Missouri Department of Health and Senior Services
Division of Community and Public Health
Section for Special Health Services
Bureau of Special Health Care Needs

Children and Youth with Special Health Care Needs (CYSHCN) Program

PROVIDER MANUAL

December 29, 2015

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CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM DESCRIPTION

The Children and Youth with Special Health Care Needs (CYSHCN) Program provides assistance statewide for individuals from birth to age 21 who have or are at increased risk for a disease, defect or medical condition that may hinder their normal physical growth and development and who require more medical services than children and youth generally. The Program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As payer of last resort, the Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines.

Service coordination facilitates, implements, coordinates, monitors, and evaluates services and outcomes, and encourages participants/families to develop skills needed to function at their maximum level of independence.

Eligibility

To be eligible for Program services, the participant must:

- Be a resident of the State of Missouri,
- Be under age twenty-one (21),
- Have an eligible special health care need, and
- Meet financial eligibility guidelines for funded services.

Services

The Program provides two primary services:

- Program service coordination, which includes:
  - Outreach activities and early identification of participants,
  - Eligibility determination,
  - Assessment of needs,
  - Coordination of services through resource identification and referral,
  - Family support,
  - Service plan development/implementation,
  - Monitoring and evaluation,
  - Transition to community-based services, and
  - Closure.
- Limited funding for medically necessary diagnostic and treatment services.

CYSHCN is payer of last resort. The Service Coordinator will assist the participant/family with resource identification and referral. All third party liability must be exhausted prior to accessing CYSHCN funds.

CYSHCN PROGRAM PHILOSOPHY

The Program philosophy is to provide for the early identification and integration of resources for all eligible children and youth who have a special health care need. Early identification and integration of resources will enhance the best possible health outcomes with the greatest degree of independence within the community.

The Program respects the dignity of each individual and their family, and partners with the participants/families to achieve coordinated, ongoing, comprehensive care within a medical home which will provide for successful transitions into adulthood.

CORE VALUES

The Program is guided by the following core values:

- Person-centered,
- Outcome oriented,
- Community inclusion,
- Family's involvement in ongoing planning,
- Personal/family responsibility for achieving independence, and
- Collaborative relationships in all areas.

Service coordination is provided to all Program participants, regardless of financial status. Limited funding is available to participants who are medically eligible for the Program, and whose family income is at or below one hundred eighty-five (185) percent of the Federal Poverty Guidelines.

The Program is the payer of last resort. The Service Coordinator will assist the participant/family with identification and access to any and all other payment sources before submitting requests for use of Program funds. The Program will be billed only after all third party sources have been exhausted.

SPECIAL HEALTH CARE NEEDS (SHCN) MISSION

To develop, promote, and support community-based systems that enable the best possible health and greatest degree of independence for Missourians with special health care needs.

CONTACT INFORMATION

Claims are accepted by mail or fax. Claims and supporting documentation must be sent to the SHCN Central Office at the address or fax number listed. Claims sent to Service Coordinators or family members will not be accepted.

If a provider chooses to fax a claim to SHCN, please do not mail the original, unless requested to do so by SHCN Central Office. All duplicate claims will be denied.

Special Health Care Needs
P.O. Box 570
Jefferson City, MO 65102

Claims Inquiry Phone: (573) 751-6245

Claims Submission Fax: (573) 522-2107

Additional information for CYSHCN Providers can be found at the following web address: health.mo.gov/living/families/shcn/cshcnproviders.php

Provider Enrollment/Questions: (573) 751-6246

PROVIDER ENROLLMENT/APPLICATION

Special Health Care Needs (SHCN) will contract with providers to obtain medical care and ancillary services for participants covered by the Children and Youth with Special Health Care Needs (CYSHCN) Program. Participants enrolled in CYSHCN must receive services from a SHCN approved provider.

SHCN requires providers to be enrolled with MO HealthNet and Medicare to be considered for approval as a SHCN provider. Orthodontists and interpreters are excluded from this requirement.

Prospective providers must contact SHCN by telephone or in writing to obtain an application packet.

Inpatient:

- Treatment Centers who have an accreditation certification by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association, and/or Commission on Accreditation of Rehabilitation. Facilities wishing to provide comprehensive medical care must submit a:
    - Participation Agreement for Professional and Special Services Provider (DH-74A),
    - Provider Application (CC-35), and
    - Vendor Input/ACH-EFT Application.

