Orthotics

Therapeutic Shoes for Diabetics

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

Spinal Orthoses

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

Helmets

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

Cranial Orthosis for Plagiocephaly

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal. Dynamic orthotic cranioplasty, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic cranioplasty, is not a covered benefit for the non-operative management of positional or non-synotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

Cervical Orthoses

A cervical orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the neck; or**
- **To facilitate healing following an injury to the cervical spine or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or**
- **To otherwise support weak cervical muscles and/or a deformed cervical spine.**

Hip Orthoses

A hip orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the hip; or**
- **To facilitate healing following an injury to the hip or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the hip or related soft tissue; or**
- **To otherwise support weak hip muscles and/or a hip deformity.**

Knee Orthoses

A knee orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the knee; or**
- **To facilitate healing following an injury to the knee or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the knee or related soft tissue; or**
- **To otherwise support weak knee muscles and/or a knee deformity.**

These devices are not provided solely for use during sports-related activities.

Ankle–Foot/Knee–Ankle–Foot (AFO) Orthoses

AFOs Not Used During Ambulation

A static AFO is covered if the following criteria are met:

- **Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,**
- **Reasonable expectation of the ability to correct the contracture; and,**
- **Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,**
- **Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR**
- **The patient has plantar fasciitis.**

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.

If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.

A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

AFOs and KAFOs Used During Ambulation

AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

Knee–ankle–foot orthoses (KAFO) are covered for ambulatory patients for whom an ankle–foot orthosis is covered and for whom additional knee stability is required.
If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

Foot Orthosis

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
    - Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
    - Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).
  - Children (skeletally immature feet):
    - Hallux valgus deformities
    - In-toe or out-toe gait
    - Musculoskeletal weakness (e.g., pronation, pes planus)
    - Structural deformities (e.g., tarsal coalitions)
    - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

Orthopedic Footwear

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes

are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.

Upper Limb Orthoses

An upper limb orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the joint(s)
- To facilitate healing following an injury to the joint(s) or related soft tissues
- To facilitate healing following a surgical procedure on the joint(s) or related soft tissue

Elastic Supports

Elastic supports are covered when they are ordered for one of the following indications:

- Severe or incapacitating vascular problems, such as
  - acute thrombophlebiti
  - massive venous stasis'
  - pulmonary embolism
- Venous insufficiency
- Varicose veins
- Edema of lower extremities
- Edema of pregnancy
- Lymphedema

Trusses

Trusses are covered when a hernia is reducible with the application of a truss.

Orthotic-Related Supplies

Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.

Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe

A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:

- to protect a cast from damage during weight-bearing activities following injury or surgery;
- to provide appropriate support and/or weight-bearing surface to a foot following surgery;
- to promote good wound care and healing via appropriate weight distribution and foot protection; or
- when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

Specific Exclusions

Non-covered devices and supplies include, but are not limited to, all of the following:

- Experimental or investigational devices
- Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)
- Items to have on hand for backup or duplicates to have available at various locations
- Devices and supplies for residents of nursing facilities
- Equipment or supplies covered by another agency

Replacing Orthotic Devices

When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device. **Prior authorization by medical plan required for orthotics over $1,000**
Outpatient Diagnostic Procedures **Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)**
Oxygen **Outpatient** **Go to DURABLE MEDICAL EQUIPMENT in this section.** **Prior authorization by medical plan required.**
Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient **Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.** **Speech Therapy:** **Covered as medically necessary for either of the following:** • **A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.** • **A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).** **When all of the following criteria are met:** • **The treatment being recommended has the support of the treating physician;** • **The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;** • **The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;** • **Meaningful improvement is expected from the therapy and** • **The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.** **Speech or voice therapy is not covered in any of the following situations:** • **Any computer-based learning program for speech or voice training purposes** • **School speech programs** • **Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)** • **Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)** • **Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver**

- **Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work**
- **Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences**
- **Therapy or treatment provided to improve or enhance job, school or recreational performance**
- **Long-term rehabilitative services when significant therapeutic improvement is not expected**

Physical Therapy:

Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- **The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;**
- **The program is expected to result in significant therapeutic improvement over a clearly defined period of time and**
- **The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.**

Physical therapy is not covered for the following:

