provider, may bill for a minimal office visit (CPT code 99211) and for a hemoglobin laboratory procedure (CPT code 85018) performed during a certification or re-certification of MO HealthNet eligible WIC clients, only if the agency is able to substantiate its costs exceed any amounts received from other sources of funding. Costs associated with the WIC services are non-reimbursable costs for FQHCs.

If the WIC agency cannot substantiate its costs exceed funds received from other sources, then the agency cannot bill MHD for the WIC services.

Pediatric Vaccine Counseling

Providers may bill for stand-alone vaccine counseling visits in which providers talk to families about the importance of vaccines for children under age 21 as part of the HCY benefit, even when the child does not receive a vaccine. Parents or guardians of children enrolled in MO HealthNet can be counseled, without the children present, on the benefit of receiving the vaccine even if the parent or guardian is not enrolled in MO HealthNet. The vaccine counseling session for the parent or guardian can be billed using the child's MO HealthNet ID. There is no requirement for a specific diagnosis code.

All enrolled providers approved to administer pediatric vaccines may provide this service. Vaccine counseling can be provided in person or via telehealth.

Covered procedure codes are listed in the table below.

Procedure Code	Description
G0312	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, five (5) - 15 mins time.
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16 - 30 mins time.
G0314	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16 - 30 mins time.
G0315	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, five (5) - 15 mins time.

2.10 Depression Screening and Follow-Up

Depression screening may be provided via telemedicine or in person by physicians, physician assistants, Advanced Practice Registered Nurses, and pharmacists. The below describes patient criteria and limitations for these screenings.

Participant Criteria	Limit Per Year	Modifier
General population (12 years and older)	One (1) unit	No modifier
Perinatal population (pregnant/postpartum)	Four (4) units	TH

MHD accepts the following procedure codes for depression screening for participants ages 12 and older.

HCPSC Codes	Description	Max Allowable Amount
G8431	Screening for Depression is documented as being positive and follow-up plan is documented	\$13.55
G8510	Screening for Depression is documented as being negative, a follow-up plan is not required	\$13.55

Depression screening for a caregiver administered by a child's pediatrician as part of the child's well child check is reported using procedure code 96161.

Standardized Depression Screening Tools

Providers must use an age-appropriate, standardized, and validated depression screening tool and document the name of the tool utilized and the results as positive or negative in the participant's medical record.

Examples of standardized depression screening tools include, but are not limited to:

Tools	Examples
Perinatal Screening Tools	Beck Depression Inventory (BDI) Beck Depression Inventory-II (BDI-II) Edinburgh Postnatal Depression Scale Patient Health Questionnaire 9 (PHQ-9) Postpartum Depression Screening Scale Center for Epidemiologic Studies Depression Scale (CES-D) Zung Self-Rating Depression Scale

Tools	Examples
Adult Screening Tools (18 Years and Older)	BDI BDI-II CES-D Computerized Adaptive Testing Depression Inventory (CAT-DI) Computerized Adaptive Diagnostic Screener (CAD-MDD) Cornell Scale for Depression in Dementia (CSDD) Depression Scale (DEPS) Duke Anxiety-Depression Scale (DADS) Geriatric Depression Scale (GDS) Hamilton Rating Scale for Depression (HAM-D) PHQ-9 PRIME MD-PHQ-2 Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
Adolescent Screening Tools (12-17 Years)	BDI-Primary Care Version (BDI-PM) CES-D Mood Feeling Questionnaire (MFQ) PHQ-9 PHQ for Adolescents (PHQ-A) Pediatric Symptom Checklist (PSC-17) PRIME MD-PHQ-2

Positive Depression Screening Follow-Up Plan

Documented follow-up for a positive depression screening must include one (1) or more of the following:

- Referral to a practitioner who is qualified to diagnose and treat depression
- Psychotherapy and/or pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

If a depression screen is positive, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, a suicide risk assessment or additional screening using a standardized tool is not sufficient to qualify as a follow-up plan.

2.11 Reporting Child Abuse Cases

210.115 RSMo requires physicians, hospitals, and other specified personnel to report possible child abuse cases to the Family Support Division (FSD) [Child Abuse and Neglect Hotline](#) at (800) 392-3738, Relay Missouri at (800) 735-2466 (voice) or (800) 735-2966 (text).

2.12 Sexual Assault Findings Examinations and Child Abuse Resource Education Examinations

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by DHSS are covered by MHD. Children enrolled in a Managed Care health plan receive SAFE-CARE services as a benefit outside of the health plan on a FFS basis.

MO HealthNet enrolled providers furnishing SAFE-CARE examinations must identify children who are eligible for MO HealthNet or MO HealthNet Managed Care benefits. To maximize funding, claims for these children should be submitted to MHD for processing. Do not send claims for these children to FSD or to the local county FSD offices for reimbursement.

Eligibility may be verified by accessing [eMOMED](#) or by calling Provider Communications at (573) 751-2896 or toll-free (833) 222-7916. The provider needs either the child's MO HealthNet or Managed Care ID number, the child's Social Security Number and date of birth, or the mother's MO HealthNet or Managed Care ID number and the child's date of birth. Refer to the [General Sections Manual](#) for more information on eligibility.

When provided by a MO HealthNet enrolled SAFE trained provider, the examination for sexual or physical abuse for children enrolled in MO HealthNet (Managed Care and FFS) must be billed using one (1) of the following procedure codes:

Procedure Code	Description
99205U7	SAFE
99205U752	CARE

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

The laboratory tests for sexual or physical abuse, when requested or ordered by a MO HealthNet enrolled SAFE trained provider, for all MO children enrolled in MO HealthNet (Managed Care and FFS) must be billed using the following procedure code(s):

Laboratory Study Procedure Codes:

56820 U7	57420 U7	57452 U7	81025 U7	86317 U7	86592 U7
86631 U7	86688 U7	87077 U7	87390 U7	87535 U7	87538 U7
86632 U7	86689 U7	87110 U7	87391 U7	87536 U7	87539 U7
86687 U7	87076 U7	87210 U7	87534 U7	87537 U7	99170 U7

Claims for laboratory tests performed by someone other than the SAFE-CARE provider requires the referring physician information on the professional claim. Laboratories performing these tests are not required to be authorized as a SAFE-CARE provider to perform and receive reimbursement for the testing.

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

Providers may contact the SAFE-CARE Network by calling (573) 751-6261 or by emailing info@health.mo.gov. Refer to [DHSS SAFE-Care Network](#) for more information.

2.13 Bureau of Special Health Care Needs

Refer to the [Bureau of Special Health Care Needs](#) (BSHCN) for information regarding individuals with special health care needs who have or are at increased risk for a medical condition that may hinder the achievement of normal physical growth and development and who may also require health and related services of a type or amount beyond that required by individuals generally. The BSHCN can be reached by calling (573) 751-6246, toll-free (800) 451-0669, or by emailing hscn@health.mo.gov.

2.14 Supervision

Physician's Office/Independent Clinics

Services and supplies rendered in a private practice setting are considered incidental to a physician's professional services (and therefore billable by the physician) only when there is direct personal supervision by the physician. This rule applies to services of auxiliary personnel employed by the physician and working under the physician's supervision such as nurses, technicians, therapists, physician assistants, and other aides.

Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel are performing services. Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

If auxiliary personnel perform the services outside the office setting, the services are likewise covered as incidental to the physician services only if there is direct personal supervision by the physician. For example, if a nurse accompanies the physician on house calls and administers an injection, the injection is covered; if the same nurse makes the call alone and administers the injection, the service is not covered since the physician is not providing direct personal supervision.

Physician Assistant

Physician assistant services billed by a collaborating physician must be billed using modifier AR (Physician provider services in a physician scarcity area/physician assistant services). Physician assistant services will also be reimbursed when provided in a hospital setting. The services must also be billed using modifier AR by a collaborating physician.

Physician assistants may enroll as a MO HealthNet provider and submit claims for service reimbursement. Refer to [MMAC Provider Enrollment](#) for more information on enrolling as a MO HealthNet provider.

A physician assistant shall only practice at a location where a physician routinely provides patient care, except existing patients of the collaborating physician in the patient's home. The collaborating physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Appropriate supervision shall require the collaborating physician to be working within the same facility as the physician assistant for at least four (4) hours within one (1) calendar day for every 14 days on which the physician assistant provides patient care. The requirement of appropriate supervision shall be applied so that no more than 13 calendar days in which a physician assistant provides patient care shall pass between the physician's four (4) hours working within the same facility.

A collaborative practice agreement shall limit a physician assistant to practice only at locations with a geographic proximity to be determined by the Board of Registration for the Healing Arts. For physician assistants working in certified community behavioral health clinics, RHCs, or FQHCs, no supervision requirements, in addition to the federal law, shall be required.

A physician assistant must be licensed by the Missouri Board of Healing Arts as set forth in [20 CSR 2150-7](#) and must practice within their scope of practice as referenced in [334.735 RSMo](#) which includes:

- Taking patient histories
- Performing physical examinations of a patient

- Performing or assisting in the performance of routine office laboratory and patient screening procedures
- Performing routine therapeutic procedures
- Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures
- Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a licensed physician
- Assisting the collaborating physician in institutional settings, including reviewing of treatment plans, ordering of tests, diagnostic laboratory and radiological services, and ordering of therapies using procedures reviewed and approved by a licensed physician
- Assisting in surgery, however physician assistants cannot be assistant surgeons
- Performing such other tasks not prohibited by law under the supervision of a licensed physician
- Shall not perform or prescribe abortions

Physician assistants shall not:

- Prescribe nor dispense any drug, medicine, device, or therapy unless pursuant to a physician collaborative practice agreement in accordance with the law
- Prescribe lenses, prisms, or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye
- Administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures

Prescribing and dispensing of drugs, medications, devices, or therapies by a physician assistant shall be pursuant to a physician assistant collaborative practice agreement which is specific to the clinical conditions treated by the collaborating physician and the physician assistant shall be subject to the following:

- A physician assistant shall only prescribe controlled substances in accordance with [334.747 RSMo](#)
- The types of drugs, medications, devices, or therapies prescribed or dispensed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the collaborating physician
- All prescriptions shall conform with state and federal laws and regulations and shall include the name, address, and telephone number of the physician assistant and the collaborating physician

- A physician assistant or advanced practice registered nurse (RN) as defined in [335.016 RSMo](#) may request, receive, and sign for non-controlled professional samples and may distribute professional samples to patients
- A physician assistant shall not prescribe any drugs, medicines, devices, or therapies the collaborating physician is not qualified or authorized to prescribe
- A physician assistant may only dispense starter doses of medication to cover 72 hours or less

Nurse Practitioner Services

Nurse practitioner services billed by a collaborating physician are only billable when there is direct personal supervision by the physician. Direct personal supervision does not mean that the physician must be present in the same room with the auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the nurse practitioner is performing the service. Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

Nurse practitioners may enroll as providers with MHD. Refer to [MMAC Provider Enrollment](#) for more information on enrolling as a MO HealthNet provider.

Nurse practitioners are subject to the benefit limitations and coverage restrictions set forth in this manual. The [supervision policy](#) above is only for those nurse practitioner services billed by a supervising physician.

Assistant Physician Services

An assistant physician (AP) is a medical school graduate who has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination within the three (3) year period immediately preceding application for licensure as an AP, or within three (3) years after graduation from a medical college or osteopathic medical college, whichever is later.

An AP has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding three (3) year period, unless when such three (3) year anniversary occurred they were serving as a resident physician in an accredited residency in the United States and continued to do so within 30 days prior to application for licensure as an AP.

An AP must have a collaborative practice arrangement with a licensed physician as referenced in [334.037 RSMo](#). The collaborating physician is always responsible for the oversight of the AP and accepts all responsibility for the primary care services provided by the AP.

An AP may only provide primary care services and vaccines within the scope of a collaborative practice arrangement. Primary care services are those identified by the following CPT codes:

Procedure Codes	Description
99202 through 99215	New and established patient office or other outpatient evaluation and management (E/M) visits
99304 through 99340	Initial, subsequent, discharge, and other nursing facility or intermediate care home E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services
99341 through 99350	New and established patient home E/M visits

Collaborative practice arrangements may delegate to an AP the authority to administer or dispense drugs and provide treatment if the delivery of such health care services is within the scope of practice of the AP, and is consistent with that AP's skill, training, and competence and the skill and training of the collaborating physician.

Residents in Teaching/Clinical Setting

For a teaching physician to bill for services of a resident, the teaching physician must be physically present during the key portion of the service. The teaching physician must personally document, in the medical record, their presence and participation in the service. MHD does not provide reimbursement for medical direction or supervision of students in a teaching, training, or other setting.

Medicare Primary Care Exception

MO HealthNet recognizes the Medicare Primary Care Exception. Under this exception, MHD may be billed for reasonable and necessary low to mid-level E/M services when provided by a resident without the presence of a teaching physician.

Resident Requirements

Residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least six (6) months of a Graduate Medical Education (GME) approved residency program. Centers must maintain the documentation under the provisions at [42 CFR 413.75](#).

Residents generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include acute care for ongoing conditions, coordination of care furnished by other physicians and providers, and comprehensive care not limited by organ system or diagnosis.

Teaching Physician Requirements

Teaching physicians submitting claims under this exception may not supervise more than four (4) residents at a time and must be immediately available if needed. The teaching physician must have no other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident. The teaching physician must have the primary medical responsibility for patients cared for by the residents, ensure that the care provided was reasonable and necessary, review the care provided by the resident during or immediately after each visit, and document the extent of their own participation in the review and direction of the services furnished to each patient.

Location of Services

The services must be furnished in a center that is in an outpatient department of a hospital or another ambulatory care entity in which the time spent by the residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a non-hospital entity, providers should verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in [42 CFR 413.75](#).

Billing Guidelines

The GE modifier must be used to denote services provided under the primary care exception. The primary care exception applies only to specific low and mid-level E/M codes for both new and established patients. The new patient CPT codes to which the exception applies are 99202, and 99203.

The established patient procedure codes are as follows:

99211	99213	99215	99422
99212	99214	99421	99423

Public Health Department Clinics and Planned Parenthood Clinics

The physician's presence is not required onsite in Public Health Department and Planned Parenthood Clinic settings when a written protocol is developed, implemented, and evaluated by the physician and the RN. The facility must ensure the protocols are current. The physician must ensure the services are appropriate and medically necessary.

A copy of this protocol must be located in each individual clinic. Clinic staff must furnish or make this protocol available for inspection by the Department of Social Services (DSS) upon request.

This policy applies only to the services provided in a clinic setting as typically maintained by Public Health Department clinics and Planned Parenthood clinics. This policy does not apply in individual physician offices or independent clinics. The policy in those situations continues to require that the physician be on-site and render direct personal supervision. This policy also does not apply to psychiatric services wherever provided. The policy in those situations continues to require that the services be personally provided by the physician.

All services must be billed by the clinic on a professional claim. The provider number of the enrolled physician assuming responsibility for these services through a written protocol must be shown in the appropriate field on the claim for each service billed.

2.15 Current Procedural Terminology Definitions and Levels of Service

Services billed to MHD as rendered for a given diagnosis should not exceed the level of service defined for new or established patients. Definitions are described in the Guidelines section of the CPT book. Please refer to the definitions and explanation given for the use of codes when determining the level of service to be used for each patient. The CPT definitions and levels pertain to office or other outpatient services, hospital, inpatient services, consultations, home services, etc.

2.16 Place of Service

Physician services may be provided in settings such as the physician's office, the participant's home or other place of residence, the hospital, or settings such as a clinical facility, ambulatory surgical care facility, or school.

Two (2)-digit numeric place of service (POS) codes must be used when filing claims to MHD. A listing of POS codes and definitions is in [Section 4](#) of this manual.

2.17 Office or Other Outpatient Services

The procedure codes used to report E/M services provided in the physician's office, an outpatient hospital facility, or other ambulatory facilities are found in the CPT book. A patient is considered outpatient until inpatient admission to a health care facility occurs. For billing purposes, non-emergency services provided in an emergency room should be considered clinic (outpatient) POS.

Limitations to Office/Outpatient Services

Office/outpatient services are to be used for 'illness' care and are limited to one (1) visit per participant per provider per day. Additional medically necessary visits on the same day may be covered if a properly completed [Certificate of Medical Necessity](#) is attached to the claim and approved by the medical consultant. Refer to the [General Sections Manual](#) for instructions on completion of the [Certificate of Medical Necessity](#) form.

An office/outpatient physician visit includes, but is not limited to, the following:

- Examining the patient and obtaining a medical history for symptoms or indications of an illness or medical condition. For children's examinations as required for school education purposes, refer to [Section 2.10](#) in this manual. Reference the [HCY Provider Manual](#) for information on HCY screenings.
- Administering injections
- Preparing bacterial, fungal and cytopathology smear(s), and cultures
- Obtaining specimens (urine, blood, etc.)
- Using any instrument to examine and/or diagnose the illness or condition
- Fitting a diaphragm
- Furnishing supplies (e.g., gowns, drapes, gloves, urine cups, swabs. Refer to [Section 6](#) in this manual for billable supplies.
- Preparing medical records and all required forms

An office/outpatient service may not be billed on the same date of service as a home visit, subsequent hospital visit, consultant, preventive medicine services, HCY screening, or nursing facility visit. An office visit may be billed on the same date of service as a hospital admission if the office visit is not related to the hospital admission. All office/outpatient services provided by the admitting physician in conjunction with the admission are considered part of the initial hospital care.

An office/outpatient visit may not be billed on the same date of service as any of the psychotherapy visits. Refer to [Section 2.43](#) in this manual for information on psychiatric services.

An office visit is not covered if the only service is to obtain a prescription, the need for which has been determined previously

An office/outpatient visit may only be billed on the same date of service as a physical medicine modality or procedure when an office/outpatient visit service is provided. If planned therapy is the only service received, an office/outpatient visit should not be billed in addition to the therapy procedure.

Procedure code 99202 (new patient) or 99211 (established patient) may be billed for the administration of an injection if the injection does not have an administration procedure code.

'New patient' office/outpatient services are limited to one (1) per provider for each participant. Visits subsequent to the 'new patient' office/outpatient services must be coded as 'established patient' office/outpatient services as defined in the CPT book.

Full and partial HCY screenings are covered in accordance with the periodicity schedule and procedures outlined in the [HCY Provider Manual](#).

A 'new patient,' office/outpatient, for a physician in a group or clinic is defined as one that has not been seen by another member of the group who has the same specialty. Subsequent services must be coded as 'established patient' services.

History and Examination (Outpatient) Prior to Outpatient Surgery

Procedure codes 99202-99215 may be used in the outpatient setting (POS 19 (Off-Campus Outpatient Hospital) or 22 (Outpatient Hospital)) for the initial history and physical workup prior to outpatient surgery.

Healthcare Visits for Children Entering Foster Care

Initial Health Examination Required with New Modifier

Per [13 CSR 35-73.055](#), children under the age of three (3) must have an initial health examination with a physician or APRN within 72 hours after entering the custody of the Missouri Department of Social Services (DSS), Children's Division (CD), unless being discharged directly from a medical facility. For children over age three (3), the initial health examination may occur within 30 days prior to placement, or within 72 hours after entering foster care. Whenever possible, the initial health examination should be completed by the child's current primary care provider who is familiar with the child's medical history. For continuity of care, it is ideal for children in foster care to have a medical home that remains the same despite changes in foster placements.

For the initial health examination, MO HealthNet Division (MHD) or Show Me Healthy Kids (SMHK) enrolled providers should report the most appropriate procedure code from the below list, with the HA modifier (child/adolescent program). Reporting the HA modifier will allow MHD and SMHK to track and monitor healthcare exams for children and youth in foster care.

It is also important for the provider of the initial healthcare exam to share documentation of the exam with the CD or contracted foster care case management (FCCM) caseworker, so they can help ensure follow-up with any recommended services.

Below are the procedure code and modifier combinations to use when billing MHD/SMHK for new patients for an Initial Health Examination:

Proc Code	Modifier	Description
99202	HA	Office or Outpatient Visit for New Patient with Expanded Problem-Focused History and Expanded Problem-Focused Examination, Straightforward Medical Decision Making
99203	HA	Office or Outpatient Visit for New Patient with Medically Appropriate History and/or Examination and Low-Level Medical Decision Making
99204	HA	Office or Outpatient Visit for New Patient with Medically Appropriate History and/or Examination and Moderate Level Medical Decision Making
99205	HA	Office or Outpatient Visit for New Patient with Medically Appropriate History and/or Examination and High-Level Medical Decision Making

Below are the procedure code and modifier combinations to use when billing MHD/SMHK for established patients for an Initial Health Examination:

Proc Code	Modifier	Description
99211	HA	Office or outpatient visit for an established patient that may not require the presence of a physician
99212	HA	Office or outpatient visit for an established patient that requires medically appropriate history and/or examination and straightforward medical decision making
99213	HA	Office or outpatient visit for an established patient that requires medically appropriate history and/or examination and low-level medical decision making
99214	HA	Office or outpatient visit for an established patient that requires medically appropriate history and/or examination and moderate level medical decision making
99215	HA	Office or outpatient visit for an established patient that requires medically appropriate history and/or examination and high-level medical decision making

Full HCY Screening Required with New Modifier

Per **13 CSR 35-73.055**, children in foster care must receive medical examinations in accordance with the **HCY Provider Manual**. No later than 30 days after entering CD custody, children/youth must receive a full HCY screening which consists of a physical examination and other developmental components, including, but not limited to, vision, hearing, social/emotional, and dental screenings. A full HCY screen must be performed by a physician, assistant physician, physician assistant or APRN. A nurse midwife may also perform a full HCY screen for infants age zero-two (0-2) months and females age 15-20 years old. An Initial Health Examination may be considered a full HCY screening if the Initial Health Examination contains a review of all sections within the HCY screening.

For full HCY screenings, MHD or SMHK enrolled providers should report the most appropriate procedure code from the below list, with the EP modifier (per the **HCY Provider Manual**) and the HA modifier (child/adolescent program). Reporting the additional HA modifier is a new requirement that will allow MHD and SMHK to track and monitor healthcare exams for children and youth in foster care.

The appropriate Early Periodic Screening diagnosis code must appear as the primary diagnosis on a claim submitted for HCY services: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, or Z00.129.

Modifier UC should also be reported if a referral is made. Claims for the full HCY screening and/or full HCY screening with referral should be submitted promptly and within 60 days from the date of screening.

It is important for the provider of the full HCY screening to share documentation of the exam with the CD or contracted FCCM caseworker, so they can help ensure follow-up with any recommended services.

Below are the procedure codes to use when billing MHD for new patients for a full HCY screening:

Proc Code	Mod 1	Mod 2	Description
99381	EP	HA	Initial comprehensive preventive medicine evaluation and management for new patients under one year
99382	EP	HA	Initial comprehensive preventive medicine evaluation and management for new patients between the ages 1 and 4
99383	EP	HA	Initial comprehensive preventive medicine evaluation and management for new patients between the ages 5 and 11
99384	EP	HA	Initial comprehensive preventive medicine evaluation and management for new patients between the ages of 12 and 17
99385	EP	HA	Initial comprehensive preventive medicine evaluation and management for new patients between the ages 18 and 39

Below are the procedure codes to use when billing MHD for established patients for a full HCY screening:

Proc Code	Mod 1	Mod 2	Description
99391	EP	HA	Periodic comprehensive preventive medicine reevaluation for established patients under one year
99392	EP	HA	Periodic comprehensive preventive medicine reevaluation for established patients between the ages of 1 and 4
99393	EP	HA	Periodic comprehensive preventive medicine reevaluation for established patients between the ages of 5 and 11
99394	EP	HA	Periodic comprehensive preventive medicine reevaluation for established patients between the ages 12 and 17
99395	EP	HA	Periodic comprehensive preventive medicine reevaluation for established patients between the ages of 18 and 39

2.18 Special Services and Reports

Physician Services After Hours

For physician office/clinic services and RHC/FQHC services only, procedure code 99050 (Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed) may be billed in addition to the appropriate procedure code for the service, for those services provided before or after the physician's designated office hours. 'Designated office hours' are defined as those hours known and understood by the public as times the office is regularly open for business.

For physician office/clinic services and RHC/FQHC services only, 'After hours' designation may only be applied to those unusual circumstances occurring outside the regular/designated office hours as represented to the public, and during which the physician is not normally on-site.

Physician Services Sundays/Holidays

For those physician office/clinic services requested on Sundays or on one of the following specified holidays, the physician may bill procedure code 99051 (Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours), in addition to the appropriate procedure code for the service performed.

The following holidays are recognized:

- Memorial Day
- Independence Day

- Labor Day
- Thanksgiving Day
- Christmas Day
- New Year's Day

Critical Care Services

Critical care services represent delivery of medical services by a team of skilled professionals, directed by an appropriately trained physician or physicians, for a critically ill or injured patient. A critical illness or injury connotes a high likelihood of imminent or life-threatening deterioration in the patient's condition and the risk of organ failure requiring the immediate availability of skilled health care providers who can continuously monitor the patient's condition, as well as recognize and treat organ system failure. Critical care services require an extensive and specialized medical knowledge base, advanced and complex medical decision-making, and considerable technical expertise.

Some conditions that require critical care services include, but are not limited to:

- Cardiac
- Cardiogenic or septic shock
- Hemorrhagic
- Hepatic or renal failure
- Hypovolemic
- Life threatening post-operative complications
- Respiratory

Procedure codes used for critical care services are described below.

Procedure Codes	Description
99291-99292	Used when services are provided to a critically ill neonate or young child in an intensive care unit that does not provide 24-hour direct physician supervision (not a Pediatric Intensive Care Unit (PICU) or a Neonatal Intensive Care Unit (NICU)). These procedure codes should be used to report the actual minutes spent in direct care
99471-99472	Used to report physician services provided in a PICU by a physician directing the care of a critically ill infant or young child from 29 days of postnasal age up through 24 months of age

Procedure Codes	Description
99468-99469	Used to report services provided by a physician directing the care of a neonate 28 days or less in a NICU
99478-99480	Used to report services subsequent to the day of admission provided by a physician directing the continuing intensive care of the low birth weight or very low birth weight infant who no longer meets the definition of critically ill
99471-99480	Used when the health care team is under 24-hour direct physician supervision and may only be reported once a day

Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The supervising physician assumes complete responsibility for the direct provision of critical care services and/or the supervision of the team providing these services at all times. When the supervising physician is not immediately available at the bedside, it is required that the supervising physician maintains constant awareness of the experience, skills, and capabilities of those skilled medical professionals immediately available to the bedside pending their physical presence. It is likewise incumbent upon the skilled team members immediately available to the patient to ensure that the supervising physician is made aware of changes in the patient's condition that might necessitate their physical presence.

All members of the critical care services team must be credentialed to provide critical care services and the procedures necessary to accomplish those services by their institution and state licensing boards. The team composition will vary by setting, patient age, and diagnosis and may include certified neonatal nurses, physician assistants, residents, fellows, neonatal nurse practitioners, hospitalist physicians, pediatric intensivists, or attending neonatologists.

Every health care setting is strongly encouraged by MHD to ensure a minimum level of competency for all medical professionals serving in areas where critical care services are provided, and for those periods when the supervising physician is not immediately available to the bedside.

