Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 4—Conditions of Participant Participation, Rights and Responsibilities

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 4—Conditions of Participant Participation, Rights and Responsibilities

13 CSR 70-4.030 Participant Liability for Medical Services Not Reimbursable to the Provider by the MO HealthNet Agency

PURPOSE: This rule establishes the guidelines for determination of participant liability for medical services not reimbursable to the provider by the MO HealthNet agency.

(1) When an enrolled MO HealthNet provider provides an item or service to a MO HealthNet participant eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the participant's MO HealthNet benefits and seeks reimbursement from the MO HealthNet agency in accordance with all of the applicable MO HealthNet rules. This presumption shall be overcome only by written evidence of an agreement between the provider and the participant indicating that MO HealthNet is not the intended payor for the specific item or service but rather that the participant accepts the status and liabilities of a private pay patient. All third-party resource benefits must be exhausted before payment will be made by the division for the item or service rendered to that participant. For purposes of this rule, neither the provider nor the participant shall be required to exhaust all third-party resources in those situations where the provider or participant elect not to pursue contingent liability from a third-party tortfeasor. Both the provider and the participant have an affirmative duty to report the existence of contingent liability to the MO HealthNet Division and the participant has the duty to cooperate with the MO HealthNet Division if the division elects to pursue the contingent liability.

(2) When an item or service is rendered to a MO HealthNet participant who was eligible for the item or service on the date provided and provision of the item or service is billed to the MO HealthNet agency by an enrolled MO HealthNet provider who is not reimbursed by the agency for the item or service claimed, the item or service will not be the liability of the participant if the item or service would have been otherwise payable by the MO HealthNet agency at the MO HealthNet allowable amount had the provider followed all of the policies, procedures and rules applicable to the item or service as of the date provided. If the item or service is not otherwise payable for reasons unrelated to the actions of the provider, the participant is liable to the provider for payment of the item or service.

(3) The creation of a presumptive acceptance by a provider of the MO HealthNet benefits for a MO HealthNet covered service and the requirement for written evidence of an agreement to overcome presumptive acceptance, as established in this rule, shall not be applicable to services provided to a participant who is dually eligible and entitled to both MO HealthNet and Medicare Part B medical insurance benefits.

(4) The provisions of this rule shall apply to items or services provided on or after July 11, 1985.

AUTHORITY: section 207.020, RSMo 2000 and sections 208.152 and 208.153, RSMo Supp. 2007. This rule was previously filed as 13 CSR 40-81.140. Original rule filed April 16, 1985, effective July 11, 1985. Amended: Filed March 2, 1988, effective May 12, 1988. Amended: Filed Oct. 12, 2007, effective April 30, 2008.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993; 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978(2), 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007; and 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007.*

13 CSR 70-4.040 Eligibility Corrective Action Participant Payments

PURPOSE: This rule establishes the basis on which participants may be reimbursed by the MO HealthNet program for Title XIX services and for services covered under state-only types of assistance programs and after this referred to as MO HealthNet paid by them to providers between the date of the initial agency decision denying their eligibility and the date of the agency or court decision establishing their eligibility for MO HealthNet.

(1) All participants whose eligibility for MO HealthNet benefits is denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision or any other final agency decision rendered on or after January 1, 1986 may be reimbursed by the MO HealthNet agency for MO HealthNet services paid by the participants to providers between the date of the agency decision denying their eligibility and the date of the agency or court decision establishing their eligibility for MO HealthNet benefits.

(A) Payments to a participant will be made only for medical services which were covered services at the time provided in accordance with MO HealthNet program benefits, limitations and requirements applicable to the services or the participant as of the date provided, except that prior authorization requirements will not apply.

(B) Payments may be made for services of either an enrolled MO HealthNet provider or for providers who do not participate in MO HealthNet.

(C) Payments to a participant will be limited to the lesser of the MO HealthNet allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the participant for the covered item or service.

(D) Any medical expenses paid by the participant which are for the purpose of meeting that participant's spenddown obligation are not payable.

(E) All third-party resource benefits received by the participant for MO HealthNet covered services must be applied against the lesser of the MO HealthNet allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the participant for the covered item or service. No payment shall be made to the participant until all third-party resource benefits have been exhausted as would have been applicable to participants receiving MO HealthNet. For purposes of this rule, neither the provider nor the participant shall be required to exhaust all third-party resources in those situations where the provider or the participant elects not to pursue contingent liability from a third-party tortfeasor. Both the provider and the participant have an affirmative duty to report the existence of contingent liability to the MO HealthNet Division and the participant has the duty to cooperate with the MO HealthNet Division if the division elects to pursue the contingent liability.

(F) As evidenced by the MO HealthNet agency's date of receipt, the participant or person legally responsible will have one (1) year from the date of the final agency or court decision establishing eligibility to submit all written requests for participant payment to the MO HealthNet agency with sufficient documentation to determine the appropriate reimbursement amount under the applicable provisions of subsections (1)(A), (C) and (E) for the MO HealthNet-covered items or services paid by the participant.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2007. This rule was previously filed as 13 CSR 40-81.141. Original rule filed April 16, 1985, effective Jan. 1, 1986. Amended: Filed Jan. 22, 1992, effective Sept. 6, 1992. Amended: Filed May 1, 2003, effective Nov. 30, 2003. Amended: Filed Oct. 12, 2007, effective April 30, 2008.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services

PURPOSE: This rule implements recipient copayment for certain Missouri Medicaid program areas.

(1) Recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. The services to be affected by the copayment or coinsurance requirements are—

(A) Dental services related to trauma or the treatment of a disease/medical condition;

(B) Optical services related to trauma or the treatment of a disease/medical condition, and one (1) eye exam every two (2) years;

(C) Podiatry services provided through the podiatry program;

(D) Inpatient hospital services;

(E) Hospital outpatient clinic/emergency room services; and

(F) All physician-related services.

(2) Participating providers of services in the program areas named shall be required to charge copayment or coinsurance, as applicable, on each subject item of service performed or furnished, or on each date of service as applicable.

(3) Copayment charged shall be in accordance with 42 CFR 447.54 and, applicable to the services described in subsections (1)(A), (excepting dentures), (B), (C), and (F), based on the following schedule:

Medicaid Payment for Each Item of Service	Recipient Copayment Amount
$10 or less	$0.50
$10.01–$25	$1.00
$25.01–$50	$2.00
$50.01 or more	$3.00

(4) Under this rule, coinsurance shall apply only to Medicaid-covered full and partial dentures. The coinsurance amount to be charged shall be five percent (5%) of the lesser of the Medicaid maximum allowable amount for the service or the provider's billed charge.

(5) Copayment to be charged for inpatient hospital services shall be ten dollars ($10) per hospitalization, applicable to the first day of the Medicaid-covered hospital stay and to be charged to the recipient prior to discharge.

(6) Co-payment to be charged for hospital outpatient clinic or emergency room services shall be three dollars ($3) for each date of service on which the recipient receives, either one (1) or both, outpatient clinic or emergency room services.

