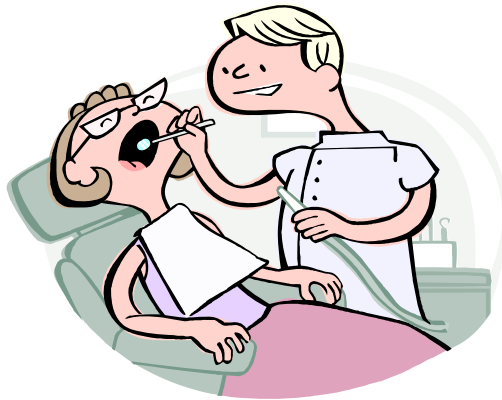


MO HealthNet Dental Billing Book



Missouri Department of Social Services
MO HealthNet Division

Created by the Provider Education Unit

MO HealthNet Dental Billing Book

Preface

This Dental training booklet contains information to help you submit claims correctly. The information is only recommended for MO HealthNet dental providers and billers. This booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

CDT 2011-2012 (Current Dental Terminology) codes, descriptions and other data are copyright 2010 (or other such date of publication of CDT) by the American Dental Association. All Rights Reserved.

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SECTION 1
MO HealthNet PROGRAM RESOURCES
<http://www.dss.mo.gov/mhd/providers/index.htm>

CONTACTING MO HealthNet

PROVIDER COMMUNICATIONS

573-751-2896

MO HealthNet providers can contact the Provider Communications Unit with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

The IVR (Interactive Voice Response) system is accessed by calling the 573-751-2896 number. The IVR system can address participant eligibility, last two check amounts and claim status inquiries. At anytime during the IVR options, providers may select "0" to speak with the next available specialist. Calls are put into a queue and will be answered in the order received. Providers must use a touchtone phone to access the IVR.

Providers may send and receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk Staff. This application is available through the MO HealthNet Web portal at www.emomed.com. Once logged in and on the eProvider page, click on the 'Provider Communications Management' icon, this opens the 'Manage Provider Communications' page. From here click on 'New Request' to open the 'Create New Request' form to enter and submit an inquiry. Providers are limited to one inquiry per E-mail. The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry.

The Provider Communications Unit also responds to written inquiries. Written inquiries should be sent to:

Provider Communications Unit
PO Box 5500
Jefferson City, Missouri 65102

WIPRO INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK

573-635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Wipro Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers are required to notify the Provider Enrollment Unit regarding changes to the Provider Master File. Changes include, but are not limited to, physical address, tax identification, ownership, individual's name or practice name, or NPI number.

Changes may be reported via E-mail at providerenrollment@dss.mo.gov or by mail to:

Provider Enrollment Unit
MO HealthNet Division
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

573-751-2005

Call the Third Party Liability Unit to report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MO HealthNet participant.

PROVIDER EDUCATION

573-751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for MO HealthNet claims. Contact the unit for training information and scheduling. Providers may also send E-mails to the unit at mhd.provtrain@dss.mo.gov.

PARTICIPANT SERVICES

800-392-2161 or 573-751-6527

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MO HEALTHNET PHARMACY AND CALL CENTER

800-392-8030

Providers can call this toll free number to:

- Request pre-certification for specific DME items;
- Initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program;
- Request information on Medicare Part D;
- Request a drug prior authorization; or,
- Request medical pre-certification for a CT scan or MRI.

Providers are encouraged to sign up for the MO HealthNet Web tool – CyberAccessSM – which automates the pre-certification process. To become a CyberAccessSM user, contact the ACS-Heritage help desk at 1-888-581-9797 or 573-632-9797 or send an E-mail to MoMedCyberaccess@heritage-info.com. The CyberAccessSM tool allows each pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and procedure codes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the HIPAA-EDI Companion Guide online by going to the MO HealthNet Division Web page at <http://www.dss.mo.gov/mhd/providers/index.htm> and click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the MO HealthNet Trading Partner Agreement, click on the link to Section 1- Getting Started; then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Wipro Infocrossing Healthcare Services Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR) **573-751-2896**

The Provider Communications Unit Interactive Voice Response (IVR) system, 573-751-2896, requires a touchtone phone. The ten-digit NPI (National Provider Identifier) number must be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options listed below. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

- Option 1 Participant Eligibility
Participant eligibility must be verified each time a participant presents and should be verified prior to the service. Eligibility information can be obtained by a participant's MO HealthNet number (DCN), social security number and date of birth, or if a newborn, using the mother's MO HealthNet number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status
After entering the participant's MO HealthNet ID number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MO HealthNet PROVIDERS