The following services are included in the reimbursement for critical care when performed during the critical period by the physician:

- Interpretation of cardiac output measurements
- Chest x-rays
- Pulse oximetry, blood gases, and information data stored in computers, e.g., electrocardiograms (ECGs), blood pressures, hematologic data
- Gastric intubation; temporary transcutaneous pacing

- Ventilator management
- Pulse oximetry
- Vascular access procedures

Any services performed which are not listed above may be reported separately.

Initial Care Services

Initial care services are services for a patient who is not critically ill but who is in a critical care unit. Hospital visits may not be billed on the same date of service, by the same physician, as any of the critical care procedure codes.

Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the critical care time, even when they are performed in the critical care unit at a patient's bedside.

Select procedure codes for initial care services are described below. Providers should refer to the CPT book for additional descriptions.

Procedure Codes	Description
99291	Used only for initial care for the first 30 to 74 minutes (maximum quantity is one (1))
99292	Used for each additional 30 minutes up to a maximum of eight (8) units per day (four (4) additional hours per day)
99231-99233	Used for services for a patient who is not critically ill but who is in a critical care unit

Newborn Care

Refer to [Section 2.55](#) in this manual for information regarding newborn care.

2.19 Office Medical Supply Codes

Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit. Appropriate supplies may be billed by the provider with the appropriate procedure code. Refer to [Section 6](#) in this manual for a list of supply and material procedure codes. Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

An invoice of cost showing the cost, and the description of the supply, must be submitted with the claim when procedure code 99070 (Supplies and materials (except spectacles), provided by the physician over and above those usually included) is billed.

An electronic invoice of cost attachment is available to providers in [eMOMED](#). Refer to the [General Sections Manual](#) for more information regarding eMOMED.

2.20 Prescription Drugs

Chemotherapy

Chemotherapy injections are covered for the treatment of malignancies. Providers bill for the drug using the appropriate NDC on the pharmacy claim. Chemotherapy administration services 96401 through 96425 are covered in an office setting.

Refer to Infusion Therapy below for more information.

Infusion Therapy

The following infusion therapy procedures are covered in the office setting and require the presence of the physician during the infusion. They are not to be used for intradermal, subcutaneous, intramuscular, or routine IV drug injections. Physicians may bill a maximum of eight (8) units of IV services using procedure code 96361 in addition to one (1) hour of 96360 making a total of nine (9) units of IV therapy.

The services of the physician supervising infusion therapy in the inpatient or outpatient hospital setting are to be billed using the appropriate E/M procedure codes. Infusion therapy by nurses in an inpatient or outpatient setting is included in the facility charge and is not separately billable (e.g., chemotherapy, antibiotic therapy, hydration therapy, immune globulin therapy, IV rate change, pitocin).

Injectable Medications

Refer to the [Pharmacy Provider Manual](#) for information on drug billing.

Insertion, Revision and Removal of Implantable Intravenous Infusion Pump or Venous Access Port

The surgeon should bill for the actual insertion of an implantable intravenous infusion pump. If performed on an inpatient basis, the hospital includes the cost of the pump in its ancillary charges. If done in the outpatient facility, the pump should be billed by the hospital using the outpatient supply code.

Maintenance Medication

Maintenance medications are defined as drugs with a common indication for treating a chronic disease, and the therapeutic duration is expected to exceed one (1) year for most participants. Refer to the [Pharmacy Provider Manual](#) for more information.

Exceptions to Billing on the Pharmacy Claim

The following exceptions apply in specific instances:

- Ambulatory Surgical Centers (ASC) (Specialty B5) must not bill separately for injections, as the facility payment includes all supplies and equipment
- Mental Health Regional Centers (Specialty 56) are restricted to annual assessments and daily specialized services only
- Public Health Department Clinics must bill on the professional claim in accordance with special instructions for vaccines provided by the Centers for Disease Control and Prevention (CDC). Contact Provider Communications at (573) 751-2896, toll-free (833) 222-7916, or via [eMOMED](#) for more information. All other (purchased) vaccines must be billed on the pharmacy claim.

Prescription Drug Monitoring Program

Prescribers of controlled substances for MO HealthNet participants are required to check an available Prescription Drug Monitoring Program (PDMP) prior to prescribing a controlled substance to the participant.

In the case that the prescriber is unable to check the available PDMP prior to prescribing a control substance the prescriber shall:

- Document such good faith effort, including why the prescriber was unable to perform such check
- Have said documentation available in the participant record to be submitted to the state upon request.

Additional resources are available at [Public Laws Rules and Regulations](#).

2.21 Emergency Services

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

Emergency medical condition means 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 the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of 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: (1) that there is inadequate time to affect a safe transfer to another hospital before delivery; (2) that transfer may pose a threat to the health or safety of the woman or the unborn

Post stabilization care services refer to covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized conditions or to improve or resolve the participant's condition.

2.22 Out-of-State, Nonemergency Services

All nonemergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, must be prior authorized before the services are provided. Services that are not covered by MO HealthNet are not approved.

13 CSR 70-3.120(3) defines out-of-state as not within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries.

Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma, and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A **PA Request** is not required for out-of-state nonemergency services. To obtain **PA** for out-of-state, nonemergency services, a written request must be submitted by a physician to the Participant Services Unit (PSU) by fax to (573) 526-2471, email to **MHD.PSULReferrals@dss.mo.gov**, or mail to:

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

The written request must include:

- A brief past medical history
- Services attempted in Missouri
- Where the services are being requested and who will provide them
- Why services can't be done in Missouri

PA for out-of-state services expires 180 days from the date the specific service was approved by the state.

The out-of-state medical provider must agree to complete an enrollment application and accept MO HealthNet reimbursement for any covered service. Refer to **MMAC Provider Enrollment** for more information.

Exceptions to Out of State Prior Authorization

The following are exempt from the out-of-state [PA](#) requirement:

- All Medicare/MO HealthNet crossover claims, refer to the [Medicare/Medicaid Claims Processing Provider Manual](#) for more information
- All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require [PA](#) continue to require [PA](#) by out- of-state providers even though the service was provided to a Foster Care child
- Emergency ambulance services
- Independent laboratory services
- All border state providers

2.23 Consultations

Effective for claims with dates of service on or after July 1, 2026, and after, the MO HealthNet Division (MHD) will not reimburse consultation service codes 99242-99245 and 99252-99255. Consultation services should be reported with an appropriate Evaluation and Management (E&M) code that represents the location where the visit occurred and the level of complexity of the visit performed.

A consultation is a type of service provided by a physician whose opinion or advice regarding E/M of a specific problem is requested by another physician or other appropriate source. It is not a referral of a patient to another physician for care and treatment.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or appropriate source.

Consultations are not appropriate when the consultant and the attending physician concurrently continue to monitor, treat, and prescribe on an ongoing basis. In these situations, hospital or office visits should be used, being especially aware of the diagnosis for which each physician is providing treatment.

Office or Other Outpatient Consultations

Follow-up visits in the consultant's office or other outpatient facility that are initiated by the consultant are not to be reported as consultations. These services are to be reported using office visit codes for established patients (99211-99215).

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

2.24 Concurrent Care

Concurrent care is defined as medical care rendered by more than one (1) physician to a seriously ill patient during an illness when the patient's condition requires the special skills of more than one (1) physician (e.g., neurologist following surgery involving brain and spinal cord; cardiologist following open-heart surgery; internist following amputation of a limb for participant with diabetes).

Payment is made for concurrent care visits by more than one (1) physician specialist or subspecialist on the same date of service only when the medical need is clearly documented by the nature of the diagnosis and the description of the service provided.

Routine concurrent care visits made at the request of the below are not covered:

- Patient
- Family
- As a matter of personal interest in a continuing patient/physician relationship

2.25 Adult Physicals

One (1) adult 'preventive' examination/physical, including a well woman exam (ages 21 and older) per 12 months is covered by MO HealthNet. Physicals are also covered when required as a condition of employment. Diagnosis codes Z00.00 or Z00.01 or diagnosis codes Z01.411 or Z01.419, should be used and billed under the appropriate preventative medicine procedure code (99385-99387 or 99395-99397).

A physician may charge the appropriate E/M procedure code that includes one (1) or more of the following services:

- Obtaining a medical history
- Pelvic examination
- Breast examination
- Preparation of smears (e.g., Pap smear, bacterial smear)

MHD payment for screening and interpretation of a Pap smear can only be made to a clinic or certified independent laboratory employing an approved pathologist (cytologist) or to an individual pathologist (cytologist). All providers of laboratory services must have a Clinical Laboratory Improvements Act (CLIA) certificate.

2.26 MO HealthNet Managed Care Program

MO HealthNet eligible participants who meet specific eligibility criteria receive services through a Managed Care health plan known as the MO HealthNet Managed Care Program. Participants enroll in a health plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the MO HealthNet Managed Care Program can choose their own health plan and primary care provider. Most physician services are included in the Managed Care Program.

Providers are advised to verify MO HealthNet eligibility prior to delivering a service because MO HealthNet eligibility can and often does change. If the patient is a participant in the Managed Care Program, specific procedures must be followed before a service can be rendered. For complete information on the MO HealthNet Managed Care Program, reference the [General Sections Manual](#).

2.27 Hospital Services

Physician Services

All physician services provided in hospital inpatient, outpatient, or emergency room setting must be billed on the professional claim. This policy includes the professional components of radiology and pathology.

MO HealthNet enrolled physicians who are not hospital salaried or contractually compensated by the hospital may bill for their own services, or the group/clinic with whom the physician is associated may bill for the physician services, identifying the performing provider on the professional claim. All services billed by the physician/clinic using the individual provider number must have been performed by the billing provider and there must be documentation in the patient's medical record for each service billed.

Hospital Salaried Physicians

Services provided in the hospital or a clinic that is considered by Medicare as part of the hospital must be billed using the 'All Department' provider identifier in the billing field and the individual who performed the service in the performing field.

All physicians and advanced practice providers who provide services to MO HealthNet participants must enroll individually.

If there are clinics that are considered part of the hospital, then all the individual practitioners providing services in the clinic(s) must also enroll individually.

A hospital may enroll their departments separately only if they have a separate Medicare identifier and National Provider Identifier (NPI) for each department.

Refer to [MMAC Provider Enrollment](#) for more information.

Hospital Care

E/M services on the same date provided in sites other than the hospital that are related to the admission should not be reported separately by the admitting physician, as they are considered part of the initial hospital care. The inpatient care level of service reported by the admitting physician should include the services related to the admission that the physician provided in the other sites of service as well as those in the inpatient setting.

Limitations

- Inpatient hospital lengths of stay are limited to the lesser of:

- The number of medically necessary days billed by the hospital
- The number of days approved through admission and continued stay reviews based on the diagnosis/age/surgery limitations for infants less than one (1) year of age at admission, all medically necessary days are paid
- Daily hospital visits are limited to one (1) per provider per day for each participant
- Hospital discharge day management (99238-99239) is a covered service to report the physician's final examination, continuing care instructions, etc., and can only be billed by the admitting physician. Providers should not bill these procedure codes for completion of the discharge summary only.
- A hospital visit may not be billed on the same date of service as hospital discharge day management (99238)
- A hospital visit for the same patient on the same day as another medical procedure (non-visit type of service) billed by that physician is non-covered
- Services provided in an inpatient or outpatient hospital setting by nursing and/or hospital personnel are not billable services by a physician, for example, starting of IVs, catheterizations, etc.

NOTE: For planning purposes, physicians should be aware of established and special lengths of stay when admitting patients.

2.28 Inpatient Hospital Certification Reviews

Inpatient hospital admissions must be certified as medically necessary and appropriate before MHD reimburses for inpatient services. All MO HealthNet enrolled hospitals in Missouri and bordering states are subject to this admission certification requirement. The State's inpatient review authority will receive all the appropriate information necessary to review admissions subject to admission certification. Refer to the [**Hospital Provider Manual**](#) for more information on Inpatient Hospital Certification Reviews.

2.29 Anesthesia Services

Anesthesia services are covered when performed by an Anesthesiologist, CRNA or AA. Medical direction of anesthesiologists by an anesthesiologist is also a covered service.

Services involving administration of anesthesia are reported using the anesthesia CPT procedure codes (00100-01999) plus the following modifier codes:

Modifier	Description
AA	Anesthesia service performed personally by anesthesiologist
QK	Medical direction of two (2), three (3), or four (4) concurrent anesthesia procedures involving qualified individuals
QX	CRNA/AA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

The service for which anesthesia is billed must be a covered service. The provider of anesthesia services is required to ensure the procedure is a covered service.

Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery or delivery fee, and a separate charge for administration is non-allowed.

An epidural performed as a separate procedure is reimbursable at 100% of the MHD allowable fee, whether a physician or a CRNA performs the service. Injections of anesthetic substance (e.g., epidural), must be billed using the appropriate CPT procedure code (i.e., 62322 or 62326). Providers may only bill using a unit of one (1). Spinal anesthesia is not covered with modifiers AA, QK, QX, and QZ.

Local anesthesia is not covered as a separate service. It is included in the procedure/surgery charge if provided in a physician's office; included in the facility charge if provided in an ASC or outpatient department of a hospital; or included in the accommodation charge for the facility if provided on an inpatient basis.

Anesthesia agents or supplies used in the physician's office prior to the performance of other surgical procedures may be billed by using supply code 99070. An invoice showing the cost, and the description of the supply must be submitted with the claim.

Anesthesia services include the:

- Usual preoperative and postoperative visit
- Anesthesia care during the procedure
- Administration of fluids and/or blood
- Usual monitoring procedures, e.g., monitoring of blood gases, cardiac monitoring

Providers should not bill MHD separately for services that are included in the anesthesia service. Moderate (Conscious) Sedation includes:

- Assessment of the patient
- Establishment of IV access

- Administration of agent(s)
- Maintenance of sedation
- Monitoring of oxygen saturation
- Heart rate
- Blood pressure
- Recovery

The following codes are payable by MHD:

99151	99152	99153	99155	99156	99157
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Insertion of an intra-arterial, central venous, or Swan-Ganz catheter is not included in routine monitoring and may be billed separately.

General Anesthesia for Computed Tomography Scans

There may be an occasional need for anesthesia during Computed Tomography (CT) scan services because of medically necessary circumstances, e.g., hyperactive child, intellectually disabled individual. Procedure code 76499, unlisted diagnostic radiologic procedure, may be billed. A copy of the anesthesia report is required and is manually priced by the State Medical Consultant. Procedure code 01922, anesthesia for non-invasive imaging or radiation therapy, with the appropriate modifier may be billed.

Payment for anesthesia services is determined within the MO HealthNet system and is based on minutes of use, the Anesthesia Relative Value and the conversion factor for the anesthesiologist or CRNA.

Certified Registered Nurse Anesthetist

MHD recognizes qualified CRNAs as independent providers with the capability for direct billing of medical or surgical services if they are allowed to furnish these services under Missouri State law. Payments may be made directly to the CRNA or to the hospital or physician employing or contracting the CRNA.

The CRNA must have a valid license as a registered nurse and maintain current certification from the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

MHD does not reimburse CRNAs for the critical care codes 99291 and 99292, as these procedures are payable only to a physician. However, procedures such as insertion of a Swan-Ganz catheter by a CRNA during a critical care visit are payable.

Inpatient Hospital Services

CRNAs whose services are billed on a professional claim should enroll as MO HealthNet providers. Teaching Department Hospitals may bill with their NPI and enter the CRNA MO HealthNet provider identifier as the performing provider.

Refer to [MMAC Provider Enrollment](#) for more information.

Outpatient Hospital Services

All CRNA services provided in the outpatient department of a hospital must be billed on a professional claim. Hospital-based or contractually compensated CRNAs should be enrolled as MO HealthNet providers to bill for their services. Reimbursement is on a FFS basis. Refer to [MMAC Provider Enrollment](#) for more information.

The billing provider may be the hospital if the CRNA is hospital salaried or contractually compensated. If the CRNA is employed by a physician, the physician may bill for those services using the appropriate modifier. CRNAs who are self-employed and have no financial compensation from the hospital may bill for outpatient hospital services under their own provider identifier, also using the appropriate modifier.

Medical Direction by Anesthesiologist

MHD covers reimbursement to anesthesiologists for medical direction of qualified and licensed anesthetists, i.e., CRNA and AA. CRNAs may or may not be independently enrolled for an anesthesiologist to qualify for medical direction.

Regardless of the employment/contractual relationship that may exist between the CRNA/AA physician/anesthesiologist/hospital, the criteria/protocols present in each facility that dictate the presence of and medical direction by, an anesthesiologist is accepted, if criteria as stipulated in this manual have been/are being met.

MHD does not provide reimbursement for medical direction or supervision of students in a teaching, training, or other setting.

Concurrent Medical Direction

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

For each patient, the physician:

- Performs and documents a pre-anesthetic examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergency
- Ensures that any procedures in the anesthesia plan that the physician does not perform are performed by a qualified individual

- Monitors the course of anesthesia administration at frequent intervals
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

A physician who is concurrently directing the administration of anesthesia should ordinarily not be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area or periodic monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician. However, if the physician leaves the immediate area of the operating suite for other than a short duration or devotes extensive time to other patients or situations, medical direction ends.

Supervision Billing Guidelines

Providers should follow the billing guidelines below:

- All physician claims for anesthesia medical direction are one (1)-line claims limited to anesthesia services provided to individual participants and containing the adjusted total number of minutes of anesthesia rendered to the specific patient
- The modifier to be used for medical direction is QK
- Medical direction is payable to physicians with provider specialty 05 (anesthesiology)
- Bill the anesthesia procedure code for the major procedure on the professional claim
- Procedure codes to be used are the CPT anesthesia procedure codes: 00100- 01999
- When the anesthesiologist and anesthetist are both involved in a single anesthesia service (supervision of only one (1) anesthetist), the service is considered to be personally performed by the anesthesiologist, and the procedure should then be billed using modifier AA. No separate payment is allowed for supervision, nor for the anesthetist's service, regardless of whether the anesthetist (i.e., CRNA) is independently enrolled as a MO HealthNet provider. A separate payment for the CRNA is only payable if documentation is attached showing that it was medically necessary for both the anesthesiologist and the CRNA to be involved. If the CRNA service was not medically necessary, recoupment of the CRNA service may be made.
- Medical direction of two (2), three (3), or four (4) anesthetists is allowed by billing for the adjusted total number of minutes representing the entire procedure(s) appropriate to each participant (regardless of the number of concurrent procedures performed on each participant) as no percentage reductions are made for concurrent procedures. Billing for concurrent medical direction must be adjusted to accurately reflect only that portion of time during which medical direction, as defined, continues to be provided.
- Medical direction by a surgeon may not be billed to MHD

Anesthesiologists in a Group Practice

For those anesthesiologists in a group practice, one (1) physician member may provide the pre-anesthesia examination and evaluation while another furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

Anesthesiologist Services (Dental) Ambulatory Surgical Center

MO HealthNet covers certain dental services in a freestanding ASC facility for those patients who are unable to cooperate in the conventional dental setting due to age, disability, or behavioral health problems. These services include:

- Tooth extraction
- Removal of wisdom/impacted teeth
- Pedodontic restoration which may include one (1) or more of the following:
 - Complete clinical examination
 - Prophylaxis
 - Fluoride treatment
 - Restorations
 - Extractions
 - Removal of wisdom/impacted teeth
 - Pulpotomies
 - Root canals
 - Crowns

Adults with a limited benefit package have restricted dental benefits. Please reference the [Dental Provider Manual](#).

When anesthesia services are performed in an ASC facility for any of the types of dental procedures listed above, the anesthesiologist must bill procedure code 00170 (Anesthesia for intraoral procedures, including biopsy; not otherwise specified). The code is limited to one (1) per participant per date of service using the appropriate anesthesia modifier and place of service 24, ASC.

Enter the total number of minutes on the professional claim. An operative report and anesthesia report are required.

Anesthesia Services for Multiple Surgeries

Anesthesia providers may only bill for one (1) procedure per operative setting using the appropriate anesthesia modifier. When anesthesia is administered for multiple surgical procedures for the same

participant (same operative setting and date of service), only the major surgical procedure may be billed. Anesthesia time for all the procedures should be calculated into total minutes and billed using the major procedure code only. Services may not be billed separately for the other procedures performed.

If the participant was taken back to surgery because of medical complications, a [Certificate of Medical Necessity](#) or Anesthesia Report must be attached documenting surgery performed during another time frame.

Calculation of Anesthesia Services

Base Rate (Relative Value x Conversion Factor) + Time (Time Unit(s) x Conversion Factor) = Maximum Allowable Fee.

- The base rate (Relative Value x Conversion Factor, appropriate for the provider type) is reflected as the 'payment amount' in the pricing file. This is not the total reimbursement amount but is used in the calculation.
- Anesthesia time unit(s): Each 15-minute unit of anesthesia is equal to a time unit of one (1). For instance, an anesthesia service (i.e., administration or supervision) of one (1) hour constitutes a unit value of four (4). However, the total number of minutes of anesthesia (60) must be shown on the professional claim. The system converts into units.
- Increments less than 15 minutes are priced at a percentage of the conversion factor and added to the total amount payable.
 - One-five (1-5) minutes over one (1) unit = 25%
 - Six-nine (6-9) minutes over one (1) unit = 50%
 - 10-13 minutes over one (1) unit = 75%
 - 14-15 minutes over one (1) unit = 100%

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

If more than 15 minutes elapse between the Operating Room (OR) time and the start of surgery, an explanation should be provided in the patient's medical record.

The industry standard for time between transferring the patient to the recovery room and the anesthesia stop time is five (5) to 15 minutes. If it is longer than this, documentation in the patient's medical record should clearly explain the reasons for the prolonged anesthesia time.

The professional claim must reflect the appropriate anesthesia procedure code, modifier, and the actual anesthesia time in minutes.

The system calculates the reimbursement amount based on the above information. This must be entered correctly for the correct payment to be made.

Qualifying Circumstances for Anesthesia

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

Procedure Code	Description
99100	Anesthesia for patient of extreme age, under one (1) year and over seventy
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions (specify)

When reporting one (1) of the above procedure codes, the maximum quantity is always one (1), as reimbursement is based on a fixed maximum allowable amount. Do not use the anesthesia modifiers, AA, QC, QK, or QZ when billing for these specific procedures.

Anesthesia services for surgical procedures requiring an [Acknowledgement of Receipt of Hysterectomy Information](#) form must be accompanied by this document, properly executed, to be allowed. Refer to [Section 3](#) in this manual for more information on documentation requirements.

Anesthesia Non-Covered Services

Any surgical procedure listed as non-covered for surgery is also non-covered for anesthesiology. Anesthesiologist monitoring telemetry in the operating room is a non-covered service.

Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients. Anesthesiologist, CRNA and AA services are not covered in the recovery room.

Anesthesiologist Assistant

MO HealthNet allows an AA to enroll as a MO HealthNet provider. An AA is a person who works under the supervision of a licensed anesthesiologist and provides anesthesia services and related care. They must be licensed by the Missouri Board of Healing Arts as set forth in [20 CSR 2150-9](#), rules and regulations and submit a copy of the license to MMAC. The AA must also submit the name and mailing address of the supervising anesthesiologist. Refer to [MMAC Provider Enrollment](#) for more information.

An AA shall practice only under the direct supervision of an anesthesiologist who is physically present or immediately available. A supervising anesthesiologist shall be allowed to supervise up to four (4) AAs concurrently.

An AA must practice within their scope of practice referenced in [334.402 RSMo](#). This includes:

- Obtaining a comprehensive patient history, performing relevant elements of a physical exam and presenting the history to the supervising anesthesiologist
- Pretesting and calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and monitors, in consultation with an anesthesiologist
- Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques
- Establishing basic and advanced airway interventions, including intubation of the trachea and performing ventilator support
- Administering intermittent vasoactive drugs, and starting and adjusting vasoactive infusions
- Administering anesthetic drugs, adjuvant drugs, and accessory drugs
- Assisting the supervising anesthesiologist with the performance of epidural anesthetic procedures, spinal anesthetic procedures, and other regional anesthetic techniques
- Administering blood, blood products, and supportive fluids
- Providing assistance to a cardiopulmonary resuscitation (CPR) team in response to a threatening situation
- Participating in administrative, research, and clinical teaching activities as authorized by the supervising anesthesiologist
- Performing other tasks not prohibited by law under supervision of a licensed anesthesiologist that an AA has been trained and is proficient to perform

An AA is prohibited from the following:

- Prescribing any medications or controlled substances
- Administering any drugs, medicines, devices, or therapies the supervising anesthesiologist

is not qualified or authorized to prescribe

- Practicing or attempting to practice without the supervision of a licensed anesthesiologist or in any location where the supervising anesthesiologist is not immediately available for consultation, assistance, and intervention

The provider of anesthesia services is required to ensure the procedure is a covered service. An AA and a CRNA are not allowed to bill for the same anesthesia services.

When the anesthesiologist personally performs a service, the procedure should be billed using the AA modifier. No separate payment is allowed for supervision by the anesthesiologist, nor for the AA's service, regardless of whether the AA is independently enrolled as a MO HealthNet provider. A separate payment for the AA is only payable if documentation is attached showing that it was medically necessary for both the anesthesiologist and the AA to be involved. If the AA service was not medically necessary, recoupment of the AA service may be made.

Reference the MO HealthNet [Fee Schedule](#) for coverage and reimbursement information. AA codes are listed under Anesthesia-CRNA/AA.

2.30 Surgery

Surgical services under the MO HealthNet Program are covered as described in this manual, and are also subject to certain restrictions, limitations, exclusions, and requirements, as specified.

Orthopedic Surgery Casting, Removal, and Materials

Application of casts, strapping and splints (29000-29584) are replacement procedures only to be used during the 30-day post-operative period if the casting is performed due to a complication (e.g., patient fell and broke cast, wound infection) or after the 30-day postoperative period. Subsequent visits are payable only if additional services were provided at the time of cast application.

Codes for cast removal (29700-29710) should be used only for casts applied by another physician.

Reference the appropriate [Healthcare Common Procedure Coding System \(HCPCS\)](#) codes for cast supplies.

Electromagnetic Treatment of Fractures Using Noninvasive Osteogenesis Stimulator Device

CPT procedure code 20974, Electrical stimulation to aid bone healing; non-invasive (non-operative), is a covered service for treatment of:

- Nonunion of long bone fractures (one (1) cm or less)
- Failed fusion
- Congenital pseudoarthrosis

This procedure requires [PA](#).

The patient's history, general medical information, prior orthopedic history, present diagnosis and condition, and prescription measurements must be visible on the corporate (supplier) orthopedic prescription form signed by the prescribing physician.

The prescription form and a [PA Request](#) must be submitted for review by the State Medical Consultant and returned to the supplier dispensing the stimulator, indicating approval or denial. Refer to the [General Sections Manual](#) for information on [PA](#) request procedures.

The fee includes x-ray evaluation and consultation by the physician's medical staff, fabrication and loan (six (6) months or more) of a treatment unit calibrated to the patient's site specifications, shipping, and any necessary servicing or technical support.

Routine Foot Care/Debridement of Nails

MO HealthNet does not cover routine foot care. This involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement or reduction), and other hygienic or preventive maintenance.

Foot care is not considered routine when the claim indicates the participant has a diagnosis of diabetes mellitus or other peripheral vascular disease (e.g., diabetes with peripheral circulatory disorders, Raynaud's Syndrome, thromboangiitis obliterans, and other specified peripheral vascular disease).