(7) The following is a list of exemptions to the Medicaid copayment requirement:

(A) Services provided to recipients under nineteen (19) years of age;

(B) Services provided to recipients residing within a skilled nursing facility, an intermediate care facility, a residential care facility, an adult boarding home or a psychiatric hospital;

(C) Services provided to recipients who have both Medicare and Medicaid entitlement if Medicare covers the service and provides payment for it;

(D) Emergency or transfer inpatient hospital admissions;

(E) Emergency services provided in an outpatient clinic or emergency room, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part;

(F) Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

(G) Family planning services;

(H) Services provided to pregnant women;

(I) Services provided to foster care recipients;

(J) Services identified as medically necessary through an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen;

(K) Services provided through MC+ Managed Care Contracts;

(L) Personal care services;

(M) Mental health services;

(N) Services provided to the blind;

(O) Hospice services; and

(P) Medicaid waiver services.

(8) Providers are responsible for collecting the copayment or coinsurance amounts from individuals. The medical assistance program shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient. A provider shall collect a copayment from a recipient at the time each service is provided or at a later date. Providers of services as described in this rule and as subject to a copayment or coinsurance requirement may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment or coinsurance amount when charged.

(9) A recipient's inability to pay a required coinsurance or copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient liability to pay the due amount or prevent a provider from attempting to collect a copayment.

(10) Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any coinsurance or copayment amount required of the recipient.

(11) Providers of services in the program areas named must charge copayment or coinsurance as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program.

(12) Providers must maintain records of copayment or coinsurance amounts for five (5) years and must make those records available to the Department of Social Services upon request.

(13) If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

(14) A provider shall give a Medicaid recipient a reasonable opportunity to pay an uncollected copayment.

(15) A provider shall give a Medicaid recipient with uncollected debt advanced notice and a reasonable opportunity to arrange care with a different provider before services can be discontinued.

(16) If a provider is not willing to provide services to a recipient with uncollected copayments and the requirements of this regulation have been met, the provider may discontinue future services to an individual with uncollected copayments. In accordance with 42 *Code of Federal Regulations* (CFR) 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient and accept their ability/inability to pay the required copayments.

AUTHORITY: sections 208.152, RSMo Supp. 2004 and as enacted by the 93rd General Assembly and 208.201, RSMo 2000. This rule was previously filed as 13 CSR 40-81.054. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. Emergency amendment filed Jan. 21, 1983, effective Feb. 1, 1983, expired May 11, 1983. Amended: Filed Jan. 21, 1983, effective May 12, 1983. Amended: Filed Aug. 14, 1984, effective Nov. 11, 1984. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Amended: Filed May 16, 2005, effective Nov. 30, 2005.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004 and 208.201, RSMo 1987.*

13 CSR 70-4.051 Copayment for Pharmacy Services

PURPOSE: This rule establishes the regulatory basis for the Medicaid requirement of eligible recipient copayment when receiving covered pharmacy services.

(1) All Medicaid-eligible recipients shall be responsible for a copayment upon receipt of each original or refilled prescription of a Medicaid-covered drug unless the service is exempted under provisions of section (2). Copayment responsibility and amounts collectible shall be as follows:

Medicaid Maximum Allowable Amount for Each Item of Service	Recipient Copayment Amount
$10.00 or less	$0.50
$10.01–$25.00	$1.00
$25.01 or more	$2.00

The Medicaid maximum allowable amount for each item of service is the lesser of the providers billed charge or the price(s) in the drug pricing file 13 CSR 70-20.070(3).

(2) Services exempted from the copayment requirement for drugs are—

(A) Services to recipients under nineteen (19) years of age;

(B) Services to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;

(C) Those drugs specifically identified as relating to family planning services (oral contraceptives);

(D) Those drugs which are prescribed and identified as relating to an Early Periodic Screening, Diagnosis and Treatment (EPSDT) program screening or referral service; and

(E) Those drugs prescribed for foster care children.

(3) Those drugs which are exempt from the requirement of copayment as related to an EPSDT screening or referral service must be confirmed as such to the dispenser through one (1) of the following methods:

(A) The prescribing physician (MD, DO, dentist, podiatrist) identifies on the prescription that it relates to EPSDT examination and treatment; or

(B) The prescribing physician verbally states that the prescription relates to EPSDT examination and treatment in cases of telephone prescribing. This verbal assertion must be included in the dispensing provider's reduction into writing of the prescription.

(4) Providers of service may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment amount when charged.

(5) A recipient's inability to pay a required copayment amount, as due and charged when a service is delivered, shall in no way extinguish the recipient liability to pay the due amount.

(6) Providers of service must collect copayment as specified in accordance with section 208.152, RSMo. Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any copayment amount required of the recipient and collected or collectible as charged by the provider.

(7) Providers must maintain records of copayment amounts for five (5) years and must make these records available to the Department of Social Services upon request.

(8) The computation and application of the required copayment as it applies to all nonexempted Medicaid-covered drug prescriptions shall be performed by the provider dispensing the covered Medicaid drug. No alterations or changes are to be made to claims by providers which reflect the collection or application of the required copayment amount.

AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 1994. This rule was previously filed as 13 CSR 40-81.055. Original rule filed April 14, 1982, effective July 11, 1982. Amended: Filed Oct. 13, 1983, effective Jan. 13, 1984. Amended: Filed May 15, 2000, effective Nov. 30. 2000.*

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

13 CSR 70-4.060 Required Reporting of Injuries Received by Title XIX Recipients

PURPOSE: The Division of Family Services has statutory responsibility under House Bill 1086, 208.215.8. to require that recipients of benefits as defined in Chapter 208, RSMo report injuries to the Division of Family Services.

(1) All recipients of benefits provided for in Chapter 208, RSMo, within thirty (30) days of the date of benefit receipt, shall provide the county office in the county of their residence with detailed information concerning any occurrences, other than an illness, routine medical service or other medical treatment not related to a casualty, where medical treatment is given as a result of a casualty.

(2) Casualty as used in this regulation means an accident, event due to sudden unusual occurrence, misfortune or mishap.

(3) Recipient is defined as any person for whom medical benefits are provided for in Chapter 208, RSMo.

(4) Failure to supply the information on a form prescribed by the Medical Services Division within thirty (30) days of the occurrence, as determined by the Division of Family Services, may be held as constituting recipient failure to cooperate and result in loss of benefits.

(5) Loss of benefits resulting from a determination of recipient failure to cooperate in accordance with the provisions of this rule shall not penalize nor deny reimbursement to

a Title XIX provider who provided covered services to a recipient presenting valid evidence of Title XIX eligibility as of the date service is provided, where the provider has advised the Division of Family Services that the covered services rendered may have resulted from circumstances defined in this rule by completing the accident portion of the claim form or other written notice.

AUTHORITY: sections 207.020, 208.153 and 208.159, RSMo 1986. This rule was previously filed as 13 CSR 40-81.092. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.159, RSMo 1979.*

13 CSR 70-4.070 Title XIX Recipient Lock-In Program

PURPOSE: This rule establishes the regulatory basis for implementation of a method to limit or restrict the use of the recipient's Medicaid identification card to designated providers of medical services.

(1) Definitions which shall apply in the administration of this program.