Individual Providers:

- Providers who are licensed/certified by the State of Missouri and wish to receive payment in their name must submit a:
    - Participation Agreement for Professional and Special Services Provider (DH-74A),
    - Provider Application (CC-35), and
    - Vendor Input/ACH-EFT Application.

Group Providers:

- Providers, who are members of a provider group that is licensed/certified by the State of Missouri and submit invoices for payment under the group name, must make a group application.
- The authorized representative designated by the group must complete a Participation Agreement for Professional and Special Services Provider (DH-74A), Provider Application (CC-35), and Vendor Input/ACH-EFT Application.
- The group provider is responsible for ensuring that appropriately certified or licensed staff provide services to CYSHCN participants.
- The Department of Health and Senior Services, Special Health Care Needs will not reimburse for services that require a license or certification if provided by individuals who are not licensed or certified by the State of Missouri.

Approval:

- If the provider meets SHCN provider qualifications, approval will be sent to the provider with a copy of the approved Participation Agreement for Professional and Special Services Provider (DH-74A).
- If the provider does not meet SHCN provider qualifications, notification will be sent to the provider outlining the reason for denial.

Notification of Change of Information:

- All providers must notify SHCN in writing when there is:
    - An official name change,
    - A change in address, and/or
    - A change in Federal Tax Identification Number.
- If needed, SHCN will request that an updated Participation Agreement for Professional and Special Services Provider (DH-74A), Provider Application (CC-35), and Vendor Input/ACH-EFT Application be submitted.

Licensure Requirements:

- Temporary licenses are not acceptable.
- Licensure requirements for SHCN providers:

PROVIDER TYPE	PROFESSIONAL REQUIREMENTS
Audiologist	• Missouri License
Chiropractor	• Missouri License • Certified by the American Chiropractic Association
Dentist	• Missouri License • Certified by the American Dental Association
Dietitian	• Certification from the American Dietetic Association, Commission on Dietetic Association
Durable Medical Equipment Respiratory Therapy Services	• Missouri License (if applicable)
Emergency Transportation	• Missouri License
Emergency Care Center	• Missouri License
Hospitals	• Missouri License
Interpreter – Bilingual	• Demonstrated Competency
Interpreter – Sign	• Missouri License
Nurse Practitioner	• Missouri License
Occupational Therapist	• Missouri License
Ophthalmologist/Optometrist	• Missouri License
Pharmacy	• Missouri License
Physical Therapist	• Missouri License

Physician	• Missouri License • Board Certified or Board Eligible (Board Diplomat or Active Board Candidate) by the American Medical Association or American Osteopathic Association
Speech Pathologist/Speech Therapist	• Missouri License

SHCN PROVIDER MONITORING

Providers must maintain accurate client invoice files. DHSS has the authority to review client records and Provider billings. Program Staff will monitor all providers periodically.

CONFIDENTIALITY
SHCN providers must maintain strict confidentiality, as indicated by the Participation Agreement, regarding all participant information supplied to them by SHCN or obtained as a result of contract activities.

Breach of confidentiality may result in one or more of the following sanctions:

- Suspension and/or termination of the Participant Agreement for Professional and Special Services Provider (DH-74A).
- Withholding of payment.
- Referral for investigation to the State Board of Registration for the Healing Arts or other appropriate state licensing agency.

BILLING/CLAIM PROCEDURES

CYSHCN billing guidelines must be followed in order for services to be considered for payment. Billing guidelines include but are not limited to:

- Participant must be actively enrolled in the CYSHCN Program on the date of service.
- Provider must be an enrolled SHCN provider on the date of service.
- CYSHCN must receive provider claims within 60 calendar days of the date of service or within 60 calendar days of the Explanation of Benefits (EOB)/Remittance Advice (RA) process date but no longer than 6 months from the date of service.
- CYSHCN will only reimburse up to the amount of the participant's/family's responsibility.
- Participants/families will not be billed for approved CYSHCN services.
- Some services require prior authorization which must be obtained before the delivery of services.
- Services must be medically necessary and directly related to the participant's CYSHCN eligible diagnosis.
- CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.
- Participants with private insurance or MO HealthNet must utilize in-network providers.
- CYSHCN is the payer of last resort.
- Hearing aid claims must be accompanied by the invoice.
- Claims must be billed to CYSHCN (not the participant/family or other third party payers).
- The claim should list the Usual and Customary Rate (UCR), not the prior authorized amount.
    - UCR is the individual provider's standard charge to the general public for the service, supply or equipment.

