State Missouri

Home health services are only covered for a Medicaid recipient if provided in the recipient's home. Home health visits will be limited to the number of visits on a Plan of Care. The number of home health visits (skilled nurse and aide) during one year may not exceed 100, except skilled nurse visits as approved by the MO HealthNet Division or their designee. These services are restricted to performance by a registered or licensed practical nurse, home health aide, physical therapist, occupational therapist, or speech therapist, in the employ of or under contract to a home health agency licensed by the State of Missouri. To be eligible for home health services, a recipient must require the services of a skilled nurse or therapist, as defined in paragraphs 7.a and d below. The services which are required must be reasonable and necessary for the treatment of an illness or injury and must require performance by the appropriate licensed or qualified professional to achieve the medically desired result.

7.a. Intermittent or part-time nursing service

Intermittent skilled nursing care by a registered or licensed practical nurse which is reasonable and necessary for the treatment of an injury or illness is covered when delivered in accordance with the plan of treatment. Purely preventive care is not covered.

7.b. Home-health aide services

Home health aide services must be specified on the plan of care. The services of the aide must be reasonable and necessary to maintain the recipient at home and there must be no other person who could and would perform the service.

7.c. Medical supplies, equipment, and appliances

Medically necessary supplies which are not routinely furnished in conjunction with patient care visits and which are direct, identifiable services to an individual patient are reimbursable to the agency. Examples include: Ostomy sets and supplies, irrigation sets and supplies, tapes, catheters and supplies.

Needed items of medical equipment prescribed by a physician are available to all recipients including recipients of home health, through the Durable Medical Equipment program.

Revised 1.31.11



State Missouri

7.d. Physical therapy, occupational therapy, and speech therapy:

Skilled therapy services as defined under 42 CFR 440.70(b)(4) will be considered reasonable and necessary for treatment under the home health program if the following conditions are met.

(A) The Services:

1. Must be consistent with the nature and severity of the illness, and the recipient's particular medical needs, and;

2. Must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition, and;

3. Must be provided with the expectation, based on the assessment by the attending physician of the recipient's rehabilitation potential, that the recipient's condition will improve materially in a reasonable and generally predictable period of time, and;

4. Are necessary for the establishment of a safe and effective maintenance program, or for teaching and training a caregiver.

5. Must be provided in accordance to 42 CFR 440.110.

(B) Therapy services may be delivered for one certification period (up to 62 days), if services are initiated within 60 days of onset of the condition or within 60 days from date of discharge from the hospital, if the recipient was hospitalized for the condition. Prior authorization to continue therapy services beyond the initial certification period may be requested by the home health provider. Prior authorization requests will be reviewed by MO HealthNet Division, and approval or denial of the continuation of services will be based on the services' continued adherence to the criteria used in the original determination.

9. Clinic services

Clinic services are payable to a clinic only if

(1) The clinic has signed a participation agreement and has been set up as a participating provider under one of the following provider types: Independent Clinic, Public Health Department Clinic, Planned Parenthood Clinic, Professional Clinic Optometry, Community Mental Health Center.

Revised Submission 5/10/11



State Missouri

(2) The physician or optometrist actually performing, or exercising a direct personal supervision of the performance of the service, unless exempted by the Medicare Primary Care Exception as defined in 42 CFR 415.174 , is participating in the Physician or Optical Care Program and is identified on each line item of service representing a professional service for which they are responsible by their provider identification number. This applies to all clinic provider types.

Clinic services are payable in accordance with all guidelines, restrictions, and limitation of Physicians' Services for all the clinic provider types except Professional Clinic Optometry which is the same as Optometrists Services and those Independent Clinics having an Ambulatory Surgical Care Type of Service designation. Ambulatory Surgical Care covered services are those specifically listed surgical procedures and related ancillaries which are provided in accordance with A.S.C. guidelines. Obstetrical delivery services are not included. Prior Authorization is required for the surgical procedures of Blepharoplasty and Excision of Keloids when performed in an Ambulatory Surgical Care Clinic.

The global prenatal benefit covers all prenatal visits, routine urinalysis testing and pregnancy related conditions during the recipient's pregnancy period. Coverage of this benefit requires a minimum of four prenatal visits be provided and will be limited to one global service per pregnancy.

Coverage for clinical services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Corneal transplants are covered without a requirement of prior authorization.

Revised 7.22.11



Adult Day Health Care Services:

Service is provided to recipients 18 and over with functional impairments who would otherwise require a nursing facility level of care. An individual plan of care provides up to 10 hours of care, and includes a program of organized therapeutic, rehabilitative and social activities, as well as medical supervision, medication services, meals and snacks, and necessary transportation.

The plan of care is developed in collaboration with a physician and must be reviewed at least every six months.

Adult day health care services will sunset as of December 31, 2012.

Revised 2.28.11



State: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The definition and determination of reasonable charge as administered by the MO HealthNet Division in establishing rates of payment for medical services will be that charge which most nearly reflects the provider's usual and customary charge to the general public for the service, as qualified by application of available prevailing charge resources and the upper and lower limitations of payment stipulated or optionally provided in Federal regulation.