The MO HealthNet Division (MHD), in cooperation with Wipro Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers. MO HealthNet providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify participant eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply online at <http://www.dss.mo.gov/mhd/providers/index.htm>. At this site choose the "Apply for Electronic/Internet system access" link in the left hand column. Each user is required to complete this online application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Wipro Infocrossing Healthcare Services Help Desk, 573-635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET

Providers can access MO HealthNet participant eligibility files via the Web site. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MO HealthNet CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
 - Professional
 - Dental
 - Institutional (hospital inpatient and outpatient, nursing home, and home health care)

➤ Pharmacy (NCPCD)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The MO HealthNet program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive paper RAs. All providers and billers must have Internet access to obtain the printable electronic RA via the Wipro Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Wipro Infocrossing Help Desk, 573-635-3559, to learn how to obtain a paper remittance.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

MO HealthNet PROVIDER MANUALS AND BULLETINS ONLINE

<http://www.dss.mo.gov/mhd/providers/index.htm>

MO HealthNet provider manuals are available online at the MHD Web site, <http://www.dss.mo.gov/mhd/providers/index.htm>. To access the provider manuals, click on the "Provider Manuals" link at the bottom of the page. This brings up the <http://manuals.momed.com/manuals/> page where a search by manual and specific criteria can be done.

MO HealthNet provider bulletins are also available at the MHD Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear online at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

Claims Processing Schedule for Fiscal Year 2012

FINANCIAL CYCLE DATE₁	PROVIDER CHECK DATE
Friday 06/24/2011	Tuesday 07/05/2011
Friday 07/08/2011	Wednesday 07/20/2011
Friday 07/22/2011	Friday 08/05/2011
Friday 08/12/2011	Friday 08/19/2011
Friday 08/26/2011	Tuesday 09/06/2011
Friday 09/09/2011	Tuesday 09/20/2011
Friday 09/23/2011	Wednesday 10/05/2011
Friday 10/07/2011	Thursday 10/20/2011
Friday 10/21/2011	Friday 11/04/2011
Friday 11/04/2011	Friday 11/18/2011
Friday 11/18/2011	Friday 12/02/2011
Friday 12/09/2011	Friday 12/16/2011
Friday 12/23/2011	Thursday 01/05/2012
Friday 01/13/2012	Friday 01/20/2012
Friday 01/27/2012	Monday 02/06/2012
Friday 02/10/2012	Wednesday 02/22/2012
Friday 02/24/2012	Monday 03/05/2012
Friday 03/09/2012	Tuesday 03/20/2012
Friday 03/23/2012	Thursday 04/05/2012
Friday 04/13/2012	Friday 04/20/2012
Friday 04/27/2012	Monday 05/07/2012
Friday 05/11/2012	Monday 05/21/2012
Friday 05/25/2012	Tuesday 06/05/2012
Friday 06/08/2012	Wednesday 06/20/2012

Note 1: Closeout is 5:00 p.m. on the date shown

State Holidays

July 4, 2011 Independence Day	January 2, 2012 New Year's Day
September 5, 2011 Labor Day	January 16, 2012 Martin Luther King's Birthday
October 10, 2011 Columbus Day	February 13, 2012 Lincoln's Birthday
November 11, 2011 Veteran's Day	February 20, 2012 Washington's Birthday
November 24, 2011 Thanksgiving	May 8, 2012 Truman's Birthday
December 26, 2011 Christmas	May 28, 2012 Memorial Day

SECTION 2

ADA 2002, 2004 CLAIM FILING INSTRUCTIONS

The ADA (American Dental Association) 2002, 2004 version dental claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

Wipro Infocrossing Healthcare Services
P.O. Box 5300
Jefferson City, MO 65102

Or submitted electronically at www.emomed.com.

Information about ordering claim forms and provider labels is in Section 3 of the MO HealthNet Provider Manual available at <http://www.dss.mo.gov/mhd/providers/index.htm>.

NOTE: An asterisk (*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

<u>Field number and name</u>	<u>Instructions for completion</u>
1-2.	Not required.
3* Primary Payer Information	Enter Name, Address, City, State and Zip Code for the insurance company or third-party payer.
4-11** Other Coverage	Required only if participant has a second dental policy. Leave blank if there is no other Dental Coverage
12-17** Primary Insured Information	When verifying the participant's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field #32, section: "Other Fees". Leave blank if there is no other dental coverage.
18-19.	Not required.
20* Patient Name	Enter the participant's last name, first name and middle initial as shown on the participant's MO HealthNet ID card. Enter the participant's street address, city of residence and state.
21. Date of Birth	Not required.

