Volume 30, Number 18
Pages 1885–1986
September 15, 2005

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

ROBIN CARNAHAN

Administrative Rules Division
James C. Kirkpatrick State Information Center
600 W. Main
Jefferson City, MO 65101
(573) 751-4015

DIRECTOR

BARBARA WOOD

•

EDITORS

BARBARA MCDOUGAL JAMES MCCLURE

•

ASSOCIATE EDITORS

CURTIS W. TREAT SALLY L. REID

•

PUBLISHING STAFF

WILBUR HIGHBARGER JACQUELINE D. WHITE

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO
Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.mo.gov/adrules/moreg/moreg.asp and the CSR is http://www.sos.mo.gov/adrules/csr/csr.asp. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2004. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by e-mail at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

September 15, 2005 Vol. 30 No. 18 **Pages 1885–1986**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2005	**September 1, 2005**	September 30, 2005	October 30, 2005
August 15, 2005	**September 15, 2005**	September 30, 2005	October 30, 2005
September 1, 2005	**October 3, 2005**	October 31, 2005	November 30, 2005
September 15, 2005	**October 17, 2005**	October 31, 2005	November 30, 2005
October 3, 2005	**November 1, 2005**	November 30, 2005	December 30, 2005
October 17, 2005	**November 15, 2005**	November 30, 2005	December 30, 2005
November 1, 2005	**December 1, 2005**	December 31, 2005	January 30, 2006
November 15, 2005	**December 15, 2005**	December 31, 2005	January 30, 2006
December 1, 2005	**January 3, 2006**	January 29, 2006	February 28, 2006
December 15, 2005	**January 17, 2006**	January 29, 2006	February 28, 2006
January 3, 2006	**February 1, 2006**	February 28, 2006	March 30, 2006
January 17, 2006	**February 15, 2006**	February 28, 2006	March 30, 2006
February 1, 2006	**March 1, 2006**	March 31, 2006	April 30, 2006
February 15, 2006	**March 15, 2006**	March 31, 2006	April 30, 2006
March 1, 2006	**April 3, 2006**	April 30, 2006	May 30, 2006
March 15, 2006	**April 17, 2006**	April 30, 2006	May 30, 2006
April 3, 2006	**May 1, 2006**	May 31, 2006	June 30, 2006
April 17, 2006	**May 15, 2006**	May 31, 2006	June 30, 2006
May 1, 2006	**June 1, 2006**	June 30, 2006	July 30, 2006
May 15, 2006	**June 15, 2006**	June 30, 2006	July 30, 2006

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2004), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951 ext. 160

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2742

Eden Theological Seminary/
Webster University
Eden/Webster Library
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660 ext. 7812

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University
Washington University Law Library
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6443

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300 ext. 247

Maryville University Library
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

St. Charles City-County Library
Middendorf-Kredell Branch
2750 Hwy K
O'Fallon, MO 63366-7859
(636) 978-7997

Truman State University
Pickler Memorial Library
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 204 South Union St.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

James C. Kirkpatrick Library
Central Missouri State University
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
14 West 10th Street
Kansas City, MO 64105
(816) 701-3546

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

University of Missouri-Kansas City
Miller Nichols Library
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

St. Joseph Public Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Missouri Western State College
Hearnes Learning Resources Ctr.
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948 ext. 325

Missouri Southern State University
Spiva Library
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9342

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3615

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
106 B Ellis Library
Columbia, MO 65211-5149
(573) 882-0748

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65211-7298
(573) 882-9369

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161 ext. 359

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Central Methodist College
Smiley Memorial Library
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6279

Library
University of Missouri-Rolla
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Lebanon-Laclede County Library
135 Harwood Ave.
Lebanon, MO 65536-3017
(417) 532-2148

University Library
Southwest Baptist University
1600 University Ave.
Bolivar, MO 65613-2597
(417) 328-1631

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411 ext. 3551

Garnett Library
Southwest Missouri State University
304 Cleveland
West Plains, MO 65775-3414
(417) 255-7945

Springfield-Greene County Library
4653 S. Campbell
Springfield, MO 65801-0760
(417) 874-8110

Meyer Library
Southwest Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title *[4] 7—[DEPARTMENT OF ECONOMIC DEVELOPMENT]* ***DEPARTMENT OF TRANSPORTATION***
Division 265—*[Division of]* **Motor Carrier and Railroad Safety**
Chapter 10—Motor Carrier Operations

EMERGENCY AMENDMENT

[4] 7 **CSR 265-10.020 Licensing of Vehicles**. The commission is amending subsection (1)(C); sections (2), (3), (4), and (5), and subsection (5)(A).