(A) Misutilization of medical services is defined as the act of seeking or obtaining medical services, or both, from a number of like providers and in quantities which exceed the levels that are considered medically necessary by current medical practices, standards and policies of the Missouri Title XIX Medicaid Program.

(B) Lock-in is defined as the method to limit or restrict the use of the recipient's Medicaid identification (ID) card to a designated provider(s) only. When one (1) of the designated providers is a physician, this provider is the primary-care physician and is responsible for providing or directing, or both, the recipient's medical care and for making any necessary referrals to other providers as medically indicated.

(C) The Division of Medical Services, Surveillance and Utilization Review System Unit will review all suspect or potential cases of lock-in. The Surveillance and Utilization Review System Unit professional staff will initiate lock-in procedures after utilization review of documented services indicate misutilization of Title XIX services, benefits, or both.

(2) The lock-in or limitation is for one (1) person and the fiscal agent audit is for that person's individual Medicaid ID number. Payment to any other provider(s) with the provider type of the designated provider is limited to—

(A) Documented emergencies; and

(B) Referral from the designated provider, with designated provider's name or provider's number on all claims submitted by the other provider(s) to show designated provider as the referring physician or provider.

(3) In cases where treatment or service by another provider of the same type as the designated provider is needed is not an emergency and the designated provider is not available to render service to the recipient, the recipient may obtain an authorization from the individual's Division of Family Services local office which allows the recipient to obtain the needed service from a different provider. The form is titled Medical Referral Form of Restricted Recipient and is numbered MSS-S/UR-118. This form is also available from the state office Division of Medical Services, Surveillance and Utilization Review System Unit, P.O. Box 6500, Jefferson City, MO 65102-6500. The form must be attached to the different provider's claim for reimbursement.

(4) Change of the designated provider may be requested by the recipient during a period of lock-in. The recipient must contact his/her Division of Family Services local office and request the change of provider by completing the Recipient Lock-In Form Authorization for Medical Services. The change of approved authorized provider(s) will be effective the first day of the month following the receipt of the completed Authorization for Medical Services Form. In the event the change of authorized provider(s) cannot be reflected on the recipient's Medicaid ID card on the first day of the month following the receipt of the Authorization for Medical Services Form, the recipient's Division of Family Services local office may replace the Medicaid ID card with a corrected income maintenance letter of eligibility showing the proper listing of designated provider. A copy of the income maintenance letter must be forwarded to the Division of Medical Services Surveillance and Utilization Review System Unit for case documentation. No more than one (1) provider-type change may be allowed in a three (3)-month period. Exceptions to the previously mentioned may be approved if documentation is presented for just cause of additional authorized provider changes within the three (3)-month period. This documentation must be submitted by the recipient's caseworker in writing for review and approval by the Division of Medical Services Surveillance and Utilization Review System Unit professional staff.

(5) Lock-In Provider Types.

(A) Medical—physician.

(B) Pharmacy.

(C) Dental.

(D) Optometrist.

(E) Optical company.

(F) Ambulance.

(G) Durable medical equipment.

(H) Institutional—inpatient—outpatient—emergency room facility.

(I) Audiology.

(J) Home health.

(K) Podiatry.

(L) Independent clinic

(6) Recipients have free choice of providers who are participants in the Missouri Medicaid program. Professional practitioners have the right to accept or refuse recipients for treatment. Both the provider and recipient must be agreeable to the lock-in relationship. If the recipient does not cooperate in designating a lock-in provider, the Division of Medical Services or local Division of Family Services office may arrange for a provider after documenting the recipient's lack of cooperation in designating a provider. The medical ID card may be held only as a mechanism to get the recipient to the Division of Family Services office to discuss or select a lock-in provider.

(7) The recipient selected for lock-in has the right to the fair hearing procedures as offered under applicable state law and federal regulations.

(8) The lock-in period will be for a minimum of twelve (12) months and a maximum of twenty-four (24) months. Not sooner than twelve (12) months but no longer than twenty-four (24) months after a recipient has been placed on lock-in, the Surveillance and Utilization Review System Unit professional staff will review the case and continue the recipient on lock-in if review of documented services indicates continuing misutilization of Title XIX services, benefits, or both. The lock-in period will again be for a minimum of twelve (12) months and a maximum of twenty-four (24) months before another review is conducted, after which lock-in may again be renewed. Recipients who have initially been placed on the lock-in program prior to December 1, 1985 will continue to be subject to twelve (12)-month reviews. The recipient has the right to the fair hearing procedures as offered under applicable state law and federal

regulations if s/he is continued on lock-in after a review. The effective date for the start of lock-in should be the same for the medical ID card and the audit implementation of the fiscal agency by the Surveillance and Utilization Review System Unit. A form processed by electronic data processing and forwarded to the fiscal agency will give the effective date of lock-in. If a case is closed during a twelve (12)-month period, the lock-in restriction would automatically still be in effect at the fiscal agent unless the medical ID number was changed. The lock-in period should be continued a full twelve (12) months. A new Authorization of Medical Services Form should be submitted on any change of provider. The Surveillance and Utilization Review System Unit should also be advised of any name or Medicaid ID number changes instigated in behalf of lock-in recipients.

(9) If Missouri Medicaid recipients are identified as misutilizing the Title XIX Medicaid Program in the following areas, but not limited to, lock-in proceedings, referral to the Division of Investigation, or both, will be implemented:

(A) Lending Medicaid ID card to noneligible persons;

(B) Submitting forged documents to providers for medical benefits or services;

(C) Seeking excessive or unnecessary medical care as defined in subsection (1)(A) of this rule, that is, drugs, office visits, eyeglasses, dentures, etc.;

(D) Utilizing multiple medical providers; or

(E) Refusing to submit to or failing to have predicted urine or blood levels following testing for opioid or opioid-like controlled substances covered by Missouri Medicaid while engaged in a pain or substance abuse treatment regimen.

AUTHORITY: section 208.201, RSMo 2000. This rule was previously filed as 13 CSR 40-81.200. Emergency rule filed July 13, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 13, 1981, effective Oct. 11, 1981. Amended: Filed Sept. 4, 1985, effective Dec. 1, 1985. Amended: Filed Nov. 2, 1988, effective Jan. 13, 1989. Amended: Filed Aug. 1, 2003, effective Feb. 29, 2004.*

**Original authority: 208.201, RSMo 1987.*

13 CSR 70-4.080 State Children's Health Insurance Program

PURPOSE: This rule establishes components of the State Children's Health Insurance Program which will provide health care coverage to uninsured, low income children.

(1) Definitions.

(A) Children. Persons up to nineteen (19) years of age.

(B) Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) An uninsured child/children in a family(ies) with gross income of more than one hundred fifty percent (150%) of the federal poverty level shall not have had health insurance prior to application pursuant to 208.631, RSMo.

(3) Parent(s) and guardian(s) of uninsured children with gross income of more than one hundred fifty percent (150%) but less than three hundred percent (300%) of the federal poverty level must certify, as a part of the application process, that the child does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage available to the parent(s) or guardian(s) through their association with an identifiable group (for example, a trade association, union, professional organization) or through the purchase of individual health insurance coverage. Access to affordable employer-sponsored health care insurance or other affordable health care coverage shall result in the applicant not being eligible for the Health Care for Uninsured Children program for the child/children in families with gross income of more than one hundred fifty percent (150%) but less than three hundred percent (300%) of the federal poverty level.