- **Treatment provided to prevent or slow deterioration in function or prevent reoccurrences**
- **Treatment intended to improve or maintain general physical condition**
- **Long-term rehabilitative services when significant therapeutic improvement is not expected**
- **Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)**
- **Work hardening programs**
- **Back school**
- **Vocational rehabilitation programs and any program with the primary goal of returning an individual to work**
- **Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)**
- **Services for the purpose of enhancing athletic performance or for recreation**

Occupational Therapy:

Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- **The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;**
- **The program is expected to result in significant therapeutic improvement over a clearly defined period of time and**
- **The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.**

Occupation Therapy is not covered for the following:

- **Treatment provided to prevent or slow deterioration in function or prevent reoccurrences**
- **Treatment intended to improve or maintain general physical condition**

- **Long-term rehabilitative services when significant therapeutic improvement is not expected**
- **Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)**
- **Work hardening programs**
- **Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work**
- **Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)**
- **Driving safety/driver training**

Prior authorization by medical plan required after 60 combined visits per incident.

Physician Charges

Preventive Services

- **Services recommended by the U.S. Preventive Services Task Force (categories A and B)**
- **Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention**
- **Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration**
- **Preventive care and screenings for women supported by the Health Resources and Services Administration**

Annual physical exams (Well man, woman and child) -
one per calendar year
Age-specific cancer screenings:

- **Mammograms**
- **Pap smears**
- **Prostate cancer screenings**
- **Colorectal screenings**
- **Colonoscopy and sigmoidoscopy screenings**

For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

Prostheses (Prosthetic Devices)
Basic equipment that meets medical needs

Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related.

Prior authorization by medical plan required for prostheses over $1,000.

Skilled Nursing Facility
Benefits are limited to 120 days per calendar year.

Prior authorization by medical plan required.

Surgery (Inpatient and Outpatient)
Includes sterilization

Prior authorization by medical plan required for outpatient surgeries:

- **Potential cosmetic surgery**
- **Sleep Apnea surgery**
- **Implantable Stimulators**
- **All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries)**
- **Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure.**

Oral surgery

- **Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams**
- **Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth**
- **Reduction of fractures and dislocations of the jaw**
- **Excision of exostosis of jaws and hard palate**
- **External incision and drainage of cellulitus**
- **Incision of accessory sinuses, salivary glands or ducts**
- **Frenectomy**

Transplants
When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan.

Contact medical plan for arrangements, prior authorization and transplant network.

Travel, if approved, is limited to $10,000 maximum per transplant. **Network** **Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence.** **Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.** **Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).** **Meals: Not covered.** **Prior authorization by medical plan required.** **Non-network** **Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum.** **Travel, lodging and meals not covered.** **Prior authorization by medical plan required.**
Urgent Care **Paid as network benefit.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.060 *[PPO 300 Plan,]* **PPO** *[500]* ***600*** **Plan, PPO 1000 Plan, PPO 2000 Plan,** ***and*** **HDHP***[, and Copay]* **Plan Limitations**. The Missouri Consolidated Health Care Plan is deleting sections (2), (33), (48), (50), (52), and (57); amending the rule title, rule purpose, and sections (1), (7), (8), (11)–(13), (26), (28), (30), (31), (37), (45), (49), (51), and (53); adding new sections (3), (6), (7), (9)–(11), (15), (16), (30), (33), (37), (41), (42), (48), (54), (56), and (63); and renumbering as necessary.

PURPOSE: This amendment includes changes by the board of trustees in regard to the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Plan.

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan [PPO 300 Plan,] PPO [500] ***600*** *Plan, PPO 1000 Plan, PPO 2000 Plan,* ***and*** *HDHP[, and/or Copay] Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services**,** or supplies which do not come within the definition of covered charges *[or within any of the sections of this rule]*. **In addition, the items specified in this rule are not covered, unless expressly stated otherwise and then only to the extent expressly provided herein.**

[(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.]

*[(3)]***(2)** Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(3) Acts of war—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(6) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.

(7) Athletic trainer services—services by a licensed athletic trainer not covered.

*[(6)]***(8)** Autopsy.

(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscense, gastric leaking, and embolism).

(10) Blood donor expenses—not covered.

(11) Blood pressure cuffs/monitors—not covered.