Current Claims Submission Guidelines can be found at:
http://health.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf

Additional Provider Responsibilities

- CYSHCN Program participants are issued an eligibility letter and are instructed to present this letter to providers before the provision of service. It is the provider's responsibility to obtain a copy of this eligibility letter.
- The provider is encouraged to consult with the participant's Service Coordinator to verify participant eligibility and to obtain a prior authorization for services when required. The Service Coordinator's contact information is listed on the participant's eligibility letter.
- It is the responsibility of the provider to obtain prior authorization of services from CYSHCN. Neither CYSHCN nor the participant/family will be responsible for payment of a service when the provider fails to complete the CYSHCN prior authorization process. (Refer to the section "Prior Authorization".)

- The provider must submit claims on the appropriate billing form:
    - CMS-1500,
    - UB-04, or
    - Dental Claim Form.

Third Party Coverage

- If the participant is covered by other payment sources (private insurance or MO HealthNet), claims must be filed with these payers prior to filing with CYSHCN.
- CYSHCN may be billed only after all third party sources have been exhausted.
- CYSHCN may consider the patient responsibility remaining after third party settlements.
- A copy of the Explanation of Benefits (EOB) indicating the reimbursement received from insurance, a rejection statement, and/or the MO HealthNet Remittance Advice including an explanation and/or denial codes must be submitted with the claim.
- The provider will submit any evidence regarding the filing of liens and/or litigation regarding the claim.
    - Such evidence must support the claim and contain information concerning future potential recoveries.

Submission Deadlines

- CYSHCN must receive provider claims within 60 calendar days of the date of service or within 60 calendar days of the Explanation of Benefits (EOB)/Remittance Advice (RA) process date but no longer than 6 months from the date of service.
    - Services delivered prior to June 30th must be submitted to CYSHCN no later than July 31st due to fiscal year limitations. CYSHCN is under no obligation to pay claims for dates of service in the prior fiscal year if these claims are submitted after July 31st.
- If a claim is denied for lack of required documentation (e.g. medical records, hearing aid invoice, EOB, etc.), a new claim form must be submitted with the required documentation within 60 calendar days of the SHCN warrant/voucher date. Medical records/documentation submitted without an accompanying claim form will not be processed.
- Requests for repayment of inappropriate refunds must also be made within 60 calendar days of the SHCN warrant/voucher date.

Reimbursement

- Current reimbursement rates and prior authorization information can be found at: http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf
- Reimbursement of charges may be delayed if appropriate documentation is not received with the claim.
- CYSHCN reimbursement for eligible services must be accepted as payment in full.
    - The provider cannot request payment for eligible services from CYSHCN participants or their families.

- Repair or replacement of supplies/equipment due to any reason other than normal wear and tear or physical growth of the participant will not be considered for reimbursement. Providers shall report suspected abuse of supplies/equipment to the Service Coordinator.
- CYSHCN retains the right to deny payment when a participant becomes ineligible for coverage.
- Reimbursement is calculated based on the provider's Usual and Customary Rate (UCR) for the billed service/product.
- Claims are processed in the order they are received by SHCN, not by the date of service.

Corrected Claims

When inaccurate information has been submitted on a previous claim form, the provider must submit a new claim and indicate “corrected claim” at the top of the new claim.

Overpayments/Refunds

- If a provider submits a claim that results in an overpayment or receives payment from another third party source, after a claim has been reimbursed by CYSHCN, it is the responsibility of the provider to notify SHCN. The provider shall submit a refund to SHCN immediately and include:
    - Participant name,
    - Participant DCN,
    - EOB/RA when applicable, and
    - Explanation for the refund.
- Requests for repayment of inappropriate refunds must be made within 60 calendar days of the SHCN warrant/voucher date.

