Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 25—Physician Program

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 25—Physician Program

13 CSR 70-25.100 Abortions

PURPOSE: This rule complies with Federal Law and rules relating to abortions and maintains compliance with the requirements of the Title XIX program which provides funding for needy persons in the state.

(1) No funds appropriated for the payment of medical claims shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term and a physician has found and certified in writing to the Medical Services Division that, on the basis of his/her professional judgment, the mother's life would be endangered if the fetus were carried to term. The certification shall set out the name, address and medical assistance number of the patient.

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.101. Emergency rule filed July 2, 1980, effective July 12, 1980, expired Oct. 12, 1980. Original rule filed July 2, 1980, effective Oct. 11, 1980. Emergency amendment filed Nov. 20, 1980, effective Nov. 30, 1980, expired March 11, 1981. Amended: Filed Nov. 20, 1980, effective March 12, 1981. Emergency amendment filed July 9, 1981, effective July 21, 1981, expired Oct. 10, 1981. Amended: Filed July 9, 1981, effective Oct. 11, 1981.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982 and 1986.*

13 CSR 70-25.110 Payment for Early Periodic Screening, Diagnostic and Treatment Program Services

PURPOSE: This rule establishes the basis and criteria for payment of screenings and related services resulting from the Early Periodic Screening, Diagnosis and Treatment Program.

(1) The Department of Social Services shall administer an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. In Missouri, the EPSDT Program is administered as the Healthy Children and Youth (HCY) Program. The EPSDT/HCY Program provides for thorough physical and dental examinations for MO HealthNet-eligible persons under the age of twenty-one (21) years and for all persons under the age of twenty-one (21) years in the legal custody of the Department of Social Services or any division of the department at no cost to the child or to the parents or guardians if they accept the offer of this service. Funding for EPSDT services is through Title XIX of the federal Social Security Act (Medicaid) and Missouri.

(2) EPSDT services are available to participants under the age of twenty-one (21) years who are eligible to receive medical assistance benefits under the provisions of sections 208.151, 208.162, and 208.204, RSMo.

(3) The EPSDT Program shall make a general physical examination available to eligible participants under the age of twenty-one (21) years. The components of the general physical examination shall include a health history, an unclothed physical examination, appropriate laboratory tests, immunizations, a developmental/mental health screen, a vision screen, and a dental screen. These screens will be made available at the frequency recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentists.

(A) Interperiodic screenings outside the recommendations of the American Academy of Pediatrics or the American Academy of Pediatric Dentists are available when medically indicated.

(B) Partial screens for vision, hearing, dental, unclothed physical examination, an interval history, and appropriate laboratory tests and immunizations, developmental/mental health assessment, and anticipatory guidance shall be reimbursable services.

(4) Providers of the screening services must be enrolled MO HealthNet providers.

(5) Reimbursement for medically necessary treatment services identified as a result of a screening shall be provided by the Department of Social Services, MO HealthNet Division, if the services are available under Section 1905(a) of the Social Security Act. These services shall be limited by medical necessity. Experimental services are not covered. Any service authorized must be effective in addressing the participant's need. Services may be prior-authorized to assure medical necessity.

(6) Medical and dental services which Section 1905(a) of the Social Security Act permits to be covered under MO HealthNet and which are necessary to treat or ameliorate defects, physical, and mental illness or conditions identified by an EPSDT screen are covered regardless of whether or not the services are covered under the Medicaid state plan. Services provided under this program will be sufficient in amount, duration, and scope to reasonably achieve their purpose. The services are limited due to medical necessity. Services identified as needed as the result of a screening which are beyond the scope of the Medicaid state plan require a plan of care identifying the treatment needs of the child in regard to amount, scope, and prognosis. Prior authorization of services may be required for these services needs and for services of extended duration unless otherwise noted in the benefits and limitations section of the provider manual of the appropriate provider of the service. Examples of services beyond the scope of the state Medicaid Plan are—orthodontic services; physical, occupational, and speech therapy evaluations and services; psychology and counseling services; private duty nursing services; and medical supplies. Services may be made available on an inpatient, outpatient office, or home setting depending upon the medical condition of the participant and availability of services.