*[(7)]***(12)** Blood storage*[,]***—not covered,** including whole blood, blood plasma, and blood products.

*[(8)]***(13)** Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

*[(9)]***(14)** Care received without charge.

(15) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(16) Childbirth classes.

*[(10)]***(17)** Comfort and convenience items.

*[(11)]***(18)** Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease*[,]* **or** injury, or congenital defect or abnormality (for a participant under the age of nineteen (19))**,** or to restore symmetry following a mastectomy.

*[(12)]***(19)** Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets *[and]***;** supervision of medication that is usually self-administered**; or other services that can be provided by persons without the training of a health care provider**.

*[(13)]***(20)** Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound**,** natural teeth **and tissue that are viable, functional, and free of disease**. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral

surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

*[(14)]***(21)** Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

*[(15)]***(22)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(16)]***(23)** Examinations requested by a third party.

*[(17)]***(24)** Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(18)]***(25)** Exercise equipment.

*[(19)]***(26)** Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

*[(20)]***(27)** Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

*[(21)]***(28)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(22)]***(29)** Services obtained at a government facility—not covered if care is provided without charge.

(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

*[(23)]***(31)** Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

*[(24)]***(32)** Health and athletic club membership—including costs of enrollment.

(33) Home births.

*[(25)]***(34)** Immunizations requested by third party or for travel.

*[(26)]***(35)** Infertility **treatment.***[—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.]*

*[(27)]***(36)** Level of care, if greater than is needed for the treatment of the illness or injury.

(37) Long-term care.

*[(28)]***(38)** Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one (1) of its agencies; or

(B) Any state's cash sickness or similar law**,** including any group insurance policy approved under such law.

*[(29)]***(39)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the *[subscriber]* **participant**, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(30)]***(40)** Military service connected injury or illness**—including expenses relating to Veterans Affairs or a military hospital**.

(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

(42) Nocturnal enuresis alarm.

*[(31)]***(43)** Non-network providers—subject to **higher** deductible and non-network coinsurance.

*[(32)]***(44)** Not medically necessary services—with the exception of preventive services.

[(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the

most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).]

*[(34)]***(45)** Orthognathic surgery.

*[(35)]***(46)** Orthoptics.

*[(36)]***(47)** Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(48) Outpatient birthing centers.

*[(37)]***(49)** Over-the-counter medications—except for insulin **and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary** through the pharmacy benefit.

*[(38)]***(50)** Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

*[(39)]***(51)** Physical fitness.

*[(40)]***(52)** Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

*[(41)]***(53)** Private duty nursing.

(54) Prognathic and maxillofacial surgery.

*[(42)]***(55)** Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.

*[(43)]***(57)** Services not specifically included as benefits.

*[(44)]***(58)** Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

*[(45)]***(59)** Stimulators (for bone growth)—not covered unless **prior** authorized by claims administrator **and clinical eligibility is met**.

*[(46)]***(60)** Surrogacy—pregnancy coverage is limited to plan member.

*[(47)]***(61)** Temporo-Mandibular Joint Syndrome (TMJ).

[(48) Third-party examinations.]

*[(49)]***(62)** Tobacco cessation—patches and gum are not covered. *[There is a limited benefit available under the pharmacy benefit.]*

(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:

(A) Allogenic Bone Marrow—$143,000;
(B) Autologous Bone Marrow—$121,000;
(C) Heart—$128,000;
(D) Heart and Lung—$133,000;
(E) Lung—$151,000;
(F) Kidney—$54,000;
(G) Kidney and Pancreas—$97,000; and
(H) Liver—$153,000.

[(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.]

*[(51)]***(64)** Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services. **Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.**

[(52) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.]

*[(53)]***(65)** Travel expenses—not covered *[unless authorized by claims administrator]* **except for transplants in a network facility**.

*[(54)]***(66)** Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

*[(55)]***(67)** Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

*[(56)]***(68)** Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

[(57) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.]

*[(58)]***(69)** Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other **similar** legislation *[of similar program]*.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is deleting section (1), amending and renumbering sections (2)–(6), and adding new sections (1) and (3).

PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and was terminated on January 20, 2011.*

[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.]

