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

PROPOSED RULE

22 CSR 10-3.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 30, 2018.

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

PRIVATE COST: This proposed rule 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 rule 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.*