When coding unilateral or bilateral debridement of nails, procedure code 11720 (debridement of nail(s) any method, one (1) to five (5)) or procedure code 11721 (same, six (6) or more), the number of units of service (quantity) should be one (1) for each procedure code.

Assistant Surgeon

MO HealthNet adheres to the guidelines set by Centers for Medicare & Medicaid Services (CMS) for assistants at surgery. Only physicians may be considered assistant surgeons. Follow-up care provided by the assistant surgeon is subject to the 30-day postoperative policy as described in this manual. Refer to [Section 2.32](#) in this manual for more information.

The services of an assistant surgeon are billed with modifier 80. Reference the [Medicare Physician Fee Schedule Relative Value File](#) (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the assistant surgeon column of the database instruct carriers how to reimburse for services.

NOTE: Not all codes in the listing are covered by MO HealthNet; refer to the MO HealthNet [Fee Schedule](#) for additional information.

An assistant surgeon's fee is payable at 20% of the surgeon's fee for the surgical procedure. Only one (1) assistant surgeon can be paid for those procedures that warrant an assistant.

If the surgeon's claim is systematically priced, the assistant surgeon's claim is also systematically priced. If the surgeon's claim is manually priced, the assistant surgeon's claim is also manually priced, and an operative record must be attached to the claim for payment.

The surgeon and assistant surgeon must each submit separate professional claims for services provided, using their individual provider number.

MHD does not reimburse for the services of an assistant surgeon when a co-surgeon is used.

A clinic may submit a single professional claim for the surgeon and assistant surgeon, using the clinic's provider number and must also include each individual provider's number as the performing provider.

NOTE: For assisting at cesarean deliveries, the appropriate procedure code for the delivery only must be billed, regardless of whether the surgeon billed the global procedure. A 'global' delivery indicates that the prenatal care, delivery and postpartum care are provided by a single physician; therefore, global delivery procedure codes may not be billed by the assistant surgeon.

Co-Surgeon's Services (Two Surgeons)

'Co-surgeons' are defined as two (2) primary surgeons working simultaneously to perform distinct parts of a total surgical service during the same operative session. Reimbursement is based on 100% of the major procedure for the primary surgeon and 62.5% for the secondary surgeon.

MO HealthNet adheres to guidelines set by CMS for co-surgeons. Reference the [MPFSRVU](#) (MPFSDB). The MPFSRVU (MPFSDB) indicators in the co-surgeon column of the database instruct carriers how to reimburse for services.

The surgeon and co-surgeon must file separate claims, each using their own individual MO HealthNet provider number. The surgical procedure code together with modifier 62 (Two (2) Surgeons) should be shown on both claims. The name of both surgeons must appear on the claim form in the 'Description' area.

NOTE: Not all codes in the listing are covered by MO HealthNet; refer to the MO HealthNet [Fee Schedule](#).

Multiple Surgical Procedures

When multiple surgical procedures are performed for the same body system through the same incision, the major procedure is considered for payment at 100% of the allowable fee for the procedure. No reimbursement is made for incidental procedures.

Multiple surgical procedures performed on the same participant, on the same date of service, by the same provider, for the same or separate body systems through separate incisions must be billed in accordance with the following guidelines:

- The major, secondary, and tertiary procedures should be indicated on the claim form using appropriate CPT codes. The major, secondary, and tertiary procedures are usually determined by the allowed amount of the procedure code. The procedure with the highest allowed amount is considered the major procedure.
- A copy of the Operative Report may be attached to claims for multiple surgeries to provide additional information. If not attached, a copy may be requested to assist with the claim

processing.

Claims for multiple surgeries are allowed according to the following:

- 100% of the allowable fee for the major procedure
- 50% of the allowable fee for the secondary procedure
- 25% of the allowable fee for the tertiary procedure

Exception to Multiple Surgical Procedures

An exception to the multiple surgical procedure policy is diagnostic endoscopies. When more than one (1) diagnostic endoscopy is performed on the same day with the same or different approaches, but different instruments, both are reimbursable at 100% of the allowable fee for the procedure.

When more than one (1) diagnostic endoscopy is performed on the same day using the same approach and the same instrument, only the major procedure is payable.

Hysterectomies

In accordance with Federal Regulations [42 CFR 441.251](#), [42 CFR 441.252](#), [42 CFR 441.255](#), and [42 CFR 441.256](#) regarding Sterilization by Hysterectomy:

A. A hysterectomy is not a MO HealthNet covered service if:

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

B. A hysterectomy is a MO HealthNet covered service if:

- The conditions in paragraph A of this section do not apply
- The person who secured authorization to perform the hysterectomy has informed the individual and her representative (e.g., legal guardian, husband), if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing
- The individual or her representative, if any, has signed a written [Acknowledgement of Receipt of Hysterectomy Information](#) form prior to surgery. The completed form must be attached to the MHD claim at the time the claim is submitted for payment.

C. Exceptions to the requirement for an [Acknowledgement of Receipt of Hysterectomy Information](#) form may be made in the following situations:

- The individual was already sterile before 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 an 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 retroactive to this time. 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 to one (1) of the following situations:
 - The individual was informed before the operation that the hysterectomy will make her permanently incapable of reproducing, and the procedure is not excluded from MO HealthNet coverage under “A”
 - The individual was already sterile before the hysterectomy
 - The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. A description of the nature of the emergency must be included

A **Certificate of Medical Necessity** cannot be used for procedures that require the **Acknowledgement of Receipt of Hysterectomy Information** when performed as an emergency procedure.

Acknowledgement of Receipt of Hysterectomy Information

Refer to the MO HealthNet **Fee Schedule** for procedures that require an **Acknowledgement of Receipt of Hysterectomy Information** form.

All providers (surgeon, assistant surgeon, anesthesiologist, hospital) must present all required documentation. It is the secondary provider's responsibility to obtain the necessary certification from the performing physician.

Requirements concerning hysterectomies apply to an individual of any age. Hysterectomies are not to be reported as family planning services.

The **Sterilization Consent Form** may not be used in lieu of the **Acknowledgement of Receipt of Hysterectomy Information** form. Refer to **Section 3** in this manual for more information on documentation requirements.

Sterilizations

Sterilization is defined as any medical procedure, treatment, or operation performed 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 and must always be reported as family planning services.

It is important to correctly identify family planning services by both diagnosis and procedure code, since the federal financial participation rate of the payment for these procedures is 90% (rather than the normal rate of approximately 60%). The remaining percentage is funded by state general revenue.

The **Sterilization Consent Form** should be completed and submitted separately from a claim via **eMOMED** or by mail to the following:

Wipro Infocrossing
PO Box 5900
Jefferson City, MO 65102

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. For any emergency voluntary sterilization service provided in non-bordering states for which a consent form is required, a consent form approved for use in another state may be accepted, providing it includes all the federally prescribed content and the same required information that the Missouri-approved form contains.

The **Sterilization Consent Form**, as described above, must be completed and signed by the participant at least 31 days, but not more than 180 days, prior to the date of the sterilization procedure. There must be 30 days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. The only exceptions to these time requirements are for situations involving premature delivery or emergency abdominal surgery.

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

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 advised the individual of all the following information or advice:

- 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, and it does not cause the loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.
- Have been given a description of available alternative methods of family planning and birth control
- The sterilization procedure is considered permanent and irreversible
- Given a thorough explanation of the specific sterilization procedure to be performed, verbally and in writing
- The discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthetic to be used
- Given a full description of the benefits or advantages that may be expected because of the sterilization
- 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 either the language used on the **Sterilization Consent Form** or the language used by the person obtaining consent
- 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 by:

- The individual to be sterilized. The Sterilization Consent Form must be signed and dated at the same time and will not be returned to the provider for addition of the participants missing signature or date. If either of these requirements is not met, the procedure will be denied.
- The interpreter (if one was necessary)
- The person who obtained the consent (on or after the date of the participant signature)
- The physician who performed the sterilization. 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.

All applicable items of the Sterilization Consent Form must be completed.

The date of the sterilization must match the date of service on the claim form.

Per **42 CFR 441.253**, the participant must:

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

A **Certificate of Medical Necessity** cannot be used for procedures that require the **Sterilization Consent Form** when performed as an emergency procedure.

2.31 Postoperative Care

Postoperative care includes 30 days of routine follow-up care for those surgical or diagnostic procedures having a MHD reimbursement amount of \$75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ASC or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing facility)

Pain management is considered part of postoperative care. Visits for the purpose of postoperative pain control are not separately reimbursable.

Physician services are audited against claims that have already been paid as well as against those claims currently in process.

Supplies necessary for providing the follow-up care in the office, such as splints, casts, and surgical dressings in connection with covered surgical procedures that meet the postoperative care policy, may be billed under the appropriate supply code. Providers should also attach an invoice if applicable. Refer to [Section 6](#) in this manual for procedure code information.

Physician Services Subject to Postoperative Restriction

The following procedures are subject to the postoperative editing when billed within 30 days after the date of a surgical procedure. These services are included in the postoperative care and are not billable as separate services.

Office or Other Outpatient Services

99202	99204	99211	99213	99215
99203	99205	99212	99214	

Home Medical Services

99341	99343	99345	99348	99350
99342	99344	99347	99349	

Hospital Inpatient Services

99231	99233	99235	99238	
99232	99234	99236	99239	

Nursing Facility Care

99304	99306	99308	99310	99316
99305	99307	99309	99315	

Residential Care Facility I (RCF-I) and Residential Care Facility II (RCF-II)

99341	99342	99342	99349	
99342	99342	99342	99350	

Emergency Department Services

99281	99282	99283	99284	99285
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Unlisted Evaluation and Management Services

99499

Preventive Medicine Services

99381	99384	99387	99393	99396
99382	99385	99391	99394	99397
99383	99386	99392	99395	

Ophthalmologist

92002	92004	92012	92014	
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Special Services Codes

99050	99051	99053	99056	99058
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Exceptions

Exceptions to the postoperative care policy may be reimbursed for complications or extenuating circumstances that have been documented and determined to be exempt by the State Medical Consultant. In addition, the following services are exempted from the postoperative policy limitations:

- Initial hospital visits to allow payment for physician services when a patient is admitted to the hospital on the same date of service as a surgery (procedure codes 99221, 99222, 99223)
- Consultations (99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255)
- Renal dialysis (90935, 90937)
- Physician services provided prior to the date of surgery (For deliveries, if billing the global delivery code, this includes all routine prenatal care, in addition to 30- day postoperative care.)
- All surgeries or procedures billed having a reimbursement amount of less than \$75.00
- Newborn care (99460, 99461, 99462, 99465)
- Suture removal:
 - If the sutures are removed by the same physician who performed the surgery, the charge is included in the surgical fee and is not paid separately
 - If another physician removes the sutures, use code 99202 or 99211

Postoperative Care Other than the Surgeon

Postoperative care is non-covered when rendered by another member of a group or corporation to which the operating surgeon belongs when the second physician's specialty is the same as the operating surgeon. Postoperative care by another member of a group or corporation whose specialty is different from the surgeon is payable.

Postoperative care by a physician other than the surgeon is payable if:

- The diagnosis treated is not related to the surgery
- The illness would have required hospitalization in its own right
- The surgeon would not be expected to handle the condition

2.32 Separate/Incidental Procedures

Some procedures are commonly carried out as an integral part of a total service and as such do not warrant a separate identification. However, when such a procedure is performed independently of, and is not immediately related to other services, it may be listed as a 'separate procedure.' Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure. Providers should attach copies of the operative report(s) for the medical consultant's review in these instances.

Examples: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue is removed, or when debridement is carried out separately without immediate primary closure (11042-11047). Simple ligation and exploration of blood vessels, nerves or tendons in an open wound is part of wound closure and is not paid separately.

Surgeries considered incidental to, or a part of another surgical procedure, performed on the same day, are not paid separately, but rather are included in the fee for the major procedure. The following are examples of procedures that are included in the reimbursement and not paid separately when incidental to other specified services.

- Anoscopy, proctosigmoidoscopy, sigmoidoscopy, prior to diagnostic, or therapeutic colonoscopy
- Application of cast with open or closed reduction of a fracture
- Application of dressing, casts, and/or splints with tendon repair
- Biopsy of breast prior to a mastectomy
- Biopsy of mesentery, omentum, and peritoneum when performed with another abdominal surgery
- Control of postoperative bleeding (e.g., tonsillectomy, removal of prostate (TUR), hemorrhoidectomy, hysterectomy)
- Debridement (simple) of an open wound prior to skin graft or repair of laceration
- Diagnostic dilation and curettage (uterus), salpingo-oophorectomy prior to hysterectomy, same day
- Diagnostic endoscopy; preceding surgery, same day, using the same approach and the same instruments
- Exploratory laparotomy when it is the route of entry for another abdominal surgery
- Insertion of T-tube, Penrose drain, Foley catheter, chest tube, hemovac, etc., during surgery and removal after
- Iridotomy or iridectomy when performed with cataract extraction

- Laminotomy, craniotomy or thoracotomy, preceding surgery, same approach, same day
- Laparoscopy preceding laparotomy
- Local or regional anesthesia by surgeon or obstetrician
- Lysis of abdominal adhesions, when another abdominal surgery (e.g., colon resection, hysterectomy, etc.) is performed
- Mobilization of the intestine during abdominal surgery
- Obtaining a donor graft
- Pharyngoscopy, laryngoscopy, tracheoscopy, when performed with bronchoscopy or esophagoscopy with upper gastrointestinal endoscopy
- Removal of packs (e.g., nasal, uterine, etc.) after insertion
- Urethral catheterization and calibration preceding cystourethroscopy
- Ureteral endoscopy preceding renal endoscopy through established nephrostomy

2.33 Unlisted Services or Procedures

A service or procedure not listed in the CPT book may be considered for payment. However, the procedure must be related to an unusual or complicating situation involving a MO HealthNet covered service, as identified in the CPT book or a specific [MO HealthNet Provider Manual](#). When reporting such a service, the appropriate 'Unlisted Procedure' code must be used to indicate the service, identifying it by 'Special Report.' Pertinent information attached to the claim for payment should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. All claims are manually reviewed by the state medical consultant for appropriateness and payment.

An unlisted procedure code is not to be used when a code is already available in the CPT book or is otherwise described in this manual.

Not all services contained in the CPT book are covered by MO HealthNet. Some codes, although defined and contained in the CPT book as updates, additions, deletions, or revisions may not yet be on file and are, therefore, non-covered. Procedures that are not covered or are not on file, are non-covered and should not be billed using any of the 'Unlisted' or '99' codes.

2.34 Limiting Certain Surgical Procedures to Other than an Inpatient Basis

Many minor surgeries/procedures are such that they are considered 'office' procedures. Others, while more difficult, can be performed in an adequately staffed and equipped office, an ASC, or outpatient department of the hospital.

Inpatient hospital admissions must be certified as medically necessary and appropriate before MHD will reimburse for inpatient services. MO HealthNet has generally adopted those procedures identified by Medicare that can be performed safely in an ASC as outpatient procedures. MHD currently provides facility payment to MO HealthNet enrolled ASC facilities for procedures identified by Medicare as ASC procedures.

The criteria used considers risk factors, existing co-morbidities, the planned course of treatment on admission, and other factors that justify inpatient admission for performance of the procedure. Reference the [Hospital Provider Manual](#) for more information.

2.35 Non-Covered Services

Non-covered services may be billed to the participant. Refer to [Section 2.37](#) in this manual for non-allowable services which may not be billed to the participant.

Services beyond those normally covered under the MO HealthNet Program may be approved for those participants under the age of 21 who are eligible for HCY services, based on the medical necessity of the service/procedure. These services may require [PA](#). Refer to the [HCY Provider Manual](#) for more information.

To determine whether a service is covered by MO HealthNet, contact Provider Communications at (573) 751-2896, toll-free at (833) 222-7916, or via [eMOMED](#).

Although it is not possible to list every situation or procedure that is non-covered through the Physician Program, the following list has been compiled:

- Acupuncture
- ~~Acupuncture is covered through the Complementary Health and Alternative to Chronic Pain Management program, refer to [Section 2.66](#) in this manual for more information~~
- Ambulance service to the physician's office
- Autopsy (postmortem examination)
- Ballistocardiogram
- Biofeedback services
- Clinical studies, trials, testing, experimental, and investigational medical procedures, drugs, equipment, etc.
- Contact lenses
- Cosmetic surgery directed at improving appearance (e.g., augmented mammoplasty, face lifts, rhinoplasty)
- Ear piercing
- Foot care (routine)

- Foot care for diabetes mellitus and other peripheral vascular diseases are not considered routine and are covered
- Garter belts, elastic stockings, Jobst and pressure garments for hand and arms, Spenco boots, and other foot coverings
- Hair transplants
- Implantation of nuclear-powered pacemaker
- Keloids, excision of (unexposed areas of body)
- Necropsy (Autopsy)
- Occupational therapy services (age 21 and over)
- Orthopedic shoes or supportive devices for the feet for ages 21 and over
 - Orthopedic shoes, when an integral part of the brace, may be obtained through the Durable Medical Equipment (DME) Program, refer to the [DME Provider Manual](#) for more information
- Penile prostheses or insertion of
- Personal comfort items
- Preparation of special reports sent to insurance companies
- [Puberty Blockers used for gender change](#)
- Psychiatric reports for court evaluation or juvenile court
- Reimbursement for medical direction or supervision of students in a teaching, training or other setting
- Salpingoplasty
- Services rendered anywhere when a physician is not in attendance and in direct supervision of the service except where exempt as stated in [Section 2.15](#) in this manual
- Sex therapy
- Speech therapy (except as training in use of an artificial larynx for participants age 21 and over)
- Tattoos, removal of
- Treatment of infertility
- Surgical procedures for gender change such as:
 - Hysterectomy
 - Mammoplasty

- Mastectomy
- Orchiectomy
- Penectomy
- Penile construction
- Release of vaginal adhesions
- Revision of labia
- Vaginal dilation
- Vaginal reconstruction
- Vaginoplasty
- Treatment of impotence
- Tuboplasty vasovasostomy (sterilization reversal)
- Vials of insulin (covered under Pharmacy Program, refer to the [Pharmacy Provider Manual](#))
- Vitamin injections (Refer to the [Pharmacy Provider Manual](#))
- Weight control, unless criteria in [Section 2.51](#) is met

2.36 Non-Allowable Services

The following services are included in the MHD provider's reimbursement for the procedure/surgery and are not separately allowable, billable to the participant, or to the MO HealthNet Program as office/outpatient visits, or in any other manner:

- Administration of medication/injection (if the patient is examined/treated as the service is included in the office/outpatient visit or other procedure performed)
- Assistant surgery fees for surgeries/procedures identified by Medicare as non- payable
- Canceled or 'no show' practitioner appointments
- Cast removal when the cast was applied by the same physician
- Catheterization for a urine specimen in the office
- Claim filing
- Debridement of a laceration and abrasion with immediate primary closure of wound
- Drawing fees
- Follow-up visits for interpretation of the tuberculin tests Purified Protein Derivative (PPD) or Tine when office visits are within two (2) to five (5) days of the test

- Handling and/or conveyance of a specimen to an independent laboratory for interpretation
- Hospital visits for the same patient on the same date of service as another medical procedure billed by that physician
- Incidental surgical procedures performed through the same incision
- Incorrect billing
- Intralesional injections
- Local anesthesia
- Medical testimony
- Office visits to obtain a prescription, the need of which had already been ascertained
- Postage
- Professional fees for 'Clinical Diagnostic Laboratory Procedures'
- Removal or placement of sutures by the operating physician/surgeon
- Routine postoperative care following a surgery or procedure
- Services not directly related to the participant's diagnosis, symptoms or medical history, or services in excess of those deemed medically necessary to treat the patient's condition
- Services considered part of a MO HealthNet covered service/procedure
- Services or supplies covered through another MO HealthNet Program
- Services or supplies furnished free of charge by any governmental body (e.g., injectable material)
- Telephone calls
- Venipuncture for the purpose of obtaining a blood specimen

2.37 Pathology and Laboratory

Clinical Diagnostic Laboratory Procedure Reimbursement

Section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369) contains guidelines for reimbursement for certain clinical diagnostic laboratory services and is applicable to physicians (individual or group practices), independent laboratories, and outpatient hospitals. These guidelines contain a requirement that MHD reimbursement may not exceed the national limitation amount.

Outside Laboratory Reimbursement

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

- In their hospital's laboratory
- By an independent laboratory enrolled as a MO HealthNet provider under an arrangement which 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 which documents that the hospital is responsible for billing the services provided by the independent laboratory

Providers need document the instances above and keep a copy of this documentation, as well as the appropriate CLIA certification on file, and be able to provide the information upon request.

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

Please note that facility charges cannot be billed if laboratory services are the only services provided during a visit.

Clinical Laboratory Improvement Amendments Requirements

Under the CLIA of 1988, all laboratory sites, including independent laboratories, hospitals, physician offices, nursing facilities, etc., 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; or be exempt by virtue of the fact that the laboratory is licensed by an approved state program.

CLIA requires all laboratories to meet quality standards, to be certified by DHSS Bureau of Hospital Licensing and Certification, and hold the proper certificate for the tests performed. Providers must have the appropriate CLIA certification on file with MMAC to allow accurate claims processing. A copy of the certificate(s) is required to ensure that the provider files contain all the necessary information.

The CLIA number is a ten-digit number. Laboratories are initially issued either a registration certificate or a certificate of waiver as appropriate. The registration certification is valid for a period of two (2) years, or until the laboratory is inspected or accredited as meeting CLIA standards. The schedule for inspections is based on the number of tests a laboratory performs. Regulations mandate biannual onsite surveys. The goals are to ensure safe and accurate laboratory work, to preserve patient access to clinical tests, and to encourage technological innovation.

MO HealthNet uses the [Categorization of Tests](#) found on the CMS website for codes subject to CLIA edits, codes exempt from CLIA edits, list of CLIA Waived tests, list of Physician Performed Microscopy Procedures (PPMP) and the Clinical Diagnostic Laboratory Tests. Refer to [CMS CLIA](#) for more information.

Laboratory Test Codes that Include Preparation Only

Claims submitted for special stains, technical component, or preparation only are not subject to CLIA requirements. However, providers billing only the professional component, or the technical and professional components combined, are subject to the CLIA requirements and must be registered with the CLIA program.

The following information provides billing guidelines for laboratory services. A physician order must be retained by the billing laboratory for each service billed. Physician orders must be individualized; standing orders are not acceptable.

Professional and Technical Component, Laboratory Service

- Must be billed on a professional claim only
- May only be billed by the provider who processes and interprets the specimen
- May never be billed in inpatient or outpatient place of service
- May be billed by physicians/clinics (including FQHCs and provider based RHCs) and independent laboratories with CLIA certification
- Referring physician's NPI is required when billed by independent laboratory
- Diagnosis required

Professional Component, Laboratory

- Must be billed on a professional claim
- May only be billed by provider interpreting the specimen
- May be billed by physician/clinics (including FQHCs and provider based RHCs) or independent laboratory (when CLIA certified)
- Referring physician's NPI is required if provider is independent laboratory
- Diagnosis required

Technical Component, Laboratory

- When billing for clinical diagnostic laboratory procedures, the technical component is the only appropriate component to bill
- Must be billed on a professional claim for physician billing
- May only be billed by provider who processes the specimen
- Must be billed on UB-04 claim form for outpatient hospital billing
- The technical component may never be billed for services provided on an inpatient basis
- May be billed by physician/pathologist or independent laboratory (when CLIA certified)

- Referring physician's NPI is required when biller is independent laboratory
- Diagnosis required

Billing Codes When the 26/TC Modifiers Do Not Apply

Some codes listed for professional/technical component modifiers have indicators that the concept of a professional/technical component does not apply. When procedure codes have these indicators, the codes should be billed without a modifier. For the complete listing of indicators refer to the 26/TC indicator column on the [MPFSRVU](#).

Multi-Test Laboratory Panels

Providers should refer to the CPT book for the appropriate procedure codes for multi-test laboratory panels. The panel components are not intended to limit the performance of other tests. If medically necessary additional tests are performed in addition to those specifically indicated for a particular panel, those tests may be billed separately in addition to the panel code.

To bill a panel procedure code, it is required that all indicated components in a panel test be performed on the same date of service. If all components of a specific panel are performed on the same date of service, each test must not be unbundled and billed separately. The panel procedure code must be billed. Any laboratory tests performed on the same date of service that are included in the panel must not be billed in addition to the panel procedure code. The laboratory must have the appropriate CLIA Certificate for all laboratory tests performed.

Drug Screening Tests

Qualitative (presumptive) and semi-quantitative drug screening tests are covered by the MO HealthNet Program. Providers should refer to the CPT book for appropriate procedure codes to reflect testing on single or multiple drug classes. A drug screen test reports what drug classes (e.g., tricyclic antidepressants, phenothiazines, amphetamines, benzodiazepines, barbiturates, cannabinoids, methadone, opiates) are present (qualitative) and may provide an estimate (semi-quantitative) of the concentration. An initial drug screen or preliminary test that yields qualitative or semi-quantitative results must be reported with an appropriate drug testing procedure code categorized as such in the CPT book. Codes in the Therapeutic Drug Assay or Chemistry Sections of the CPT book may not be used to report qualitative (presumptive) or semi-quantitative drug screening and preliminary test results.

The MO HealthNet Program only covers quantitative (definitive) or 'confirmative' tests (i.e., procedure codes from the Therapeutic Drug Assay or Chemistry sections of the CPT book) if there is a positive screen for the drug class to be quantified and if the physician has documented the medical necessity in the patient medical record.

Physician offices may bill for initial drug screens performed at point of care (e.g., by use of CLIA waived test devices) or independent and/or hospital laboratories may bill for screenings they performed. Both providers cannot bill for the same date of service for the same participant.

Ordering Physician Responsibilities

The ordering physician has the following responsibilities:

- Must coordinate the billing of the drug screen tests with the performing laboratory
- Must document medical necessity in the patient medical record when ordering quantification of a drug class or a confirmatory drug test
- Must sign each order for drug screening tests by signing a paper order, or by electronic signature that conforms with the requirements of [13 CSR 65-3.050](#). The requirements state that an electronic signature means a computer data compilation of any symbol or series of symbols executed, adopted, or authorized by an individual with the intent to be the legally binding equivalent of the individual's handwritten signature. The use of biometrics does not constitute an electronic signature; however, biometrics may be used as part of electronic signature verification. A signature stamp does not constitute an electronic signature.

Performing Laboratory Responsibilities

The performing laboratory has the following responsibilities:

- Must ensure the physician has provided documentation of medical necessity when requesting quantification of a drug class or a confirmatory drug test
- Must not perform quantification of a drug class or a confirmatory drug test without documentation of medical necessity

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Testing

Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) testing is a covered service when the participant's physician has reason to believe that tests should be performed to rule out AIDS. Some indications for AIDS testing include frequent drug use, hemophilia, patients who are sexually active, and those having frequent blood transfusions.

Co-Receptor Tropism Assay (Profile)

Patients diagnosed with AIDS who have evidence of viral replication may be screened with Profile testing to receive a new class of drugs. This blood test determines whether a patient will respond to the drugs classified as CCR5 antagonists.

The Trofile test must be done to determine the necessity for the CCR5 antagonist drug Selzentry® (maraviroc). If the Trofile test is not performed, Selzentry® (maraviroc) will not be covered without additional justification for medical necessity. Refer to the [SmartPA Criteria Proposal](#) for clinical criteria for Selzentry® (maraviroc).