CYSHCN CLAIMS SUBMISSION GUIDELINES

Special Health Care Needs (SHCN)
Claims Submission Guidelines for CYSHCN Program

BILLING REMINDERS:

- The participant must be actively enrolled in the CYSHCN Program on the date of service.
- The provider must be an enrolled CYSHCN provider on the date of service.
- The provider must be in-network for the participant's private insurance, including MO HealthNet, for CYSHCN to consider reimbursement.
- The provider must submit claims on the appropriate billing form (CMS-1500, UB-04, or Dental Claim Form).
- A copy of the Explanation of Benefits (EOB) indicating the reimbursement received from insurance, a rejection statement, and/or the MO HealthNet Remittance Advice (RA) including an explanation and/or denial codes must be submitted with the claim.
- CYSHCN must receive provider claims within *60 calendar days* of the date of service or within *60 calendar days* of the EOB/RA process date but no longer than 6 months from the date of service.
  - Services delivered prior to June 30th must be submitted to CYSHCN no later than July 31st due to fiscal year limitations. CYSHCN is under no obligation to pay claims for dates of service in the prior fiscal year if these claims are submitted after July 31st.
- The provider must bill the Usual and Customary Rate (UCR) for all services, not the CYSHCN reimbursement amount.
- CYSHCN will consider the patient responsibility, up to the authorized reimbursement amount, after insurance has been exhausted.
- CYSHCN reimbursement for eligible services must be accepted as payment in full.
  - The provider cannot request payment for eligible services from CYSHCN participants or their families.
- Some services require prior authorization which must be obtained prior to delivery of services.
- CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.
- CYSHCN is the payer of last resort.
- CYSHCN may request medical records to assist in determining if services will be covered.

PHARMACY CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- NDC – National Drug Code
- Name of medication (generic or brand name),
- Insurance EOB/MO HealthNet RA or insurance payment amount, and
- Participant's/Family's financial responsibility.

HEARING AID CLAIMS:

- Health Insurance Claim Form (CMS-1500 or UB-04),
- Insurance EOB (if applicable),
- MO HealthNet RA (if applicable), and
- Hearing Aid Invoice (wholesale cost).

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

DENTAL CLAIMS:

- Health Insurance Claim Form (CMS-1500) or Dental Claim Form,
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

Reimbursement of charges will be denied or delayed if specified claim attachments are not received.

Provider Enrollment/Questions:
(573) 751-6246

Claims Questions:
(573) 751-6245

Claims and supporting documentation should be sent to:
Special Health Care Needs
PO Box 570
Jefferson City, MO 65102
OR
Claims Fax: (573) 522-2107

For prior authorization requirements and reimbursement information visit:
http://www.health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

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PRIOR AUTHORIZATION

The CYSHCN Program has limited financial resources. Prior authorization of services allows the Program to ensure efficient utilization of these resources through appropriate planning and budgeting.

Medically necessary services/equipment that are directly related to the participant's eligible condition will be considered for CYSHCN coverage. To ensure there is adequate documentation of medical necessity and that participants receive the least costly medically appropriate services/equipment certain services/equipment require prior authorization. It is the responsibility of the provider to obtain prior authorization from CYSHCN for services/equipment requiring prior authorization. Neither CYSHCN nor the participant/family will be responsible for payment of a service when the provider fails to complete the CYSHCN prior authorization process.

Prior approval must be obtained through the Service Coordinator and must be requested by the provider in writing on business letterhead and include:

- A detailed description of the service/equipment being requested including justification of medical necessity and
- An itemized statement of charges.

Requests for prior authorization shall be submitted no later than five (5) business days prior to the anticipated date of service. Verification of prior authorization must be obtained by the provider before the date of service in order for CYSHCN to consider reimbursement.

The CYSHCN Reimbursement Rate Schedule provides a comprehensive list of services and prior authorization requirements. It is located at http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf.

COVERED SERVICES

Based solely upon annual appropriations, the CYSHCN Program will consider payment for medically necessary diagnostic and treatment services when directly related to the participant's CYSHCN eligible diagnosis. This section provides information for some of the covered services. This is not an all-inclusive listing. Requests for services not included in this section or outside the prescribed purview below may be sent to the Program Manager, through the Service Coordinator, and will be clinically reviewed on a case by case basis.

Some services require prior authorization to be considered for payment. Please refer to the Prior Authorization section of this Manual or contact the Service Coordinator for information on the prior authorization process. For additional information on prior authorization requirements and reimbursement information, please refer to the CYSHCN Reimbursement Rate Schedule located at:
www.health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

Covered services include but are not limited to:

Audiology

Augmentative Communication Devices (including Evaluation, Purchase and Repair)

Consultation: CYSHCN approved physician may request a consultation from another SHCN approved physician whose opinion or advice is desired for the evaluation and/or management of the CYSHCN participant's care.

