Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 99—Comprehensive Day Rehabilitation

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 99—Comprehensive Day Rehabilitation

13 CSR 70-99.010 Comprehensive Day Rehabilitation Program

PURPOSE: This rule establishes the regulatory basis for the administration of the Comprehensive Day Rehabilitation Program. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available under the Medicaid program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of provider participation, criteria and methodology for provider reimbursement, recipient eligibility, and amount, duration, and scope of services covered are included in the Comprehensive Day Rehabilitation Program manual, which is incorporated by reference in this rule and available at the website www.dss.mo.gov/dms.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid Comprehensive Day Rehabilitation Program shall be administered by the Department of Social Services, Division of Medical Services. The Comprehensive Day Rehabilitation services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services and shall be included in the Medicaid provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, July 1, 2005. This rule does not incorporate any subsequent amendments or additions. Comprehensive Day Rehabilitation program shall include only those that are prior authorized by the Division of Medical Services.

(2) Persons Eligible. Prior authorized Comprehensive Day Rehabilitation services are covered for individuals with disabling impairments as the result of a traumatic head injury that are under the age of twenty-one (21), blind, or pregnant. The program provides intensive, comprehensive services designed to prevent or minimize chronic disabilities while restoring the individual to an optimal level of physical, cognitive, and behavioral function. Emphasis in the program is on functional living skills, adaptive strategies for cognition, memory or perceptual deficits, and appropriate interpersonal skills. The recipient must be eligible on the date the service is furnished. It is the provider's responsibility to determine the coverage benefits for a recipient based on their type of assistance as outlined in the Comprehensive Day Rehabilitation Program manual. The provider shall ascertain the patient's Medicaid/managed care status before any service is performed. The recipient's eligibility shall be verified in accordance with methodology outlined in the Comprehensive Day Rehabilitation Program manual.

(3) Provider Participation. To be eligible for participation in the Missouri Medicaid Comprehensive Day Rehabilitation Program, a provider must have the certificate of accreditation (CARF) from the Rehabilitation Accreditation Commission, employ and retain qualified/licensed head injury professionals qualified to render the services covered through the Comprehensive Day Rehabilitation Program, be a free standing rehabilitation center or in an acute hospital setting with space dedicated to head injury rehabilitation, and be an enrolled Medicaid provider.

(4) Prior Authorization. Comprehensive Day Rehabilitation services must be prior authorized by the Division of Medical Services in order for the provider to receive reimbursement. The request is reviewed by a medical consultant, and the provider is notified if the request is approved or, if not approved, the reason for denial. No more than six (6) months of services will be approved. It is possible to receive an additional six (6)-month authorization if the patient is showing progress toward treatment goals. The maximum period of Comprehensive Day Rehabilitation services covered is one (1) year.

(5) Covered Services. Comprehensive Day Rehabilitation Program services are covered for half-day (three (3) to four (4) hours) and full day (five (5) or more hours) units when the recipient meets the admission criteria and is prior authorized by the Division of Medical Services.

(6) Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services. Providers must bill their usual and customary charge for Comprehensive Day Rehabilitation services. Reimbursement will not exceed the lesser of the maximum allowed amount determined by the Division of Medical Services or the provider's billed charges. Comprehensive Day Rehabilitation Program services are only payable to the enrolled, eligible, participating provider. The Medicaid program cannot reimburse for services performed by non-enrolled providers.

(7) Documentation Requirements for Comprehensive Day Rehabilitation Program.

(A) The following must be maintained in the recipient's clinical record:

1. Presenting complaint/request for assistance;
2. Relevant treatment history and background information;
3. Reported physical/medical/cognitive/psychological complaints;
4. Pertinent functional weaknesses and strengths;
5. Findings from formal assessments;
6. Plan of care;
7. Interview and behavioral observations;
8. Diagnostic formulation;
9. Recommendations for further evaluation and/or treatment needs; and
10. Dates of periodic review of the plan of care.

(8) Records Retention. These records must be retained for five (5) years from the date of service. Fiscal and medical records coincide with and fully document services billed to the Medicaid agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal, or retain adequate documentation for services billed to the Medicaid program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.152, 208.471 and 208.631, RSMo Supp. 2004 and 208.153, 208.164, 208.201 and 208.633, RSMo 2000 and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005. Emergency rule filed Aug. 11, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Original rule filed June 1, 2005, effective Nov. 30, 2005.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; 208.164, RSMo 1982, amended 1995; 208.201, RSMo 1987; 208.471, RSMo 1992, amended 2001; 208.631, RSMo 1998, amended 2002; and 208.633, RSMo 1998.*