Lead Screening

Laboratory tests for blood lead levels are covered by MO HealthNet for all ages and are reimbursed in addition to the office visit and/or HCY screening. Procedure code 83655 is payable to the laboratory processing the specimen. Reimbursement for obtaining the specimen (drawing fee) is included in the reimbursement for the office visit and/or HCY screening and must not be billed to the patient.

Refer to the [HCY Provider Manual](#) for more information regarding HCY lead screening and lead assessments.

Hemostasis

Prothrombin time, prothrombin consumption, thrombin time, clotting time, bleeding time, thromboplastin (PTT), platelet count, etc., are covered for the diagnostic and/or therapeutic approach to disorders of hemostasis. Anticoagulation therapy (Heparin, Coumadin) must be documented in the diagnosis box of the claim form 'on anti-coagulant,' except when billing for an independent laboratory.

Skin Testing

Tuberculosis Test

Tuberculosis (TB) intradermal test is a covered MO HealthNet service. This procedure is exempt from the CLIA requirements.

Providers must bill for the medication used during the test through the pharmacy claim form in [eMOMED](#), or other electronic equivalent, using the NDC. The test itself should be billed with the appropriate CPT code.

Allergy Sensitivity Tests

Allergy sensitivity tests are selective cutaneous and mucous membrane tests in correlation with the patient's history, physical examination, and other observations. The number of tests performed should be based upon the history, physical findings, and clinical judgment. All patients should not necessarily receive the same tests nor the same number of sensitivity tests.

When billing for allergy testing, indicate on the professional claim the number of individual tests performed, since these procedures instruct the biller to 'specify number of tests.'

Allergen Immunotherapy

Office visit codes may be billed in addition to allergen immunotherapy only if other identifiable services are provided on the same date. Examples of other identifiable services are:

- Stinging insect venom, single dose vials are covered
- Services billed using the unlisted allergy/clinical immunologic service or procedure code is reviewed and manually priced by the State Medical Consultant. Clinical documentation must be attached to the claim.
- Syringes used for self-administration must be billed with a unit of one (1) using the appropriate supply procedure code. An invoice showing the cost, description, and quantity

must be submitted with the professional claim.

NOTE: An invoice is not required for the therapeutic allergen.

Radioallergosorbent Tests

Providers should use the appropriate procedure code that represents the radioallergosorbent testing provided. The number of tests provided should be reflected in the number of units billed.

Smears and Cultures

The following identifies smears and cultures covered services:

- Diagnosis and treatment of acute infection
- Bacterial, fungi, microplasma, endotoxin, tissue, virus, tubercle cultures, etc.
- Sensitivity studies
- Wet and dry mount smears

The following identifies smears and cultures non-covered services:

- Thayer-Martin used in venereal disease testing
- Bacterial smear and cultures of the same area on the same date of service; only the culture is payable

Carcinoembryonic Antigens

Carcinoembryonic Antigens (CEA) tests are payable only for cancer of the colon, stomach, pancreas, or lung.

The test employing the reagent must be used with other tests that are acceptable for diagnosing cancer or a test for tumor growth recurrence in patients who have had a tumor irradiated or removed surgically.

Urinalysis

Clinical pathology urinalysis codes must be consistent with the diagnosis (disease, procedure).

A clean-catch kit to collect a clean-voided midstream specimen for culture is covered in the physician's office by billing the appropriate supplies and materials procedure code. An invoice showing the cost and the description of the supply must be submitted with the claim.

Routine urinalysis is non-covered except for monthly prenatal visits and new patient examinations (when applicable). When billing the global prenatal codes or global prenatal/delivery codes, the fee for this procedure includes all urinalysis testing during the prenatal period and is not covered separately.

Simple catheterization of the urethra to collect a urine specimen is included in the fee for the office visit and is not separately covered.

Culture media (e.g., agar, broth egg base, Thayer-Martin, culturette) are part of the culture and are not paid separately.

When microscopy and urinalysis are performed on the same date of service, use the urinalysis procedure code only. Do not bill separately.

Pap Smears

Pelvic examinations and obtaining the specimen for a Pap smear are included in the reimbursement for the office visit. Processing and interpreting the Pap smear are only payable to a CLIA certified facility employing a pathologist (cytologist).

Cytopathology

Procedures for cytopathology services must be performed by a pathologist. Therefore, these procedures and types of service are appropriate only in settings with appropriate CLIA registration certificates.

A unit of service for these codes is the specimen and is defined as tissue or tissues submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. The diagnosis(es) is/are required. Two (2) or more such specimens from the same patient (e.g., separately identified endoscopic biopsies, skin lesions) are each appropriately assigned an individual procedure code reflective of the proper level of service.

Any unlisted specimen should be assigned to the code that most closely reflects the physicians work involved when compared to other specimens assigned that code. Reference the CPT book for a full explanation of specimens within each level.

Therapeutic Apheresis (Plasma and/or Cell Exchange)

Therapeutic apheresis is a medical procedure utilizing specialized equipment to remove selected blood constituents (plasma or cells) from whole blood and return the remaining components to the person from whom the blood was taken. Other supplies, e.g., IV fluids, must be billed on the pharmacy claim form using the NDC.

2.38 Hospice

The hospice benefit is designed to meet the needs of patients with terminal illnesses and to help their families cope with the problems and feelings related to this difficult time. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care.

Refer to the MO HealthNet [Hospice Provider Manual](#), for specific program information.

Reimbursement for Hospice Services

When a participant elects hospice services, the hospice provides or arranges for all care, supplies, equipment, and medicines related to the terminal illness. MHD reimburses the hospice provider who then reimburses the provider of the service(s).

Services not related to the terminal illness are available from any MO HealthNet participating provider of the participant's choice. The provider of these services is reimbursed directly by MHD.

Identification of Hospice Participants

Services related to the terminal illness must be billed by, and reimbursed to, the hospice provider elected by the participant. Therefore, it is important that all providers be able to readily identify participants who have elected hospice services.

When providers verify participant eligibility, the hospice participant is identified by a lock-in provider. Eligibility may be verified by calling (573) 751-2896, toll-free (833) 222-7916, or the provider may use **eMOMED** to verify eligibility and inquire on third party resources. Refer to the **General Sections Manual** for more information.

When a participant's hospice election begins, the participant must present the MHD Hospice Enrollment Computer-Generated Letter to the provider, along with their MO HealthNet ID card, new approval letter, or replacement letter. This is necessary to alert other providers of medical services, e.g., ambulance, DME, home health, hospital, nursing facility, personal care, and pharmacy providers of the restrictions on billing. Non-hospice providers are encouraged to contact the hospice indicated in **eMOMED** when they have questions about whom to bill for a specific service.

If the participant dis-enrolls from hospice services, MHD issues a letter to the participant acknowledging the disenrollment that the participant must present, along with the MO HealthNet ID card, to providers to obtain services that can be billed directly to MHD.

Attending Physician

The attending physician is a doctor of medicine or osteopathy and is identified by the individual at the time the individual elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care. The attending physician is the participant's physician of choice who participates in the establishment of the plan of care and works with the hospice team in caring for the patient. The attending physician must certify that the patient is terminally ill with a life expectancy of six (6) months or less. The physician must sign the **Physician Certification of Terminal Illness** within eight (8) days of the date of the hospice election. MHD requires continuous re-certifications every 60 days after the second period. Subsequent re-certifications may be documents on the **Physician Certification of Terminal Illness**. The physician continues to give the medical orders and may have privileges in the hospice inpatient care.

MHD reimburses the hospice participant's attending physician directly if the physician is not employed by the hospice provider. The services are reimbursed at the lower of the physician's billed charges or the MHD maximum allowable amount.

2.39 Physician Services in Nursing Facilities

Title XIX Patients in Nursing Facilities

The following is a summary of physician services required for MO HealthNet residents in a Title XIX facility and are usually performed in the nursing facility (NF). The list below includes both federal and state licensing requirements. For more information, reference the [**Nursing Home Provider Manual.**](#)

- A thorough medical history and physical examination (assessment) of each resident must be performed and entered into the resident's record of admission to a MO HealthNet bed
- The physician must see the resident every 30 days for the first 90 days and at least every 60 days thereafter
- The physician must review and sign the medical orders when the physician sees the resident. State rules require that physician orders must be signed every other calendar month.
- There must be an assessment performed at least annually with the portion of it pertaining to the medical condition of the resident established by the physician. In addition, an assessment must be done whenever there is a significant change in the resident's condition.
- All physician telephone orders must be signed within seven (7) days

Nursing Facility or Intermediate Care Home Patients (Not Title XIX)

The following are physician services for MO HealthNet residents not in a Title XIX facility:

- There must be a medical examination at the time of admission or within 30 days prior to admission, then annually thereafter
- There must be physician certification at the time of admission or prior to MHD payment that NF or intermediate care home services are necessary
- There must be a physician recertification of need for these services every 12 months
- There must be a written plan of care established by a team of professionals, of which the physician is a member. The plan of care must be reviewed every 90 days by the team.
- All orders prescribed by the physician must be signed
- All orders must be renewed in writing every 90 days

2.40 Nursing Facility Services

Two (2) major subcategories of NF services are recognized: Initial NF Care and Subsequent NF Care. Both subcategories apply to new or established patients. Initial assessments may be performed at one (1) or more sites in the assessment process: the hospital, office, NF, domiciliary/non-NF or patient's home.

When the patient is admitted to the NF in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office), all E/M services provided by that physician in conjunction with that admission are considered part of the initial NF care and POS 32 (NF) should be entered on the professional claim.

The (single) level of service reported by the admitting physician should include all services related to the admission the physician provided in the other site(s) of service as well as in the NF setting, except for hospital discharge services, which may be reported separately.

The annual NF assessment is to be billed using CPT procedure codes 99307 through 99310.

For those participants who have both Medicare and MO HealthNet coverage, the annual NF assessment may be billed directly to MHD.

2.41 Advance Health Care Directives

OBRA 90, Section 4715(1)(58), requires each state to develop a written description of the law of the state concerning advance directives. An advance directive allows participants to designate a person to make certain health decisions for them at a future time in which the participant may be incapacitated.

The following MO HealthNet providers who receive Title XIX (Medicaid) payments are subject to the OBRA 90 requirements concerning advance health care directives and are required to follow certain rules and procedures:

- Hospitals
- NFs
- Home health care providers
- Personal care service providers
- Hospice providers
- Health Maintenance providers

2.42 Psychiatry

Psychiatric services are those services rendered by a physician (psychiatrist), a Psychiatric Clinical Nurse Specialist (CNS), or a Psychiatric Mental Health Nurse Practitioner (PMHNP), who deals with the study, treatment, and prevention of mental illness.

Documentation for each service provided must be contained in each participant's medical record at the specific location the services were rendered. All time-based services require documentation of start and stop times. For information on guidelines and limitations for psychotherapy, refer to the [**Behavioral Health Services Provider Manual**](#).

Psychiatric Treatment Plan

A treatment plan is a plan of action developed by the provider using information gathered during the assessment and/or testing. The treatment plan must include the psychosocial information, scope, frequency, duration of services, short-term goals, long-term goals, and discharge plan. A separate reimbursement is not allowed for the development of a treatment plan.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is covered as a second or third line treatment for major depressive disorder and bipolar depression and is limited to a series of two (2) sessions per week for a three (3) to five (5) week period in conjunction with drug management. A [Certificate of Medical Necessity](#) attached to the claim is necessary if a third ECT per week is required.

Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is a non-invasive method of brain stimulation. The technique involves placement of a small coil over the scalp and passing a rapidly alternating current through the coil wire, which produces a magnetic field that passes unimpeded through the brain. Refer to the [Behavioral Health Services Provider Manual](#) for more information on TMS.

Definition of Psychiatric Emergency Admission for Children

It is important for psychiatric hospitals serving children and youth 20 years of age and under to determine whether an admission is an emergency.

The type of admission determines if the certification of need for inpatient services and the medical/psychiatric/social evaluation must be made by an independent team or by the hospital's interdisciplinary team. Information may be requested from the attending physician as part of this review.

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

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

Psychiatry Limitations

- Telephone consultations are non-allowable
- Team management/staffing are non-allowable
- Only one (1) of the following is covered on a single date of service:
 - Office/outpatient visit
 - Home visits (including residential care facility and school)
 - Hospital visit
 - Psychotherapy (individual or group)
 - Psychiatric diagnostic
 - ECT

- Narcosynthesis
- Psychiatric services are not covered for diagnoses relating to intellectual disabilities
- Subsequent hospital visits, using the appropriate level of service, may be allowed on the days that the patient is seen but therapy is not done
- Group therapy (90853) may not be billed on the same date of service as family therapy (90846 or 90847) unless the participant is inpatient, in a residential treatment facility, or custodial care facility
- Psychiatrists and advanced practice nurses should utilize either the appropriate E/M code or the appropriate psychotherapy code. The billing of a combination of psychotherapy and E/M code for a single date of service by the same billing or performing provider is not allowed.

Services Provided in Group Home, Home, and School

A group home is a childcare facility, which approximates a family setting, provides access to community activities and resources, and provides care to no more than two (2) to 12 children. When providing therapy to a group of children in a group home, 90853 is billed with POS 14 (Group Home).

Group therapy is not covered in the home (POS 12) for a family unit living under the same roof. If therapy is provided to a family unit, family therapy must be billed. Settings which do not necessarily approximate a family setting, but whose purpose is to provide one (1) shelter for a group of individuals (homeless or pregnant teens), group therapy is billed instead of family therapy with POS 14 (Group Home).

Services provided in a public school must be billed using POS 03 (School). Services provided in a private school setting must be billed using POS 99 (Other Place of Service).

Modifier U8 must be used when submitting claims for POS 12 (Home) or 99 (Other). The U8 modifier is not appropriate when billing 90853, regardless of the POS.

2.43 Dialysis

Hemodialysis and peritoneal dialysis services are covered through the MO HealthNet Program.

An E/M code (99221-99233) may be billed on the same day that an inpatient dialysis treatment was provided if a significant, separately identifiable service is rendered.

All E/M services related to the patient's End Stage Renal Disease (ESRD) that are rendered on a day when dialysis is performed and all other patient care services that are rendered during the dialysis procedure are included in the dialysis procedure.

Dialysis Physician Services

Monthly End Stage Renal Disease

Procedure codes 90951 through 90962 (based on the patient's age) are used for the monthly supervision of ESRD patients.

The appropriate code should be used for ongoing monitoring of the patient, regardless of whether a service is rendered on every day of the month. When billing for monthly supervision, identify only the first date of the month as the date of service and '1' for the number of units. The Monthly ESRD procedure codes are reported once per month and should not be used if the patient is hospitalized during the month.

Daily End Stage Renal Disease Services

If the physician is not involved in continuous supervision of the patient, or becomes involved late in the month, daily visits must be billed. When billing supervision for less than a full month (procedure codes 90951 through 90967 (based on the patient's age), identify the first day of dialysis to the last day of dialysis. The number of units must equal the number of days within the range of dates. If treatment periods within a month are interrupted (i.e., hospitalization), providers should bill on separate lines for each continuous period using these same guidelines. Daily visits are not to be billed for ongoing/monthly supervision.

Example: Patient is admitted to the hospital as an inpatient on July 11 and discharged on July 27, which is 17 days of hospitalization. The appropriate daily ESRD dialysis procedure code is billed as July 1-July 10 = 10 days and July 29 - July 31 = three (3) days, for a total of 13 days billed.

Example: Patient is in the hospital on July 1 and discharged on July 3, which is three (3) inpatient days for July. The appropriate daily ESRD procedure code is billed from July 4 - July 31 = 28 days billed.

Daily visits are not to be billed for ongoing/monthly supervision.

NOTE: Monthly and daily supervision are not to be billed in the same month.

Hemodialysis/Miscellaneous Dialysis Services

Procedure codes 90937 (hemodialysis procedure requiring repeated evaluations) and 90947 (dialysis procedure other than hemodialysis requiring repeated evaluations) are only acceptable when performed on an inpatient hospital basis.

Procedure codes 90935 (hemodialysis) and 90945 (dialysis procedure other than hemodialysis) may be performed on an inpatient basis, in freestanding dialysis centers located within or outside the premises of the hospital.

Freestanding Dialysis Centers

The technical component of dialysis provided in a freestanding dialysis clinic must be billed on the professional claim using procedure code 90999 SU.

Continuous Ambulatory Peritoneal Dialysis and Hemodialysis in the Home

Continuous Ambulatory Peritoneal Dialysis (CAPD) is a MO HealthNet covered service. This method of treatment frees patients from the confinement of a machine and from the dietary restrictions associated with intermittent hemodialysis or peritoneal dialysis.

Reimbursement of Dialysis Facility Training Fee

A training fee is payable to the dialysis facility that has responsibility for furnishing training to the patient. Dialysis and hemodialysis training services and supplies include personnel services (including home visits, if necessary), dialysis supplies, parenteral items routinely used in dialysis, training manuals and materials, and routine laboratory tests.

Procedure code 90989 (Dialysis training, patient including helper where applicable, any mode, completed course) must be billed by the dialysis facility using POS 65 (ESRD Treatment Facility), with a quantity of one (1). Each patient trained must be billed using the individual's MO HealthNet ID number. The date of service to be used is the first day of training. This is a one (1) time only procedure and covers all training provided by the facility.

Procedure code 90993 (Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session) must be billed by the dialysis facility using POS 65 (ESRD Treatment Facility), and the number of training sessions completed as the quantity.

NOTE: Procedure code 90993 must never be billed if reimbursement has been made for procedure 90989.

Dialysis and Hemodialysis in the Home

Hemodialysis and peritoneal dialysis services may be performed in the following POS:

POS Code	POS Description
12	Home
31	Skilled NF
32	NF
33	Custodial Care Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)

Refer to [Section 4.7](#) in this manual for more information on POS codes.

The maximum allowable reimbursement for home dialysis/hemodialysis services is \$1,599.00 per month regardless of the frequency of the treatments. Reimbursement for claims processed over this dollar amount is reduced or denied. The following guidelines provide specific billing information:

Procedure Code	Description	Maximum Units
S9335	Hemodialysis Procedure, with Single Physician Evaluation, in the Home	13
S9339	Dialysis other than Hemodialysis, with Single Physician Evaluation, in the Home	31

Providers may bill for hemodialysis services on the professional claim using a separate line for each date of service and a unit of one (1). More than one (1) date of service may be billed on each claim. The provider number of the supervising physician must be shown as the performing provider on the professional claim.

Providers may bill 'From-Thru' dates for consecutive days of dialysis provided within the same month. However, care must be taken to assure that the days billed match the number of units billed on the professional claim.

If dates of service are not consecutive or are not within the same month, separate lines must be used for each non-consecutive date of service and for consecutive dates that span more than one (1) month. The NPI of the supervising physician must be shown as the performing provider on the professional claim.

Items and Services Included in the Composite Rate

The following items and services are covered and included in the composite rate and must be furnished by the facility, either directly or through arrangements, to all MO HealthNet dialysis patients. Items and services include, but are not limited to:

- Medically necessary home dialysis equipment
- Home dialysis support services, which include the delivery, installation, maintenance, repair, and testing of home dialysis and support equipment
- Purchase and delivery of all necessary home dialysis supplies including things such as weight scales, sphygmomanometer, IV stand, dialysate heaters, and consumable and disposable supplies such as dialysate, tubing, and gauze pads
- All dialysis services furnished by the facility's staff
- ESRD related laboratory tests at the frequencies specified below. Any test furnished in excess of the frequency listed, or any test furnished that is not listed is covered only if there is documentation of its medical necessity.
 - Every Month:
 - Albumin

- Alkaline Phosphatase (ALP)
- Aspartate Aminotransferase (SGOT)
- Blood Urea Nitrogen (BUN)
- Calcium
- Carbon Dioxide (C02)
- Creatinine
- Dialysate Protein
- Hematocrit (HCT)
- Hemoglobin (Hgb)
- Lactate Dehydrogenase (LDH)
- Magnesium
- Phosphate
- Potassium
- Sodium
- Total Protein
- Every three (3) months:
 - Platelet Count
 - Red Blood Cell
 - White Blood Cell
- Every six (6) months:
 - 24-hour Urine Volume
 - Bone Mineral Density
 - Chest X-Ray
 - Electrocardiograms (EKG/ECG)
 - Motor Nerve Conduction Velocity (MNCV)
 - Residual Renal Function

Other examples (but not an all-inclusive list) of items and services that are covered in the composite rate and may not be billed separately when furnished by a dialysis facility are:

- Staff time used to administer blood

- De-clotting of shunts and any supplies used to de-clot shunts
- Oxygen and the administration of oxygen
- Staff time used to administer separately billable parenteral items

Medications are not included in the composite rate and may be billed separately.

Hospital-Based Dialysis Clinics

Outpatient or Home Services

The following revenue codes are used to bill for dialysis performed in the outpatient setting.

Revenue Code	Description
0821	Hemodialysis
0831	Peritoneal Dialysis
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD)
0851	Continuous Cycling Peritoneal Dialysis (CCPD)

2.44 Ophthalmology/Optical

Physicians (Medical Doctor (M.D.) or Osteopathic doctor (D.O.)) must use 92002 through 92499 when billing for eye examinations or special ophthalmological services.

Physicians who also dispense eyeglasses or artificial eyes must obtain an optical provider number to receive reimbursement for optical services.

Billing Ophthalmology Services

The following procedure codes should be used to bill for ophthalmology services:

Procedure Codes	Description
92002 through 92014	General services
92015 through 92140	Special services
99221 through 99223* 99281 through 99285*	Hospital, emergency department and other institutional medical services
65091, etc.	Report surgical services, see surgery procedure codes, eye and ocular adnexa

*Unless specific ophthalmological codes (92002 through 92499) are more appropriate

2.45 Otorhinolaryngology

Vestibular Function Tests

CPT procedure codes 92531 through 92548 and 92700 should be used for billing vestibular function test services.

Audiology

Audiologist Employed by a Physician

If an audiologist is employed by a physician and works in the same office suite as the physician, audiological services covered through the MO HealthNet Physician Program may be billed under the physician's MO HealthNet ID number. The provisions of [Section 2.15](#) in this manual apply which state in part:

"Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the auxiliary personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel is performing services."

Medical records must be co-signed by the billing provider to signify that the physician was present at the time the service was rendered.

Audiologist in Private Practice

When an audiologist works in a different location than the physician and receives referrals from a physician, the audiologist must be enrolled as a MO HealthNet provider and bill under the hearing aid MO HealthNet provider ID number. Refer to [MMAC Provider Enrollment](#) for more information.

A referral by a physician is required for an adult patient who has a pre-existing medical condition that would be adversely affected without these services. The referral must include the referring physician's name and NPI number, type of services needed, and medical condition. The diagnosis must be related to a medical condition and supporting documentation must be retained in the patient's file.

Diagnostic Audiology Services

The following procedure codes are covered for individuals 21 and over when performed by an audiologist. These procedure codes must be billed with an SC modifier (Medically necessary service or supply) and must be ordered by a physician.

Procedure Code	Description
92552	Pure tone audiometry, threshold; air only
92553	Pure tone audiometry, threshold; air and bone

92556	Pure tone audiometry, threshold; with speech recognition
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92567	Tympanometry, impedance testing
92568	Acoustic reflex testing; threshold

2.46 Cardiovascular

Electrocardiogram

EKGs/ECGs (93000) must be consistent with the diagnosis/medical condition for which care is received, e.g., angina, chest pain, congestive heart failure, tachycardia, bradycardia, and myocardial infarction.

ECGs are non-covered; e.g., prior to each hospital admission or surgery or when performing physical examinations, unless medically indicated.

Interpretation of an ECG (93010) in the hospital or nursing home is paid to the consulting physician, not to the attending physician.

A cardiovascular stress test (93015) and an EKG/ECG are not payable for the same participant on the same date of service. Only the cardiovascular stress test is payable.

An echocardiogram and EKG/ECG may be allowed for the same participant on the same date of service.

EKG monitoring by an anesthesiologist during surgery should not be billed separately.

Cardiac Rehabilitation

Cardiac rehabilitation is a covered service through the outpatient department of the hospital. Procedure codes 93797 (Outpatient cardiac rehabilitation without continuous ECG monitoring) and 93798 (Outpatient cardiac rehabilitation with continuous ECG monitoring) cover the equipment and personnel needed to provide outpatient hospital services. A facility code may not be billed by the hospital on the same date of service unless a physician provided services on that day.

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician, have a documented diagnosis of acute myocardial infarction within the preceding 12 months, have had coronary bypass surgery, or have stable angina pectoris.

Cardiology Services Requiring Prior Authorization

Effective February 2, 2026, MO HealthNet's Radiology Benefit Manager, [HealthHelp](#), will begin managing certain Cardiology Services. Prior Authorization (PA) will be required for the newly added procedure codes in the table below.

All PA requests must be initiated by an enrolled MO HealthNet provider. Requests must meet the clinical edit criteria established by the MHD contractor, HealthHelp. Clinical guidelines for the procedure codes requiring PA are available on the [HealthHelp](#) website.

Requests for PA can be submitted using [CyberAccess](#), through the [HealthHelp](#) portal or by calling the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 option five (5). Ordering providers are responsible for providing the rendering provider with a copy of the PA number for billing purposes.

PAs are reviewed and approved on an individual patient basis. Each PA must specify the performing provider. Performing providers must be certified through the HealthHelp DiagnosticSite program to receive a referral from an ordering provider. Refer to the [HealthHelp](#) Website for additional information regarding DiagnosticSite.