22.	Sex	Not required.
23*	Patient ID Number	Enter the participant's eight-digit MO HealthNet identification number (DCN) exactly as shown on the participant's ID card.
24*	Procedure Date	Enter the actual date services were rendered in MM/DD/CCYY numeric format. Reminder: The date of service for dentures (full or partial) is the date of placement.
25.**	Oral Cavity	Report the area of the oral cavity. Alveoloplasties, gingivectomies, and gingivoplasties should be billed using 10 for upper right quadrant, 20 for upper left quadrant, 30 for lower left quadrant and 40 for lower right quadrant. In any of the following instances, leave this field blank: a. the procedure identified in #29 requires the identification of a tooth or a range of teeth; b. the procedure identified in #29 incorporates a specific area of the oral cavity in its nomenclature; or, c. the procedure identified in #29 does not relate to any portion of the oral cavity.
26.	Tooth system	Not required.
27**	Tooth Number or Letter	Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, this field may be left blank. The valid values are: A-T - Deciduous teeth 1-32 - Permanent teeth AS-TS - Deciduous supernumerary teeth 51-82 - Permanent supernumerary teeth When billing for partial dentures, enter the tooth number of one of the teeth being replaced in this field.
28**	Tooth Surface	Enter the appropriate service code, if applicable, otherwise, leave blank. The valid values are: M – Mesial D – Distal O – Occlusal L – Lingual I – Incisal F – Facial B – Buccal

29*	Procedure Code	Enter the five-digit procedure code for the service performed as well as any applicable modifiers.
30**	Description	Only required in specific situations as described in Section 13 of the MO HealthNet Provider Manual.
31*	Fee	Enter the provider's usual and customary fee for the procedures(s) performed. Do not subtract the copay or coinsurance amounts from the charge.
32.**	Other Fees	When other charges are applicable to dental services provided, this field must be reported. Enter the amount here.
33*	Total Fee	Enter the total of the charges shown.
34.	Missing Teeth	Not required.
35**	Remarks	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely. If applicable, provide the billing provider taxonomy code.
36-38		Not required.
39**	Number of Enclosures	Complete whether or not radiographs, oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore, no possible attachments are missing.
40.	Is treatment Orthodontics?	If no, skip to #43. If yes, answer #41.
41.	Date Appliance placed	Required if answer to #40 was yes.
42.	Months of Treatment Remaining	Not required.
43.	Replacement of Prosthesis	This item applies to crowns and all fixed or removable prosthesis: a. If claim does not involve a prosthetic restoration check "no" and proceed to #45. b. If claim is for the initial placement of a crown or fixed or removable prostheses, check "no" and go to #45 c. The participant has previously had these teeth replaced

- by a crown, check "yes" and go to #44.
44. Date of Prior Placement Complete if the answer to #43 was yes.
45. Treatment Resulting From If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box and proceed to items #46 & 47. If services are not the result of an accident, skip to item #48. The valid values are:
AA – Auto Accident
EM – Employment Related
OA – Other Accident
46. Accident Date Enter the date on which the accident in #45 occurred, otherwise leave blank.
47. Auto Accident State Enter the state in which the auto accident in #45 occurred, otherwise leave blank.
- 48* Name, Address, City, State Enter the name and complete address of the billing dental provider.
- 49* Provider ID Enter the NPI assigned to the billing dentist or dental entity.
50. License # Not required.
51. SSN or TIN Not required.
52. Phone Number Enter provider's phone number
- 53.* Signature & Date Signature of treating dentist and the date form is signed.
- 54.** Provider ID Enter the NPI of the treating dentist (performing provider).
55. License # Not required.
- 56.** Address, City, State, MO Enter the name and complete address of the treating dentist (performing provider).
57. Phone Number Enter treating dentist phone number.
- 58.** Treating Provider Specialty If applicable, provide the treating dentist (performing provider) taxonomy code.

SECTION 3 ADJUSTMENTS & RESUBMISSIONS

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Wipro Infocrossing web portal at, www.emomed.com. Adjustments may not be requested when the net difference in payment is less than \$4.00, or \$.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the \$4.00, or \$.25 minimum limitation does not apply.

Providers receive real time notification of receipt for adjustments for claim credits submitted via the Internet. The status of the adjustment is provided.

Paid Claim Options on eMomed

Only claims in 'paid' or 'to be paid' status can be voided or replaced. Voiding and replacing claims are done through "Claim Management" on the emomed.com website. Providers may do claim search by the ICN (Internal Control Number), the participant's DCN (MO HealthNet ID number) or by the date the claim was originally submitted.

VOID - To void a claim from the claim status screen on eMomed, select 'Void' from the menu bar. When the claim is brought up, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The claim has now been submitted to be voided or credited in the system.