(1) Medical and Pharmacy Service Appeals. There is an internal appeals process through the claims administrators for urgent care, pre-service, and post-service claims that a member may request reconsideration of an adverse benefit determination. There is a two (2)-level internal appeal process for medical services and a one (1)-level appeal process for pharmacy services. Once the internal appeal process is complete, the member may further appeal through an external review process.

(A) Claims are divided into two (2) types: pre-service and post-service claims.

1. Pre-service claims are requests for approval that the health plan contractor or claims administrator requires a member to obtain before getting medical care, such as prior authorization or a decision on whether a treatment or procedure is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the health plan contractor or claims administrator has received the claim. The health plan contractor or claims administrator may extend the time period up to an additional fifteen (15) days if, for reasons beyond the claims administrator's control, the decision cannot be made within the first fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The health plan contractor or claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that requires a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within twenty-four (24) hours and will follow-up with written confirmation of the decision.

2. Post-service claims are all other claims for benefits including claims after medical services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the claims administrator has received the claim. If, because of reason beyond the health plan contractor or claims administrator's control, more time is needed to review the claim, the claims administrator may extend the time period up to an additional fifteen (15) days. The health plan contractor or claims administrator must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the health plan contractor or claims administrator. The claims administrator then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

*[(2)]***B.** The *[plan administrator, agent]* **health plan contractor** or claims administrator, upon receipt of a notice of request,

shall furnish to the employee the forms as are usually furnished for filing proof*[s]* of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proof*[s]* of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.

*[(3)]***C.** Written proof of claims incurred should be furnished to the **health plan contractor or** claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

*[(4)]***D.** In the case of medical benefits, the **health plan contractor or** claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

E. The member is entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim in question.

F. A first level appeal for medical and pharmacy services of an adverse benefit determination shall be submitted in writing within one hundred eighty (180) days of the date on the original claim decision notice.

(I) Submit the first level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 30546, Salt Lake City, UT 84130-0546;

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) Include any additional information or documentation to support the reason the original claim decision should be overturned.

(III) The first level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The first level appeal shall be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the health plan contractor or claims administrator received the first level appeal request.

G. An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care.

(I) Submit the expedited appeal to the health plan contractor or claims administrator by telephone or fax to—

(a) UMR telephone 1-866-868-7758 or by fax to 1-866-912-8464, Attention: Appeals Unit;

(b) Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by fax to 1-314-214-3233, Attention: Corporate Appeals; or

(c) Express Scripts, Clinical Appeals—MH3, 6625 West 78th Street, BL0390, Bloomington, MN 55439 or fax to 1-877-852-4070.

(II) The expedited appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved.

(III) The expedited appeal will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision within three (3) working days of providing notification of the determination.

H. A second level appeal for medical services shall be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination.

(I) Submit the second level appeal to the health plan contractor or claims administrator in writing to—

(a) UMR Claims Appeal Unit, PO Box 8086, Wausau, WI 54402-8086; or

(b) Mercy Health Plans, Attn: Corporate Appeals, 14528 S. Outer 40 Road, Suite 300, Chesterfield, MO 63017.

(II) Include any additional information or documentation to support the reason the first level appeal decision should be overturned.

(III) The second level appeal will be reviewed by the health plan contractor or claims administrator who will have someone review the appeal who was not involved in the original decision or first level appeal and will consult with a qualified medical professional if a medical judgment is involved.

(IV) The second level appeal shall be responded to in writing to the member within sixty (60) days for post service claims and thirty (30) days for pre-service claims from the date the claims administrator received the second level appeal request.

*[(5)]***(2)** All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. *[Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.]* **Following the completion of the internal appeal process, an external appeal for medical and pharmacy services is available through the Missouri Department of Insurance, Financial Institutions and Professional Registration. Submit written request for an external appeal to Missouri DIFP, Attn: Consumer Affairs, PO Box 690, Jefferson City, MO 65102-0690. An external appeal request may be requested online at https://insurance.mo.gov/consumer/complaints/consumercomplaint.php and may also be faxed to 573-526-4898.**

(3) Dental and Vision Plan Appeals. Appeals involving services from the dental and vision plans are solely through the dental and vision plan contractor.