Prior Authorization for Cardiology Services Managed by HealthHelp

Procedure Code	Procedure Description
32701	Thorax Stereo Rad Target/Tx
33202	Insert Epicard Eltrd Open
33203	Insert Epicard Eltrd Endo
33215	Reposition Pacing-Defib Lead
33218	Repair Lead Pace-Defib One
33220	Repair Lead Pace-Defib Dual
33222	Relocation Pocket Pacemaker
33223	Relocate Rocket for Defib
33226	Reposition L Ventric Lead
33236	Remove Electrode/Thoracotomy
33237	Remove Electrode/Thoracotomy
33238	Remove Electrode/Thoracotomy
33243	Remove Eltrd/Thoracotomy
33270	Ins/Rep Subq Defibrillator
33271	Insj Subq Impltbl Dfb Eltrd
33272	Rmvl of Subq Defibrillator

Procedure Code	Procedure Description
33273	Repos Prev Impltbl Subq Dfb
33274	Tcat Insj/Rpl Perm Ldls Pm
33275	Tcat Rmvl Perm Ldls Pm W/Img
33285	Insj Subq Car Rhythm Mntr
33286	Rmvl Subq Car Rhythm Mntr
33289	Tcat Impl Wrsl P-Art Prs Snr
33340	Perq Clsr Tcat L Atr Apndge
33361	Replace Aortic Valve Perq
33362	Replace Aortic Valve Open
33363	Replace Aortic Valve Open
33364	Replace Aortic Valve Open
33365	Replace Aortic Valve Open
33366	Trcath Replace Aortic Valve
33418	Repair Tcat Mitral Valve
33875	Thoracic Aortic Graft
33877	Thoracoabdominal Graft
33880	Endovasc Taa Repr Incl Subcl
33881	Endovasc Taa Repr W/O Subcl
33883	Insert Endovasc Prosth Taa
33886	Endovasc Prosth Delayed
33975	Implant Ventricular Device
33976	Implant Ventricular Device
33977	Remove Ventricular Device
33978	Remove Ventricular Device
33979	Insert Intracorporeal Device

Procedure Code	Procedure Description
33980	Remove Intracorporeal Device
33981	Replace Vad Pump Ext
33982	Replace Vad Intra W/O Bp
33983	Replace Vad Intra W/Bp
33990	Insj Perq Vad L Hrt Arterial
33991	Insj Perq Vad L Hrt Artl&Ven
33992	Rmvl Perq Left Heart Vad
33993	Reposg Perq R/L Hrt Vad
33995	Insj Perq Vad R Hrt Venous
34701	Evasc Rpr A-Ao Ndgft
34702	Evasc Rpr A-Ao Ndgft Rpt
34703	Evasc Rpr A-Unilac Ndgft
34704	Evasc Rpr A-Unilac Ndgft Rpt
34705	Evac Rpr A-Biiliac Ndgft
34706	Evasc Rpr A-Biiliac Rpt
34830	Open Aortic Tube Prosth Repr
34831	Open Aortoiliac Prosth Repr
34832	Open Aortofemor Prosth Repr
35301	Rechannelling Of Artery
36465	Njx Noncmpnd Sclrsnt 1 Vein
36466	Njx Noncmpnd Sclrsnt Mlt Vn
36470	Njx Sclrsnt 1 Incmptnt Vein
36471	Njx Sclrsnt Mlt Incmptnt Vn
36475	Endovenous Rf 1st Vein

Procedure Code	Procedure Description
36476	Endovenous Rf Vein Add-On
36478	Endovenous Laser 1st Vein
36479	Endovenous Laser Vein Addon
36482	Endoven Ther Chem Adhes 1st
36483	Endoven Ther Chem Adhes Sbsq
37215	Transcath Stent Cca W/Eps
37216	Transcath Stent Cca W/O Eps
37217	Stent Placemt Retro Carotid
37218	Stent Placemt Ante Carotid
37700	Ligation&Div Long Saph Vein
37718	Lig Div&Strpg Short Saph Vn
37722	Lig Div&Strpg Long Saph Vein
37735	Lig&Div&Compl Strpg Saph Vn
37760	Lig Prfratr Vn Radical 1 Leg
37761	Ligate Leg Veins Open
37780	Revision Of Leg Vein
37785	Ligate/Divide/Excise Vein

2.47 Physical Medicine

The following guidelines apply to all eligible participants unless the therapy is identified as medically necessary because of an HCY screening for participants under age 21.

Physical medicine codes 97012-97799 are provided to assist in the diagnosis, recovery, and rehabilitation of patients with neuromuscular, orthopedic, and other disabilities, when prescribed by a physician.

Physical medicine services may be performed in an office, clinic, home, or outpatient department of the hospital. Physical medicine services performed on an inpatient basis are not separately reimbursable but rather are included in the hospital's per diem rate.

Payment for 97010 (application of a modality to one (1) or more areas; hot or cold packs) is bundled into the payment for all other services including, but not limited to, office visits and physical therapy. The patient cannot be billed separately for this service.

Physical medicine modalities or procedures must be performed by or supervised by a physician. Physical medicine codes 97012-97799 are not covered for adults receiving a limited benefit package.

Modalities and Procedures Limitations

- A limited level of service (99211) may be billed on the same date of service for follow-up therapy
- A 'special report' describing the procedure must accompany the claim for procedure code 97039, unlisted modality (specify) and 97139, unlisted procedure (specify)
- Diathermy (97024) is non-covered for the treatment of asthma, bronchitis, etc.
- Spinalator treatment is non-covered
- Massage therapy (97124) is only paid if used in conjunction with another physical therapy procedure
- Electrical stimulation (97014) is covered for the treatment of spasticity, incapacitating muscle spasm and semiparesis
- Manipulation of spine requiring anesthesia, any region (22505), does not include E/M services (99202-99215 or 99221-99233)
- Procedure code 97010 (application of hot or cold packs) is not covered. Payment for application of hot and cold packs is bundled into payment for all other services including, but not limited to, office visits and physical therapy and the patient cannot be billed separately for this service.

2.48 Nervous System

Transcutaneous Electrical Nerve Stimulator (TENS) rental and/or purchase and the application of the battery-operated portable TENS unit are only covered by MO HealthNet under the HCY Program. Referrals for these services should be made to a DME provider.

Physical therapy modalities and procedures (97000 series) as listed in the CPT book, may be used for treatment. Procedure code 97010 (application of hot or cold packs) is not covered. Payment for application of hot and cold packs is bundled into payment for all other services including, but not limited to, office visits and physical therapy. The patient cannot be billed separately for this service.

Referrals for these services should be made to participating DME providers.

2.49 Digestive System

Nutritional Supplements

There are many patients who, because of chronic illness or trauma, cannot ingest enough food orally to support healing and maintain normal activities of daily life. These people must use an alternative method of nutritional therapy, either parenteral nutrition or enteral tube nutrition, depending upon the patient's medical condition. Long term enteral therapy via a feeding tube (i.e. gastrostomy or jejunostomy tube) is covered under the MO HealthNet Physician Program. Use the appropriate CPT code for surgery.

Enteral Feedings for Age 21 and Over

Nutritional supplements such as Ensure, and Sustacal are non-covered for participants age 21 and over. Non-covered services may be requested through the MO HealthNet exception process. (Refer to the [Exceptions Provider Manual](#).) For participants residing in NF's, these supplements are included in the NF) per diem.

Enteral Feedings for Age Zero to 20

Nutritional supplements such as Ensure, Sustacal, infant formula, and Phenylketonuria (h) nutrition are MO HealthNet covered services for individuals age 0-20 through the HCY Program. Refer to the [DME Provider Manual](#) for the restriction guidelines.

Total Parenteral Nutrition

Cut down placement of central venous catheter, for the parenteral administration of greater than customary amounts of nutrients into a large central vein for those patients who cannot eat, and a constant vascular access for those patients requiring venipuncture(s) who have no peripheral access available, are covered services under the MO HealthNet Physician Program.

Total parenteral nutrition (TPN) and supplies used to administer TPN are covered services under the DME Program. Refer to the [DME Provider Manual](#) for policy guidelines.

Total Parenteral Nutrition for Nursing Facility Residents

TPN is covered under the DME Program for participants in a nursing home. Refer to the [DME Provider Manual](#) for policy guidelines.

2.50 Obesity

Surgical Treatment of Obesity

The surgical treatment of obesity is covered by MO HealthNet when the treatment is an integral and necessary course of treatment for a concurrent or complicating medical treatment.

Procedures for bariatric surgery, gastroplasty, laparoscopic sleeve gastrectomy, stomach, and gastric bypass for morbid obesity are covered surgical procedures when one (1) or two (2) of the following criteria, and number three (3) must be met:

1. Body Mass Index (BMI) greater than 40 with or without a co-morbid condition, or
2. BMI of 35-40 and at least one (1) of the following co-morbid conditions:
 - Secondary diabetes mellitus
 - Diabetes mellitus
 - Essential hypertension
 - Hypertensive heart disease
 - Hypertensive chronic kidney disease
 - Hypertensive heart and chronic kidney disease
 - Secondary hypertension
3. Must be non-smoker/tobacco user or provide evidence of smoking/tobacco-cessation

The following codes must be prior authorized. A [PA Request](#) and supporting documentation must be submitted to the fiscal agent for processing. Refer to the [General Sections Manual](#) for additional information regarding PA.

Procedure Codes

43644	43645	43645	43645	43645	43645	43645
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Procedure codes 43770 through 43774 are covered by MHD for patients if the above criteria are met, but do not require a PA request.

When billing MHD for surgical services related to obesity, the primary diagnosis must be for a concurrent or complicating medical condition. The claim should reflect obesity as a secondary diagnosis.

Biopsychosocial Treatment of Obesity

MHD reimburses for Biopsychosocial Treatment of Obesity services. These services are for youth and adults enrolled in MO HealthNet FFS and Managed Care.

Biopsychosocial Treatment of Obesity provides integrated Medical Nutrition Therapy (MNT) and behavioral health services, coordinated by the primary care or referring physician, or other licensed practitioner, to facilitate behavior changes to manage obesity and associated co-morbidities for youth and adult participants.

This program offers services consistent with the United States Preventive Services Task Force (USPSTF) recommendations for intensive, multicomponent behavioral interventions to improve weight status for adults and children/youth with obesity.

Refer to the [Behavioral Health Services Provider Manual](#) for more information.

2.51 Case Management

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

Case Management Provider Enrollment Criteria

To provide and bill for case management services, a provider must be enrolled as a case management provider with MO HealthNet. Upon approval, a specialty code of Case Management, or Targeted Case Management—Children EPSDT, is added to the existing provider file.

To be eligible for participation as a MO HealthNet case management provider, the following must be met:

- Have at least two (2) years' experience in the development and implementation of coordinated individual maternal and child health plans
- Be able to demonstrate the ability to ensure that every pregnant woman and infant/child being case managed has access to comprehensive health services
- Have a minimum of one (1) year experience in the delivery of public health or community health care services including home visiting
- Employ licensed registered nurses (RNs), licensed clinical social workers, or social workers with a Masters in Social Work (MSW), with a minimum of one (1) year experience as medical social work, certified nurse practitioners, physician assistants, or licensed physicians (MD or DO) case managers who have knowledge of:
 - Federal, state, and local entitlement and categorical programs related to children and pregnant women such as Title V, WIC, Prevention of Intellectual Disability, Children and Youth with Special Health Care Needs, etc.
 - Individual health care plan development and evaluation
 - Community health care systems and resources
 - Perinatal and child health care standards (American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), etc.) and the ability to:
 - Interpret medical findings
 - Develop an individual case management plan based on an assessment of client health, nutritional status, psycho/social status, and personal and community resources
 - Reinforce client responsibility for independent compliance

- Establish linkages among service providers
- Coordinate multiple entity services to the benefit of the client
- Evaluate client progress in accessing appropriate medical care and other needed services
- Educate clients regarding their health conditions and implications of risk factors

Refer to [MMAC Provider Enrollment](#) for more information.

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

Case Management for Pregnant Women

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

Case management services should be explained to the participant, with each assessed for needs on an individual basis. Services reviewed may include but are not limited to those which will assist individuals to gain access to needed medical, social, educational, or other services that promote the health of participants. Only MO HealthNet participating providers who meet the prenatal case management criteria, as established by MHD, are eligible for reimbursement of prenatal case management services for participants considered 'at risk' as a result of the appraisal.

A list of prenatal case management providers can be found in [Section 6.2](#) of this manual.

Procedure Codes for Case Management for Pregnant Women

Procedure Code	Description
H1001TS	Prenatal care, at risk enhanced service; antepartum management; follow up service
H1001	Prenatal care, at risk enhanced service; antepartum management; Limited to one (1) per participant per provider per calendar month
H1004	Prenatal care, at risk enhanced service; follow-up home visit; Limited to one (1) per participant per provider per calendar month
H1001TS52	Prenatal care, at risk enhanced service; antepartum management; follow-up, reduced service
G9012	Other specified case management service not elsewhere classified

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

Case management services are exempt from cost sharing.

*The initial case management for pregnant women visit must be provided prior to the date of delivery.

Healthy Children and Youth Case Management

Medically necessary case management services under Section 1905(a) of the Social Security Act are covered for persons under the age of 21 through the HCY Program. Refer to the [HCY Provider Manual](#) for information about the HCY Program.

HCY case management is an activity under which responsibility for locating, coordinating, and monitoring necessary and appropriate services for a participant rests with a specific individual or organization. It centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment 'loop.'

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

Health care providers should be aware of this service so that patients who have a medical need for such services can be referred to a case management entity. HCY case management services require [PA](#), unless otherwise stated and are limited as follows.

Initial Month—Healthy Children and Youth Case Management

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

Procedure Code	Description	Restrictions
T1016EP	Case Management, Child, Month with initial visit	PA required and limited to one (1) per child per provider

Subsequent Months—Healthy Children and Youth Case Management

Subsequent months of case management should be billed using procedure code T1016EPTS. This code cannot be billed during the same month as the initial case management visit.

Procedure Code	Description	Restrictions
T1016EPTS	Case Management, HCY	PA Required

Prior Authorization Process for Healthy Children and Youth Case Management

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

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

Emergency requests may be submitted to BSHCN by calling (573) 751-6246 or by fax to (573) 751-6237.

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

For information on completing the **PA Request**, refer to the **General Sections Manual**.

Healthy Children and Youth Case Management Assessment and Care Plan

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

Contact Provider Communications via **eMOMED** or at (573) 751-2896 or toll-free (833) 222-7916 for more information.

Lead Case Management for Children Services

Children with one (1) blood lead level of 20 micrograms per deciliter (µg/dL) or greater, or who have had two (2) venous tests at least three (3) months apart with elevations of 15 µg/dL or greater must be referred for case management services through the HCY Program. To be reimbursed for these services the lead case management agency must be an enrolled provider with MO HealthNet. Refer to [MMAC Provider Enrollment](#) for more information.

The following procedure codes have been established for billing lead case management. [PA](#) is not required.

Lead Case Management with Initial Visit

Procedure code T1016UA (Lead case management, with initial visit) should be used for admission to case management within two (2) weeks of receiving a confirmatory blood-lead level. This includes client/family assessment, establishes a point of contact, and reinforcing education provided by health care providers. The client/family will be provided the case manager's name and telephone number. The higher the blood lead level, the timelier the initial visit should occur.

Procedure Code	Description
T1016UA	Lead Case Management, Month with Initial Visit

Lead Case Management, Subsequent Months

Procedure code T1016UATS should be used for the three (3) month encounter following initial encounter to assess progress of the affected child and review and reinforce client/family education and medical regime.

This procedure code should also be used for the six (6) to seven (7) months after the initial encounter which includes discharge counseling regarding lead status and ongoing nutrition and environmental maintenance. Discharge is contingent upon the following three (3) conditions being met:

- Blood lead level remains less than 15 µg/dL for at least six (6) months
- Lead hazards have been removed
- There are no new exposures

Other reasons for discharge may include:

- Blood lead level remains below 20 µg/dL for one (1) year. This closure reason is intended for use in cases where all efforts to reduce a child's blood lead level have been made (e.g, hazards in the home environment have been reduced, personal hygiene, nutritional, and housekeeping behaviors have been appropriately modified, etc.), yet the child's body burden of lead causes the child's blood lead level to consistently remain between 15-20 µg/dL.

- Refusal of service
- The child is older than 72 months of age
- Unable to locate

A minimum of three (3) client/family case management encounters, all face-to-face, are mandatory. If more than three (3) case management fees are billed per participant, documentation of medical necessity and copies of progress notes are required for the additional visits and must be attached to the claim. These encounters must be at two (2) to three (3) month intervals, all being face-to-face.

Procedure Code	Description
T1016UATS	Lead Case Management

Lead Case Management Services Documentation

The following information must be included in the client record:

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

Additional Lead Case Management Services

- Case management of children with elevated blood levels greater than 20 µg/dL may be continued beyond the minimum of three (3) encounters until two (2) acceptable blood-lead levels are documented
- Encounters must be at two (2) to three (3) month intervals, all being face to face
- Documentation must be attached to the claim to include validation of the blood- lead level and significant interaction. Procedure code T1016UATS should be billed.

Reference the [Bureau of Special Health Care Needs \(BSHCN\) Area Offices map](#), which are MO HealthNet enrolled case management agencies. If a case management provider cannot be located for the child, contact the area BSHCN office located on the BSHCN Area Office County Listing for case management assistance.

2.52 Obstetric Services

Obstetric Panel

The obstetric panel (80055) must include the tests listed in the CPT book. Billing for these procedures individually or in addition to the obstetric panel is not allowed, regardless of the procedure code or method used. However, these panel components are not intended to limit the performance of other medically necessary tests, which when performed in addition to those specifically indicated for a particular panel may be reported separately. Refer to [Section 2.38](#) in this manual for additional laboratory panel information.

Ultrasound Exams (Sonograms) in Pregnancy

Routine ultrasounds are not indicated in normal pregnancies. However, MHD reimbursement is available for up to three (3) ultrasound procedures during any one (1) rolling year when reasonable and necessary based on medical indication(s).

More than three (3) ultrasounds provided during a rolling year must be medically necessary. All services must be adequately recorded in the patient's record and must demonstrate appropriateness of use in proper diagnosis, management, and treatment of pregnancy-complicating or potentially complicating conditions.

Denied services may not be submitted for exception consideration; however, a medical review of a denied service may be requested. Referring physicians are encouraged to include information regarding the patient's diagnosis for use by the billing provider. Failure of medical records to adequately document and support the utilization of ultrasonography procedures shall result in the recovery of all payments made for these services at the provider's liability.

This policy of limitation applies only to program reimbursement for the service. It does not apply to the exercise of medical judgment as to need.

Ultrasound Indication Checklist

- First day of LMP not known within one (1) week
- Prior still birth
- Use of fertility drugs for this pregnancy
- Menstrual cycle length varies more than two (2) weeks
- Size/date discrepancy; three (3) weeks
- Prior small-for-gestational-age (SGA) baby
- Diabetes Mellitus
- Chronic hypertension
- Chronic renal disease
- Suspected pelvic disease
- Suspected pelvic mass

- Suspected fetal demise
- Suspected ectopic pregnancy
- Suspected molar pregnancy
- Suspected twin pregnancy
- Suspected Intrauterine Growth Retardation (IUGR)
- Amniocentesis
- Cervical cerclage
- Vaginal bleeding; undetermined etiology
- Abnormal Maternal Serum Alpha-feto Protein (MSAFP) screen
- Fetal malpresentation
- Suspected abruptio placenta
- Suspected oligo/polyhydramnios
- Suspected macrosomia
- Preeclampsia
- Preterm labor
- Premature rupture of membrane (PROM)
- Suspected placenta previa
- Post-date pregnancy
- Suspected fetal anomaly
- Other (requires definition)

Non-Covered Ultrasound Services

- Routine screening of all pregnant women
- Use of any apparatus in auscultation of fetal heart tones

Fetal Contraction Stress Test and Fetal Non-Stress Test

The total component (both the professional and technical components of the procedure) for fetal stress (59020) and non-stress (59025) procedures are covered when performed in an office/clinic setting.

Modifier 26 is used when only the professional component is performed in an inpatient, outpatient, or office/clinic setting.

Modifier TC is used when only the technical component is performed in an outpatient or office/clinic setting. If performed inpatient, payment for this charge is included in the per diem rate paid to the hospital.

Prenatal Visit Definition

A prenatal visit is defined as a face-to-face visit with the pregnant MO HealthNet participant at which time all the following services must be performed:

- Patient's weight
- Blood pressure
- Urine check
- Fetal heart tone (FHT) attempt
- Fundal height
- Interim history

A telephone call is not a prenatal visit/contact, nor is a WIC referral or other visit for any other reason not directly related to the pregnancy, e.g., treatment for cold, allergy shot.

Notification of Pregnancy and Risk Screening

MO HealthNet enrolled providers (including FFS and Managed Care health plan providers) who provide obstetric care/services, primary care, and emergency care to MO HealthNet participants should notify MHD and the Managed Care health plans of a participant's pregnancy by completing the Notification of Pregnancy (NOP) and Risk Screening directly in to the secure and Health Insurance Portability and Accountability Act (HIPAA) compliant [NOP and Risk Screening Portal](#).

The NOP and Risk Screening process notifies MHD and the appropriate Managed Care health plan of the participant's pregnancy and the participant's risk factors to ensure supports can be provided to participants as early as possible. The [NOP and Risk Screening Portal](#) should be completed during all initial encounters during which the pregnancy is diagnosed and/or confirmed.

Billing and Reimbursement for Notification of Pregnancy and Risk Screenings

Reimbursement is limited to two (2) prenatal and one (1) postpartum screening per patient, per calendar year. The codes below are reimbursed at \$50.00 for completion.

Procedure Code	Description
G9919 TH	Positive comprehensive SDOH screening and provision of recommendations/referrals
G9920 TH	Negative comprehensive SDOH screening

Billing for Prenatal Screening

The following guidelines should be met when billing for a prenatal NOP and Risk Screening:

- Screening must be entered into the [**NOP and Risk Screening Portal**](#)
- Include a diagnosis code that represents gestational age in weeks
 - Gestational weeks one (1) through seven (7) should always be reported as Z3A01. For example, if the gestational age is two (2) weeks, Z3A01 should be included on the claim.
 - Gestational weeks eight (8) and older should be reported as Z3Axx, with 'xx' being the estimated weeks gestational age. For example, if the gestational age is 18 weeks, then Z3A18 should be included on the claim.
- Corresponding SDOH diagnosis codes (Z-codes) will populate on the printer friendly document provided after entry of the screening in the [**NOP and Risk Screening Portal**](#)
 - Providers billing for a positive screening (G9919 TH) should include all relevant SDOH Z-codes (Z55-Z65). At least one (1) Z-code must be present on the claim. Some SDOH information captured on the screening may not have an associated SDOH DX code.
 - Providers billing for a negative screening (G9920 TH) should not include a Z-code as no concerns were identified

Billing for Postpartum Screening

The following guidelines should be met when billing for a postpartum NOP and Risk Screening:

- Document the findings in the patient's record but findings should not be entered in the NOP and Risk Screening Portal
- Include diagnosis code Z39.2 to indicate a postpartum screening
- Providers billing for a positive screening (G9919 TH) should include all relevant SDOH Z-codes (Z55-Z65). At least one (1) Z-code must be present on the claim. Some SDOH information captured on the screening may not have an associated SDOH DX code.
- Providers billing for a negative screening (G9920 TH) should not include a Z-code as no concerns were identified

Global Prenatal

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, and vaginitis.

Only one (1) prenatal care code, 59425 (four to six (4-6) visits) or 59426 (seven (7) or more visits) may be billed per pregnancy. The provider must have seen the MO HealthNet eligible participant for four (4) or more prenatal visits and performed all of the 'prenatal visit' services (at each visit) as defined above.

If a provider does more than three (3) visits but the participant goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes, except for exempted visits/consultations as described in [Section 2.53](#) in this manual. Women with complicating conditions should be referred for consultations or specialty care, as indicated.

The global prenatal fee is reimbursable when one (1) physician or physician group practice provides all the patient's obstetric prenatal care. For this purpose, a physician group is defined as an obstetric clinic, there is one (1) patient medical record, and each physician/physician assistant/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care.

The clinic may elect to bill globally for all prenatal care services provided within the clinic under the primary care physician's MO HealthNet provider number as the performing provider.

When fewer than four (4) complete prenatal visits were performed, providers must bill for individual dates of service, using the appropriate E/M code.

The date of the delivery is the date of service to be used when billing the global prenatal codes. Providers must enter the date of LMP on the professional claim form when billing this procedure.

The following are global prenatal procedure codes:

Procedure Code	Description
59425	Antepartum care only; four-six (4-6) visits
59426	Antepartum care only; seven (7) or more visits
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59510	Routine obstetric care including antepartum care, cesarian delivery, and postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

Exempted Visits/Consultations

The following describes visits and consultations that may be exempted from prenatal global codes:

- **Entry into Care:** A total of two (2) visits may be paid by MHD to allow the initial provider (not providing ongoing care) to perform an initial examination, diagnose the pregnancy, and make a referral to a second provider. The second provider, who then provides the remainder of the prenatal care, may bill for global prenatal/global delivery, as appropriate, if all other conditions applicable to the global billing and delivery of service are met.
- **Consultations:** In addition, two (2) consultations by referral to another MO HealthNet provider may be paid and still permit billing of the global prenatal or global delivery (by the referring physician) if all other conditions applicable to the global billing and delivery of service are met.
- **Services for High-Risk Patients:** For those pregnant women who develop a high-risk condition for which more than two (2) consultative visits by an obstetrician are required, MHD allows payment for the consultative visits in addition to the global prenatal care code billed by a previous provider. The consultative services must be medically necessary and properly documented. This policy is an effort to assure adequate and appropriate prenatal services for high-risk pregnant women.
- If the prenatal care is transferred to the consulting physician, global payment is not allowed for either provider.

Global Prenatal/Delivery Transition from Fee-For-Service to MO HealthNet Managed Care

When the obstetrical care begins under a FFS setting and continues into a MO HealthNet Managed Care health plan, and the Managed Care health plan reimburses the provider a global fee, the provider must not bill any visits to MHD FFS. If a global fee is not received from the Managed Care health plan, the provider may bill MHD FFS for each visit provided.

Fetal Monitoring Internal (59050)

The attachment of electrodes to the scalp or buttocks during the first stage of labor (the period from the onset of regular uterine contractions to full dilation and effacement of the cervix) is part of the delivery and should not be billed separately. During the first stage of labor, the obstetrician may be informed of severe variable decelerations and may request a consultation.

The consultant may be reimbursed for this procedure.

Fetal monitoring during labor by a consultant is a MO HealthNet covered service. This procedure may only be performed on an inpatient hospital basis by a consultant.

Global Prenatal/Delivery/Postpartum

The fee for the global prenatal/delivery/postpartum care (59400, 59510, 59610, 59618) includes all prenatal visits, routine urinalysis testing during the prenatal period, subsequent care for pregnancy-related conditions; e.g., nausea, vomiting, cystitis, and vaginitis. The fee also includes the initial hospital visit, the delivery, and postpartum care. If a provider does more than three (3) visits but the participant goes to another provider for the rest of her pregnancy, the global prenatal/delivery/postpartum care procedure codes cannot be billed. Each date of service must be billed separately.

If a pregnant woman is high risk, a referral should be made to a case manager of the participant's choice. Reference [Section 2.52](#) in this manual for information concerning Case Management for Pregnant Women.

The global prenatal/delivery/postpartum fee is reimbursable when one (1) physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, there is one (1) patient medical record, and each physician/physician assistant/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as they occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic may elect to bill globally for all prenatal, delivery, and postpartum care services provided within the clinic, using the primary care physician's provider number as the performing provider.

NOTE: LMP is required on all claims for global and/or prenatal/delivery services.

When billing for this service, the date of delivery is the service date to be entered on the professional claim form.

A delivery diagnosis code must be used.

It is inappropriate to bill global delivery when the pregnancy terminates at or prior to 20 weeks gestation. Services are to be billed using the appropriate E/M services code(s) and/or medical/surgical procedure(s) performed.

Delivery Only

The delivery only (procedure codes 59409, 59514, 59612, 59620) are used when more than one (1) provider is involved in the prenatal care and delivery, and the physician at delivery:

- Has provided no prenatal care
- Does not provide postpartum care
- Elects to bill FFS
- Elects to bill global prenatal for prenatal services and delivery

Providers must enter the date of the LMP on the professional claim. The date of service is the delivery date. A delivery diagnosis code must be used.

It is inappropriate to bill a delivery code when the pregnancy terminates at or prior to 20 weeks gestation. Services are to be billed using the appropriate E/M Services code(s) and/or medical/surgical procedure(s) performed.

Delivery Only Including Postpartum Care (59410, 59515, 59614, 59622)

The delivery only including postpartum care procedure codes are used when more than one (1) provider is involved in the prenatal care and delivery and the physician at delivery has provided no prenatal care and provides the delivery and postpartum care.

Postpartum Care Only

The postpartum care only (procedure code 59430) is used when the physician provides postpartum care only.