If the funds at the disposal or which may be obtained by the MO HealthNet Division for the payment of medical assistance benefits on behalf of any person under one or more of the following specific medical services reimbursement methods, shall at any time become insufficient to pay the full amount thereof, then, pursuant to state law, the amount of any payment on behalf of each of such persons shall be reduced to pro rata in proportion to such deficiency in the total amount available or to become available for such purpose. In accordance with requirements of Title 42, Code of Federal Regulations, 447.204, the agency's payments will not be reduced beyond the point at which they become insufficient to enlist enough providers so services under the plan are available to recipients at least to the extent that those services are available to the general population.

PHYSICIAN, DENTAL AND PODIATRY SERVICES

Physician Services (includes doctors of medicine, osteopathy, podiatry, dentistry).

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the MO HealthNet Division. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CFR 447 Subpart F. Agency payment will be the lower of:

(1) The provider's actual charge for the service; or
(2) The allowable fee based on reasonable charge as above determined.

For certain specified diagnostic laboratory services included under the Title XVIII Medicare fee schedule, and when provided in a physician's place of service, Medicaid payment will not exceed the maximum allowable Medicare payment.

Payment for physician services for those organ and bone marrow transplant services covered as defined in Attachment 3.1-E will be made on the basis of a reasonable charge determination resulting from medical review by the Medical Consultant.

The state agency will reimburse providers of Physician's Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

Revised 2.28.11



STATE: Missouri

OPTOMETRIC SERVICES

For optometric services including services provided by professional clinics of optometry, the state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the MO HealthNet Division. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CRF 447 Subpart D. Agency payment will be the lower of:

(1) The provider's actual charge for the service; or
(2) The allowable fee based on reasonable charge as above determined.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of optometric services including services provided by professional clinics of optometry. The agency's fee schedule rate was set as of July 1, 2010 and is effective for services provided on or after that date. The fee schedule and any annual periodic adjustments to the fee schedule are published at http://www.dss.mo.gov/mhd/index.htm.

The state agency will reimburse providers of any Optometric Services that may be covered under Medicare Part B, to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

Revised 2.28.11



State Missouri

EMERGENCY AMBULANCE SERVICES

The state agency will establish rates for reimbursement which are defined and determined as reasonable by the MO HealthNet Division in accordance with 42 CFR 447 Subpart D. Reimbursable elements of service shall be a basic service charge, specified ancillaries, and a specified allowance for mileage. Payment will be based on the lower of:

1. The provider's actual charge, or;
2. The reasonable rate as determined above.

The state agency will reimburse providers of Emergency Ambulance Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

HOME HEALTH SERVICES

The state agency will establish rates for reimbursement as defined and determined by the MO HealthNet Division in accordance with 42 CFR 447 Subpart D and state regulation 13 CSR 70-90.020. Payment will be based on the lower of:

(A) The provider's billed charge for the service; or
(B) The Title XVIII interim Medicare rate in effect as of the date of service as determined by the Medicare fiscal intermediary; or
(C) The Medicaid maximum allowable fee for service.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both public and private providers of home health program services (intermittent or part-time nursing services, home health aide services, therapy services, and medical supplies). The agency's fee schedule rate was set as of July 1, 2008 and is effective for services provided on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dss.mo.gov/mhd/index.htm.

DRUG SERVICES

The state agency will utilize the definitions, standards and methods described in 42 CFR 447.301 and 447.331 through 447.334 in establishing payment rates for prescribed drugs on the Missouri drug list.

Reimbursement for multiple source drugs selected by HCFA will be made at the lower of the –

(A) Usual and customary charge as billed by the provider; or

Revised 6/17/11



State Missouri

Medical Equipment Services

The state agency will reimburse Durable Medical Equipment, orthotic and prosthetic devices, rehabilitative training, hearing aids and audiological services in accordance with the provisions of 42 CFR 447 Subpart F. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service, or;
(2) The allowable fee based on reasonable charge as above determined.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both public and private providers of Durable Medical Equipment, orthotic and prosthetic devices, rehabilitative training, hearing aids and audiological services. The agency's fee schedule rate was set as of August 15, 2010 and is effective for services provided on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dss.mo.gov/mhd/index.htm.

The state agency will reimburse providers of Durable Medical Equipment, orthotic and prosthetic devices, rehabilitative training and any such Medicare covered audiological services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

Rural Health Clinic Services

Rural Health Clinic services will be reimbursed using the methods established under the Medicare Program. Ambulatory services provided but not covered under the Rural Health Clinic Program will be reimbursed on a fee-for-service basis using rates established by the state agency.

Ambulatory Surgical Care Clinics

The state agency will reimburse Ambulatory Surgical Care providers for covered surgical procedures and related ancillaries in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for service will be made on the lower of:

(1) The provider's actual charge for the service, or;
(2) The Medicaid maximum allowable fee under the established all-inclusive rate.