(A) For families with gross income of more than two hundred twenty-five percent (225%) but less than three hundred percent (300%) of the federal poverty level affordable employer-sponsored health care insurance or other affordable health care coverage is health insurance requiring a monthly dependent premium of five percent (5%) of two hundred twenty-five percent (225%) of the federal poverty level for a family of three (3).

(B) For families with gross income of more than one hundred eighty-five percent (185%) but less than two hundred twenty-six percent (226%) of the federal poverty level affordable employer-sponsored health care insurance or other affordable health care coverage is health insurance requiring a monthly dependent premium of four percent (4%) of one hundred eighty-five percent (185%) of the federal poverty level for a family of three (3).

(C) For families with gross income of more than one hundred fifty percent (150%) but less than one hundred eighty-six percent (186%) of the federal poverty level affordable employer-sponsored health care insurance or other affordable health care coverage is health insurance requiring a monthly dependent premium of three percent (3%) of one hundred fifty percent (150%) of the federal poverty level for a family of three (3).

(4) An uninsured child/children with gross income of more than two hundred twenty-five percent (225%) but less than three hundred percent (300%) of the federal poverty level shall be eligible for service(s) thirty (30) calendar days after the application is received if the required premium has been received. An uninsured child/children with gross income of more than one hundred fifty percent (150%) but less than two hundred twenty-six percent (226%) of the federal poverty level shall be eligible for services once the required premium has been received.

(A) Parent(s) or guardian(s) of uninsured children with gross income of more than one hundred fifty percent (150%) but less than one hundred eighty-six percent (186%) of the federal poverty level are responsible for a monthly premium equal to four percent (4%) of monthly income between one hundred fifty percent (150%) and one hundred eighty-five percent (185%) of the federal poverty level for the family size.

(B) Parent(s) or guardian(s) of uninsured children with gross income of more than one hundred eighty-five percent (185%) but less than two hundred twenty-six percent (226%) of the federal poverty level are responsible for a monthly premium equal to four percent (4%) of monthly income between one hundred fifty percent (150%) and one hundred eighty-five percent (185%) of the federal poverty level for the family size plus eight percent (8%) of monthly income between one hundred eighty-five percent (185%) and two hundred twenty-five percent (225%) of the federal poverty level for the family size.

(C) Parent(s) or guardian(s) of uninsured

children with gross income of more than two hundred twenty-five percent (225%) but less than three hundred percent (300%) of the federal poverty level are responsible for a monthly premium equal to four percent (4%) of monthly income between one hundred fifty percent (150%) and one hundred eighty-five percent (185%) of the federal poverty level for the family size plus eight percent (8%) of monthly income between one hundred eighty-five percent (185%) and two hundred twenty-five percent (225%) of the federal poverty level for the family size plus fourteen percent (14%) of monthly income between two hundred twenty-five percent (225%) and three hundred percent (300%) of the federal poverty level for the family size.

(D) The monthly premium shall not exceed five percent (5%) of the family's gross income.

(E) The premium must be paid prior to service delivery.

(F) The premium notice shall include information on what to do if there is a change in gross income.

(G) No service(s) will be covered prior to the effective date which is thirty (30) calendar days after the date the application is received for uninsured children in families with an income of more than two hundred twenty-five percent (225%) of the federal poverty level.

(5) If the parent(s) or guardian(s) with an income of more than two hundred twenty-five percent (225%) of the federal poverty level fails to meet the premium payment requirements, a past due notice shall be sent requesting remittance within twenty (20) calendar days from date of the past due letter. Failure to make payment within this time period shall result in the child's ineligibility for coverage for ninety (90) days.

(6) Premium adjustments shall be calculated yearly in March with an effective date of July 1 of the same calendar year. Individuals shall be notified of the change in premium amount at least thirty (30) days prior to the effective date.

(7) The thirty- (30-) calendar-day delay in service delivery is not applicable to a child/children already participating in the program when the parent's or guardian's income changes. Coverage shall be extended for sixty (60) calendar days to allow for premium collection and to ensure continuity in coverage. Coverage shall be discontinued for the child/children if the premium payment is not made within the sixty- (60-) day extension.

(8) Any child identified as having "special health care needs," defined as a condition which left untreated would result in the death or serious physical injury of a child, who does not have access to affordable employer-subsidized health care insurance shall not be required to be without health care coverage in order to be eligible for services under sections 208.631 to 208.658, RSMo and shall not be subject to the thirty- (30-) day waiting period required under section 208.646, RSMo, as long as the child meets all other qualifications for eligibility.

(9) The total aggregate premiums for a family covered by this rule shall not exceed five percent (5%) of the family's gross income for a twelve- (12-) month period of coverage beginning with the first month of service eligibility. Waiver of premiums shall be made upon notification and documentation from the family that payments for premiums have been made up to five percent (5%) of their yearly gross income.

(10) For the purposes of this rule, a child/children whose annual maximum benefits of a particular medical service under their private insurance has been exhausted is not considered insured and does not have access to affordable health insurance.

AUTHORITY: sections 208.633, 208.650, 208.655, and 208.657, RSMo 2000, and sections 208.631, 208.636, 208.640, 208.643, 208.646, 208.647, and 208.658, RSMo Supp. 2014. Original rule filed July 15, 1998, effective Feb. 28, 1999. Emergency amendment filed Aug. 4, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Amended: Filed April 29, 2005, effective Nov. 30, 2005. Amended: Filed Nov. 15, 2005, effective May 30, 2006. Emergency amendment filed June 15, 2006, effective July 1, 2006, expired Dec. 28, 2006. Amended: Filed June 15, 2006, effective Dec. 30, 2006. Amended: Filed Sept. 17, 2007, effective March 30, 2008. Amended: Filed Feb. 1, 2008, effective Aug. 30, 2008. Amended: Filed June 2, 2008, effective Nov. 30, 2008. Amended: Filed Sept. 25, 2014, effective March 30, 2015.*

**Original authority: 208.201, RSMo 1987, amended 2007; 208.631, RSMo 1998, amended 2002, 2006, 2007; 208.633, RSMo 1998; 208.636, RSMo 1998; 208.640, RSMo 1998, amended 2005, 2007; 208.643, RSMo 1998; 208.646, RSMo 1998; 208.647, RSMo 2004; 208.650, RSMo 1998; 208.655, RSMo 1998; and 208.657, RSMo 1998.*

13 CSR 70-4.090 Uninsured Women's Health Program

PURPOSE: This rule establishes the Uninsured Women's Health Program. This program will provide payment for women's health services for uninsured women who do not qualify for other medical assistance benefits, and would lose their MO HealthNet eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, and for women ages eighteen (18) to fifty-five (55) who have a net family income of at or below one hundred eighty-five percent (185%) of the Federal Poverty Level (FPL) and have assets totaling no more than two hundred fifty thousand dollars ($250,000), in order to reduce the possibility of a family's future dependence on welfare as authorized pursuant to section 208.040, RSMo. The program is authorized pursuant to award of the Missouri's Women's Health Services Program approved by the Centers for Medicare and Medicaid Services.