Anesthesia for Delivery

The anesthesiologist, CRNA, and anesthesiologist providing medical direction for general anesthesia must bill for services using the appropriate CPT anesthesia procedure code.

Multiple Births

When it is medically necessary to perform a cesarean section on a subsequent delivery after a child has been delivered vaginally, reimbursement is 100% for both deliveries. Documentation must be kept in the patient's file indicating the need for both procedures.

Subtotal or Total Hysterectomy After Cesarean Delivery

The subtotal or total hysterectomy after cesarean delivery (59525, 59510, 59515) procedure requires the [Acknowledgement of Receipt of Hysterectomy Information](#) form. Refer to [Section 3](#) in this manual for more information.

Billing Instructions

For those situations in which services are provided in a clinic setting (i.e., public health, family planning, or other group practice), caution must be used to assure that duplicate billing does not occur by the clinic provider and physician of record. When this occurs, duplicate payments may be made, resulting in subsequent recovery of the overpayments.

Free Standing Birth Centers

MHD will enroll free standing birth centers as MO HealthNet providers. A free standing birth center is defined as a facility, not licensed as part of the hospital, which provides maternity care away from the mother's usual residence and where low risk births are planned following a normal uncomplicated pregnancy. Refer to [MMAC Provider Enrollment](#) for more information.

Covered Services

The free standing birth center facility payment includes all room charges for the mother and baby, equipment, and supplies. Providers will use CPT code 59409 with modifier SU to bill for facility services provided in a birthing center. If labor has begun in a birthing center, but the woman had to be transferred to a hospital for the birth, the birthing center may bill CPT code S4005. Birthing center facility services are limited to one (1) per participant per pregnancy.

The physician or certified nurse midwife must submit separate claims for their professional services. Services provided before and after the delivery, such as antepartum and postpartum care are included in the professional payment for the physician or certified nurse midwife.

Group Prenatal Care

MO HealthNet covers group prenatal care. Group prenatal care offers an alternative prenatal care model, aligning with the ACOG guidelines, which emphasizes education and social support via eight (8) to 10 semi-structured, collaborative sessions conducted every two (2) to four (4) weeks throughout the prenatal period. Group prenatal care models are designed to improve patient education and include opportunities for social support while maintaining the risk screening and physical assessment of individual prenatal care. Sessions are led by trained facilitators (e.g., obstetricians or other obstetric care providers) who engage groups of eight (8) to 10 pregnant patients of similar gestational age through a tailored curriculum covering a range of topics related to nutrition, labor expectations, postpartum adjustments, etc. Each session should be at least 90 minutes.

Providers must submit a claim for each group prenatal care visit using CPT code 99078 with modifier TH. Group prenatal care visits may be billed in addition to regular obstetric services.

Limitations

Participants may receive up to 10 group prenatal care visits per rolling year.

Doula Services

All MO HealthNet enrolled pregnant women are eligible for doula services when recommended by a physician or other licensed practitioner of the healing arts. This requirement may be met in one (1) of the following ways:

- Joining either the [Missouri Community Doula Council](#) or the [Missouri Doula Association](#). Each of these organizations can assist doulas who are members of their associations in obtaining an appropriate recommendation for MO HealthNet participants.
- Obtain a signed letter from each participant's maternity care provider (obstetrician, certified nurse midwife, etc.) recommending doula services. Review [Sample Recommendation for Doula Services](#) for a template of a letter.
- Managed Care members that have been issued a recommendation letter applying to its members

Doula services provide a stable source of psychosocial support and education throughout the perinatal period and during the birth utilizing trained providers, community-based doulas, with the aim of improving a range of maternal and infant health outcomes by enhancing relevant knowledge and encouraging healthy behaviors.

Covered Services

Doula services include a combined total of six (6) prenatal and postpartum support sessions, one (1) birth attendance, and up to two (2) visits for general consultation on lactation. Community navigation services that occur outside these billable visits may be billed up to ten (10) times total over the course of the pregnancy and postpartum period. Additional medically necessary visits on the same day may be covered if a properly completed [Certificate of Medical Necessity](#) is attached to the claim and approved by the medical consultant. Refer to the [General Sections Manual](#) for instructions on completion of the [Certificate of Medical Necessity](#) form.

Doula Services include the following:

- Prenatal Support Sessions: Promote health literacy and knowledge of what to expect during pregnancy and birth; what experiences are normal during pregnancy; how to relay concerns to providers; and providing information on topics such as nutrition, exercise, tobacco cessation, and self-monitoring of existing health risks or conditions. Support sessions may also include a doula attending the participant's obstetric (OB) visits in a supportive role. Doula services include a combined total of six (6) prenatal and postpartum support sessions.
- Community Navigation Services: Navigation of social services and assistance programs include taking a community-based approach to connect expecting women and families with available resources, including understanding the services and supports available to pregnant and postpartum women on MO HealthNet and facilitating access to those resources based upon an assessment of social service needs. Community navigation services that occur outside the other billable visits listed in this section may be billed up to ten (10) times total over the course of the pregnancy and postpartum period.
- Birth Attendance: Attendance and support during birth, including providing information about what to expect during birth; helping create a birth plan; and attending the birth to provide non-medical comfort measures, information, emotional support, and advocacy throughout the labor, including support of personal and cultural preferences regarding childbirth. Doula services include one (1) birth attendance.
- Lactation Consultations: Education and support that includes any of the following:
 - A session during pregnancy that is primarily focused on the health benefits of breastfeeding for both mother and infant
 - Supporting the mother and infant immediately after birth to provide guidance and goal setting to promote breastfeeding

- Providing ongoing support education during pregnancy on the health benefits of breastfeeding
- Providing ongoing general education and support and referral to licensed lactation professionals if/when services are needed.

Doula services include up to two (2) visits for general consultation on lactation.

- Postpartum Support Sessions: Help women know what to expect, what is normal, how to relay concerns to providers; aiding the transition back to well-woman care, family planning, screening for postpartum depression; providing information on topics such as safe sleep, preventing unintended child injuries, nutrition, positive parenting skills; education about breastfeeding rights; and goal setting for the future including continuing education, finding employment and childcare, and transition to other insurance as needed. Doula services include a combined total of six (6) prenatal and postpartum support sessions.

Procedure Codes

The following procedure codes should be used by doulas to bill for their services. The time requirement must be met for each service to bill.

Proc Code	Proc Code Desc	MHD Service Desc	Time Req	Limit Per Pregnancy	Reimb
S9443	Lactation classes, nonphysician provider, per session	Lactation education and support session, including arranging referrals	30+ minutes	Two (2)	\$50.00
S9445 TH	Patient education, not otherwise classified, nonphysician provider, individual, per session	Prenatal session	60+ minutes	Six (6)	\$75.00

Proc Code	Proc Code Desc	MHD Service Desc	Time Req	Limit Per Pregnancy	Reimb
S9445 TS	Patient education, not otherwise classified, nonphysician provider, individual, per session	Postpartum session	60+ minutes	Six (6) combined with prenatal sessions	\$75.00
S9482	Family stabilization services	Community navigation services	15+ minutes	In person or by phone; up to 10	\$25.00
T1033	Services performed by a doula birth worker, per diem	Attendance at labor and delivery	Up to 24 hours	One (1)	\$800.00
T1032	Services performed by a doula birth worker, per 15 minutes	Attendance at labor and delivery	Above 24 hours	Up to 95 units (23h 45m)	\$5.00

Birth attendance, defined as continuous labor support and planned attendance of the birth, should typically be billed using T1033. When attendance at the birth exceeds 24 hours, T1032 may be used to bill additional time, up to 48 hours. Births lasting longer than 48 hours may be reimbursed subject to MO HealthNet medical review. T1032 may also be billed by a backup doula or in situations where false labor occurs on a date prior to the birth.

Birth attendance (T1033) may be billed for all deliveries.

Eligible Providers

To be eligible for participation in the MO HealthNet Doula Program a provider must be enrolled as a MO HealthNet provider and must be at least 18 years of age. All doula providers must hold liability insurance as an individual or through a supervising organization.

All doula providers must be determined eligible in one (1) of the following ways:

- Possess a current certificate issued by a national or Missouri-based doula training organization whose curriculum meets the guidelines in the Curriculum Definitions and Standards below

- For doulas whose training came from another source, or from multiple sources, MHD will determine eligibility for reimbursement by verifying that an individual's training and experience satisfies the curriculum definitions and standards below through a public roster maintained by a statewide association composed of doula trainers from three (3) or more independent, well-established doula training organizations located in Missouri whose purpose includes validation of core competencies of trainings; currently MO HealthNet recognizes the [Missouri Community Doula Council](#) and the [Missouri Doula Association](#) for this purpose.

Refer to [MMAC Provider Enrollment](#) for more information.

Curriculum Definitions and Standards

- Curriculum covers a doula's role which includes breastfeeding support, perinatal mood and anxiety disorders, anticipatory care strategies, cultural competency, how to deliver perinatal education and support, how to increase client autonomy during birth, and how to support clients who may need additional care
- Curriculum covers the importance of health-related social needs, including navigation of social services, trauma-informed care, and strategies specific to the community served.
- The doula must successfully complete the training program and be deemed competent to provide doula services. Certification is attained after evaluation by a birth professional or trainer affiliated with the training organization, where a birth professional or trainer is either a certified or credentialed doula with a minimum of two years of documented experience providing services or a certified instructor affiliated with a training organization whose curriculum meets the standards listed above; or a licensed healthcare professional with documented expertise in perinatal care and experience supervising or training doulas
- Completion of at least six (6) continuing education unit (CEU) hours per year, or equivalent continuing education as specified by the training organization

The national or Missouri-based doula training organizations currently recognized as meeting the curriculum standards are listed below:

- Academy of Childbirth Educators
- Birth Arts International
- Birthing Advocacy Doula Trainings
- Birth It Forward Academy
- BirthWorks International
- Childbirth and Postpartum Professional Association (CAPPA) International
- Childbirth International
- Common Sense Childbirth Institute

- Doula Foundation Academy
- Doulas of North America (DONA) International
- Doula Trainings International
- International Childbirth Education Association (ICEA)
- International Doula Institute
- Jamaa Birth Village / Okunsola's Community Doula Training
- ToLabor
- New Beginnings
- Small Moments Academy
- Uzazi Village
- Virtuous Doula Training Academy

2.53 Maternity Stays and Post-Discharge Home Visits

Coverage through the MO HealthNet Program is available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a C-section for a mother and newly born child. A shorter length of hospital stay for services related to maternity and newborn care may be approved if the shorter stay meets with the approval of the attending physician after consulting with the mother. In which case, post-discharge care is required.

Criteria for Early Discharge Following Delivery

In accordance with the most current version of the 'Guidelines for Perinatal Care' prepared by the AAP and the ACOG, or similar guidelines prepared by another nationally recognized medical organization, the following criteria is considered appropriate for early discharge and subsequent home health follow-up:

- The antepartum, intrapartum, and postpartum courses for both mother and baby are uncomplicated
- Term (38-42) weeks with birth weight appropriate for gestational age
- Vital signs for baby are normal and stable for at least 12 hours: heart rate 100- 160/minute, respiratory rate <60/minute, and axillary temperature 97 to 98 degrees Fahrenheit in an open crib with appropriate clothing
- Two (2) successful feedings with coordinated sucking, swallowing, and breathing while feeding
- No evidence of excessive bleeding at the circumcision site for at least two (2) hours
- Physician examination reveals no abnormalities that require continued hospitalization

- There is no evidence of significant jaundice in the first 24 hours
- The mother has received instruction and mother verbalizes/demonstrates her knowledge, ability, and confidence of the below:
 - Bottle or breast feeding
 - Adequacy of breast feeding assessed by latch-on and swallowing
 - Urine and stool frequency
 - Cord, skin and infant genital care
 - Recognition of signs of illness
 - Common problems
 - Jaundice
 - Infant safety (car seat and position for sleeping)
- Support person(s) available in the home to assist the mother
- No unresolved family, environmental, or social risk factors present such as:
 - Untreated parental substance abuse
 - History of child abuse or neglect
 - Mental illness of parent in the home
 - No fixed home
 - Untreated domestic violence, especially during this pregnancy
- Mother has stable vital signs and can ambulate without vertigo
- Initial hepatitis B vaccine is administered, or appointment made for administration within the first week of life
- Initial newborn screenings performed prior to discharge, if performed before 24 hours of milk feeding, a repeat is ordered or scheduled during the follow-up visit
 - Follow-up care within 48 hours with result reported to physician on the same day

Coverage of Post Discharge Visits

MHD reimburses up to two (2) post-discharge skilled nurse visits in the home within two (2) weeks of an early inpatient discharge for a stay of less than 48 hours for a vaginal delivery and for a stay of less than 96 hours for a C-section delivery when provided by a home health agency. Visits must be physician ordered and included in a plan of care. The criteria for an early inpatient discharge and the post-discharge visits must be met.

The first post-discharge visit shall be provided within 48 hours of an inpatient discharge unless otherwise ordered by a physician and the second post-discharge visit, if appropriate (e.g., breast feeding not well established) shall be provided within two (2) weeks of an inpatient discharge. These services are exempt from the home-bound requirement. The post discharge visit(s) covers both the mother and newborn.

2.54 Newborn Care

Initial examinations have been identified as HCY screenings. The newborn's medical record must document that all aspects of a full HCY examination were performed. Future screenings should be billed under the appropriate screening codes according to the HCY periodicity schedule. Reference the [HCY Provider Manual](#).

Neonatal Intensive Care

Procedure codes 99468 and 99469 are used to report services provided by physicians directing the care of a critically ill neonate or infant in a neonatal intensive care unit (NICU). These codes represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered critically ill, the codes for Subsequent Hospital Care (99231-99233) should be utilized.

These NICU codes are to be used in addition to codes 99360 and 99465 or 99464 as appropriate, when the physician is present for the delivery and newborn resuscitation is required.

Care rendered includes management; monitoring, and treatment of the patient including nutritional, metabolic and hematologic maintenance; pharmacologic control of the circulatory system; case management services; parent counseling; and personal direct supervision of the health care team.

Newborn Care in the Hospital

Initial Hospital/Birthing Center Care

The following procedure code should be used for the initial (normal) newborn examination only. This is a one (1) time only code and should be billed using the infant's MO HealthNet DCN and the date of birth as the date of service.

Procedure Code	Description
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant. This code should also be used for birthing room deliveries.

Subsequent Hospital/Birthing Center Care

The following procedure code should be used for subsequent examinations performed in the hospital on days following the date of birth.

Procedure Code	Description
99462	Subsequent hospital care, per day, for evaluation and management of normal newborn

For illness or critical care, the hospital inpatient services, neonatal intensive care or critical care codes should be used. The procedure and diagnosis must support the use of these service codes.

Inpatient Newborn Care

Procedure codes 99231TG, 99232TG and 99233TG are limited to services provided to newborns/infants for the specific diagnosis codes listed below.

Procedure Codes

A40.0	A41.50	P39.4	P07.14	P36.0	P39.3
A40.1	A41.51	P39.8	P07.15	P36.10	P39.4
A40.3	A41.52	P39.9	P07.16	P36.19	P39.8
A40.8	A41.53	P55.0	P07.02	P36.2	P39.9
A40.9	A41.59	P55.8	P07.03	P36.30	P55.0
A41.01	A41.81	P55.9	P07.10	P36.39	P55.1
A41.02	A41.89	P07.00	P07.14	P36.4	P55.8
A41.1	A41. 9	P07.01	P07.15	P36.5	P55.9
A41.2	A42.7	P07.02	P07.16	P36.8	R788.1
A41.3	P39.2	P07.03	P07.17	P36.9	
A41.4	P39.3	P07.10	P22.0	P39.2	

Newborn Care (Other than Hospital or Birthing Room Setting)

Procedure Code	Description
99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center. This is a one (1) time only code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service

Procedure Code	Description
99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date. This is a one (1) time code and should be billed using the infant's MO HealthNet ID number and the date of birth as the date of service

Newborn Enrollment in MO HealthNet Managed Care Health Plans

A child born to a participant enrolled with a health plan is automatically enrolled with the mother's Managed Care health plan effective on the date of birth if the child is determined to be eligible on that date.

When providing services to a newborn whose mother is enrolled with a health plan, providers are urged to contact the health plan immediately regarding any incurred charges for the child. Refer to the [General Sections Manual](#) for more information.

Home Apnea Monitoring

A home apnea monitor is covered through DME for MO HealthNet eligible infants with symptoms of Sudden Infant Death Syndrome (SIDS). A [Certificate of Medical Necessity](#) completed and signed by the physician is required every six (6) months. The rental of the monitor is manually reviewed. The monitor must be prescribed by a MD or DO.

2.55 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 when prescribed by a physician or a health care professional with prescribing authority and may be provided by a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Registered Pharmacist (RPh.)

Diabetes self-management training services are not available to adults receiving a limited benefit package. Refer to ME Codes in the [General Sections Manual](#).

Diabetes Self-Management Training Provider Enrollment Criteria

To provide and bill for diabetes self-management training, a provider must be approved and enrolled as a diabetes self-management provider with MO HealthNet. Following are the requirements to enroll as a provider under the Diabetes Self-Management Training program:

- CDE: Must hold a permanent Missouri license as a registered nurse, physician assistant, or physician. CDE must also hold current certification from the National Certification Board for Diabetes Educators (NCBDE) through the American Association of Diabetes Educators (AADE). CDEs practice under the Scope of Practice for Diabetes Educators developed by AADE.

- RD: Must hold a permanent Missouri license as a registered nurse, physician assistant, physician, social worker, pharmacist, registered dietitian, or other health care professional. When the RD is licensed by Missouri, the RD must submit a copy of the license as an RD. The RD must also hold current certification from the Commission on Dietetic Registration through the American Dietetic Association (ADA). RDs practice under American Dietetic Association Standards of Professional Practice by the ADA.
- RPh: Must hold a permanent Missouri license as licensed pharmacist and must have completed the National Community Pharmacists Association (NCPA) 'Diabetes Care Certification Program' or completed the American Pharmaceutical Association (APhA)/AADE certification program 'Pharmaceutical Care for Patients with Diabetes.'

Refer to [**MMAC Provider Enrollment**](#) for more information.

Diabetes Self-Management Training Provider Service Limitations

Diabetes self-management training services are limited to the initial diagnosis of diabetes and any significant change in the patient's symptoms, condition, or treatment, with documentation of the need for services maintained in the provider's file.

Diabetes self-management training must be prescribed by a physician or health care provider with prescribing authority to the CDE, RD, or RPh.

An initial assessment is reimbursed once per lifetime. The initial assessment must be performed by a physician or a CDE.

The initial assessment should include but not be limited to information from the patient on the following:

- Health and medical history
- Use of medications
- Diet history
- Current mental health status
- Use of health care delivery systems
- Life-style practices
- Physical and psychological factors
- Barriers to learning; family and social supports
- Previous diabetes education, actual knowledge and skills

Two (2) subsequent visits are reimbursed per rolling year. The two (2) subsequent visits may be individual, group, or a combination of individual and group.

Any additional visits require a [Certificate of Medical Necessity](#) from a physician or health care provider with prescribing authority documenting the need for any additional visits be kept in the patient's file.

The diabetes self-management training services for patients enrolled in a Managed Care health plan are the responsibility of the health plan.

Procedure Codes for Diabetes Self-Management Training

Procedure Code	Description
99205U9	Initial Assessment-Comprehensive Diabetes Education - Minimum one (1) hour
G0108	Diabetes Education-Subsequent Visit-Minimum 30 minutes
G0109	Diabetes Education-Group Subsequent (No more than eight (8) persons)-Minimum 30 minutes

Diabetes Self-Management Training Billing Procedures

The diabetes self-management training services must be billed on a professional claim, with the appropriate procedure code as listed above.

The POS code must be one (1) of the following:

POS Code	POS Description
3	School
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
99	Other Unlisted Facility

Refer to [Section 4.7](#) in this manual for more information on POS codes.

Training provided by a CDE, RD, or RPh not employed by the hospital, must be billed using POS 21 (Inpatient Hospital) or 22 (Outpatient Hospital) using their own diabetes self-management training provider number.

Diabetes education providers employed/contracted with FQHCs or RHCs bill with their individual diabetes self-management training provider number with payment designated to the FQHC or RHC.

Diabetes education services provided on an inpatient basis by hospital staff are included in the hospital per diem rate.

When diabetes education services are provided in an outpatient setting by hospital staff, the CDE, RD, or RPh enrolls as a diabetes self-management training provider with payment designated to the hospital on the provider enrollment forms.

2.56 Hyperbaric Oxygen Therapy

Physician attendance and supervision of hyperbaric oxygen therapy (HBO), per session (procedure code 99183) is a covered MO HealthNet service for the professional component. E/M services and/or procedures (e.g., wound debridement) provided in conjunction with HBO should be reported separately.

2.57 Podiatry Services

Podiatrists must follow policy and procedure as stated in this manual below. Podiatrists are limited to the services identified below:

- Services that podiatrists are legally authorized to perform in the state where they are licensed
- Medical, surgical, and mechanical services for the foot or any area not above the ankle joint

Podiatry Limitations

The following podiatry services are not covered for adults receiving a limited benefit package regardless of what provider type bills for the services:

Procedure Code	Description
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method(s); one (1) to five (5)
11721	Debridement of nail(s) by any method(s); six (6) or more
11750	Excision of nail and nail matrix, partial or complete
29540	Strapping of ankle and/or foot

2.58 Circumcisions

MHD pays for elective circumcisions for all newborn infants less than 28 days old using CPT codes 54150 and 54160. Procedure codes 54162, 54163, and 54164 require [PA](#). Documentation from a physician that a disease, pathology, or other abnormality exists that requires a medically therapeutic circumcision must be attached to the [PA Request](#).

2.59 Vagus Nerve Stimulation

Vagus nerve stimulation is covered for patients with medically refractory partial onset epileptic seizures for whom surgery is not recommended or for whom surgery has failed.

The procedure is performed in the hospital and usually requires an overnight stay. Surgeons should code the implant procedure as electrode placement and neurostimulator placement. In addition, a physician (usually a neurologist) typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant.

The physician should bill the following CPT codes:

CPT Code	Description
95970	Electronic analysis of an implanted neurostimulator pulse generator/transmitter, without programming, by a physician or other qualified healthcare professional
95976	Electronic analysis of an implanted neurostimulator pulse generator/transmitter system
95977	Electronic analysis of an implanted neurostimulator pulse generator system, specifically with intraoperative or subsequent programming, for each additional 30 minutes

These analysis and programming procedure codes may also be billed periodically to test and reprogram the device.

The device is included in the hospital per diem if the surgery is performed in an inpatient hospital setting. If the surgery is performed in an outpatient hospital setting, the device is billable under the outpatient supply code.

2.60 Show Me Healthy Women

Missouri women who are diagnosed with breast or cervical cancer under Show Me Healthy Women may be eligible to receive treatment through the MO HealthNet Program. Uninsured women under the age of 65 who have been screened and need treatment for breast or cervical cancer may qualify for full MO HealthNet coverage. This includes treatment of certain precancerous conditions and early-stage cancer.

Eligibility Criteria

To qualify for medical assistance based on the need for breast or cervical cancer treatment all the following criteria must be met:

- Need for treatment for breast or cervical cancer including certain precancerous conditions
- Under the age of 65 years old
- Have a Social Security Number (SSN)
- Citizenship or alien status
- Uninsured, or have health coverage that does not cover breast or cervical cancer treatment
- A Missouri resident

Presumptive Eligibility

Presumptive eligibility determinations are made by a qualified entity, usually a hospital, FQHC, or RHC. When a provider determines a woman is eligible for presumptive eligibility, they issue a MO HealthNet approval letter. MO HealthNet coverage under presumptive eligibility begins on the date the provider determines the woman needs treatment.

MO HealthNet Coverage

MO HealthNet coverage under Show Me Healthy Women begins on the first day of the month of an approved application and continues until the last day of the month that the regular MO HealthNet application is approved, or breast and cervical cancer treatment is no longer required, whichever is later.

Services can be obtained from enrolled MO HealthNet providers on a FFS basis. Participants eligible based on the need for breast and cervical cancer treatment are not enrolled in Managed Care.

Presumptive eligibility, Show Me Healthy Women, and regular MO HealthNet eligibility provide full MO HealthNet benefits.

For additional information call the Cancer Information Service at (800) CANCER which translates to (800) 422-6227.

2.61 Participant Name Change

Documentation must accompany claims for a participant whose name changes after a form is completed, (i.e., sterilization). For example, a letter of explanation should be submitted to document a name change due to marriage or divorce.

2.62 Bilateral Procedures

MO HealthNet covered procedures that are performed bilaterally and are identified by Medicare Services as appropriate bilateral procedures, must be billed using the 50 modifier and quantity of one (1). For bilateral procedures identified by Medicare Services, please reference the [MPFSDB](#).

The MPFSRVU (MPFSDB) indicators in the bilateral surgery column of the database instructs providers how to reimburse for services.

2.63 Telemedicine Services

Telemedicine services are health care services provided through information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site.

Telemedicine offers participants, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.

Covered Services

Services provided through telemedicine must meet the standard of care that would otherwise be expected should such services be provided in person.

The parent or guardian of a child shall provide authorization for telemedicine services prior to the delivery of these services in a school. The authorization shall include the ability for the parent or guardian to authorize services via telemedicine in the school for the whole school year.

Eligible Providers

Any licensed health care provider shall be authorized to provide telemedicine services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person.

To be reimbursed for telemedicine services health care providers treating patients in this state, utilizing telemedicine, must be fully licensed to practice in this state and be enrolled as a MO HealthNet provider prior to rendering services. Refer to [MMAC Provider Enrollment](#) for more information.

Reimbursement

Reimbursement to the health care provider delivering the medical service at the distant site is equal to the current [Fee Schedule](#) amount for the service provided. Use the appropriate CPT code for the service along with POS 02 (Telemedicine provided outside the participant's home), with some exceptions noted below.

Distant site services provided on school grounds should be billed with POS 03 (School) and a GT modifier.

When a participant is located in a residential or inpatient POS, providers delivering behavioral health services via telemedicine must bill with the GT modifier and with the POS where the participant is physically located. In these instances, providers must not bill with POS 02.

POS Code	POS Description
14	Group Home
21	Inpatient Hospital
33	Custodial Care Facility
51	Inpatient Psychiatric Facility
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
61	Comprehensive Inpatient Rehabilitation Center

Refer to [Section 4.7](#) in this manual for more information on POS codes. The originating site is only eligible to receive a facility fee for the telemedicine service. Claims should be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). This procedure code is used by the originating site to receive reimbursement for the use of the facility while telemedicine services are being rendered.

Refer to the [Telemedicine Billing Presentation](#) for more information.

Documentation for the Encounter

A health care provider is required to keep a complete medical record of a telemedicine service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with [13 CSR 70-3.030](#).

2.64 Chiropractic Medicine

[Effective July 1, 2026, MO HealthNet no longer pays for chiropractic services and will not pay for any visits to a licensed chiropractor.](#)

Covered Services

~~Chiropractic services are limited to examinations, diagnoses, adjustments, manipulations and treatments of malpositioned articulations, and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice.~~

Eligible Providers

~~To be eligible for participation in the MO HealthNet Chiropractic Program, a provider must be licensed to practice chiropractic by complying with the provisions of Chapter 331, RSMo and be enrolled as a MO HealthNet provider prior to rendering services. Refer to [MMAC Provider Enrollment](#) for more information.~~

Eligible Participants

~~Any person found to be eligible for MO HealthNet and in need of chiropractic services in accordance with the procedures described above shall be deemed eligible to receive these services.~~

Limitations

~~Participants may receive up to 20 visits per year for chiropractic services.~~

2.65 Complementary Health and Alternative to Chronic Pain Management

Effective July 1, 2026, MO HealthNet no longer pays for acupuncture, chiropractic and physical therapy services under the Complementary Health and Alternative to Chronic Pain Management program.