Dental Care: Only active participants who have a medical diagnosis of Cleft Lip and/or Palate, Seizure Disorder, and/or Velopharyngeal Incompetency (VPI) may be eligible for dental care. Prior approval must be obtained from the Service Coordinator for all dental care except routine dental checkups.

Participants with a diagnosis of Cleft Lip & Palate are eligible to receive:

- Dental Care - A maximum of two (2) routine dental checkups may be approved annually WITHOUT prior approval. A routine dental check-up consists of:
    - Examination
    - Fluoride treatment
    - Prophylaxis
    - Restorations (up to and including three (3) fillings - need not be on same day as the check up)
    - Sealants - need not be on same day as check up
    - X-rays
- Additional preventive or restorative dentistry, endodontics, periodontics, oral surgery, orthodontics, prosthodontics, and adjunctive treatments require a written prior approved dental plan.

Participants with a diagnosis of Seizure Disorder may be eligible to receive:

- Gingivectomy for participants on anticonvulsant therapy. This service requires prior approval through the Program Manager.

Participants with a diagnosis of Velopharyngeal Incompetency (VPI) are eligible to receive:

- Dental Care - only as it relates to prosthetic management.

Durable Medical Equipment/Supplies (including Purchase, Rental, and Repair)

Emergency Care Centers:

- When emergency care is necessary to stabilize the participant
- When severe harm would be caused if emergency care was not received

It is the responsibility of the provider to notify CYSHCN within three (3) business days of the provision of emergency care. Neither CYSHCN nor the participant/family will be responsible for payment for a service when the provider fails to notify CYSHCN within three (3) business days.

Emergency Transportation:

- When emergency transportation is necessary to stabilize the participant
- When severe harm would be caused if emergency transportation was not received

Hearing Aid/Ear Molds/Repairs: When recommended by the evaluating Audiologist and Otolaryngologist, the following care and/or equipment may be considered for reimbursement:

- Audiological Evaluation - Includes all testing performed by the audiologist to determine if a hearing impairment is present.
- Cochlear Implants or Implanted Hearing Aids - The following care may also be considered for payment:
    - Equipment
    - Post-surgical aural rehabilitation
    - Pre-surgical evaluation
    - Surgical implantation and hospitalization costs
- Earmolds
- FM System/Auditory Training Unit - CYSHCN will cover the cost of a personal FM System/Auditory Trainer for home use. CYSHCN will not purchase FM Systems to be used by multiple students in a school/classroom. CYSHCN will cover the cost of accessories to a personal hearing aid that will allow the use of a school/classroom FM System.
- Hearing Aid Batteries
- Hearing Aid Evaluation
- Hearing Aid Purchase - Hearing aid(s) selection is not restricted. Hearing aid requests are subject to prior approval by the Program Manager. The audiologist shall assure and include as part of their written report that the hearing aid

selected is the least expensive of the appropriate hearing aids tested during the hearing aid evaluation. If only one model hearing aid is appropriate, this should also be stated in the hearing aid evaluation report.

- Hearing Aid Repair - The cost of repair of a hearing aid worn by a participant may be billed to CYSHCN. It is the responsibility of the Audiologist to utilize existing warranties and to consider the cost of repair to an "old" hearing aid in comparison to the purchase price of a new hearing aid. Consultation with the participant's Service Coordinator is recommended if there is question of the appropriate action. Abuse to the hearing aid or the need for frequent repair should be reported to the participant's Service Coordinator.
- Postage and Handling

Hemophilia Factor

Inpatient Care: The provider will notify CYSHCN within three (3) business days of admission in order for CYSHCN to consider payment. Neither CYSHCN nor the participant/family will be responsible for inpatient care service charges when the three (3) business days' notification is not received.

Interpreter Fees: When the provision of service coordination is not possible due to the inability to communicate.

Medical Record Fees: Only if the provider is not enrolled with SHCN.

Office Visits

Out-of-State Coverage: Only in cases of emergency or when the service is not available in the State of Missouri.

The provider will notify CYSHCN within three (3) business days of the emergency service in order for CYSHCN to consider payment. Neither CYSHCN nor the participant/family will be responsible for emergency care service charges when the three (3) business days' notification is not received.

Outpatient Care

Prescription Medications: Generic and brand name prescription medications are considered for coverage; however, over-the-counter medications are not covered.