PURPOSE: This emergency amendment will eliminate the requirement that motor carriers who have properly registered their interstate operations, and have paid the Missouri regulatory license fee for each motor vehicle operated in interstate commerce within this state, must obtain and display an additional form of regulatory license when they operate the same vehicle in intrastate commerce. The rule currently requires interstate carriers to display a MoDOT license decal on each motor vehicle operated intrastate, in addition to the credentials they already must carry whenever they operate the same vehicle in Missouri interstate commerce. The amendment will not excuse any carriers from paying the same, annual, regulatory license fee of ten dollars ($10) for each motor vehicle operated in Missouri, but merely eliminates the provisions that currently require carriers to obtain dual interstate and intrastate credentials for the same vehicle.

EMERGENCY STATEMENT: By authority delegated from the Missouri Highways and Transportation Commission, the Missouri Department of Transportation finds that an immediate danger to the public health, safety or welfare requires emergency action, or that this amendment is necessary to preserve a compelling governmental interest that requires an early effective date, to eliminate the dual licensing requirements imposed on interstate motor carriers by the current rule— in time to avoid urgent and significant expenditures by MoDOT and by the affected motor carriers.

It takes at least six (6) to nine (9) months after filing to complete the rulemaking procedures required for a proposed amendment. But unless this emergency amendment is filed and adopted promptly, over the next one (1) to five (5) months MoDOT must incur expenses of approximately four thousand five hundred twenty-seven dollars ($4,527) for the production of the 2006 annual license decals, and for the envelopes and postage needed to send those decals to interstate motor carriers, who must obtain dual credentials for their vehicles to operate both interstate and intrastate under the present rule. In addition, MoDOT must devote its employees' labor—with an estimated value of thirty-one thousand four hundred thirty-four dollars ($31,434)—as needed to issue dual regulatory licenses to these interstate motor carriers, even though they already paid Missouri's annual license fees for the same vehicles, when they registered their Missouri interstate operations. These public expenditures can be avoided only by the filing and adoption of this emergency amendment, because only that will relieve MoDOT of the duty, under the current rule, to issue approximately thirty-five thousand six hundred seventy (35,670) intrastate license decals, to two thousand one hundred seventy-one (2,171) registered interstate motor carriers who operate the same vehicles in both interstate and intrastate commerce.

Meanwhile, unless this emergency amendment is filed and adopted, approximately two thousand one hundred seventy-one (2,171) interstate motor carriers who use the same vehicles in both interstate and intrastate commerce will incur costs of approximately two hundred twenty-seven thousand ten dollars ($227,010). These are the estimated labor costs of compliance with the dual licensing requirement of the present rule, for the motor carriers who must obtain, handle, and display the required intrastate license decals, upon approximately thirty-five thousand six hundred seventy (35,670) motor vehicles which are subject to this dual licensing requirement. But these expenses will be needlessly wasteful and duplicative for the affected motor carriers, because they will have already paid MoDOT's annual regulatory license fees, and will have already obtained interstate credentials, when they registered their interstate operations. The adoption of this emergency amendment would eliminate the existing requirement that these carriers must obtain dual licenses for the same vehicle, when it is used in both interstate and intrastate commerce.

The regulatory licenses issued pursuant to this rule are effective from January 1 to December 31 in the next succeeding year. However, it is necessary for MoDOT to begin issuing these annual license renewals much earlier, to provide sufficient time for the motor carriers to complete and file their license renewal applications, for MoDOT to process the applications and deliver the proper credentials to the carriers, and for the carriers to physically place the credentials on their motor vehicles before the January 1 effective date. MoDOT has traditionally issued these annual licenses beginning on August 1 in the year preceding the effective date, and carriers are required to file their renewal applications not later than November 30. Unless there is emergency action to amend this dual licensing requirement, these motor carriers must needlessly bear the costs of filing their 2006 annual license renewal applications (between August 1 and November 30, 2005), requesting the issuance of annual licenses in dual forms that cover the same vehicles (by December 31, 2005)—to be followed, within a few days' time (on January 29, 2006), by the effective date of a proposed amendment making it completely unnecessary for them to obtain dual credentials for the same

vehicle. That would put an unfair financial burden on the affected motor carriers, which imposes an immediate danger to the public health, safety or welfare that requires emergency action. In addition, the fickle timing of the existing requirements, followed quickly by a proposed amendment that would largely eliminate those requirements, could needlessly waste motor carrier resources, while giving the appearance of arbitrary and capricious government. To preserve a compelling governmental interest in avoiding such arbitrary and capricious regulation, and in avoiding further strain upon the financial resources of MoDOT and the affected motor carriers, an early effective date for this emergency amendment is required.