~~MO HealthNet has developed a structured Complementary Health and Alternative to Chronic Pain Management Program to help decrease the use, misuse, and prescribing of opioid medications for chronic pain.~~

~~Covered Services~~

~~Complementary health and alternative therapies include a combination of newly covered services including physical therapy, chiropractic therapy, and acupuncture, along with current coverage of cognitive-behavioral therapy (CBT) for chronic pain and non-opioid medication therapy.~~

~~Participant Eligibility~~

~~Before starting use of opioid medications for chronic pain, treatment goals should be discussed with the participant, alternative options should be provided, and a treatment plan should be initiated. Non-pharmacologic therapy and non-opioid therapy are preferred for chronic pain. MO HealthNet has established guidelines for providing complementary and alternative therapy for participants with chronic pain. These services will be available to MO HealthNet participants that meet the established criteria listed below. Therefore, MHD will reimburse for complementary health and alternative therapies for chronic pain provided pursuant to the preventative benefit Social Security Act 1905 (a)(1) and Social Security Act 1905 (a)(B) and 42 CFR 440.130(c). The patient must meet the following criteria:~~

~~Be MO HealthNet eligible~~

~~Be 21 years of age or older~~

~~Have one (1) of the following conditions:~~

~~Chronic, non-cancer neck and/or back pain~~

~~Chronic pain post-traumatic injury such as traumatic injury resulting from a motor vehicle collision~~

~~Have a qualifying chronic pain diagnosis as determined by MO HealthNet~~

~~The program is not intended for participants with active cancer therapy, end of life, or palliative care.~~

~~Treatment Options~~

~~Assessment is to be provided upon initial office visit to establish plan of care. Reassess evidence of improvement and risks of therapy benefits when considering discontinuing or requesting further treatment.~~

~~Complementary health and alternative therapy services for qualified adult participants requires a determination by the prescribing physician of a combination of physical therapy, chiropractic therapy, acupuncture, and non-opioid medication therapy, as clinically appropriate.~~

~~Non-opioid and opioid therapy include initiating the first line of treatment, alternative pain therapy, as well as establishing treatment goals. Treatment will be determined on a risk level of low or medium to high.~~

~~Over-the-counter, prescription, and opioid medications are provided based on best practice and evidence-based guidelines. Non-opioid medication (such as Nonsteroidal Anti-Inflammatory Drugs (NSAIDs), acetaminophen, and/or muscle relaxer medication) is to be considered as first line of treatment, length of treatment based on best practice, and evidence-based guidelines.~~

~~Limitations~~

~~The Complementary Health and Alternatives to Chronic Pain Management Program requires a physician's referral as well as PA to be eligible for the program. The prescribing physician must prescribe the service in the participant's plan of care during a regular office visit. Recommendations will be granted based on best practice and evidence-based guidelines.~~

~~The combination of physical therapy, chiropractic therapy, and acupuncturist's services are subject to an annual maximum limit of 30 visits or 120 units of service per year with one (1) unit equaling 15 minutes. Additional complementary and alternative therapy requests beyond the initial allocation must be deemed medically necessary. The prescribing physician shall reassess evidence of the adult participant's improvement and the risks of complementary health and alternative therapy when considering discontinuing or requesting further coverage of complementary health and alternative therapies for chronic pain.~~

~~MO HealthNet enrolled behavioral health providers may deliver Computer Based Training (CBT) via individual, family, or group modalities and may report either psychotherapy codes (90832-90853) or health and behavior assessment and intervention codes (96150-96154). Individual (90832, 90834, 90837), family (90846, 90847), and group psychotherapy (90853) require precertification and may be provided for diagnosis codes of F45.41 and F45.42. Health and behavior assessment and intervention services do not require precertification and may be provided for physical health conditions. For additional information about these services, refer to the Behavioral Health Services Provider Manual.~~

~~To obtain a PA, enrolled providers can call (800) 392-8030, Option 6, or use the CyberAccess website, a web tool that automates this process for MO HealthNet providers. To become a CyberAccess user, contact the help desk at (888) 581-9797 or (573) 632-9797, or email cyberaccesshelpdesk@conduent.com.~~

Provider Requirements

~~To refer or provide complementary health and alternative therapy, the prescribing physician and the complementary health and alternative therapy provider must be currently enrolled as a MO HealthNet provider and currently licensed in Missouri or a bordering state to provide therapy.~~

~~MHD shall provide reimbursement for complementary and alternative therapy for treatment provided to participants with chronic pain by a qualified provider who meets the outlined criteria.~~

~~Refer to MMAC Provider Enrollment for more information.~~

2.66 Asthma Education and Asthma in Home Environmental Assessment Program

Evidence has shown that the combined approach of asthma education and environmental assessments leads to better health outcomes in the pediatric population.

Provider Enrollment Criteria

To provide and bill for asthma education and asthma environmental assessment services, a provider must be approved and enrolled as an asthma education provider and/or asthma environmental assessment provider with MO HealthNet. The following describe the requirements to enroll as a provider under the Asthma Education and Asthma Environmental Assessment program.

Asthma Education Providers

Asthma Education Providers must hold either a National Asthma Educator Certification (AEC) or a state certification. State certificate training programs are provided by an accredited institute of higher education, such as a university, within the state that provides a training program utilizing curriculum incorporating similar guidelines as the national certification; it is preferable that the curriculum is accredited.

Upon successful completion of the training a certificate must be provided. A certificate recognizes that the student has completed the training, and can complete the mentoring process, as outlined below, to confirm competence to provide asthma services.

State training programs may contain a mix of didactics with practicum and work in the field, and graduates are required to maintain the same number of continuing education units (CEUs) as required by the national certification. Eligibility criteria for admission into the certification programs are determined by the administrator of the program.

Providers must be enrolled as a MO HealthNet Provider and will bill under the Disease Management provider type with an Asthma Education Specialty. Refer to [MMAC Provider Enrollment](#) for more information.

Asthma Environmental Assessors

Asthma Environmental Assessors must hold one (1) of the following:

- Renewal of National Environmental Health Association (NEHA) Healthy Home Specialist National Certificate
- Building Performance Institute (BPI) Healthy Home Evaluator Micro-Credential National Certificate
- State certification

State certification training programs are provided by an accredited institute of higher education training programs, such as a university, within the state that provides an accredited training program utilizing curriculum and certificate incorporating similar guidelines as the national certification; it is preferable that the curriculum is accredited.

Upon successful completion of the training a certificate must be provided. A certificate means that the student has successfully completed the training program and is competent to provide asthma in-home assessment services. Eligibility criteria for admission into the certification programs are determined by the administrator of the program.

Providers must be enrolled as a MO HealthNet Provider and will bill under the Disease Management provider type with an In-Home Environmental Assessor Specialty. Refer to [MMAC Provider Enrollment](#) for more information.

Mentor Program for Asthma Educators

A mentee is someone who is working towards a national or state certificate. Mentees seeking national certification can be mentored for a maximum timeframe of 18 months to obtain 1000 hours of service. Once the 1000 hours are obtained, the mentee must attempt to obtain the National Asthma Educator Specialist (AE-C).

For mentees seeking state certification the maximum timeframe, up to 18 months, and number of hours is determined by the training program. In the event the mentee fails the National AE-C examination or the state certification process, the mentee may no longer provide asthma education services to enrolled MO HealthNet participants.

Once certified, the asthma educator can become a mentor for individuals that are seeking their national or state certification. Mentors are enrolled MO HealthNet providers and can have a maximum of three (3) mentees at a time. Mentors can bill MHD for their services; however, mentees are not able to bill. Services provided by the mentees under the supervision of the mentor can be billed by the mentor.

Asthma education activities and interventions performed by the mentee shall be done according to the mentor's order, control, and full professional responsibility. The mentor shall maintain a continuing relationship with the mentee and shall meet with the mentee at a minimum of one (1) hour per month face-to-face. The mentor shall review all patient care, evaluate the quality of care delivered, and terminate any mentee relationship that fails to conform to the standard of care.

Mentors will document and approve standard of care of asthma education visits (minimum three (3) visits) and send documentation to state registrar. The state registrar will confirm training program and mentored visits. After review, the state registrar will issue a state asthma educator certificate.

Qualified Academic University Based Centers

Qualifying academic university-based centers will evaluate, certify, and track physician referrals; and will function to assist with physician referrals for asthma education and environmental home assessment statewide.

The qualified academic university-based centers will be responsible for maintaining verification for that current asthma education and asthma in-home environmental assessment providers have maintained national and/or state certification.

The qualified academic university-based centers must maintain a website, [Asthma Bridge](#), with an up-to-date provider list for prescribing providers and their offices to utilize to consult asthma educators and asthma in-home environmental assessors to provide services to participants once a [PA Request](#) has been approved.

An up-to-date provider list must also be available to providers on the [DHSS Lead Licensing](#) website.

Assessment Program Participant Eligibility Criteria

Asthma education and asthma in-home environmental assessment services require a referral and/or a prescribed service in the participant's plan of care by a prescribing provider during an office visit for a participant to be eligible for the services.

As part of the referral, the prescribing provider determines and specifies the level and type of asthma education and in-home environmental assessment based on available history and in consultation with asthma educators and in-home environmental assessors, as needed. A prescribing provider is a licensed practitioner authorized to prescribe within their scope of practice either directly or by protocol consistent with their scope of practice under state law. For participants to be eligible for asthma education and asthma environmental assessment services the individual must meet the following criteria:

- The participant must be currently enrolled in MO HealthNet
- Be younger than 21 years of age
- Have a primary diagnosis of asthma
- Have had one (1) of the following events as a result of asthma in the last 12 months:
 - One (1) or more inpatient hospital stays
 - Two (2) or more emergency department visits
 - Three (3) or more urgent care visits
- A high utilization of rescue inhalers (short-acting inhaler beta-2 agonists defined as four (4) or more prescription refills, or underutilization of inhaled corticosteroids (ICS) defined as missing four (4) or more refills based on their enrollment months, and at least one (1) emergency department or urgent care visit

Description of Services

Asthma Education

Asthma education, preventive medicine counseling, and self-management education may include but are not limited to the following:

- Increasing adherence to the ICS regimen
- Optimizing inhalation technique
- Supporting trigger reduction in indoor environment (home, school, and work)
- Identifying and reducing impairment and reducing and managing the risks of asthma exacerbation
- Increasing compliance with asthma action plans
- Measurement of lung function
- Counseling on the findings of the environmental assessment
- Management of co-morbid conditions
- Health-promoting, promotion of non-pharmacologic behaviors

- Education on nasal hygiene

Asthma Environmental Assessment

Asthma in-home environmental assessments may include but are not limited to activities that assist in identifying and support the reduction of disease-causing agents in the home leading to medical complications of asthma. Asthma in-home environmental assessments do not include remediation of issues identified in the home.

Authorization Limits

All asthma education and in-home environmental assessment services require a [PA](#) with MO HealthNet prior to starting services.

Asthma education and asthma environmental assessment services may be performed by nationally or state certified asthma educators and nationally or state certified asthma environmental assessors.

Annual limit of asthma education visits will be dependent on the codes used, but shall not exceed one (1) hour per year with the exception of one (1) 90-minute self-management session and two (2) in-home environmental assessments that are allowed annually. Additional asthma education and environmental in-home assessments beyond the initial allocation will need to go through the [PA](#) process and be deemed medically necessary.

Asthma Education Services Procedure Codes

Procedure Code	Description
S9441	Asthma education non-physician (30-minute unit)
99401	Preventive medicine counseling, individual, (15-minute unit)
99402	Preventive medicine counseling, individual, (30-minute unit)
98960	Self-management education using standardized effective curriculum, individually, either incident to a clinical encounter or as preventive service, (90-minute unit)

Procedure Codes for Asthma Environmental Assessment Services

Procedure Code	Description
S9441 SC	Asthma environmental assessment, non-physician

Asthma Education and Asthma Environmental Assessment Billing Procedures

The asthma education and asthma environmental assessment services must be billed on a professional claim, with the appropriate procedure code.

The POS code must be 12 (Home).

2.67 Diabetes Prevention Program Services for Adults

Diabetes Prevention Program (DPP) Services for adult participants are covered through the MO HealthNet Program. The intent of these services is to utilize the Center for Disease Control and Prevention's (CDC's) National Diabetes Prevention Program guidelines to provide structured medically necessary services recommended by a licensed practitioner authorized to prescribe within their scope of practice either directly or by protocol consistent with their scope of practice under state law to prevent or delay the onset of Type 2 diabetes for participants ages 21 years of age and older who are at risk for diabetes or have indications of prediabetes, in accordance with [**42 CFR 440.130 \(c\)**](#). The goal of these services is to improve health outcomes for the adult population at risk for developing Type 2 diabetes by managing obesity and associated co-morbidities.

Diabetes Prevention Program

DPP is a structured, lifestyle change program specifically developed and recognized by the CDC to prevent or delay Type 2 diabetes. The program is intended for people who have prediabetes or are at risk for Type 2 diabetes, but who do not already have diabetes, to promote lifestyle changes that decrease the progression to Type 2 diabetes. The program services include a variety of behavioral and nutritional interventions identified as evidence based by clinical research studies and/or nationally recognized organizations specializing in disease control and prevention. DPP services are provided during sessions that occur at regular periodic intervals over the course of one (1) year, and, if eligible based upon individual measurable health-outcomes, additional ongoing maintenance sessions at regular, periodic intervals for another year.

Provider Participation

DPP service providers must have pending, preliminary, full, or full plus recognition status from the CDC Diabetes Prevention Recognition Program (DPRP), [**National Diabetes Prevention Program**](#). The CDC DPRP regulates the standards needed for recognition. DPP service providers must be enrolled as MO HealthNet providers. Refer to [**MMAC Provider Enrollment**](#) for more information.

DPP service providers use lifestyle coaches for delivery of DPP services to participants. The lifestyle coaches must have completed nationally recognized training for delivery of DPP services. Lifestyle coaches may be:

- Physicians
- Licensed non-physician practitioners
- Unlicensed practitioners under the supervision of a DPP services provider or a licensed MO HealthNet practitioner

For DPP services delivered by unlicensed lifestyle coaches, the supervising MO HealthNet provider will assume professional liability for care of the patient and furnish services within its scope of practice according to the law.

All lifestyle coaches must complete a minimum of 12 hours of training in DPP services from an organization recognized by the CDC for DPP.

Participant Criteria

MO HealthNet eligible individuals who also meet the following criteria shall be deemed eligible to receive DPP services:

- Be 21 years old or older
- Not currently pregnant
- Have, as of the date of attendance at the first core session, a BMI equal to or greater than 25, or 23 if of Asian descent
- Have no previous diagnosis of Type 1 or Type 2 diabetes with the exception of gestational diabetes
- Have, within the last 12 months:
 - Hemoglobin A1C test with a value of five and seven-tenths percent (5.7%) to six and four-tenths percent (6.4%)
 - A fasting plasma glucose of 100 mg/dl to 125 mg/dl
 - Two (2) hour plasma glucose of 140 to 199 mg/dl after the 75 oral glucose tolerance test

Service Description

DPP services are structured medically necessary services that include ongoing nutrition or behavior-counseling focusing on weight reduction and lifestyle changes, physical activity, and fitness assessments. A prescriber provider's referral, utilizing the eligibility criteria set forth by the CDC, is required for the participant to be eligible for this program. The prescribing provider will need to prescribe the service in the participant's plan of care during a regular office visit. A prescribing provider is defined as a physician or other licensed practitioner of healing arts within the scope of authorized practice under State law.

Core Services Period

DPP core services period includes a 12-month period of intervention with a minimum of 22 sessions and a maximum of 26 sessions. DPP core services period include, but are not limited to, weight monitoring and tracking, physical activity tracking, and caloric intake tracking as required.

During months one (1) through six (6) of the DPP core services period, DPP service providers will be required to provide a minimum of 16 weekly sessions utilizing CDC-approved DPP core module curriculum.

This curriculum provides counseling that focuses on, but is not limited to, information about Type 2 diabetes to include:

- Prevention
- Self-monitoring weight and food intake
- Healthy eating
- Introduction to physical activity
- Dealing with lifestyle changes
- Developing lasting lifestyle changes
- Stress management

During months seven (7) through 12 of the DPP core services period DPP service providers will be required to provide a minimum of six (6) monthly sessions utilizing CDC-approved DPP core maintenance module curriculum.

This curriculum provides counseling that focuses on maintaining long-term dietary changes, increased physical activity, and behavior change strategies for continued weight loss.

Ongoing Maintenance Period

DPP ongoing maintenance period includes access to one (1) year of ongoing maintenance sessions to eligible participants.

The ongoing maintenance sessions are done in three (3) month intervals for a maximum of four (4) sessions during months 13 through 24.

A minimum weight | To qualify for the ongoing maintenance sessions after the initial 12-month program the participant must achieve one (1) of the following:

- Loss of 5% of baseline body weight at the end of the first 12 months
- A modest reduction in hemoglobin A1C (A1C) of at least two-tenths of a percent (0.2%)
- If a participant does not meet the weight loss threshold, the prescribing provider shall perform the necessary lab work to rule out the presence of other conditions (e.g. endocrine disorders) that may complicate efforts to reduce weight, and if present, should request to continue if appropriate diabetes prevention program services for the identified condition(s)

Procedure Codes

DPP services must be billed on a professional claim, with the appropriate procedure code.

Procedure Code	Description
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized DPP curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 minutes

Additional Services Request

Additional diabetes prevention program services, including core sessions and ongoing maintenance sessions beyond the initial allocation must be requested and deemed medically necessary.

Enrollment Criteria

A participant that is unable to meet and/or maintain the criteria for the additional 12 months of ongoing maintenance sessions has the option, after 12 months, to re-enroll in the DPP starting with the first 12 months if the participant meets the established criteria.

2.68 Self-Measure Blood Pressure Monitoring

Effective for dates of service on or after February 1, 2025, MHD implemented coverage for self-measured blood pressure (SMBP) monitoring. Evidence shows that SMBP monitoring, also known as home blood pressure monitoring, with clinical support, helps lower blood pressure in individuals with hypertension. Combining SMBP monitoring with clinical support increases access to care; accessibility to monitoring; and improved quality of care across the population, including the maternal population; and is an effective method of supporting individuals between medical appointments.

Covered Services

SMBP monitoring is the regular measurement of blood pressure outside the clinical setting using a home blood pressure measurement device validated for clinical accuracy that meets the criteria for the Validated Device List (VDL). Clinical support accompanies SMBP monitoring and may include but is not limited to a combination of regular one-on-one counseling sessions, support tools, and educational classes.

These services are covered when prescribed by a physician or a health care professional with prescribing authority. Prescriptions for SMBP validated monitoring devices must be made to participating DME providers and must include the request for an appropriately sized cuff.

Limitations

SMBP monitoring device limitations include:

- Eligible participants may receive one (1) device every three (3) years

- Participants should use devices with upper arm cuffs of appropriate size; a wrist cuff should only be used if an upper arm cuff is not clinically appropriate or if an appropriately sized upper arm cuff is unavailable

SMBP monitoring clinical support CPT code limitations:

- CPT Code 99473: May be submitted once per year when training the participant; device setup and calibration; instruction on proper technique; or for assessing clinical accuracy of the device.
- CPT Code 99474: May be submitted, at a maximum, once per calendar month when participants or their caregivers report their blood pressure readings back to their provider – whether it is done electronically or in person with a written log and a treatment plan has been created or modified based on documented averages of the blood pressure readings.

Participant Eligibility

Participants who are pregnant or within 12 months postpartum and have at least one (1) of the following established risk factors:

- Diagnosis of hypertension
- History of at least one (1) of the following preeclampsia, eclampsia, hypertension, or gestational hypertension
- Family history of at least one (1) of the following preeclampsia, eclampsia, hypertension, or gestational hypertension
- Obesity with BMI of 30 or greater
- Advanced maternal age defined as 35 years of age or older
- Autoimmune disorder(s)
- Elevated blood pressure during previous visit or screening
- Population-level risk factors such as race or geographical location

Other MO HealthNet participants who are not pregnant or within 12 months postpartum must meet at least one (1) of the following criteria:

- Newly diagnosed hypertension within the last six (6) months
- Uncontrolled hypertension or multiple co-morbidities such as, but not limited to, diabetes, obesity, or hypercholesterolemia
- History of a condition that affects blood pressure, such as, but not limited to, heart disease, heart failure, stroke, congenital heart disease, or renal disease

SMBP services must be billed on a professional claim, with the appropriate procedure code.

Procedure Code	Description
99473	Education and training to self-measure blood pressure
99473 TH	Education and training to self-measure blood pressure for pregnant women and 12 months postpartum
99474	Self-measured blood pressure measurements
99474 TH	Self-measured blood pressure measurements for pregnant women and 12 months postpartum
A4670	Automatic blood pressure monitor ages 21 & over
A4670 EP	Automatic blood pressure monitor ages 20 & under

Section 3: Special Documentation Requirements

Program limits may require prior authorization (PA) or medical necessity as detailed in this manual.

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 MO HealthNet [Fee Schedule](#), for a list of the required attachment(s) for surgical procedures.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to [Section 4](#) in this manual and the [Medicare/Medicaid Claims Processing Provider Manual](#), for further information. Refer to the [General Sections Manual](#) for general program documentation requirements.

3.1 Required Attachments

When submitting claims requiring attachments, be sure to:

- Include the correct attachment(s) for the service being billed (some procedures require more than one (1) attachment)
- Check that the name of the participant is the same on both the attachment and the claim
- Attach a legible copy if not submitting an original
- Check that all required information and signatures appear on the attachment
- Check that the dates of service are consistent with dates on the attachment

Resubmissions

When a claim requiring an attachment is resubmitted, the provider must include a legible copy of the attachment with the resubmitted claim. The fiscal agent cannot match the new submission to the attachment sent with the previous claim.

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 2.31](#) in this manual. Refer to the MO HealthNet [Fee Schedule](#) for the procedures that require attachments. It is the hospital's responsibility to obtain the necessary certification from the performing physician.

Hysterectomies are not to be reported as family planning services.

The [Sterilization Consent Form](#) may not be used in place of the [Acknowledgement of Receipt of Hysterectomy Information](#).

The paragraph at the bottom of the [Acknowledgement of Receipt of Hysterectomy Information](#) indicates that it must be signed by the individual or her representative prior to the surgery, but there are no time limits. The Centers for Medicare & Medicaid Services (CMS) has given guidelines on this policy stating 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.

Exceptions to the Acknowledgement of Receipt of Hysterectomy Information

There are exception situations in which the [Acknowledgement of Receipt of Hysterectomy Information](#) is not required; however, other physician certification is required in these situations, e.g., the [Certificate of Medical Necessity](#). Refer to [Section 2.31](#) in this manual for these exceptions.

3.3 Sterilization Consent Form

A [Sterilization Consent Form](#) must be attached to a claim whenever a voluntary sterilization procedure is performed. The physician should attach a legible copy of the form to the claim. Refer to the MO HealthNet [Fee Schedule](#) for the procedures that require this attachment.

Refer to [Section 2.31](#) for complete information concerning sterilization procedures, including instructions for completing the form and exceptions to the required attachment.

3.4 Invoice for Manually Priced Procedures

An invoice should be attached to the claim for payment of certain procedures that must be manually priced by the State Medical Consultant. As some procedures involve up-front costs to the provider for some material/supply, it is helpful if an invoice is attached outlining pertinent information regarding the material/supply. Refer to the MO HealthNet [Fee Schedule](#) for procedures that require attachments.

The following are examples of procedures that must include an invoice.

Procedure Code	Description
A4261	Medical and Surgical Supplies (Intrauterine Device (IUD)/ Diaphragm only)
A4641	Provision of Diagnostic Radionuclide(s)
A9699	Provision of Therapeutic Radionuclide(s)

Procedure codes ending in '99' are always manually priced and must include the information necessary for pricing by the State Medical Consultant.

3.5 Certificate of Medical Necessity

Certain services, procedures, or circumstances require that a [Certificate of Medical Necessity](#) be attached to a claim when it is submitted for payment. In these circumstances, 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. Refer to the MO HealthNet [Fee Schedule](#), for procedures that require a [Certificate of Medical Necessity](#).

Refer to the [General Sections Manual](#) for a full explanation of the purpose of this form, including instructions for completion.

When a Certificate of Medical Necessity is Required

The following circumstances require a [Certificate of Medical Necessity](#). Refer to the MO HealthNet [Fee Schedule](#), for additional procedures that require a [Certificate of Medical Necessity](#).

Private Hospital Room

A private hospital room is covered if there is a medical justification (e.g., infection control). A [Certificate of Medical Necessity](#) must be completed by the physician and attached to the hospital claim explaining why a private room was necessary.

A private room is also covered if all patient rooms in a facility are private. The hospital provider must contact Provider Communications via [eMOMED](#), or by calling (573) 751-2896 or toll-free (833) 222-7916, if all its rooms are private rooms. The attachment of a Certificate of Medical Necessity is not required in this instance.

A private room is not covered if requested by the patient solely for the patient's convenience.

Ultrasounds (Sonograms)

Claims for obstetrical sonograms exceeding three (3) per participant, per rolling year must be accompanied by a properly completed [Certificate of Medical Necessity](#) documenting the necessity of the additional procedures.

Certificate of Medical Necessity Instead of Required Attachments

There are situations that normally require specific policy documentation, but because of an unusual or emergency situation, a form cannot be completed or is inappropriate for the situation. In these instances, a [Certificate of Medical Necessity](#) must be completed fully describing the circumstances. The different types of circumstances are discussed below. Only the MO HealthNet [Certificate of Medical Necessity](#) is acceptable.

Refer to the [General Sections Manual](#) for the definition of emergency medical conditions.

Lock-In Participants

Services provided to participants who are locked-in to a physician or hospital require a [Medical Referral of Restricted Participant](#) (PI-118) attachment from the lock-in physician or hospital unless the services are provided in response to an emergency situation. If emergency services are provided, a completed [Certificate of Medical Necessity](#) that details the nature of the emergency as well as a copy of the progress notes must accompany the claim when it is submitted for payment. Lock-in information is available in [eMOMED](#) and should be verified along with the other eligibility information.

Procedures That Require Prior Authorization

When procedures that require [PA](#) are performed on an emergency basis, a [Certificate of Medical Necessity](#) fully explaining the emergency situation must be attached to the claim.

3.6 Admission Certification Forms

Inpatient hospital admissions must be certified as medically necessary and appropriate before MHD will reimburse for inpatient services. All MO HealthNet enrolled hospitals in Missouri and bordering states are subject to this admission certification requirement. The State's inpatient review authority will receive all the appropriate information necessary to review admissions subject to admission certification. Refer to the [Hospital Provider Manual](#) for more information on Inpatient Hospital Certification Reviews.

Section 4: Billing Instructions

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 online at [eMOMED](#). For access to [eMOMED](#), providers are required to register. Each individual provider, billing staff, or billing service/clearing house representative must be approved to access [eMOMED](#).

