IMPORTANT NOTICE REGARDING SERVICES FOR MEDICAID AND MC+ ADULTS

<<<Recipient Name>>> August 1, 2005
<<<Address>>> <<<DCN>>>
<<<City, State, Zip>>>

IMPORTANT NOTICE REGARDING SERVICES FOR MEDICAID AND MC+ ADULTS

Dear Medicaid/MC+ Recipient:

Medical Services Reductions:
Senate Bill 539 was passed by Missouri's 93rd General Assembly eliminating certain optional Medicaid services for adults. Beginning September 1, 2005 your Medicaid or MC+ card will no longer cover the services listed below in the Missouri Medicaid/MC+ programs except for children or persons receiving Medicaid under a category of assistance for pregnant women or the blind and nursing facility residents. Eliminated services include the following:

- Comprehensive Day Rehabilitation
- Dental Services (including dentures) Adult coverage is limited to treatment for trauma or disease/medical related.
- Durable Medical Equipment (examples of eliminated equipment include but are not limited to, wheel chair accessories and batteries, three wheeled scooters, decubitus care cushions and mattresses, patient lifts, trapeze, all body braces (orthotics), hospital beds and side rails, commodes, catheters, canes, crutches, walkers, BiPAP, CPAP and nebulizers, parenteral and enteral nutrition, artificial larynx, and augmentative communication devices)
- Rehabilitation Services (i.e. occupational, speech or physical therapy)
- Audiology-Hearing Aids and associated testing services

- Optical Services (Except for one eye exam every two years)
- Foot Care Services are limited
- Diabetes Self Management training

Reminder – Medicaid/MC+ children, pregnant women, blind, and nursing facility residents will still be covered for the above services.

Prior Authorizations
All Prior Authorizations for the above services will end August 31, 2005. Services will not be paid if they are for dates of service after August 31, 2005 even if they were previously approved. Items that were ordered or fabricated prior to September 1 will be paid.

Co-Payments:

Beginning with dates of service of September 1, 2005 co-payments are due at the time of service. Co-payments are small amounts you may have to pay for services received that range from fifty cents ($0.50) to ten dollars ($10.00). The provider will tell you how much you owe. You are responsible to pay the co-payments at the time of service or when billed by the provider. The following services are subject to the co-payment requirement:

- All optometric services (eye exam every two years);
- Inpatient hospital services;
- Hospital Outpatient, clinic or emergency services; and
- All physician-related services

The following are not subject to the co-payment requirement:

- Recipients under 19 years of age;
- Managed Care enrollees;
- Persons receiving Medicaid under a category of assistance for pregnant women or the blind;
- Services to residents of a skilled nursing facility; intermediate care nursing home; residential care home; adult boarding home or psychiatric hospital;
- Services to recipients who have both Medicare and Medicaid;
- Emergency or transfer inpatient hospital admissions;
- Emergency services provided in a hospital outpatient clinic or emergency room to treat a life threatening condition;
- Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy, and chronic renal dialysis) except when provided as an inpatient hospital service;
- Family planning services;
- Services provided to pregnant women, directly related to the pregnancy or complications of the pregnancy;
- Foster Care recipients;
- In-Home/Personal care services;
- Hospice services;
- Medically necessary services identified through an Early Periodic Screening, Diagnosis and Treatment screen (EPSDT);
- Mental Health services;
- Medicaid Waiver services

Pharmacy
The recipient portion of the pharmacy dispensing fee ($.50 - $2.00) is not changed.

Please call Recipient Services at 1-800-392-2161 if you have any questions.

Sincerely,

Division of Medical Services