(1) Uninsured women who do not qualify for other medical assistance benefits, and would lose their MO HealthNet eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, and women ages eighteen (18) to fifty-five (55) who have a net family income of at or below one hundred eighty-five percent (185%) of the Federal Poverty Level (FPL) and have assets totaling no more than two hundred fifty thousand dollars ($250,000), shall be eligible to receive medical services to the extent and in the manner provided in this regulation. Uninsured women who do not qualify for other medical assistance benefits, and would lose their MO HealthNet eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage regardless of income, and women ages eighteen (18) to fifty-five (55) who have a net family income of at or below one hundred eighty-five percent (185%) of the Federal Poverty Level (FPL) and have assets totaling no more than two hundred fifty thousand dollars ($250,000), will continue to be eligible for women's health services only. Women's health services are defined as: pelvic exams and pap tests, sexually transmitted disease testing and treatment (the treatments of medical complications occurring from the sexually transmitted disease are not covered for this program), family planning counseling/education on various methods of birth control, United States Department of Health and Human Services approved methods of contraception including sterilization and x-ray services related to the sterilization, and drugs (excluding antiretrovirals), supplies, or devices related to the women's health services described in this rule when they are prescribed by a physician or

advanced practice nurse, subject to the National Drug Rebate Program requirements.

(2) Uninsured women who do not qualify for other benefits, and would lose their MO HealthNet eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, and women ages eighteen (18) to fifty-five (55) who have a net family income of at or below one hundred eighty-five percent (185%) of the Federal Poverty Level (FPL) and have assets totaling no more than two hundred fifty thousand dollars ($250,000), are not required to pay a co-payment for women's health services.

(3) The Department of Social Services, MO HealthNet Division shall provide for granting an opportunity for a fair hearing to any applicant or participant whose claim for benefits under the Section 1115, Missouri's Women's Health Services Program is denied by the MO HealthNet Division. There are established positions of state hearing officers within the Department of Social Services, Division of Legal Services in order to comply with all pertinent federal and state law and regulations. The state hearing officers shall have authority to conduct state level hearings of an appeal nature and shall serve as direct representative of the director of the MO HealthNet Division.

AUTHORITY: sections 208.040 and 208.201, RSMo Supp. 2008 and section 660.017, RSMo 2000. Emergency rule filed Sept. 13, 1999, effective Sept. 23, 1999, terminated Oct. 15, 1999. Original rule filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 29, 2001, effective Oct. 30, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expired Dec. 27, 2002. Amended: Filed June 11, 2002, effective Nov. 30, 2002. Emergency amendment filed June 7, 2005, effective July 1, 2005, expired Dec. 27, 2005. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Amended: Filed May 14, 2009, effective Nov. 30, 2009.*

**Original authority: 208.040, RSMo 1939, amended 1941, 1949, 1951, 1953, 1955, 1957, 1973, 1977, 1982, 1983, 1984, 1987, 1994, 1999, 2001; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-4.100 Preventing Medicaid Payment of Expenses Used to Meet Spenddown

PURPOSE: This rule establishes the basis on which the Medical Assistance program may reimburse for Title XIX services after spenddown has been met. Spenddown is a process by which aged persons (over sixty-five (65) years), blind persons, or people with disabilities become Medicaid eligible based on their incurred medical expenses when they would not otherwise be eligible.

(1) Aged persons (over sixty-five (65) years), blind persons, or people with disabilities with income above limits established under section 208.151.1(25), RSMo for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits, as amended, are allowed to deduct from income incurred medical expenses (that is, spenddown) to become eligible.

(2) Spenddown eligibility shall be calculated on a monthly basis.

(3) The Missouri Medical Assistance program (Medicaid) will only reimburse enrolled Medicaid providers for covered medical expenses that exceed a recipient's spenddown amount. Medicaid does not pay the portion of a claim used to meet the applicant's spenddown obligation. For example, for the first day of coverage, the Division of Medical Services denies or splits (partially pays) a claim or claims until the applicant's spenddown liability is reduced to zero (0).

(4) After the Division of Medical Services has reduced the recipient's liability to zero (0) for the first day of coverage, other claims submitted for that day of spenddown coverage and claims for the time remaining in the month are paid up to the Medicaid rate.

(5) Recipients shall have the option to pay their monthly spenddown requirement to the Division of Medical Services, much like a premium payment, in order to have continuous Medicaid coverage. Recipients may also arrange to make the monthly spenddown payment through electronic funds transfer (EFT) from a bank account.

AUTHORITY: sections 208.151, RSMo Supp. 2004 and 208.153 and 208.201, RSMo 2000. Emergency rule filed April 25, 2005, effective May 5, 2005, expired Oct. 31, 2005. Original rule filed April 29, 2005, effective Oct. 30, 2005.*

**Original authority 208.151, RSMo 1967, amended 1973, 1981, 1982, 1987, 1988, 1989, 1990, 1991, 1993, 1995, 2001; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*

13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized MO HealthNet Eligible Persons

PURPOSE: This rule implements the guidelines for placement of liens on the property of certain institutionalized MO HealthNet eligible persons, in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

(1) When an applicant for MO HealthNet or a MO HealthNet participant is a patient, or will become a patient, in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, the Department of Social Services will determine if the placement of a lien against the property of the applicant or participant is applicable. A lien is imposed on the property of an individual, in accordance with the authority given states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), when—

(A) The MO HealthNet participant is or has made application to become a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his/her income required for personal needs;

(B) The institutionalized MO HealthNet participant owns property. Property includes the homestead and all other real property in which the person has a sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than fair market value within thirty-six (36) months prior to the person entering the nursing facility;

(C) The department has determined after notice and opportunity for hearing that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home. The hearing, if requested, will proceed under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. The fact that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home may be substantiated by one (1) of the following:

1. Applicant/participant states in writing that he/she does not intend to return home within one hundred twenty (120) days;

2. Applicant/participant has been in the institution for longer than one hundred twenty (120) days; and

3. A physician states in writing that the applicant/participant cannot be expected to be discharged within one hundred twenty (120) days of admission; and

(D) A lien is imposed on the property unless one (1) of the following persons lawfully resides in the property:

1. The institutionalized person's spouse;

2. The institutionalized person's child who is under twenty-one (21) years of age or is blind or permanently and totally disabled; or

3. The institutionalized person's sibling who has an equity interest in the property and who was residing in such individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the institution.

(2) After determining the applicability of the lien, the MO HealthNet participant is given an Explanation of TEFRA Lien. A person who objects to the imposition of a lien is ineligible for medical assistance. Ineligibility is based on the person's objection without good cause to the imposition of the lien, which impedes the department's ability to implement its lien requirements.