The state agency will reimburse providers of Ambulatory Surgical Care services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

Nurse-Midwife Services

The state agency will reimburse providers of nurse-midwife services the lower of the provider's usual and customary charge to the general public or the Medicaid maximum allowable amount. For those services reimbursable as nurse-midwife services, the maximum allowable amount will be the same as the physician fees applicable to comparable services.

Revised 7.22.11



State Missouri

Adult Day Health Care

The state agency shall reimburse Adult Day Health Care services in accordance with provisions of state regulation 13 CSR 70-92.010. Payment will be made in accordance with a fixed fee per unit of service as defined and determined by the MO HealthNet Division. A unit of service is defined as a full day (6-10 hours) of service or a half day (3-5 hours) of service. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or
(2) The established rate per service unit as determined by the state agency.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Adult Day Health Care. The agency's fee schedule rate was set as of June 30, 2008 and is effective for services provided on or after that date. All rates are published at http://www.dss.mo.gov/mhd/index.htm.

The total monthly payment made in behalf of an individual for Adult Day Health Care services in combination with other alternative services, including personal care and Home and Community-Based Waiver Services for the Elderly within a calendar month cannot exceed one hundred percent (100%) of the average statewide monthly cost to the state for care in a nursing institution (excluding state mental hospitals and state mental institutions for mental retardation).

Adult day health care services will sunset as of December 31, 2012.

Case Management Services for the Developmentally Disabled, Severely Emotionally Disturbed, Chronically Mentally Ill

The state agency will reimburse Case Management Services providers at rates as defined and determined by the MO HealthNet Division and established in accordance with the provisions of 42 CFR 447 Subpart F. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service; or
(2) The Medicaid maximum allowable fee for service.

The state payment for each service will be the lower of the provider's actual charge or the Medicaid maximum allowable fee for the service. State developed fee schedule rates are the same for both governmental and private providers of case management services. The agency's fee schedule rate was set as of April 2009 and is effective for services provided on or after that date. All rates are published at http://www.dss.mo.gov/mhd/index.htm.

Revised 2.28.11



State Missouri

Method establishing payment rates for case management services for developmentally disabled individuals.

For employees of the state, county SB-40 boards, affiliated community service providers, and not-for-profits:

The initial uniform prospective hourly fee for case management will be established based on the weighted average hourly cost of all providers as calculated from providers' most recent available cost reports. Cost reports include non-productive time including training time, vacation, holiday and sick leave. The initial calculated fee, which will be based on costs for FY '00, will include an annual and, if appropriate, partial year inflation factor. Annually thereafter until rebasing, on July 1 the previous year's uniform hourly fee will be adjusted by the Consumer Price Index as determined by the Bureau of Labor Statistics or, if available, a Missouri-specific health care index of inflation. The uniform prospective hourly fee will be rebased at least once every ten years. For each rebasing year, the uniform prospective hourly fee will be calculated in the same manner as the initial fee described above. The unit of service is 5 minutes with a limit of 240 units per day per participant. The uniform prospective hourly fee is further computed to a 5 minute fee. All providers, statewide, are reimbursed at the same fee.

Method for establishing payment rates for case management services for Severely Emotionally Disturbed (SED) children

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems. Cost reports include non-productive time including training time, vacation, holiday and sick leave. The unit of service is 15 minutes with a limit of 32 units per day or 96 units per month per participant. The fee is statewide. All providers, governmental and non-governmental, are reimbursed at the same fee.

Method for establishing payment rates for case management services for chronically mentally ill adults.

The payment rate for case management services will be on a fee for service basis. The fee will be established on the basis of actual cost data derived from cost reporting systems. A separate fee for community reintegration services will be established on the basis of actual cost data derived from cost reporting systems. . Cost reports include non-productive time including training time, vacation, holiday and sick leave. The unit of service is 15 minutes with a limit of 32 units per day or 96 units per month per participant. Each fee is statewide. All providers, governmental and non-governmental, are reimbursed at the same fee.

Added 2.28.11



State: Missouri

Independent Clinics

Services provided by Independent Clinics shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the MO HealthNet Division

Except as otherwise noted in the State Plan state developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after February 10, 2011 for these services can be found on the MO HealthNet Division's official Web site at http://www.dss.mo.gov/mhd/index.htm.

Public Health Clinics

Services provided by Public Health Clinics shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the MO HealthNet Division

Except as otherwise noted in the State Plan state developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after February 10, 2011 for these services can be found on the MO HealthNet Division's official Web site at http://www.dss.mo.gov/mhd/index.htm.

Community Mental Health Clinics

Services provided by Community Mental Health Clinics shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the MO HealthNet Division

Except as otherwise noted in the State Plan state developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after February 10, 2011 for these services can be found on the MO HealthNet Division's official Web site at http://www.dss.mo.gov/mhd/index.htm.

Planned Parenthood Clinics

Services provided by Planned Parenthood Clinics shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule as determined by the MO HealthNet Division

Except as otherwise noted in the State Plan state developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after February 10, 2011 for these services can be found on the MO HealthNet Division's official Web site at http://www.dss.mo.gov/mhd/index.htm.