

## 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 *90 calendar days* of the date of service or within *90 calendar days* of the EOB/RA process date but no longer than 6 months from the date of service.
  - Services delivered prior to June 30<sup>th</sup> must be submitted to CYSHCN no later than July 31<sup>st</sup> 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 31<sup>st</sup>.
- 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 payor 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),
- HCPCS/CPT Code and UCR,
- 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**  
**[CYSHCNClaims@health.mo.gov](mailto:CYSHCNClaims@health.mo.gov)**

**For CYSHCN provider information visit:**

**<https://health.mo.gov/living/families/shcn/cshcnproviders.php>**

**PROVIDER 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.