(3) A lien may be imposed upon the property but the department will not seek adjustment or recovery of the costs of medical assistance correctly paid on behalf of the participant when the participant's child over the age of twenty-one (21) resides in the home and facts are established, to the satisfaction of the department, by sworn affidavit of the participant's child or authorized representative with personal knowledge of the facts, conclusively showing that—

(A) The participant's child has lived with and cared for the participant in the participant's home continuously for the two (2) years immediately prior to the participant entering a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;

(B) By providing that care the participant's child has allowed the participant to live at home rather than in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;

(C) The participant's child continues to reside in the home since the participant entered into a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;

(D) Facts to be included in the affidavit shall include but not be limited to:

1. The number of days and hours each week the child was providing care to the participant;

2. Types of care provided; such as, bathing and grooming, administering medication, providing therapeutic/health related activities;

3. Types of assistance provided; such as, household chores/cleaning, maintenance, repair, improvements; and

4. Types of errands outside the home provided; such as, shopping for groceries and household items, transportation to medical visits, pharmacy, recreational and social activities, and religious activities;

(E) The department may, at its discretion, require the participant to provide documentation to support the statements in the affidavit;

(F) The affidavit must be provided to the MO HealthNet Division, TEFRA Lien Recoveries at P.O. Box 6500, Jefferson City, MO 65102-6500 in a timely manner before the lien has been satisfied against the participant's home;

(G) Upon a determination by the department that the facts established in the affidavit satisfy the department that the exception has been met, then the TEFRA Lien shall be maintained but not enforced so long as the child resides in the property and it is not sold, transferred, or leased, other than the child may take title to the property subject to the lien;

(H) Upon a determination by the department that the facts established in the affidavit do not satisfy the department that the exception has been met, then the lien may be enforced as otherwise provided in section (6); and

(I) Participants who object to a TEFRA Lien in a timely manner under this subsection are entitled to a fair hearing, under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. A timely objection must be made in writing to the department within ninety (90) days of the objected adverse decision.

(4) The director of the department or the director's designee will file for record, with the recorder of deeds of the county in which any real property is situated, a written Certificate of TEFRA Lien. The lien will contain the name of the MO HealthNet participant and a description of the property. The recorder will note the time of receiving such notice and will record and index the certificate of lien in the same manner as deeds of real estate are required to be recorded and indexed. The county recorder shall be reimbursed by presenting a statement showing the number of certificates and releases filed each calendar quarter to the Department of Social Services.

(5) The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of the MO HealthNet participant. The amount of the lien will be for the full amount due the state at the time the lien is enforced. Fees paid to county recorder of deeds for filing of the lien will be included in the amount of the lien.

(6) The TEFRA lien does not affect ownership interest in a property until it is sold, transferred, or leased, or upon the death of the individual, at which time the lien must be satisfied, subject to the following:

(A) Any costs of sale of the property that are to be paid before the lien must be approved in advance by the department, and if a HUD-1 statement is prepared for that sale transaction, then a copy must be provided to the department prior to the closing for review and approval;

(B) Subject to the provisions of subsection (6)(A), in any case of a pending probate matter in a court of the state of Missouri for the administration of the assets and interests of the participant, including the property subject to the lien, then the following probate costs and expenses may be paid from the sale of the real estate at closing ahead of the lien:

1. Filing fees, publication fees, appraisal fees, personal representative fees, executor fees, attorney's fees;

2. Costs to maintain and repair the property for sale; such as, insurance premiums, lawn care, necessary repairs to prepare for sale, customary real estate sales commissions, publication of sale notice; and the participant or authorized representative shall produce documentation to support costs and incurred expenses; and

3. Burial costs of the participant; and

(C) The lien shall not be released against the real estate, except as required in section (7), until all net equity in the property remaining after closing costs after sale, transfer, or lease has been paid in satisfaction of the lien to the department, after payment of customary and approved costs from the sale proceeds as set forth in subsections (6)(A) and (6)(B). Closing costs are shared equally by all beneficiaries of the net proceeds of the real estate sale. In no case shall the state directly pay any costs of the sale or probate.

(7) The lien will be dissolved in the event the individual is discharged from the institution and returns home. A Notice of TEFRA Lien Release will be filed within thirty (30) days with the recorder of deeds of the county in which the original Certificate of TEFRA Lien was filed.

(8) The department shall apply a cost effectiveness review for each TEFRA lien when a reduction of recovery on the lien is requested. It shall be cost effective to accept a reduced

recovery on a lien when the reduction is less than five hundred dollars ($500) and it appears that rejection of the reduced recovery would result in an even greater reduction in recovery, no recovery at all, or result in additional costs that net a recovery which is less than the requested reduction in recovery.

AUTHORITY: sections 208.201 and 208.215, RSMo Supp. 2011. Emergency rule filed Aug. 15, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006. Original rule filed May 16, 2005, effective Nov. 30, 2005. Amended: Filed Dec. 15, 2011, effective June 30, 2012.*

**Original authority: 208.201, RSMo 1987, amended 2007 and 208.215, RSMo 1981, amended 1982, 1987, 1990, 1993, 1996, 2005, 2007, 2010.*

13 CSR 70-4.120 Department is the Payer of Last Resort, Department's Lien for Recovery, Participant's Duty of Cooperation

PURPOSE: This rule establishes the procedures for MO HealthNet's cost recovery of medical expenses from liable third party payments, settlements, awards, judgments, and insurance contracts and a participant's duty to cooperate.

(1) Definitions. The following definitions shall apply for purposes of this regulation.

(A) "Assignment" is the legal transfer from a participant to the division of the participant's right to recovery of medical expenses from a liable third party.

(B) "Assist" shall include, but not be limited to, providing full disclosure of all relevant information regarding a claim against a liable third party or insurer to the division; fully completing any and all forms requested by the division, provision of a Health Insurance Portability and Accountability Act (HIPAA) release to the division when requested; execution of any authorizations necessary to obtain release of any information the division requires in pursuit of the recovery; filing claims with potentially liable insurers when requested by the division; providing documentation of any and all settlement agreements, awards, or judgments related to claims against liable third parties; and timely responding to requests for information from insurers after a claim has been submitted.

(C) "Division" means the MO HealthNet Division of the Department of Social Services.

(D) "Identify" shall mean providing complete names, addresses, telephone numbers, and other relevant contact and location information of all potentially liable third parties, their attorneys, agents, and insurers.

(E) "Liable third party" includes any person, corporation, or institution, any employer as defined under Missouri's workers' compensation laws, and any public agency or private agency, who is liable, either pursuant to contract or otherwise, to an individual receiving public assistance on account of personal injury, disease, or disability or benefits arising from a health insurance plan to which the individual may be entitled.

(F) "Medical expense" and "medical expenses" are the cost of items and services provided under the Missouri State Medicaid Plan by the division on behalf of a participant which are related to the participant's claim against a liable third party, expressly excluding capitation fees or payments to vendors.

(G) "Medical treatment" means medical treatment rendered to a participant related to the participant's claim against a liable or potentially liable third party or insurer.

(H) "Notify" shall mean a written communication to the division of all relevant facts and information known which may be delivered to the division by United States Postal Service, facsimile transmission, or email.

1. In any case where written communication by a participant not represented by an attorney or other legal representative is not possible or is not reasonable due to disability requiring accommodation, the participant may substitute oral communication to the division either in person or by telephonic communication. The division shall provide the participant with written confirmation of the substitute oral communication and detail its contents.

