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	Required regardless of cost	**Negotiated through Prior Authorization (up to purchase price when applicable)**
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 (New & Established Patient)	Not required	**Varies by level of service**
OFFICE VISIT PROCEDURES	Required for service plan entry	**80% of UCR up to MO HealthNet Inpatient per diem rate**

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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**
PHARMACY SERVICES Includes:		
Prescription Medications	Required for service plan entry	**90% of UCR**
Compounded Medications	Required through PM regardless of cost	**90% of UCR**
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(s) for CYSHCN to consider payment.*

*** If not otherwise specified above, any service exceeding $300 annually requires prior authorization from the CYSHCN Service Coordinator and any service exceeding $2,500 annually requires prior authorization through the CYSHCN Program Manager (PM).*

CYSHCN will consider limited funding up to $25,000 annually per participant.

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

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