Professional Fees – Inpatient/Outpatient

Specialized Formula/Feeding Supplies

Therapies (including Evaluation and Treatment): In-home evaluation/therapy services are not covered.

CYSHCN REIMBURSEMENT RATE SCHEDULE

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

SERVICE*	PRIOR AUTHORIZATION REQUIREMENTS**	REIMBURSEMENT RATE
AUDIOLOGICAL PROCEDURES	Required through PM regardless of cost for service plan entry	**80% UCR**
DENTAL (Up to 2 routine dental check-ups annually)	Not required	**80% UCR**
DENTAL (Orthodontic/Prosthodontic Procedures including Extractions)	Required through PM regardless of cost	**80% UCR**
DURABLE MEDICAL EQUIPMENT Includes:		
General DME	Required if greater than $300	**80% of UCR**
Repair	Required regardless of cost	**80% of UCR**
Rental (Up to purchase price)	Required regardless of cost	**Negotiated through Prior Authorization**
Orthotic & Prosthetic Devices	Required if greater than $300	**80% of UCR**
Augmentative Communication Evaluation & Device	Required through PM regardless of cost	**80% of UCR**
Disposable Supplies (Diapers, etc.)	Required if greater than $300	**80% of UCR**
Hearing Aids	Required through PM regardless of cost	**Wholesale cost plus 10%**
Cochlear Implants, FM Systems & Magnifiers	Required through PM regardless of cost	**80% of UCR**
Ear Molds	Required for service plan entry	**80% of UCR**
Hearing Aid Accessories	Required if greater than $300	**80% of UCR**
Hearing Aid Repair	Required regardless of cost	**80% of UCR**
EMERGENCY CARE CENTERS	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
EMERGENCY TRANSPORTATION	Not required	**80% UCR**
HEMOPHILIA FACTOR	Required for service plan entry	**Average Wholesale Price – 10.43% + Dispensing Fee**
INPATIENT HOSPITALIZATION Includes:	Required through PM regardless of cost:	
Evaluation & Treatment for Eligible Condition including Surgery & Special Procedures	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
INTERPRETER FEES	Required for service plan entry	**$8.00/unit (1 unit equals 15 minutes)**
MEDICAL NUTRITIONAL SERVICES	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
OFFICE/OUTPATIENT CLINIC VISIT	Not required	**$25 Established Patient** **$60 New Patient**
OFFICE VISIT PROCEDURES	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) PROGRAM REIMBURSEMENT RATES

(For dates of service on or after 7/1/14)

OUTPATIENT PROCEDURES & SURGERY Includes:	Required through PM regardless of cost:	
Emergency	Notification required within three (3) business days for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
Non-Emergency	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**
PROFESSIONAL FEES – INPATIENT/OUTPATIENT (Ambulatory Surgical Centers, Anesthesiology, Consultation, Emergency, Pathology, Radiology & Special Procedures)	Not required	**Up to $100 paid in full. Balance of $100 or more, paid at 54% with a maximum reimbursement of $800 a day**
PRESCRIPTION MEDICATIONS Includes:		
Formula (Specialized)	Required through PM regardless of cost	**90% of UCR**
Pharmacy, Physician's Office & Treatment Center	Required for service plan entry	**90% of UCR**
THERAPIES/EVALUATIONS Includes:		
Auditory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Occupational Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Physical Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Respiratory Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Speech Therapy	Required through PM regardless of cost	**$16.50/unit (1 unit equals 15 minutes)**
Evaluations/Re-Evaluations	Not required	**$60**

** Services must be medically necessary and directly related to the participant's eligible condition for CYSHCN to consider payment.*

*** Services exceeding $300 annually require prior authorization from the CYSHCN Service Coordinator. Services exceeding $2,500 annually require prior authorization through the CYSHCN Program Manager (PM).*

Rates are subject to change. For current reimbursement rates refer to:
http://health.mo.gov/living/families/shcn/pdf/cshcnrateschedule.pdf

For current claims submission guidelines refer to:
http://health.mo.gov/living/families/shcn/pdf/ClaimsGuide.pdf

CYSHCN will consider limited funding for eligible medical conditions up to $25,000 annually per participant.