2. Communication to the division from a licensed attorney or legal representative of a participant shall be in writing, or if done orally be followed up by written confirmation of that communication and its detailed contents.

(I) "Participant" is an individual who applies for, is determined eligible for, and receives MO HealthNet benefits provided under sections 208.151 to 208.158 or section 208.204, RSMo.

(J) "Person" is any human being or other entity legally recognized as a person under Missouri law, including but not limited to, a corporation, cooperative, partnership, limited liability company, sole proprietorship, mutual insurer, and governmental entity or sub-division.

(K) "Timely" shall mean within a reasonable time, however—

1. In no case shall notification to the division occur later than ten (10) business days from the date of discovery or knowledge of the act or information to be disclosed by the participant to the division; and

2. In no case shall notification to the division occur less than thirty (30) days prior to an anticipated or potential settlement, compromise, judgment, award, or agreement regarding a participant's claim against a liable third party or potentially liable insurer.

(2) Payer of last resort. The MO HealthNet Division is the payer of last resort of medical assistance benefits to be paid on behalf of a participant, unless otherwise specified by law.

(A) Liable third parties shall meet their legal obligation to pay claims on behalf of a participant before the division pays for a participant's medical assistance benefits related to the participant's claim against the liable third party.

(B) When the division pays medical expenses on behalf of a participant, it shall pursue recovery of the cost of those medical expenses from any liable third party or insurer to the extent recovery is cost effective.

(3) Assignment right to recover medical expenses. Each participant assigns to the division all rights to recovery of medical expenses from liable third parties pursuant to section 208.215.4, RSMo, and by the terms of the voluntary application for assistance submitted to the Family Support Division.

(A) The assignment is limited to recovery of medical expenses only.

(B) The assignment is a claim which automatically attaches to any payments or benefits for past medical treatment the participant recovers or expects to recover from a liable third party or insurer.

(C) No attempt to compromise or release the assigned right to recovery of medical expenses shall be effective, enforceable, or valid without the prior written agreement of the division.

(4) MO HealthNet Division has a lien against recovery for past medical treatment.

(A) The division shall be entitled to any payments or benefits recovered, or to be recovered, by or on behalf of a participant from a liable third party or insurer to the extent the payment is compensation for past medical treatment.

(B) The division shall be entitled to the medical treatment portion of any payments, settlements, awards, judgments, and insurance contracts benefits owed to or paid to or on behalf of the participant from any liable third party or insurer, including insurance contracts owned by the participant, up to the amount of medical expenses paid on behalf of

the participant.

(C) No claim of the division shall attach, or be deemed to attach, to any portion of a recovery from a liable third party other than that portion which is compensation of past medical treatment.

(D) The participant, the participant's attorney, the participant's appointed representative, a liable third party, insurance carrier, or other interested party may request in writing that the division provide notice of the amount of the division's current claim.

(E) A notice of claim to a liable third party shall set forth the current amount of the claim. That claim amount shall be valid for thirty (30) days from the date of the notice. The claim amount may increase or decrease over time depending upon the submission and payment of provider claims and credits. It shall be the responsibility of the participant to obtain a valid claim amount from the division when the current claim amount is older than thirty (30) days when seeking to recover medical expenses from a liable third party.

(F) A notice of claim sent to a liable third party shall not include supporting documentation unless the liable third party has provided the division previously with a valid HIPAA release from the participant authorizing that disclosure. The division shall not be obligated to provide supporting documentation in order to have a valid lien without a valid authorization for release of that information from the participant, absent a court order requiring such disclosure or protective order with conditions of disclosure.

(G) Any potentially liable third party who is aware, or reasonably should be aware, of the claim or lien of the department for recovery of medical expenses due to a participant shall keep the department advised of its current contact information, including but not limited to mailing address and telephone number.

(5) MO HealthNet Division only has a lien against recovery for past medical treatment. Participants, their attorney(s), agents, and other representatives, liable or potentially liable third parties, and insurers shall allocate in settlement agreements that portion of the settlement which is recovery for past medical treatment.

(A) Payment to the division shall be deemed as payment from that portion of the settlement which is recovery for past medical treatment.

(B) The division shall not be bound by, and may object to, any settlement or allocation for medical treatment that does not include the full amount of medical expenses paid by the division.

(C) Where a settlement or judgment does not allocate an amount that is recovery for past medical treatment, the division shall allocate as recovery for past medical treatment the lesser of the amount of medical expenses paid by the division or one-half (1/2) of the gross recovery from any and all liable third parties and insurers unless an individualized allocation can be demonstrated.

(D) Participants, their attorney(s), agents, and other representatives may demonstrate an individualized allocation of recovery for past medical treatment where the division has objected to a proposed allocation or a settlement or judgment is unallocated by presenting documentation on behalf of the participant to support an individualized allocation. The division may consider documentation of any combination of the following factors as they relate to the incident when determining an individualized allocation:

1. The amount of medical expenses and past medical treatment paid by and on behalf of the participant;

2. The amount of future medical treatment expected to be accrued by the participant;

3. The amount of lost wages claimed by the participant;

4. Evidence of paralysis, permanent injury, and/or scarring or disfigurement; and

5. Other factors as they relate to the specific circumstances of the participant's claim.

(E) The burden of proof shall be on the participant to demonstrate that the division is entitled to recover less than an amount established above.

(F) Parties dissatisfied with the amount allocated as recovery for past medical treatment may seek judicial determination of the amount owed to the division under section 208.215.9, RSMo.

(6) The computerized records of the MO HealthNet Division are prima facie evidence of medical expenses paid on behalf of the participant. The computerized records of MO HealthNet Division which are certified by a custodian of those records are prima facie evidence of the money expended on behalf of a participant in any court or administrative proceeding.

(7) Duty of participant, agents, and third parties to cooperate with the division. Participants, their attorney(s), agents, and other representatives, and liable or potentially liable third parties shall fully cooperate with and assist the division, as required by section 208.215.4, RSMo, by providing information identifying liable third parties, providing information to assist the division in pursuit of any resources available from liable third parties and insurers, and in obtaining any resources to which the participant has a claim so the division can recover reimbursement for medical expenses. The duty continues and includes the duty to timely supplement as new information is discovered or known by the participant and the participant's attorneys, agents, and other representatives.

(A) No participants, attorneys, agents, or other legal representatives shall have the authority to bind the division to any settlement or compromise of any lien or claim of the division without prior written authorization from the division.

(B) Participants, their attorneys, agents, and legal representatives, and liable or potentially liable third parties shall clearly disclose in any settlement or compromise of claims against liable third parties the portion of the recovery which is compensation for medical expenses the division has paid on behalf of the participant.

