

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



Description

The CYSHCN Program provides assistance statewide for individuals from birth to age 21 who have or are at increased risk for a 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 CYSHCN Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines.

Eligibility

The participant must:

- Be a Missouri resident
- Be birth to age 21
- Have an eligible special health care need (conditions such as Cerebral Palsy, Cystic Fibrosis, Cleft Lip and Palate, Hearing Disorders, Hemophilia, Paraplegia, Quadriplegia, Seizures, Spina Bifida, and Traumatic Brain Injury)
- Meet financial eligibility guidelines for funded services (family income at or below 185% of the Federal Poverty Guidelines)

Services

The CYSHCN Program provides two primary services:

- Service coordination is provided to all participants, regardless of financial status.
 - ◆ Outreach/Identification and Referral/Application
 - ◆ Eligibility Determination
 - ◆ Assessment of Needs
 - ◆ Resource identification, referral and access
 - ◆ Family support
 - ◆ Service Plan Development/Implementation
 - ◆ Monitoring and Evaluation
 - ◆ Transition/Closure
- Limited funding for medically necessary diagnostic and treatment services for participants whose families meet financial eligibility guidelines.
 - ◆ Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies.

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.

Special Health Care Needs
PO Box 570
Jefferson City, MO 65102-0570



Phone: (573) 751-6246
Toll-free: (800) 451-0669
<http://health.mo.gov/living/families/shcn/>

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

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 Includes:		
In-home	Required for service plan entry	\$12.00/unit (1 unit equals 15 minutes) with a 2 hour minimum
Telephone	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

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.

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) 751-6245

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>

Missouri Department of Health and Senior Services

Special Health Care Needs

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

Service Coordination Contact Information

Region 1
 Kansas City Health Dept.
Bernita Rogers
 (816) 513-6143
Aaron Niefert
 (816) 513-6311

Region 5
 Ralls County Health Dept.
Maekayla Wiler
 (573) 985-7121

Region 6
 Saline County Health Dept.
Beth Thomason
 (660) 886-9091

Region 7
 Saline County Health Dept.
Kara Walton
 (636) 358-9747

Region 10
 St. Louis County Dept. of Public Health
Priscilla Woodland
 (314) 615-0469
Tiffany Blue
 (314) 679-7920

Region 11
 Jefferson County Health Dept.
Elizabeth Laurentius
 (636) 282-1010 ext. 123

Region 2
 Kansas City Health Dept.
Bernita Rogers
 (816) 513-6143
Aaron Niefert
 (816) 513-6311

Region 3
 Henry County Health Center
Nancy McCloud
 (660) 890-8226

Region 4
 Dade County Health Dept.
Lea Ann Blanchard
 (417) 637-0321

Region 8
 Morgan County Health Center
Julie Enboden
 (573) 378-0234

Region 9
 Wright County Health Dept.
Natalia Moncada-Harris
 (417) 741-7791 ext. 3

Region 12
 Madison County Health Dept.
Janell Ward-Rehkop
 (573) 783-2747 ext. 3008

Region 13
 Butler County Health Dept.
Dee Warren
 (573) 785-1013