NON-COVERED CONDITIONS

Common childhood illnesses/conditions that would not be eligible for services include, but are not limited to:

- Abscesses
- Allergies
- Backache
- Colds
- Constipation
- Cough
- Croup
- Diaper rash
- Diarrhea
- Earaches
- Fever, non-specific
- General acute illnesses
- Headache
- Head lice
- Hyperopia (Farsightedness)
- Insect bites and stings
- Myopia (Nearsightedness)
- Non-specific rash/dry skin
- Nose bleeds
- Pink eye
- Simple fractures
- Sore throat
- Sunburns
- Tonsillitis
- Upper respiratory illness

Other ineligible conditions include but are not limited to:

- Asthma
- Behavioral Disorders
- Diabetes
- Failure to Thrive
- Malignant Neoplasms
- Mental Retardation
- Progressive or Degenerative Neurological Conditions
- Psychiatric Disorders

NON-COVERED SERVICES/SUPPLIES/DURABLE MEDICAL EQUIPMENT (DME)
Common supplies, services and DME excluded from CYSHCN Program coverage include, but are not limited to:

- Cosmetic Procedures/Surgery (performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem)
- Dialysis
- Diapers/Incontinent Pads (excluded for children under the age of four (4) years)
- Experimental Treatment
- Home Health Care (nursing and personal care)
- Home Structural Adaptations
- Intelligence (IQ) Testing
- Medications Not Approved by Federal Drug Administration (FDA)
- Over-the-Counter Medications
- Organ Transplants
- Psychological/Psychiatric Evaluation and or Treatment
- Respite
- Routine Wellness Exams and Immunizations
- Vehicles/Vehicle Modifications

COVERAGE RESTRICTIONS

Coverage restrictions apply to the following conditions/services:

- Airway Obstruction – Limited to obstructions causing sleep apnea and/or dysphagia.
- Baclofen Pump – Limited to medically eligible conditions involving spasticity of the extremities. Requires prior approval with justification from a physician regarding the expected benefits.
- Benign Neoplasm – Limited to neoplasms that cause a functional impairment.
- Burns – Limited to burns that require inpatient hospitalization of at least seven (7) days and/or skin grafting.
- Cyst – Limited to long term cysts that cause significant functional impairment.
- Dental – Limited to the medical diagnosis of Cleft Lip and/or Palate, Seizure Disorder, or Velopharyngeal Incompetency (VPI).
- Craniofacial and Jaw Anomalies – Limited to anomalies that cause a significant functional impairment.
- Diapers/Incontinent Pads – Limited to children over four (4) years of age when necessity is related to an eligible medical condition.
- Ear, Nose, and Throat (ENT) Services - Limited to chronic ear pathology resulting in surgery and/or hearing impairment.
- Eye Diseases and Disorders - Limited to conditions caused by trauma or birth defect. (Myopia and Hyperopia are not covered.)
- Lymphedema – Limited to conditions requiring the use of compression garments and/or surgery.
- Metatarsus Adductus – Limited to conditions requiring surgery, casting or orthosis.
- Neuromyopathies – Limited to non-progressive conditions.
- Orthodontics – Limited to the medical diagnosis of Cleft Lip and/or Palate.
- Scar Revision – Limited to scars that cause a significant functional impairment.
- Varus & Valgus – Limited to conditions requiring casting, bracing, or surgery.
- Tonsillectomy and/or Adenoidectomy – Limited to conditions directly related to eligible ear pathology.

NON-COVERED PROVIDERS/SPECIALISTS
Services provided by the following specialist types will not be considered for coverage by the CYSHCN Program:

- Any provider/specialist with a temporary license
- Licensed Practical Nurse (LPN)
- Occupational Therapist Assistant
- Para Professional
- Physical Therapist Assistant
- Physician Assistant (PA)
- Registered Nurse (RN)

APPEAL PROCESS

Special Health Care Needs (SHCN) enrolled providers have the right to appeal decisions regarding denial of payment for services.

To appeal a decision made by SHCN, the provider must submit the following documentation to the Program Manager within *thirty (30) calendar days* of the SHCN warrant/voucher date:

- A letter describing the reason for the appeal;
- Documentation to support overturning the denial; and
- A copy of the claim being appealed.

The Program Manager will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a second appeal letter addressed to the Bureau Chief. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Program Manager's written decision date. The Bureau Chief will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a final appeal letter to the Department Director, or designee. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Bureau Chief's written decision date. The Department Director will make a final decision based on the evidence and documentation submitted with the appeal. A letter outlining the Director's decision will be mailed to the provider within *thirty (30) business days* of the receipt of the appeal.