REPLACEMENT – To replace a claim from the claim status screen on eMomed, select 'Replacement' from the menu bar. When the claim is brought up, corrections can be made to the claim by selecting the appropriate edit button then saving the changes. Once all corrections have been made scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The replacement claim with corrections has now been submitted.

Resubmitting Denied Claims on eMomed

Providers can resubmit denied claims electronically on the eMomed website. Claims may be resubmitted by entering a new claim. Claims may also be resubmitted by selecting 'Timely Filing' or 'Copy Claim' from the menu bar.

Timely Filing – To reference timely filing, choose the 'Timely Filing' tab on the claim status screen on eMomed. This function automatically places the ICN of the claim chosen. Make certain the ICN chosen meets MO HealthNet's timely filing criteria. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button.

Copy Claim/Original – This option is used to copy a claim just as it was originally entered on eMomed. Corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim'.

Copy Claim/Advanced – This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual or performing provider NPI and should have been submitted under the group NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and name information will transfer over to the new claim type. An example would be if the claim was submitted as a medical claim and should have been submitted as a dental claim.

Claim Status Codes

Once a claim is submitted, 'Claim Received' is given in real time on the 'Claim Status' page. In addition, one of the following claim status codes is provided:

C – Claim has been **Captured** and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – Claim is to be **Paid**.

K – Claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

SECTION 4 PRIOR AUTHORIZATION

Prior Authorization

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to participants under the age of 21 through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request form must be completed and mailed to Wipro Infocrossing Healthcare Services, Inc., PO Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- PA requests are not to be submitted for services prescribed to an ineligible participant. State Consultants review for medical necessity only and do not verify a participant's eligibility.
- Expanded HCY (EPSDT) services are limited to participants under the age of 21 and are **not** reimbursed for participants 21 and over even if the prior authorization request is approved.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Wipro Infocrossing Healthcare Services.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the PA request. All other documentation submitted with the PA request will not be returned, with the exception of study models submitted with requests for orthodontia treatment. Requests for changes to an approved PA must be indicated on the disposition letter and submitted to Wipro Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted. Denied or incomplete PA requests must be resubmitted to Wipro Infocrossing with additional documentation as needed. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the MO HealthNet *Provider's Manual* available on the Internet at <http://www.dss.mo.gov/mhd/providers/index.htm>. Instructions are also self-contained on the back of the PA request form.

SECTION 5 ELIGIBILITY RESTRICTIONS

A participant must be eligible for MO HealthNet benefits for each date of service provided in order for a provider to receive payment from MO HealthNet for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a participant's MO HealthNet eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

55-Qualified Medicare Beneficiary (QMB): A mandatory coverage group under MO HealthNet providing payment for qualified individuals of deductible and coinsurance amounts for *Medicare covered services*.

58 & 59-Presumptive Eligibility (TEMP): Coverage is limited to ambulatory prenatal care services only.

80 & 89-Women's Health Services: Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STDs).

82-Missouri Rx: Participants only have pharmacy Medicare Part D wrap around benefits through the MoRx.

Limited Benefit Package for Adult Categories of Assistance

The following categories of assistance receiving a limited benefit package are eligible for dental care only if it is related to trauma or when the absence of dental treatment would adversely affect the participant's preexisting medical condition.

- 01 Old Age Assistance
- 04 Permanently and Totally Disabled
- 05 MO HealthNet for Families – Adult
- 10 Refugees other than Cuban, Haitian, or Russian Jew
- 11 MO HealthNet Old Age Assistance
- 13 MO HealthNet Permanently and Totally Disabled
- 14 Supplemental Nursing Care – Old Age Assistance
- 16 Supplemental Nursing Care – Permanently and Totally Disabled
- 19 Cuban Refugee
- 21 Haitian Refugee
- 24 Russian Jew
- 26 Ethiopian Refugee
- 83 Breast or Cervical Cancer Control Project (BCCCP) – Presumptive
- 84 Breast or Cervical Cancer Control Project (BCCCP) – Regular
- 85 Ticket to Work Health Assurance Program (TWHAP) – Premium
- 86 Ticket to Work Health Assurance Program (TWHAP) – Non-Premium

Dental services for individuals in the above categories of assistance may be provided if the dental care is related to:

- ❖ Traumatic injury of jaw, mouth, teeth or other contiguous (adjoining) sites (above the neck).
- ❖ Medical condition when a written referral from the participant's physician states the absence of dental treatment would adversely affect the stated preexisting medical condition. This referral must be maintained in the participant's record and made available to the MO HealthNet Division (MHD) or its agent upon request. The referral must include the referring physician's name, type of dental services needed and the medical condition that would be adversely affected without the dental care.