(7) Services must be provided by enrolled MO HealthNet providers operating within their legal scope of practice.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2007. This rule was previously filed as 13 CSR 40-81.015. Original rule filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed Jan. 13, 1992, effective Sept. 6, 1992. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978(2), 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-25.120 MO HealthNet (Medicaid) Payment for Certain Services Furnished by Certain Physicians in Calendar Years 2013 and 2014

PURPOSE: This rule sets forth the criteria to be used by the MO HealthNet Division in establishing certain payment rate increases for certain primary care services provided in calendar years 2013 and 2014. Federal law requires certain payment rates by state Medicaid agencies of the Medicare Part B rates in effect in calendar years (CY) 2013 and 2014 or, if higher, the rate that would be applicable using the CY 2009 Medicare conversion factor (CF), for certain primary care services furnished by a physician with the specialty

designation of family medicine, general internal medicine, or pediatric medicine. The proposed rule is to encourage physicians to participate in MO HealthNet (Medicaid), and thereby promote access to primary care services for current and new MO HealthNet participants.

(1) Definitions. Primary care services are defined as procedure codes for services in the category designated primary care Evaluation and Management (E/M) codes 99201-99499 or their successor codes in the Healthcare Common Procedure Coding System (HCPCS) and services related to immunization administration for vaccines and toxoids for which Current Procedural Terminology (CPT) codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, 90474, or their successor codes apply under such system.

(2) Condition of Eligibility to Receive Payment Rate Increase. Physicians with certain specialty and sub-specialty designations (family medicine, general internal medicine, or pediatric medicine) are eligible to receive increases in payment rates when delivering primary care services as defined in section (1).

(A) Sub-specialists within the specialty designations of family medicine, general internal medicine, and pediatric medicine as recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, the American Osteopathic Association, or any other enrolled provider providing primary care services defined by the Centers for Medicare and Medicaid Services (CMS) as eligible for federal financial participation at the one hundred percent (100%) rate may also be eligible for increased payment. To be eligible—

1. The provider may be board certified; or

2. If not board certified, at least sixty percent (60%) of the services billed to MO HealthNet by the physician for CY 2012 must be for primary care E/M codes 99201-99499 or their successor codes and vaccine administration codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, 90474 or their successor codes. Claims data review will be done to ensure the sixty percent (60%) threshold is met.

3. For newly enrolled non-board certified physicians, a year end review will be done to ensure eligibility criteria are met.

4. If the condition of eligibility to receive the payment rate increase is not met the payment will no longer be made.

(3) Reimbursement. MO HealthNet reimbursement rates for primary care services and services related to immunization administration for vaccines and toxoids will be the lower of the provider's usual and customary charges to the general public or the MO HealthNet allowable amount based upon the Medicare Part B rates for office site of service using the mean values over all counties. An additional payment for vaccine administration will be made to bring the reimbursement amount up to Missouri's regional maximum fee of twenty-one dollars and fifty-three cents ($21.53). The reimbursement amount may be referenced at http://dss.mo.gov/mhd/index.htm under Alerts & Notifications.

(4) The fee-for-service and managed care payment rate increase applies to certain primary care services defined in section (1) provided in CY 2013 and 2014 only.

(5) The Federal Medical Assistance Percentage (FMAP) rate is one hundred percent (100%) of the difference between the Medicaid State Plan rate in effect on July 1, 2009, and the amount required to be paid under section 1902(a)(13)(C) of the Social Security Act. The state will be fully reimbursed for these increased payments for primary care services by the federal government.

(6) Primary care services performed by a non-physician practitioner will be paid at the higher rates if properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists or subspecialists when provided under the physician's personal supervision as services of the supervising physician. There is no increase in payment rate for independently practicing non-physician practitioners.

(7) The increased payments are available for services claimed under the physician services benefit. Increased payments are not available for federally qualified health centers (FQHCs) or rural health clinics (RHCs).

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2013. Original rule filed Oct. 10, 2013, effective April 30, 2014.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978(2), 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; and 208.201, RSMo 1987, amended 2007.*