

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

**PROPOSED AMENDMENT**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.*

*PURPOSE: This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.*

(1) Benefit Provisions Applicable to the PPO [600]750 Plan, PPO [1000]1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [600]750 Plan, PPO [1000]1250 Plan, and HSA Plan.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO [600]750 Plan, PPO [1000]1250 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);

- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);
- B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:
  - (I) Foods;
  - (II) Hymenoptera venom (stinging insects);
  - (III) Inhalants; or
  - (IV) Specific drugs (penicillins and macromolecular agents);
- C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:
  - (I) Hymenoptera venom (stinging insects); or
  - (II) Inhalants;
- D. Skin Patch Testing: for diagnosing contact allergic dermatitis;
- E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);
- F. Photo Tests: for evaluating photo-sensitivity disorders;
- G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:
  - (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
  - (II) Skin testing is unreliable;
- H. Exercise Challenge Testing for exercise-induced bronchospasm;
- I. Ingestion (Oral) Challenge Test for any of the following:
  - (I) Food or other substances; or
  - (II) Drugs when all of the following are met:
    - (a) History of allergy to a particular drug;
    - (b) There is no effective alternative drug; and
    - (c) Treatment with that drug class is essential;
- J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:
  - (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
  - (II) Food allergy;
  - (III) Hymenoptera venom allergy (stinging insects);
  - (IV) Inhalant allergy; or
  - (V) Specific drugs;
- K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;
- L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:
  - (I) Sensitivity to beryllium;
  - (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
  - (III) Thymoma; and
  - (IV) To predict allograft compatibility in the transplant setting;
- M. Allergy retesting: routine allergy retesting is not considered medically necessary;
- N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:
  - (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
  - (b) Member has a life-threatening allergy to insect stings; or
  - (c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and
  - (VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;
- O. Other treatments: the following other treatments are covered:
  - (I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:
    - (a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;
    - (b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
    - (c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;
  - (II) Rapid desensitization is considered experimental and investigational for other indications;
- P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;
- 2. Ambulance service. The following ambulance transport services are covered:
  - A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;
  - B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;
- 3. Applied Behavior Analysis (ABA) for Autism;
- 4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:
  - A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;
  - B. The following open or laparoscopic bariatric surgery procedures are covered:
    - (I) Roux-en-Y gastric bypass;
    - (II) Sleeve gastrectomy;
    - (III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);
    - (IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;
    - (V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two-(2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

**5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;**

**6. Bone Growth Stimulators.** Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[6.]7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

[7. *Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;*]

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed homecare program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

### 13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident;** and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes [*Education*]**self-management training/education** when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. **Dialysis is covered when received through a network provider.**

16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[16.]17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

[17.]18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

[18.]19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[19.]20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, [azospermia] **azoospermia**, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[20.]21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[21.]22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[22.]23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[23.]24. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[24.]25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[25.]26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[26.]27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

[27.]28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

**29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit.**

[28.]**30.** Injections [and infusions. *Injections and infusions are covered*]. See preventive services for coverage of [immunizations] **vaccinations**. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered[, *including injectables,*] are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

- (I) Pernicious anemia;
- (II) Crohn's disease;
- (III) Ulcerative colitis;
- (IV) Inflammatory bowel disease;
- (V) Intestinal malabsorption;
- (VI) Fish tapeworm anemia;
- (VII) Vitamin B12 deficiency;
- (VIII) Other vitamin B12 deficiency anemia;
- (IX) Macrocytic anemia;
- (X) Other specified megaloblastic anemias;
- (XI) Megaloblastic anemia;
- (XII) Malnutrition of alcoholism;
- (XIII) Thrombocytopenia, unspecified;
- (XIV) Dementia in conditions classified elsewhere;
- (XV) Polyneuropathy in diseases classified elsewhere;
- (XVI) Alcoholic polyneuropathy;
- (XVII) Regional enteritis of small intestine;
- (XVIII) Postgastric surgery syndromes;
- (XIX) Other prophylactic chemo-therapy;
- (XX) Intestinal bypass or anastomosis status;
- (XXI) Acquired absence of stomach;
- (XXII) Pancreatic insufficiency; and
- (XXIII) Ideopathic progressive polyneuropathy;

[29.]**31.** Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[30.]**32.** Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[31.]**33.** Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[32.]**34.** Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

- (I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;
- (II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;
- (III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and  
(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[33.]35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[34.]36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[35.]37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibularfossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

**[36.]38. Orthotics.**

**A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).**

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

**B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe.** A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;
- (d) Structural deformities such as tarsal coalitions; or
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the hip or related soft tissue;

or

- (IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue;

or

- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

- (a) Previous amputation of the other foot or part of either foot;
- (b) History of previous foot ulceration of either foot;
- (c) History of pre-ulcerative calluses of either foot;
- (d) Peripheral neuropathy with evidence of callus formation of either foot;
- (e) Foot deformity of either foot; or
- (f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

- (I) To reduce pain by restricting mobility of the trunk;
- (II) To facilitate healing following an injury to the spine or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

- (IV) To otherwise support weak spinal muscles or a deformed spine.

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

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

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

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[37.]**39.** Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]***Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older]* **Online weight management program offered through the plan's exclusive provider arrangement;**

[38.]**40.** Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[39.]**41.** Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO<sub>2</sub>max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[40.]42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[41.]43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

[42.]44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

[43.]45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

[44.]46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

*AUTHORITY: section 103.059, RSMo 2016.\* Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Rescinded and readopted: 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. 28, 2016, effective Jan. 1, 2017, expired June 29, 2017. Amended: Filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 31, 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.*