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, Version 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission.

A confirmation file is returned for each transmission.

Refer to the [General Sections Manual](#) for more information on [eMOMED](#) and claim submission.

4.3 Provider Communications

The Provider Communications Unit responds to specific provider inquiries concerning MHD eligibility and coverage verification, questions regarding proper claim filing, claims resolution and disposition, and billing errors.

Providers can also contact Provider Communications to verify participant eligibility, check amount information, claim information, provider enrollment status and participant annual review dates. Contact Provider Communications by sending an inquiry by selecting the Provider Communications Management direct messaging tool via [eMOMED](#) or by calling the Interactive Voice Response (IVR) system toll free at (833) 222-7916 or (573) 751-2896. Refer to the [General Sections Manual](#) for more information.

The MO HealthNet Technical Help Desk provides technical assistance in establishing the required electronic claims and Remittance Advice (RA) formats, network communication, HIPAA trading partner agreements, and [eMOMED](#) claim filing services. Contact the MO HealthNet Technical Help Desk at (573) 635-3559.

4.4 Resubmission of Claims

Any claim or line item on a claim that resulted in a zero (0) payment or incorrect payment can be retrieved and resubmitted in [eMOMED](#) if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider may retrieve and resubmit electronically or on a CMS-1500 or a Pharmacy Claim form, whichever is applicable. An example of a correctable error is the use of an invalid procedure code. A provider may also void a previously billed and paid claim in [eMOMED](#).

If a line item on a claim paid but the payment was incorrect, do not resubmit that line item. For instance, the units field (Field #24g) on the CMS-1500 claim form is blank and the system

automatically plugs a one (1), but the number of units provided should have been five (5), the claim cannot be resubmitted. It will deny as a duplicate.

Refer to the [General Sections Manual](#) for more information.

4.5 Billing Procedures for Medicare/MO HealthNet

When a patient has both Medicare Part B and MO HealthNet coverage, a claim must be filed with Medicare first as primary payor. If the patient has Medicare Part B but the service is not covered or the limits of coverage have been reached previously, a paper claim must be submitted to MHD with the Medicare Remittance Advice (RA) attached indicating the denial. The claim may also be submitted in [eMOMED](#) or through the 837 electronic claims transmission. Reference the [Medicare/Medicaid Claims Processing Provider Manual](#) for instructions for submission of claims to MHD.

If a claim was submitted to Medicare indicating that the participant also had MO HealthNet and disposition of the claim is not received from MHD within 60 days of the Medicare RA date, the claim must be filed in [eMOMED](#) or through the 837 electronic transmission.

Reference the [Medicare/Medicaid Claims Processing Provider Manual](#) for billing instructions.

MHD applies editing to Medicare/MO HealthNet crossover claims very similar to that used to process MO HealthNet only claims. The claims processing system can only process 25 edits or less on one (1) claim. A crossover claim will deny with RA Remark Code MA130 if processing of the claim results in more than 25 edits. The following edits will post to every line of a claim: timely filing, duplicate claim submission, third party liability, and spend down. The provider may bill a smaller claim to Medicare to avoid the 25-edit limit when claims crossover from Medicare.

4.6 CMS-1500 Claim Filing Instructions

The [CMS-1500 claim form](#) is always used to bill MHD for professional services and the Pharmacy Claim form for pharmacy services unless a provider bills those services electronically.

Instructions on how to complete the CMS-1500 and the Pharmacy Claim forms are in this section.

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

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

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

Field Number	Field Name	Instructions for Completion
1	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a MO HealthNet claim is being filed, check the Medicaid box and if the patient had both Medicare and MO HealthNet, check both boxes.
1a*	Insured's I.D. Number	Enter the patient's eight (8)-digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the patient's ID card
2*	Patient's Name	Enter last name, first name, and middle initial in that order as it appears on the ID card
3	Patient's Birth Date, Sex	Enter month, day, and year of birth, mark appropriate box
4**	Insured's Name	If there is individual or group insurance besides MO HealthNet enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13
5	Patient's Address	Enter address and telephone number if available
6**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance
7**	Insured's Address	Enter the primary policyholder's address, enter policyholder's telephone number, if available
8	Reserved for NUCC Use	Leave blank
9**	Other Insured's Name	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number two (2)

Field Number	Field Name	Instructions for Completion
9a**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. NOTE: This field is for private insurance information only. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny.
9b	Reserved for NUCC Use	Leave blank
9c	Reserved for NUCC Use	Leave blank
9d**	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. NOTE: This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny.
10a**- 10c	Is Condition Related to:	If services on the claim are related to participant's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. This field is for private insurance information only. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
10d	Claim Codes (Designated by NUCC)	Leave blank

Field Number	Field Name	Instructions for Completion
11**	Insured's Group Policy or FECA Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. NOTE: This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HHealthNet, employer's name or other information appears in this field, the claim will deny.
11a**	Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. NOTE: This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny.
11b**	Other Claim ID (Designated by NUCC)	Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
11c**	Insurance Plan Name or Program Name	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. NOTE: This field is for private insurance information only. If no private insurance is involved, leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny.

Field Number	Field Name	Instructions for Completion
11d**	Other Health Benefit Plan	Indicate whether the patient has a secondary health insurance plan, if so, complete Fields nine (9), 9a, and 9d with the secondary insurance information. NOTE: This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employer's name, or other information appears in this field, the claim will deny.
12	Patient's or Authorized Person's Signature	Leave blank
13**	Insured's or Authorized Person's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14**	Date of Current Illness, Injury, or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15	Other Date	Leave blank
16	Dates Patient Unable to Work	Leave blank
17**	Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one (1) provider using the following priority order: Referring Provider Ordering Provider Supervising Provider

Field Number	Field Name	Instructions for Completion
17a**	Other ID number	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B: State License Number 1G - Provider UPIN Number G2: State License Number 1G - Provider UPIN Number LU: Location Number (This qualifier is used for Supervising Provider only)
17b**	National Provider Identifiers	Enter the National Provider Identifier (NPI) number of the referring, ordering, or supervising provider
18**	Hospitalization Dates	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.
19	Additional Claim Information (Designated by NUCC)	Providers may use this field for additional remarks/descriptions
20**	Outside Lab	If billing for laboratory charges, mark appropriate box. The referring physician may not bill for lab work that was referred out.
21*	Diagnosis	Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Enter the ICD diagnosis code in the same order on all pages of claims with multiple lines. The ICD indicator is not used.
22**	Resubmission Code	For timely filing purposes, if this is a resubmitted claim, enter the ICN of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23	Prior Authorization	Leave blank

Field Number	Field Name	Instructions for Completion
	Number	
24A*	Date(s) of Service	Enter the date of service under "from" in month/day/year format, using six (6)-digit format in the unshaded area of the field. All line items must have a from date. A 'to' date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six (6) service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of services.
24B*	Place of Service	Enter the appropriate Place of Service (POS) code in the unshaded area of the field
24C**	EMG-Emergency	Enter a 'Y' in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
24D*	Procedure Code	Enter the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.)
24E*	Diagnosis Pointer	Enter A, B, C, D from Field 21 in the unshaded area of the field. Do not enter the actual diagnosis code.
24F*	Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.

Field Number	Field Name	Instructions for Completion
24G*	Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a '1' if the field is left blank. Anesthesia: Enter the total number of minutes of anesthesia. Consecutive visits: Subsequent hospital visits may be billed on one (1) line if they occur on consecutive days. The days/units must reflect the total number of days shown in Field 24a. Injections: Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is two (2) cc and four (4) cc are given, the quantity listed in this field is '2'.
24H**	Early Periodic Screening, Diagnostic, and Treatment (EPSDT)/Family Planning	If the services are an EPSDT/Healthy Children and Youth (HCY) screening services or referral, enter 'E'. If the services is family planning related, enter 'F'. If the services is both an HCY and Family Planning enter 'B'.
24I**	ID Qualifier	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shaded area.
24J**	Rendering Provider ID	The individual rendering the service is reported in this field. Enter the NPI number of the provider in the unshaded area of the field. This field is required for a clinic, radiology, teaching instruction, or a group practice only.
25	Federal Tax ID Number	Leave blank

Field Number	Field Name	Instructions for Completion
26	Patient Account Number	For provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here
27	Accept Assignment	Leave blank
28	Total Charge	Enter the sum of the line item charges
29	Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing, and copay amounts are not to be entered in this field
30	Reserved for NUCC Use	Leave blank
31	Provider Signature	Leave blank
32**	Service Facility Location Information	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the POS is other than home or office
32a**	National Provider Identifier Number	Enter the NPI number of the service facility location in 32
32b**	Other ID Number	Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number
33*	Provider Name/Number/Addresses	Enter the provider's name, address, and phone number
33a**	National Provider Identifier Number	Enter the NPI number of the billing provider in 33
33b**	Other ID Number	Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number

4.7 Place of Service Codes

Two (2)-digit numeric place of service (POS) codes must be used when filing claims to MHD.

POS Code	Description	Definition
2	Telehealth Provided Other than in Home	Patient is not located in their home when receiving health services or health related services through telecommunication technology.
3	School	A facility whose primary purpose is education
10	Telehealth Provided in Home	Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility (NF) or intermediate care facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services
17	Walk-In Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services

POS Code	Description	Definition
19	Off-Campus Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
23	Emergency Room Hospital	The portion of a hospital in which emergency diagnosis and treatment of illness or injury are provided
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants
26	Military Treatment Facility	A medical facility operated by one (1) or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF)

POS Code	Description	Definition
27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.
31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services that does not provide the level of care or treatment available in a hospital
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and that does not include a medical component.
34	Hospice	A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families is provided. NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient received services in a setting other than a hospice facility, then the specific location for that service should be used.
49	Independent Clinic	A location, not part of a hospital and not described by any other POS code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only
50	Federally Qualified Health Clinic	A facility located in a medically underserved area that provides primary medical care under the general direction of a physician

POS Code	Description	Definition
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require fulltime hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the Community Mental Health Center's (CMHC's) mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility that primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility that provides treatment for substances (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment

POS Code	Description	Definition
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitation nursing, physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End Stage Renal Disease Treatment Facility	A facility other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home care basis.
66	Programs of All-Inclusive Care for the Elderly (PACE) Center	A facility or location providing comprehensive medical and social services as part of PACE. This includes, but is not limited to, primary care; social work services; restorative therapies, including physical and occupational therapy; personal care and supportive services; nutritonal counseling; recreational therapy; and meals when the individual is enrolled in PACE. NOTE: This place of service should only be used when the actual service is performed in a PACE facility. If an individual enrolled in PACE facility, then the specific location for that service should be used. Refer to the PACE Provider Manual for more information.
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

POS Code	Description	Definition
72	Rural Health Clinic	A certified facility located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office
99	Other Place of Service	Other place of service not identified above.

4.8 Insurance Coverage Codes

Providers verifying a patient's eligibility via [eMOMED](#) or by calling Provider Communications at (573) 751-2896 or toll-free (833) 222-7916 can obtain the participant's Third-Party Liability (TPL) information.

Participants must always be asked if they have third party insurance regardless of the TPL information provided by [eMOMED](#) or Provider Communications. It is the provider's responsibility to obtain from the patient the name and address of the insurance company, the policy number, and the type of coverage.

Refer to the [General Sections Manual](#) for a list of the codes that identify the type of insurance coverage a participant has and additional information on TPL.

Section 5: Diagnosis Codes

The diagnosis code is a required field and the accuracy of the code that describes the patient's condition is important. Diagnosis codes are not routinely provided by the MO HealthNet Division (MHD). The current International Classification of Diseases (ICD) book should be used as a guide in the selection of the appropriate diagnosis code. The diagnosis code must be entered on the claim form exactly as it appears in the current ICD book.

Section 6: Procedure Codes

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

Reference materials regarding the HCPCS/CPT may be obtained through the [American Medical Association](#).

6.1 Supplies

Procedure Code	Description
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included
A4300	Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal)
A4344	Indwelling Catheter, Foley Type, Two (2)-Way, All Silicone
A4565	Slings
A4261	Medical and Surgical Supplies (Cervical cap for contraceptive use)
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)

6.2 Pregnant Women and Children's Programs Case Management Providers

County	Case Management Provider	Address
Adair	Adair County Health Department	1001 S Jamison Kirksville, MO 63501
Adams, IL	Blessing Hospital	1005 Broadway Quincy, IL 62301
Andrew	Andrew County Health Department	106 N 5th Street PO Box 271 Savannah, MO 64485
Audrain	Audrain County Health Department	1130 Elwood Mexico, MO 65265
Barry	Barry County Health Department	90 Barry County Dr Cassville, MO 65625
Barton	Barton County Health Department	1301 E 12th Street Lamar, MO 64759

County	Case Management Provider	Address
Bates	Bates County Health Department	501 N Orange Butler, MO 64730
Benton	Benton County Health Department	1238 Commercial St Box 935 Warsaw, MO 65355
Bollinger	Bollinger County Health Center	107 Hwy 51 N PO Box 409 Marble Hill, MO 63764
Boone	Columbia-Boone County Health Department	1005 W Worley Street Columbia, MO 65205
Boone	Compass Health, Inc	1001 W Worley St Columbia, MO 65203
Boone	University Physicians	PO Box 7687 Columbia, MO 65205
Buchanan	St Joseph-Buchanan County City of St Joseph Health Department	904 S 10th Street Suite E St Joseph, MO 64503
Butler	Butler County Health Department	1619 N Main Poplar Bluff, MO 63901
Caldwell	Caldwell County Health Department	255 W Main PO Box 66 Kingston, MO 64650
Callaway	Callaway County Health Department	4950 County Rd 304 Fulton, MO 65251

County	Case Management Provider	Address
Cape Girardeau	Cape Girardeau County Public Health Center	1121 Linden St PO Box 1839 Cape Girardeau, MO 63702
Carroll	Carroll County Health Department	5 N Ely Carrollton, MO 64633
Carter	Carter County Health Center	1611 Health Center Rd PO Box 70 Van Buren, MO 63965
Cass	Compass Health, Inc.	501 N Sunset Ln Raymore, MO 64083
Cedar	Cedar County Memorial Hospital	1401 S Park El Dorado Springs, MO 64744
Christian	Christian County Health Department	301 E Brick St PO Box 340 Ozark, MO 65721
Clark	Clark County Health Department	670 N Johnson PO Box 12 Kahoka, MO 63445
Clinton	Clinton County Health Department	106 Bush St Plattsburg, MO 64477
Cole	Cole County Health Department	3400 W Truman Blvd Jefferson City, MO 65109
Crawford	Crawford County Nursing Service	202 W Main St PO Box 367 Steelville, MO 65565

County	Case Management Provider	Address
Dade	Dade County Health Department	413 W Water St Greenfield, MO 65661
Dallas	Dallas County Health Department	901 W Main Buffalo, MO 65622
Daviess	Daviess County Health Department	609A S Main St Gallatin, MO 64640
Dent	Dent County Health Department	1010 E Scenic Rivers Blvd Salem, MO 65560
Douglas	Douglas County Health Department	603 Springfield Rd PO Box 940 Ava, MO 65608
Dunklin	Dunklin County Health Department	402 Recovery Rd Kennett, MO 63857
Franklin	Franklin County Health Services	414 E Main Street Union, MO 63084
Gasconade	Gasconade County Health Department	300 Schriller Dr Hermann, MO 65041
Gentry	Gentry Tri-County Health Department	302 N Park Stanberry, MO 64489
Greene	Cox North Medical Center	1423 N Jefferson Springfield, MO 65802
Greene	Family Medical Care Center	1423 N Jefferson Springfield, MO 65802
Greene	Springfield-Greene County Public Health Center	227 E Chestnut Expressway Springfield, MO 65802

County	Case Management Provider	Address
Grundy	Grundy County Health Department	1716 Lincoln St Trenton, MO 64683
Harrison	Harrison County Health Department	1700 Bethany Ave Bethany, MO 65668
Hickory	Hickory County Health Department	24885 State Hwy 254 Hermitage, MO 65668
Howell	Howell County Health Department	180 Kentucky Ave West Plains, MO 65775
Iron	Iron County Health Department	606 W Russell Ironton, MO 63650
Jackson	Samuel U. Rodgers Health Center	825 Euclid Ave Kansas City, MO 64124
Jackson	Swope Parkway Health Center Aid to Families with Dependent Children (AFDC) Clerk	3801 Blue Parkway Kansas City, MO 64130
Jasper	Jasper County Health Department	105 Lincoln Carthage, MO 64836
Jefferson	Compass Health Inc.	4 Hickory Ridge Suite 600 Arnold, MO 63010
Jefferson	Jefferson County Health Department	405 Main St PO Box 437 Hillsboro, MO 63050
Johnson	Johnson County Community Health Services	723 PCA Rd Warrensburg, MO 64093
Lawrence	Lawrence County Health Department	1549 Missouri Dr Mount Vernon, MO 65712

County	Case Management Provider	Address
Lewis	Lewis County Health Department	100 S Cherry St Monticello, MO 63457
Lincoln	Compass Health, Inc.	91 Troy Square Troy, MO 63379
Linn	Linn County Health Department	635 S Main PO Box 280 Brookfield, MO 63552
Macon	Macon County Health Department	503 N Missouri St Macon, MO 63552
Madison	Madison County Health Department	105 Armory St Fredericktown, MO 63645
Marion	Compass Health Inc.	1817 Gravois Rd High Ridge, MO 63409
Marion	Marion County Health Department	3105 Palmyra Rd Hannibal, MO 63401
McDonald	McDonald County Health Department	3446 S Business Hwy 71 Pineville, MO 64856
Mercer	Mercer County Health Department	305 W Main Princeton, MO 64673
Mississippi	Mississippi County Health Department	1200 E Marshall Charleston, MO 63834
Monroe	Monroe County Health Department	310 N Market St Paris, MO 65275
Montgomery	Montgomery County Health Department	400 N Salisbury Montgomery City, MO 63361

County	Case Management Provider	Address
Morgan	Morgan County Health Department	104 W Lafayette Versailles, MO 65084
New Madrid	New Madrid County Health Department	406 Hwy 61 New Madrid, MO 63869
Newton	Newton County Health Department	812 W Harmony PO Box 447 Neosho, MO 64850
Oregon	Oregon County Health Department	PO Box 189 #10 Court Square Alton, MO 65606
Ozark	Ozark County Health Center	#4 Market St PO Box 180 Gainesville, MO 65655
Pemiscot	Pemiscot County Health Center	810 E Reed Hayti, MO 63851
Perry	Perry County Health Department	406 N Spring Suite 1 Perryville, MO 63775
Pettis	Pettis County Community Health Center	911 E 16th St Sedalia, MO 65301
Phelps	Phelps County Health Department	200 Main St Suite G51 Rolla, MO 65401
Pike	Pike County Health Department	1 Healthcare Place Bowling Green, MO 63334
Pulaski	Pulaski County Health Department	101 12th St Crocker, MO 65452

County	Case Management Provider	Address
Putnam	Putnam County Health Department	103 N 18th Street PO Box 354 Unionville, MO 63565
Ralls	Ralls County Health Department	16369 Business 61 PO Box 434 New London, MO 63459
Reynolds	Reynolds County Health Department	2323 Green St Centerville, MO 63633
Ripley	Ripley County Health Department	1003 East Locust St Doniphan, MO 63935
Saline	Saline County Health Office	1825 South Atchison Ave Marshall, MO 65340
Scotland	Scotland County Health Department	214 W Madison St Memphis, MO 63555
Scott	Scott County Health Department	102 Grove Estates Ct Sikeston, MO 63801
Shannon	Shannon County Health Center	18018 Grey Jones Dr PO Box 788 Eminence, MO 65466
Shelby	Shelby County Health Center	700 E Main PO Box 240 Shelbyville, MO 63469
St Charles	St Charles County Department of Community Health & Environment	1650 Boonslick Rd St Charles, MO 63301
St Clair	St Clair County Health Center	530 Arduser Dr Osceola, MO 64776

County	Case Management Provider	Address
St Francois	St Francois County Health Center	1025 W Main St Park Hills, MO 63601
Ste Genevieve	Ste. Genevieve County Health Department	115 Basler Dr Ste. Genevieve, MO 63670
St Louis City	Affinia Healthcare	4414 N Florissant Ave St. Louis, MO 63107
St Louis City	Affinia Healthcare	3930 S Broadway St. Louis, MO 63118
St Louis City	Affinia Healthcare	1717 Biddle St St. Louis, MO 63106
St Louis City	Affinia Healthcare	2220 Lemp St. Louis, MO 63104
St. Louis City	Betty Jean Kerr People's Health Center	5701 Delmar Blvd St. Louis, MO 63112
St Louis City	Care STL Health	5471 Dr. Martin L King Dr St. Louis, MO 63112
St Louis City	Community Health in Partnership Services (CHIPS)	2431 N Grand Ave St Louis, MO 63106
St Louis City	Family Care Health Centers (Forest Park)	401 Holly Hills Ave St Louis, MO 63110
St. Louis City	Grace Hill Neighborhood Health Center	2600 Hadley St St Louis, MO 63106
St Louis City	Myrtle Hilliard Davis Comp Health Center Inc	5471 Dr Martin L King Dr St Louis, MO 63112
St Louis City	People's Health Centers	5701 Delmar Blvd St Louis, MO 63112

County	Case Management Provider	Address
St Louis City	City of St. Louis Department of Health	634 N Grand St Louis, MO 63178
St Louis City	Catholic Family Services	Suite G10 19200 Watson Rd St. Louis, MO 63126
St Louis Co	Family Care Health Centers (Carondelet)	6313 Michigan Ave St Louis, MO 63111
St Louis Co	Nurses for Newborns	7259 Lansdowne Suite 100 St. Louis, MO 63119
St Louis Co	St Louis County Department of Health	6121 N Hanley Rd Clayton, MO 63105
Stoddard	Stoddard County Health Center	1001 N Hwy 25 Bloomfield, MO 63825
Sullivan	Sullivan County Health Department	101 Hawthorne Dr PO Box 129 Milan, MO 63556
Taney	Cox Medical Center Branson	525 Branson Landing Blvd Branson, MO 65616
Taney	Taney County Health Department	15479 US Hwy 160 PO Box 369 Forsyth, MO 65653
Texas	Texas County Health Department	950 N Hwy 63 Suite 500 Houston, MO 65483
Vernon	Vernon County Health Department	301 N Washington Nevada, MO 64772

County	Case Management Provider	Address
Wayne	Wayne County Health Department	115 Hickory St Greenville, MO 63944
Washington	Washington County Health Department	520 Purcell Drive Potosi, MO 63664
Webster	Webster County Health Unit	233 E Washington Marshfield, MO 65706
Wright	Wright County Health Department	300 S Main Suite C Hartville, MO 65667

6.3 Vaccines for Children Administration Codes

Vaccines provided through the Vaccines for Children (VFC) Program include:

Vaccine	Administration Procedure Code	Description
COVID-19	91318 SL, 91319 SL, 91320 SL, 91321 SL, 91322 SL	Provided to all VFC eligible children zero (0) through 18 years of age
DT	90702 SL	Provided to VFC eligible children if pertussis vaccine is contraindicated and the child is younger than seven (7) years of age
DTaP	90700 SL	Recommended for all doses in the Diphtheria, Tetanus, and Pertussis (DTaP) series. Provided to all VFC eligible children zero (0) through six (6) years of age
DTaP/Hep B/IPV	90723 SL	Licensed for the three (3) dose primary series. Provided to all VFC eligible children zero (0) through 18 years of age
DTaP/Hib/IPV	90698 SL	Provided to all VFC eligible children zero (0) through four (4) years of age

Vaccine	Administration Procedure Code	Description
DTaP/IPV/Hib/Hep -B	90697 SL	Provided to all VFC eligible children zero (0) through 18 years of age
DTaP/IPV/Hib/Hep -B	90696 SL	Booster dose provided to all VFC eligible children four (4) through six (6) years of age
Hep A	90633 SL	Provided to all VFC eligible children zero (0) through 18 years of age
Hep B	90744 SL	Provided to all VFC eligible children zero (0) through 18 years of age
Hib	90647 SL or 90648 SL	Provided to all VFC eligible children zero (0) through 18 years of age
HPV	90649SL, 90650 SL, 90651SL	Provided to all VFC eligible children and adolescents nine (9) through 18 years of age
Influenza	90656 SL, 90657 SL, 90658 SL, 90661 SL, 90672 SL, 90674 SL, 90685 SL, 90686 SL, 90688 SL	Provided to all VFC eligible children and adolescents zero (0) through 18 years of age
Influenza (FluMist)	90660 SL	Provided to all VFC eligible children and adolescents two (2) through 18 years of age
MMRV	90710 SL	Provided for all VFC children one (1) through 18 years of age
IPV	90713 SL	Provided to all VFC eligible children six (6) weeks through 18 years of age
Meningococcal	90734 SL	Provided for all VFC children zero (0) through 18 years of age
Meningococcal Groups A, C, W, Y	90619 SL	Provided for all VFC children zero (0) through 18 years of age

Vaccine	Administration Procedure Code	Description
Meningococcal Groups A, C, W, Y (PENBRAYA)	90623 SL	Provided for all VFC children zero (0) through 18 years of age
Meningococcal B	90620 SL and 90621 SL	Provided for VFC eligible adolescents 10 through 18 years of age at increased risk for a Meningococcal disease outbreak. Series includes three (3) doses
Meningococcal/Hib	90644 SL	Provided for VFC eligible infants six (6) weeks through 18 months of age at increased risk of a meningococcal disease outbreak
MMRV	90707 SL	Provided to all VFC eligible children zero (0) through 18 years of age. Series includes two (2) doses; 2nd dose provided at least 24 days after the first dose
Pneumococcal conjugate 13-valent	90670 SL	Provided to all VFC eligible children zero (0) through 18 years of age
Pneumococcal conjugate 15-valent	90671 SL	Provided to all VFC eligible children zero (0) through 18 years of age
Pneumococcal conjugate 20-valent	90677 SL	Provided to all VFC eligible children zero (0) through 18 years of age
Pneumococcal 23-valent	90732 SL	Provided only to all VFC eligible children two (2) years through 18 years of age
Rotavirus pentavalent	90680 SL	Provided to all VFC eligible children zero (0) through one (1) year of age. Series includes a three (3) dose vaccine
Rotavirus pentavalent	90680 SL	Provided to all VFC eligible children zero (0) through one (1) year of age. Series includes a three (3) dose vaccine

Vaccine	Administration Procedure Code	Description
Rotavirus, human, attenuated	90681 SL	Provided to all VFC eligible children zero (0) through one (1) year of age. Series includes a two (2) dose vaccine
RSV	90380 SL, 90381 SL, 90382 SL, 90678 SL	Provided for all VFC eligible children zero (0) through one (1) year of age. Procedure code year of age. Procedure code 90678 SL is for pregnant individuals at 32 through 36 weeks gestational age. It is covered under the VFC program when the participant is under 19
Td	90714 SL	Booster recommended for 11 through 18 years old if five (5) years have elapsed since the previous booster dose. Tetanus and diptheria (Td) absorbed, preservative free, provided to VFC eligible in children age seven (7) years or older, for intramuscular use
Tdap	90715 SL	Provided for all VFC eligible children seven (7) through 18 years of age
Varicella	90716 SL	Provided to all VFC eligible children one (1) through 18 years of age