*[(A)]***(4)** *[Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved.]* **Administrative appeals involve issues regarding MCHCP eligibility, plan effective dates, premium payments, Lifestyle Ladder program, and plan choices.** Administrative appeals shall be submitted in writing *[as soon as possible following]* **within one hundred eighty (180) days from the date of the notice of administrative decision or** written *[or verbal notice of an MCHCP staff]* denial of the member's administrative request.

(A) All *[appeals and]* administrative appeals shall be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110-**4355**

(B) The board may, in its discretion, choose to conduct a hearing regarding a member's **administrative** appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;

2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;

3. All parties shall be notified in writing of the date, time, and location of the hearing;

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;

5. The party appealing to the board shall carry the burden of proof; and

6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that**,** if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection *[(5)(C)]* **(4)(C)** herein.

*[(6)]***(E)** In reviewing **administrative** appeals, notwithstanding any other rule, the board and/or staff may grant any **administrative** appeal*[s]* when there is credible evidence to support approval under the following guidelines*[:]***.**

*[(A)]***1.** Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

*[(B)]***2.** Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

*[(C)]***3.** Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

*[(D)]***4.** Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

*[(E)]***5.** Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

*[(F)]***6.** Termination **of** dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

*[(G)]***7.** Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for public entity (county or state) to provide subscriber with requested documentation.

*[(H)]***8.** Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

*[(I)]***9.** Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

*[(J)]***10.** *[Lifestyle Ladder]* **Wellness Program** participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder]* **the Wellness Program** due to failure of member's participation.

*[(K)]***11.** Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

*[(L)]***12.** Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

*[(M)]***13.** New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the executive director hereby terminates an emergency amendment effective January 20, 2011, as follows:

22 CSR 10-3.075 Review and Appeals Procedure **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on February 1, 2011 (MoReg 431–433).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending the rule purpose and all sections of this rule.

PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in**, and coverage of services under,** the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 20, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 20, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed January 1, 2011, becomes effective January 20, 2011, and expires on June 29, 2011.*

[(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent, or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.

(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved. Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;

2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;

3. All parties shall be notified in writing of the date, time, and location of the hearing;

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply;

5. The party appealing to the board shall carry the burden of proof; and

6. The hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions, and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing and solicit additional evidence and argument. It will review the summary of evidence and the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision as provided by Missouri law.

(D) Administrative decisions made solely by MCHCP may

be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.]

(1) Claims Submissions and Initial Benefit Determinations.

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

(2) General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal.

(3) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage once an individual has been covered under the plan, unless the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud, or unless such individual or person makes an intentional misrepresentation of material fact in connection with seeking coverage or any benefits under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level appeals shall be responded to in writing to the member within sixty (60) days for post-service claims and within thirty (30) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 8086
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through Mercy Health Plans—

(a) First and second level appeals must be submitted in writing to—

Mercy Health Plans
Attn: Corporate Appeals
14528 S. Outer 40 Road, Suite 300
Chesterfield, MO 63017

(b) Expedited appeals must be communicated by calling Mercy Health Plans telephone 1-800-830-1918, ext. 2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Clinical Appeals—MH3
6625 West 78th Street, BL0390
Bloomington, MN 55439
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

*[(6)]***(5)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines*[:]***.**

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for **the** public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder]* **Wellness Program** participation—MCHCP may deny all appeals regarding continuation of participation in *[Lifestyle Ladder]* **the Wellness Program** due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the rule purpose and sections (1) and (6), deleting section (3) and renumbering accordingly, and adding new sections (7) and (8).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for [Copay Plan, PPO 300 Plan, PPO 500 Plan,] ***the PPO 600 Plan,*** *PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) The pharmacy benefit provides coverage for prescription drugs **listed on the formulary**, as described in the following:

(A) Medications.

1. **Retail—**Network:

A. Generic: Eight**-**dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. *[Formulary brand]* **Brand**: Thirty-five**-**dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

[C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;]

*[E]***C.** Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for *[two and one-half (2 ½) regular copayments]* **a twenty-dollar ($20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent ($87.50) copayment for a brand drug on the formulary**.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: *[six]* **eight** dollars *[and sixty-seven cents ($6.67);]* **($8) for generic drug on the formulary list; and**

[(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).]

(b) Brand: thirty-five dollars ($35) for brand drug on the formulary.