MO HealthNet eligible adults in the assistance categories for pregnant women or the blind and vendor nursing facility residents continue to receive the full comprehensive benefit package.

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the MO HealthNet *Provider's Manual* available on the Internet at <http://www.dss.mo.gov/mhd/providers/index.htm>.

SECTION 6 COPAYMENT – COINSURANCE

Providers of service are responsible for collecting copayment and coinsurance amounts from participants, unless otherwise exempt. The provider shall collect copayment or coinsurance from the participant at the time each service is provided or at a later date. Providers may not deny or reduce services to participants, otherwise eligible for benefits, solely on the basis of the participant's inability to pay. Whether or not the participant is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service. The MO HealthNet program shall not increase its reimbursement to a provider to offset any uncollected copayment or coinsurance from a participant.

Copayment

The following copayment amounts are applied to *dental* services; CPT or surgical procedures are not subject to copayment. The amount of copayment to be collected from the participant is based on the MO HealthNet maximum allowed amount for each procedure code billed according to the following schedule:

<u>MO HealthNet Maximum Allowed Amount for Each Procedure</u>	<u>Participant Copayment</u>
\$10.00 or less	\$.50
\$10.01 - \$25.00	\$ 1.00
\$25.01 - \$50.00	\$ 2.00
\$50.01 or more	\$ 3.00

Exemptions to Copayment

- Participants under the age of 19 or receiving MO HealthNet with ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87 and 88;
- Foster Care participants under the age of 21 receiving MO HealthNet with ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Participants receiving MO HealthNet services for the blind under ME codes 02, 03, 12 and 15;
- Participants receiving MO HealthNet services for pregnant women under ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to Managed Care enrollees;
- Participants residing in a skilled nursing facility, an intermediate care nursing facility, a residential care home, an adult boarding home or a psychiatric hospital; or participants receiving MO HealthNet under ME codes 23 and 41;
- When coinsurance is charged for dentures

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless one of the following exceptions applies. The amount collected from the participant is 5% of the lesser of MO HealthNet’s maximum allowable amount or the provider’s billed charge.

- ❖ Participants under the age of 19;
- ❖ Foster Care participants under the age of 21
- ❖ Participants residing in a skilled nursing facility, psychiatric hospital, residential care facility or an adult boarding home; and
- ❖ Managed health care plan enrollees for services provided by the plan.

<u>Procedure Code</u>	<u>MO HealthNet Maximum Allowable</u>
D5110	\$ 503.75
D5120	\$ 504.53
D5130	\$ 549.86
D5140	\$ 550.25
D5211	\$ 377.81
D5212	\$ 379.75
D5213	\$ 542.50
D5214	\$ 542.50
D5225	\$ 466.16
D5226	\$ 467.33
D5820	\$ 286.00
D5821	\$ 286.00
D5860	\$ 621.94
D5861	\$ 620.00

Denture procedure codes D5110 through D5821 are a covered service for participants under the age of 21 or under a category of assistance for pregnant women, the blind or vendor nursing facility residents. Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to participants under the age of 21.

Federally Qualified Health Centers (FQHC) are to collect copayment and coinsurance amounts from MO HealthNet participants according to the maximum allowed amounts on the MO HealthNet fee schedule available at <http://www.dss.mo.gov/mhd/providers/index.htm>. The FQHC should not collect copayments and coinsurance according to the reimbursement amount received from the MO HealthNet program.

SECTION 7 BENEFITS & LIMITATIONS

MO HealthNet will only consider dental services for adults, age 21 and over, if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or if the absence of dental treatment would adversely affect a preexisting medical condition. Services for participants under age 21 remain unchanged as well as services for adult participants under a category of assistance for pregnant women, the blind, or residents of a vendor nursing facility.

Oral Evaluation Codes

A comprehensive oral evaluation, D0150, is limited to once per provider for a new patient or when an established patient has not been seen within two (2) years for a periodic oral exam, or when an established patient presents with a significant health change that can be documented in the patient's record.

The periodic oral evaluation code, D0120, must be used for all other general office visits for an established patient.

The limited oral evaluation code, D0140, must be used when the patient presents with a specific problem or dental emergency, to include a visual exam of the mouth by the dental provider.

The oral evaluation of a patient under the age of three (3), D0145 can be used each time the patient presents for a dental visit.

Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the participant for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written participant record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per participant per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Billing for an office visit is *expected only* for the first session in a series of treatments.

Providers cannot bill a participant for missed/broken appointments, nor will the MO HealthNet Division reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period. Prophylaxis must include scaling and polishing of teeth unless scaling is not required for the individual based on the condition at the time of the appointment. The participant's record must document scaling was not required during the visit.

