Revised Submission
11-19-12

State Missouri

Coverage of services related to the performance of certain specified elective surgical procedures is allowed when medically necessary. Elective surgical operations shall be defined as those in which the patient's life will not be threatened and the patient's health will not be permanently impaired by any delay in performing the surgery. Coverage is provided for a documented second or third opinion, at the participant's choice, when the primary recommendation for the surgery fails to confirm the need for surgery.

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

PHYSICIAN ATTESTATION POLICY FOR HOSPITALS

MO HealthNet's requirements are the same as Medicare Program requirements for physician attestation statements.

2. a. Outpatient Hospital Services

Coverage of services related to the performance of certain specified elective surgical procedures is allowed when medically necessary. Elective surgical operations shall be defined as those in which the patient's life will not be threatened and the patient's health will not be permanently impaired by any delay in performing the surgery. Coverage is provided for a documented second or third opinion, at the participant's choice, to confirm the need for surgery.

Payment is made to a hospital for physician's services only if the physician is hospital based and has signed a Medicaid participation agreement.

2.b. Rural Health Clinic Services

Payment will be made for services provided in a rural health clinic only when that clinic has been certified for participation in the Title XVIII Medicare Program by the Bureau of Hospital Licensing and Certification of the Missouri Department of Health and Senior Services or by comparable agencies in other states. RHC services include ambulatory services included in the State Plan under Title XIX of the Social Security Act and include, but are not limited to, services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers and nurses.

2.c. Federally Qualified Health Center (FQHC) Services

FQHC services include ambulatory services included in the State Plan under Title XIX of the Social Security Act and include, but are not limited to, services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers and nurses.

(1) Provider Participation. To be eligible for participation in the Missouri FQHC program, a provider must submit proof satisfactory to the MO HealthNet Division that it meets the following conditions:

(A) The health center receives a grant under section 329, 330 or 340 of the Public Health Services Act or the Secretary of Health and Human Services (HHS) has determined the health center qualifies by meeting other requirements. If a FQHC identified in the grant has multiple sites, the

4.c. Family Planning Service

Family planning is defined as any medically approved diagnosis, treatment counseling, drugs, supplies, or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. The limitations in the Pharmacy, Physician, Inpatient Hospital and Outpatient Hospital Programs also apply to recipients receiving family planning services under any of the respective programs.

Sterilizations

Voluntary sterilizations are covered if the recipient is at least 21 years old at the time consent is obtained, is not a mentally incompetent individual or an institutionalized individual, and has voluntarily given informed consent. All of the federal requirements for informed consent documentation must be satisfied and the consent form must be attached to the claim.

Hysterectomies

Medicaid will not pay for a hysterectomy with the sole or main purpose of rendering an individual permanently incapable of reproducing. Hysterectomies for medically necessary reasons are covered only if the federal requirements for prior certification of the giving and receipt of information are satisfied. Hysterectomies may also be covered if performed as a life preserving necessity and prior acknowledgment was not possible or where the individual was already sterile. These conditions require physician certification of the circumstances.

5.a. Physician Services

A new patient office visit is limited to one per provider for each participant. An adult "preventive" examination/physical, including a well woman exam (ages 21 and older) is limited to one per provider per year for each participant. Office/outpatient services are to be used for "illness" care and are limited to one visit per participant per provider per day. Additional medically necessary visits on the same day may be covered if a properly completed medical necessity form accompanies the claim and shows medical need of the additional visit.

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(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 participant'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 is allowed when medically necessary. Elective surgical operations shall be defined as those in which the patient's life will not be threatened and the patient's health will not be permanently impaired by any delay in performing the surgery. Coverage is provided for a documented second or third opinion, at the participant's choice, to confirm the need for surgery.

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