(C) Cooperation shall include, but not be limited to, the following:

1. Timely notifying the division of any accident, incident, act, or occurrence which may give rise to a claim against a liable third party for medical expenses;

2. Timely identifying to the division all potentially liable third parties, liable third parties' legal representatives, and potentially liable insurers;

3. Timely assisting the division in recovering its claim for medical expenses from liable third parties;

4. Timely identifying to the division all legal representatives of the participant with authority to act or inquire on the participant's behalf, including but not limited to, attorneys, personal representatives, holders of power of attorney, guardians, custodians, and trustees;

5. Timely notifying the division any time the participant files a lawsuit or makes a demand against any liable party, potentially liable insurer, or other entity which may be an available resource for payment of medical expenses; and

6. Timely notifying the division in writing of the dollar amount of any settlement, award, or judgment which is compensation for medical treatment related to the third party's liability with accompanying explanation for how that amount was determined and documentation of any settlement agreements.

(D) Notification to the division. All notifications to the division under this section shall be delivered as follows:

1. By mail through the United States Postal Service or other postal or package service, to MO HealthNet Division, Cost Recovery Unit, PO Box 6500, 615 Howerton Court, Jefferson City, MO 65102; or

2. By facsimile transmission (573-526-1162) to MO HealthNet Division, Cost Recovery Unit; or

3. By email to MO HealthNet Division, Cost Recovery Unit sent to the email address costrecovery@dss.mo.gov; or

4. By telephonic communication (573-751-2005) to MO HealthNet Division, Cost Recovery Unit.

(8) Release of right to recover medical expenses. No release, satisfaction, or other form of compromise of the right to recovery of medical expenses from a liable third party shall be valid, effective, or enforceable without the prior express written agreement and acceptance by the division.

(A) Any attempt by any person or entity to cause that right to recovery of medical expenses to be released, satisfied, or otherwise compromised shall be void ab initio and no defense of any claim against any person by the division absent the division's prior express written agreement and acceptance of that release, satisfaction, or other compromise.

(B) Any release, satisfaction, or other compromise executed or agreed to by the participant without the prior express written agreement of the division shall be prima facie evidence of the participant's failure to cooperate and intent to defraud the division of its right to recovery of medical expenses.

(9) Form of notification to the division and for request for claim amount. Notification to the department and requests for claim amount shall be made in writing and directed to the MO HealthNet Division in one of the manners specified above in subsection (7)(D) of this rule.

(A) Notifications and requests shall contain, at a minimum, the participant's name, date of birth, participant number, Social Security number, date of incident or injury, and the names of attorneys, insurers, and other authorized agents of the participant.

(B) Incomplete notifications and requests will be returned to the requestor for completion without processing.

(C) Requests from agents of the participant must be accompanied by a letter of representation on the agent's official letterhead and must include a valid, currently dated, HIPAA release signed by the participant or a person with verifiable authority to sign for release of the participant's protected information.

(D) Claim update requests must not be submitted until the original claim request has been fully processed and a response sent.

(E) Failure to comply will result in rejection of premature claim update requests.

(10) Pro rata lien reduction for attorney fees. A participant, his agents, or attorneys may request from the division a pro rata reduction of the lien amount based upon the total attorney fees and reasonable expenses approved by the division and actually incurred by the participant in pursuit of the claims against the liable third party(s).

(A) Any request for a pro rata reduction in the lien shall be made to the division in writing and include all necessary information and supporting documentation regarding the settlement or recovery, including, but not limited to:

1. The total amount of settlement or recovery;

2. The total amount of the settlement or recovery which is compensation for past medical treatment related to the incident;

3. The total amount of contractual attorney fees incurred;

4. The total amount of reasonable division-approved expenses;

5. A detailed listing of the claimed expenses with individual items and amounts claimed; and

6. A copy of any written documentation of the settlement or recovery terms.

A. All settlement documentation and information shall be kept strictly confidential by the division and its staff.

(B) No pro rata reduction shall be binding without prior written assurance by the participant or his or her representative that the reported settlement or recovery is final and includes all sources of recovery from the liable third party.

(C) If there are multiple liable third party sources of recovery then the request shall clearly specify a bulk pro rata on all the recoveries or a separate pro rata for each separate recovery and identify any unpaid claims not yet recovered.

(D) The pro rata reduction shall be determined using the following pro rata formula:

1. The participant's total actual attorney's fees and approved expenses divided by the total recovery equals a percentage; and

2. The total due the division times that percentage equals the amount that is the division's pro rata share of attorney's fees and expenses; and

3. The total due the division less the division's pro rata share identified above equals the dollar amount of the reduced pro rata lien due the division.

(11) Procedure for participant's handling receipt of money or benefits from liable third party or insurer. Upon receipt of money or benefits from a liable third party or insurer the participant, his agents, and attorneys shall immediately notify the division and either—

(A) Pay the division from the recovery for related past medical treatment up to the full amount of the division's current claim of medical expenses paid by the division on behalf of the participant within sixty (60) days of receipt of the money or benefits; or

(B) Place the full amount of the recovery in a trust account for the benefit of the division and immediately institute a proceeding for judicial or administrative determination of the division's rights to that portion of the recovery which is compensation for related past medical treatment the division has paid on behalf of the participant.

(12) Insurance payments where the division asserts a claim. Any payment by any insurer which is from medical payment coverage is subject to the claim and lien of the division for recovery of medical expenses up to the total amount of the department's lien.

(13) Informal process to dispute the amount of the division's lien. If a participant disputes the amount of the lien claimed by the division, the participant or the participant's attorney shall first make a written request to the division within fifteen (15) days of notification of the division's lien amount to review the lien amount for specific alleged errors for correction before seeking other avenues for resolution of the dispute.

(A) Those items which may be reviewed informally for correction may include, but are not limited to:

1. Miscalculation of pro rata reduction;

2. Inclusion of charges for services not related to the participant's claim against the liable third party giving rise to the lien claim;

3. Omission of charges for services related to the participant's claim against the liable third party giving rise to the lien claim;

4. Incorrect amounts billed or paid for medical assistance;

5. Miscalculation within the billing statement;

6. Claims that the treatments billed were not actually provided to the participant; and

7. Claims that the person identified in the billing statement is not the same person identified in the division's lien.

(B) Written requests for informal review of a disputed lien shall be delivered to the MO HealthNet Division, Cost Recovery Unit, PO Box 6500, 615 Howerton Court, Jefferson City, MO 65102 or may be sent by facsimile transmission.

(C) Participants not represented by an attorney or other legal representative may request informal review by oral communication in person or by telephone by calling the

Cost Recovery Unit if written communication is not a reasonable form of communication due to disability or other extenuating circumstance.

(D) Upon receipt of a complete and detailed request for informal review due to a participant's dispute of the lien, the division shall provide a written response to the requesting participant, or his or her representative.

(E) If the informal dispute procedure does not resolve the dispute of the lien to the satisfaction of the participant, the participant may seek resolution of the disputed lien through the procedures set out in section 208.080, RSMo, after receipt of the division's written response following the division's review of the dispute.

(F) Failure to pursue resolution through this informal procedure before seeking resolution through other avenues shall be a defense of failure to exhaust administrative remedies for the division.

AUTHORITY: sections 208.201 and 208.215, RSMo Supp. 2013. Original rule filed Sept. 26, 2013, effective March 30, 2014.*

**Original authority: 208.201, RSMo 1987, amended 2007 and 208.215, RSMo 1981, amended 1982, 1987, 1990, 1993, 1996, 2005, 2007, 2010.*