D1110 – Ages 13-125

D1120 – Ages 0-12

Fluoride treatment is a covered service for participants under the age of 21.

Fluoride treatment for participants age 21 and over is limited to the following criteria:

- Participants with rampant or severe caries (decay);
- Participants who are undergoing radiation therapy to the head and neck;
- Participants with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Participants with cemental or root surface caries secondary to gingival recession.

Fluoride varnish is covered for participants under the age of 21 when applied in a dental office.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider.

Dental sealants may be applied only on healthy, without occlusal restorations, first and second permanent molars. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. No payment is made for sealants applied to third molars. Sealants are not a covered service if applied to primary teeth. Sealants may only be applied every three years per provider, per participant, per tooth.

Periodontal Scaling and Root Planing – D4341

Procedure code D4341 requires an approved prior authorization (PA). Along with the PA request, providers must submit a pretreatment x-ray (a full mouth survey taken within the last 12 months) and a periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request. Approval, if given, is per quadrant:

- Verifiable signs of early or moderate chronic periodontia;

- Records must show two or more sites in the quadrant being treated with;
 - 1) probing depths of 5mm or greater; **and**
 - 2) early to moderate bone loss, **or**
 - 3) radiographic evidence of subgingival calculus.

Definition of bone loss:

- Early bone loss is cratering, or horizontal or vertical loss.
- Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Restorations

- ❑ The same restoration on the same tooth in less than a six-month period is not allowed.
- ❑ Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.
- ❑ When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- ❑ Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.
- ❑ An amalgam (D2140, D2150, D2160 and D2161) placed after a sealant (D1351) on the same tooth, same surface, by the same provider within one (1) year of the sealant will not be reimbursed by MO HealthNet.

Crowns

- ❑ Prefabricated stainless steel crowns (D2930 and D2931) and prefabricated stainless steel crowns with resin window (D2933) for primary and permanent teeth are covered for participants of all ages; replacement within six months is not covered.
- ❑ Prefabricated resin crowns are covered for participants of all ages for *anterior* teeth only; replacement within six months is not covered.
- ❑ The fee for fixed prefabricated crown of chrome, stainless steel, resin, stainless steel with resin window or polycarbonate includes all prior preparations.
- ❑ Porcelain crowns are covered for participants under the age of 21 on a prior authorized basis.

Extractions

- ❑ Procedure code D7140 is the appropriate code for all non-surgical extractions of erupted teeth, permanent and primary. The appropriate tooth number must be shown on the claim.
- ❑ Surgical removal of erupted teeth, D7210, is covered for permanent teeth only.
- ❑ The surgical removal of impacted teeth is a covered service. A paper claim must be submitted for the removal of impacted teeth other than third molars and must include x-rays.

- The surgical removal of residual tooth roots (cutting procedure), D2750, is covered but cannot be billed on the same date of service as an extraction of the same tooth. Pre-treatment x-rays and office notes or operative report must be sent with the claim.
- Extraction fees for routine and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and post-operative treatment.

Please refer to sections 13 and 19 of the MO HealthNet Dental Provider Manual for comprehensive coverage of dental benefits and limitations as well as covered procedure codes. The manual is available on the Internet at, <http://www.dss.mo.gov/mhd/providers/index.htm>.

SECTION 8 DENTURES

Dentures must be dispensed to the participant before the provider bills MO HealthNet; the date of service for dentures is the date of placement. Holding dentures until MO HealthNet payment is received constitutes payment for services not provided and is in violation of State Regulation 13 CSR 70-3.030(2)(A)23. Providers may not request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-3.030(3)(A)9. *This does not apply to the denture coinsurance requirement.* MO HealthNet reimbursement for dentures includes routine visits necessary in the steps required for the denture, full or partial. This includes impressions, try-ins and adjustments for six months from the date of placement.

Dentures, full or partial, are not covered for those adult participants with a limited benefit package.

Prior authorization is not required for dentures, full or partial. Prior authorization is required for overdentures, D5860 and D5861; however coverage is restricted to participants under the age of 21.

Immediate and interim dentures are restricted to once in a lifetime.

Replacement dentures are covered in cases when dentures no longer fit properly due to:

- significant weight loss as a result of illness;
- loss of bone or tissue due to some form of neoplasm and/or surgical procedure;
- normal wear and/or deterioration resulting from use over an extended period of time.

NOTE: Replacement dentures do not require prior authorization. PA requests submitted to Wipro Infocrossing will not be approved. Dentists must use their professional judgment in determining if the participant's denture meets the above replacement criteria. The reason for replacing the denture must be properly documented in the participant's record.

