**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 Section (3).

***PURPOSE: This amendment revises preventive services covered by the plan.***

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

(D) Plan benefits for the PPO 750 Plan, PPO 1250, 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;

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;

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;

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;

8. Cardiac rehabilitation;

9. Chelation therapy;

10. Chiropractic services—manipulation and adjunct therapeutic procedures/modalities;

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 and auditory brainstem implant;

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 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 Self-Management Education;

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;

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;

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;

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;

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;

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;

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

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);

24. Hearing aids (per ear). Hearing aids covered once every two (2) years for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

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

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

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;

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;

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; and

(V) Outpatient mental health services;

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;

30. Injections. See preventive services for coverage of 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 are not a medical plan benefit but are covered as part of the pharmacy benefit;

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;

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 applicable copayments, 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;

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);

34. Nutrition therapy;

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;

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;

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. Tumors and cysts, cancer, and post-surgical sequela;

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

D. Physical abnormality;

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 agoniometer 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.

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;

39. Preventive services.

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

B. 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 **preventive** services ordered as part of the exam. For benefits to be covered as preventive, 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. Online weight management program offered through the plan's exclusive provider arrangement*[;]***.**

**H. The following services permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan:**

**(I) Blood pressure monitors for individuals diagnosed with hypertension;**

**(II) Retinopathy screenings for individuals diagnosed with diabetes;**

**(III) Hemoglobin A1c (HbA1c) testing for individuals diagnosed with diabetes;**

**(IV) Peak flow meters for individuals diagnosed with asthma; and**

**(V) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease and/or bleeding disorders.**

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;

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 ($VO_2max$) 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;

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

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;

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);

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 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;

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

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, expired June 29, 2019. Amended: Filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 29, 2021, effective Jan. 1, 2022, expires June 29, 2022. Amended: filed Oct. 29, 2021.*

*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.*