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment **or coinsurance**. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

[(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including:

1. Insulin;

2. Syringes;

3. Test strips;

4. Lancets; and

5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar ($500) annual benefit.]

*[(4)]***(3)** Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

*[(5)]***(4)** Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

*[(6)]***(5)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include*[—]***:**

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply.

*[(7)]***(6)** Formulary—The formulary *[does not change during a calendar year, unless]* **is updated on a semi-annual basis, or when**—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; *[and]* **or**

(C) A drug is determined to have a safety issue.

(7) Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertention drugs; and

(O) Somatostatin analogs.

(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.092 Dental Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Dental Benefit Summary for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Two (2) dental benefit packages are available for a public entity to choose from—basic and high.

(A) The basic benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services; and
3. Coverage C—major services.

(B) The high benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;
2. Coverage B—basic and restorative services;
3. Coverage C—major services; and
4. Coverage D—orthodontic services for children younger than nineteen (19).

(2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.

(3) Dental benefits, deductibles, and coinsurance include:

DENTAL SERVICES			
	BASIC	**HIGH**	
Coverage A – Diagnostic & Preventive	**You Pay**	**You Pay**	**Note**
Examinations Prophylaxis (teeth cleaning) Fluoride X-rays Emergency Palliative Treatment Space Maintainers Sealants	No deductible 0% coinsurance	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
Coverage B – Basic & Restorative	**You Pay**	**You Pay**	**Note**
Minor Restorative Services (fillings) Oral surgery, including extractions Periodontics Endodontics	$50/person deductible* 20% coinsurance	$50/person deductible* 20% coinsurance	
Coverage C – Major Services	**You Pay**	**You Pay**	**Note**
Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays, labial veneers)	$50/person deductible* 50% coinsurance	$50/person deductible* 50% coinsurance	12-month waiting period applies to replacement prosthetic devices. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
Coverage D – Orthodontic Services for children younger than 19	**You Pay**	**You Pay**	**Note**
Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position	Orthodontia is not covered	$50/child deductible* 50% coinsurance	Orthodontic lifetime maximum of $1,000 per dependent child younger than 19
Coverage is limited to $1,000 per person per calendar year benefit period. **Coinsurance amounts apply after the $50 individual deductible is met under Coverage B, C or D, or combined.*			

(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the cost of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars ($200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars ($200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much he/she will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.093 Vision Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

VISION SERVICES		
BENEFITS	**NETWORK**	**NON-NETWORK**
Exams – once every 12 months		
Vision Exam	$10 copayment	Reimbursed up to $36
Lenses – once every 12 months – one $25 copayment for lenses and frames when purchased together		
Single vision lenses (per pair)	$25 copayment	Reimbursed up to $28
Bifocal lenses (per pair)	$25 copayment	Reimbursed up to $45
Trifocal lenses (per pair)	$25 copayment	Reimbursed up to $56
Lenticular lenses (per pair)	$25 copayment	Reimbursed up to $80
Polycarbonate lenses (per pair) Applies to dependent children only	$25 copayment	Not covered
Frames – once every 24 months – one $25 copayment for lenses and frames when purchased together		
Frames	**$25 copayment** **Up to $120 plus 20% discount on any out-of-pocket costs**	**Reimbursed up to $45**
Contact Lenses – once every 12 months in place of eye glass lenses		
Elective If member prefers contacts to glasses	$10 copayment for exam Up to $125 for contact lenses and contact lens exam (fitting and evaluation) 15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to $36 for exam Contact lenses, evaluation, design and fitting reimbursed up to $105
Necessary If medically necessary with prior approval from VSP	$10 copayment for exam Additional costs covered at 100%	Reimbursed up to $36 for exam Contact lenses, evaluation, design and fitting reimbursed up to $210
Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information		

PRK	Maximum amount you pay: $1,500 per eye	Not covered
LASIK	Maximum amount you pay: $1,800 per eye	Not covered
Custom LASIK	Maximum amount you pay: $2,300 per eye	Not covered
Other		
Optional Items (cosmetic extras)	Not covered	Not covered

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

(A) A contact lens exam;

(B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and

(C) Two (2) follow-up visits.