Denture adjustments are covered, but not for the originating dentist of a new denture until six months from the date of placement. It is the responsibility of the dentist who placed the denture to assure correct fit within this period.

Rebases and Relines

One reline or rebase is allowed during the 12 months following placement of immediate dentures. The second reline or rebase is allowed 12 months following the first reline. Additional denture relining or rebasing is limited to 36 months from the date of the preceding reline or rebase.

The initial reline or rebase of a partial or replacement denture is not covered until 12 months after the placement of the denture. Additional relining or rebasing is limited to 36 months from the date of the last preceding reline or rebase.

Denture relines or rebases, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Laboratory reline of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Tissue conditioning, D5820 and D5821, is not covered for the same date of service as a reline and/or rebase.

SECTION 9 ORTHODONTICS

Orthodontic treatment is covered as expanded HCY, Healthy Children and Youth, services. Orthodontic treatment requires prior authorization (PA) and is only approved for the most severe malocclusions. Assessment of the most severe malocclusion is determined by the magnitude of the following variables:

- Degree of mal-alignment
- Missing teeth
- Angle classification
- Overjet
- Overbite
- Openbite
- Crossbite

When requesting PA, providers must complete and submit the Prior Authorization Request form, study models, (unless a panoramic radiograph is necessary to evaluate unerupted teeth) and a written treatment plan. Photographs and cephalometric radiographs will only be required if requested by the state orthodontic consultant after review of the study models and panoramic radiograph. Reimbursement will *not* be made for diagnostic photographs or cephalometric x-rays unless specifically requested by the state orthodontic consultant after review of the study models and panoramic radiograph. After the orthodontic provider has received authorization to begin orthodontic treatment, a full set of orthodontic records must be obtained and maintained in the participant's dental records.

Comprehensive orthodontic treatment includes, but is not limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances);
- All necessary adjustments;
- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the participant for a proper period of time (approximately 18-24 months):
- Dental study models, properly occluded and trimmed so the models simulate centric occlusion of the participant when the models are placed on their heels.

The following requirements must be met to obtain orthodontia treatment through MO HealthNet. The participant must:

- ▶ Be under the age of 21;
- ▶ Have good oral hygiene;
- ▶ Be age 13 or have no deciduous teeth (unless the primary teeth are retained due to ectopic position of the underlying permanent tooth or a missing permanent tooth in this area, or had cleft palate or severe traumatic deviation;
- ▶ Score at least 28 on the Handicapping Labio-Lingual Deviation (HLD) Index or qualifies for one of the exceptions on the HLD form; or,
- ▶ Be under the age of 13 with an impacted central incisor.

For participants under the age of 13 with an impacted central incisor, providers are to use procedure code D8050 (interceptive orthodontic treatment of the primary dentition) or D8060 (interceptive treatment of the transitional dentition). D8050 and D8060 are manually priced procedure codes and also require an approved PA.

The HLD Index is used to determine the medical necessity for orthodontic services. Only those cases that score 28 points or more on the HLD Index or those that qualify under an "exception" are granted. This is not to say cases that score less than 28 points do not represent some degree of malocclusion, but simply the severity of the malocclusion does not qualify for coverage under the MO HealthNet program. It is important to note when scoring the HLD index, the provider is not diagnosing malocclusion but simply measuring and/or noting the presence of certain key indicators.

When requesting PA for orthodontic services, providers must complete and submit the PA Request form, study models, and the written treatment plan to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5700
Jefferson City, MO 65102

Upon receipt of an approved PA, the provider must verify the participant's MO HealthNet eligibility prior to beginning orthodontic treatment. It is important the participant's eligibility be verified each time a treatment/service is rendered. The approved PA will state the length of treatment authorized, i.e., 24 months, as well as the total dollar amount authorized for the duration of the treatment. Any participant transferring into the MO HealthNet program and has started orthodontic treatment shall be allowed to complete the orthodontic treatment. The reimbursement amount for the remaining treatment will be based on the MO HealthNet orthodontic fee schedule and prorated based on the time left in treatment as evaluated by the state orthodontic consultant.

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth of the total approved amount. This fee includes the orthodontic

examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances. The date of service for the initial payment is the date of banding.

Providers must bill subsequent payments on a quarterly basis. The amount of the quarterly payment is determined by the balance due after the initial payment has been deducted from the prior authorized amount. The remainder is divided by the total number of months treatment was authorized, and the result multiplied by three. This dollar amount represents the amount of all future quarterly payments with the date of service being the last day of the month of each quarter following banding.

