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

PROPOSED AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization of Services—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chelation therapy;

H. Chemotherapy for cancer diagnosis;

[G.] **I.** Chiropractic services after twenty-six (26) visits annually;

[H.] **J.** Cochlear implant device;

[I. Chelation therapy;]

[J.] **K.** Dental care;

L. Dialysis

[K.] **M.** Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

[L.]**N.** Genetic testing or counseling;

*[M.]***O.** Hearing Aids;

*[N.]***P.**Home health care;

*[O.]***Q.** Hospice care and palliative services;

*[P.]***R.** Hospital inpatient services;

*[Q.]***S.**Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

[R.] **T.** Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

[S.] **U.** Nutritional counseling after six (6) sessions annually;

*[T.]***V.**Orthognathic surgery;

*[U.]***W.** Orthotics over one thousand dollars ($1,000);

*[V.]***X.** Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

*[W.]***Y.** Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

[[X.] **Z. Prostheses over one thousand dollars ($1,000);**

*[Y.]***AA**. **Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week perio[d;**

*[Z.]***BB**. Skilled nursing facility;

CC. Speciality injectables;

*[AA.]***DD.** Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty,** and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

[BB.] **EE.** Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation, coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 30, 2018, effective Jan. 1, 2019, expires June 29, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

**Original authority: 103.059, RSMo 1992.*