(D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—

1. Standard fit contact lens patients—

A. Typically the member does not require additional time for care, training, or problem solving; and

B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and

2. Premium fit contact lens patients—

A. Typically the member will require additional time for care, training or problem solving; and

B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.

(E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

Tier One: Spherical				
Product	**Manufacturer**	**Boxes Covered**	**Replacement Wearers**	**Refit Wearers**
ACUVUE	Vistakon	4	$130	$170
ACUVUE 2	Vistakon	4		
AIR OPTIX AQUA	CIBA Vision	2		
Biofinity	CooperVision	2		
Biomedics 55 Premier	CooperVision	4		
Biomedics 55 UV	CooperVision	4		
Biomedics XC	CooperVision	4		
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2		
Frequency 38	CooperVision	2		
Frequency 55 Aspheric	CooperVision	2		
Frequency 55 Sphere	CooperVision	2		
FreshLook Handling Tint	CIBA Vision	4		
O2OPTIX	CIBA Vision	2		
Proclear Sphere (Compatibles)	CooperVision	2		
PureVision	Bausch & Lomb	2		
SofLens 39 (Optima FW, Seequence II)	Bausch & Lomb	4		
Vertex Sphere (Encore Sphere)	CooperVision	4		

Tier Two: Spherical				
Product	**Manufacturer**	**Initial Supply Boxes**	**Replacement Wearers**	**Refit Wearers**
ACUVUE ADVANCE	Vistakon	4	$160	$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4		
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2		
Avaira	CooperVision	4		
Biomedics 38	CooperVision	4		
Extreme H_20 59% - Thin	Hydrogel	4		
Extreme H_20 59% - Xtra	Hydrogel	4		
Extreme H_20 54%	Hydrogel	4		
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4		
PRECISION UV	CIBA Vision	4		

Tier Three: Specialty Lenses				
Product	**Manufacturer**	**Initial Supply Boxes**	**Replacement Wearers**	**Refit Wearers**
ACUVUE ADVANCE *for ASTIGMATISM*	**Vistakon**	**4**	**$180**	**$210**
ACUVUE OASYS *for ASTIGMATISM*	**Vistakon**	**4**		
AIR OPTIX *for ASTIGMATISM*	**CIBA Vision**	**2**		
Biofinity Toric	**CooperVision**	**2**		
Focus Monthly Toric Visitint (Focus Toric)	**CIBA Vision**	**2**		
Frequency 55 Multifocal	**CooperVision**	**2**		
Frequency 55 Toric	**CooperVision**	**2**		
Proclear EP Multifocal	**CooperVision**	**4**		
PureVision Multifocal	**Bausch & Lomb**	**2**		
PureVision Toric	**Bausch & Lomb**	**2**		
SofLens Toric	**Bausch & Lomb**	**4**		

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2010.

EXECUTIVE ORDER
10-27

WHEREAS, I have been advised by the State Emergency Management Agency that on-going and forecast severe storm systems have caused, or have the potential to cause, damages associated with high winds and tornadoes impacting communities throughout the state of Missouri; and

WHEREAS, there have been at least three deaths associated with this storm system; and

WHEREAS, the severe weather that began on December 30, 2010, and is continuing, has created a condition of distress and hazard to the safety, welfare, and property of the citizens of the state of Missouri beyond the capabilities of some local jurisdictions, and other established agencies; and

WHEREAS, interruptions of public services are occurring, or anticipated to occur, as a result of the severe weather event that started on December 30, 2010, and is continuing; and

WHEREAS, the state will continue to be proactive where the health and safety of the citizens of Missouri are concerned; and

WHEREAS, the resources of the state of Missouri may be needed to assist affected jurisdictions and to help relieve the condition of distress and hazard to the safety and welfare of our fellow Missourians; and

WHEREAS, an invocation of the provisions of Sections 44.100 and 44.110, RSMo, will be required to ensure the protection of the safety and welfare of the citizens of Missouri.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and Laws of the state of Missouri, including Sections 44.100 and 44.110, RSMo, do hereby declare that a State of Emergency exists in the state of Missouri. I do hereby direct that the Missouri State Emergency Operations Plan be activated.

I further authorize the use of state agencies to provide assistance, as needed.

This order shall terminate on January 31, 2011, unless extended in whole or in part.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 31st day of December, 2010.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State