Example:

Provider is authorized \$2,000.00 for a 24-month treatment plan. The participant is banded on October 26, 2008. The initial claim will be submitted with a date of service of 10/26/07 and a dollar amount of \$500.00. To determine the date of the first quarterly payment, the month the participant was banded is counted as month one, therefore, the date of service for the first quarterly payment in this example is 12/31/08. The quarterly payment amount to be billed is \$187.50: $\$1,500.00 \div 24 = \62.50 ; $\$62.50 \times 3 = \187.50 . The date of service for the second quarterly payment is 03/31/09; the third, 06/30/09; the fourth, 09/30/09, etc. The quarterly payment billed remains the same.

If a participant is only eligible for one or two months of the quarter, the provider must bill the exact dates the participant was seen in the office. Each month must be billed on a separate line and the allowed amount for each month is one-third of the quarterly payment.

If the participant's eligibility ends prior to the last day of the quarter, but after the participant is seen in the third month of the quarter, the last date of eligibility during the third month of the quarter is the date of service.

SECTION 10 CUSTOM-MADE ITEMS

MO HealthNet provider payment may be made for custom-made items such as dentures when a participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- ❑ The participant must have been eligible when the service was first initiated (and following receipt of an approved PA request form if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- ❑ The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- ❑ The custom-made device or item must have been delivered or placed if the participant is living;
- ❑ The provider must have entered “See Attachment” in the “Remarks” section of the dental claim form (field #35) and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value, if any, which the provider estimates is represented in cases where delivery or placement is not possible.

Payments regarding the aforementioned devices are made as follows:

- ❑ If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the billed charge or the MO HealthNet maximum allowable for the total service, less any applicable coinsurance and any payments made by another insurance company.
- ❑ If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the “net billed charge” or the MO HealthNet maximum allowable for the total service, less any applicable coinsurance. The “net billed charge” is the provider’s usual and customary billed charge(s) as reduced by any salvage value amount.

Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item.

Dentures are an example of an item representing no reasonable salvage value.

The date of service that is shown on the claim form for the item (dentures, etc.) when either of the above situation applies, must be the last date on which service is provided to the eligible participant (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided.

The use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent (currently Wipro Infocrossing Healthcare Services) in the same manner as other claims.

Payments made as described in the above situations constitute the allowable MO HealthNet payment for the service. Other than any applicable coinsurance due, no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant must be immediately advised that completion of the work and delivery or placement of the item is not covered by MO HealthNet. It is then the participant's choice whether to request completion of the work on a private payment basis. If the participant's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does not reimburse the provider.

SECTION 11 RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT DENTAL TERMINOLOGY

MO HealthNet currently uses the CDT 2011-2012 (Current Dental Terminology). This publication is a series of dental procedure codes used for reporting services rendered. All providers should obtain and refer to the CDT 2011-2012 to assure proper coding.

CURRENT PROCEDURE TERMINOLOGY (CPT)

MO HealthNet also uses the latest version of the *Current Procedural Terminology (CPT)*. All providers are encouraged to obtain and refer to the CPT book to assure proper coding.

Both of the above publications can be ordered from the following:

Practice Management Information Corporation
4727 Wilshire Blvd., Ste. 300
Los Angeles, CA 90010
800/663-7467
<http://pmiconline.com>

Ingenix Publications
P.O. Box 27116
Salt Lake City, UT 84127-0116
www.IngenixOnline.com

SECTION 12 RECIPIENT LIABILITY State Regulation 13CSR 70-4.030

If an enrolled MO HealthNet provider does not want to accept payment from MO HealthNet but instead wants the participant to be responsible for the payment (be a private pay participant), there must be a written agreement between the participant and the provider in which the participant understands and agrees that MO HealthNet will not be billed for the service(s) and that the participant is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the participant and the provider. **The written agreement must be prepared prior to the service(s) being rendered.** A copy of the written agreement must be kept in the participant's medical record.

If there is no evidence of this written agreement, the provider cannot bill the participant and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the participant is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

MO HealthNet RECIPIENT REIMBURSEMENT (MRR)

The MO HealthNet Recipient Reimbursement program (MRR) is devised to make payment to those participants whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Participants are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The participant is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call (800) 392-2161.

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); (800) 877-6916 (TTY); (800) 735-2466 (Voice & TTY). Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

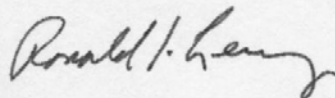
Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 (Voice); (816) 426-7065 (TDD)

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the:

U.S. Department of Agriculture
Office of Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410
(202) 720-6382 (TTY); (800) 795-3272 (Voice)

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.



Director, Department of Social Services

2009
Year