MoDOT has followed procedures best calculated to assure fairness to all interested persons and parties under the circumstances, in that MoDOT officials have personally met with representatives of the public and private entities most directly affected by this rule. On June 21, 2005, authorized MoDOT personnel met with officers from the Missouri State Highway Patrol (MSHP), a public law enforcement agency that partners with MoDOT in the enforcement of the licensing requirements of this rule. Also present at the meeting was an authorized representative of the Missouri Motor Carriers Association (MMCA), the largest nonprofit trade association representing motor carriers located within this state, who are required to comply with this rule. MoDOT provided these interested parties with a draft copy of the proposed text of this emergency amendment; together, we reviewed the draft, considered and implemented changes suggested by all parties, and provided them with a copy of the revised emergency amendment for review, along with a proposed amendment including the same changes (along with other changes that do not require emergency action, and are not included in this emergency amendment). These interested parties expressed no objections to MoDOT proceeding with this emergency amendment, simultaneous with MoDOT's promulgation of the proposed amendment. MMCA's President and CEO, Mr. George W. Burruss, has written a letter of support for this emergency and permanent rulemaking, a copy of which is on file with MoDOT.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions****. This emergency amendment was filed August 15, 2005, effective August 26, 2005, expires February 23, 2006.*

(1) No motor carrier shall operate any motor vehicle on the public highways in Missouri intrastate or interstate commerce under any property carrier registration, certificate or permit issued by the division, unless the vehicle is accompanied by a valid regulatory license**,** which shall be carried or displayed on the vehicle in compliance with this rule. As used in this rule, the terms "regulatory license" and "license" include a license sticker (decal), license stamp, or registration receipt issued in compliance with this rule. Except as otherwise provided in this rule or the **Single State Registration System (SSRS) Procedures Manual**, which is incorporated by reference in this rule the following requirements are applicable to all regulatory licenses, license fees and motor carriers within the jurisdiction of the division:

(C) When a motor carrier has paid the annual regulatory license fee for a motor vehicle **used in interstate commerce and displays or carries the proper regulatory license as required**, and the carrier*['s use of that vehicle requires it to display or carry additional or different forms of regulatory licenses, then upon the carrier's application in conformity with the applicable provisions of this rule, the division shall issue to the motor carrier all the required forms of annual regulatory licenses for that vehicle without payment of any additional fee;]* **uses the vehicle in interstate commerce transporting property or passengers exempt from Federal Motor Carrier Safety Administration (FMCSA) economic jurisdiction, or in intrastate commerce, the provisions of this rule shall not require any additional payment or display of regulatory license;**

(2) Except as provided in **subsection (1)(C) or** section (7), motor carriers engaged in interstate transportation in Missouri under authority issued by the ICC or FHWA shall pay the annual regulatory license fee for each vehicle operated within Missouri under that authority. The fees shall be paid to the registration state in which the carrier registers its ICC or FHWA authority as required in the SSRS Procedures Manual before the vehicles begin operating within Missouri. The required regulatory license for these vehicles shall be a true copy of the registration receipt issued by the registration state, showing that the carrier has paid the required Missouri annual license fees, which shall be carried in each vehicle while operating under ICC or FHWA authority in this state.

(3) *[Every]* **Except as provided in subsection (1)(C), every** motor carrier operating in intrastate commerce, or interstate commerce transporting property or passengers exempt from FHWA economic jurisdiction, or both, under a property carrier registration, certificate or permit issued by this division, shall apply to the division for the issuance of regulatory licenses no earlier than the first day of August, for each motor vehicle which it intends to operate on the public highways in Missouri during the ensuing year. Applications for these annual licenses shall be in writing and shall contain the following information:

(4) *[Motor]* **Except as provided in subsection (1)(C), motor** carriers shall display on each motor vehicle operated in intrastate commerce *[only, or both intrastate commerce and interstate commerce transporting property or passengers under ICC or FHWA authority,]* an annual license in the form of a license sticker (decal) issued by this division.

(5) *[Motor]* **Except as provided in subsection (1)(C), motor** carriers shall *[display]* **carry** on each motor vehicle operated in Missouri interstate commerce transporting property or passengers exempt from FHWA economic jurisdiction an annual license in the form of a license stamp issued by this division. These stamps shall be issued and displayed as follows:

(A) Upon the filing of the required application, and payment by a qualified applicant of the required annual license fee in conformity with the payment requirements of subsection (1)(I) of this rule, the division shall issue a license stamp which shall be permanently attached to a Form D-1—Uniform Cab Card which shall *[accompany]* **be carried in** the licensed vehicle*[. If the regulatory license fee for the particular vehicle to operate in Missouri has already been paid to the registration state in compliance with the SSRS Procedures Manual, the division shall issue to the motor carrier an annual license sticker for that vehicle without payment of any additional fee]*;

AUTHORITY: sections 622.027, [RSMo Supp. 1997] ***390.041(1), and 390.138, RSMo 2000, and 226.008 and 390.136, RSMo Supp. 2004.*** *This rule was previously filed as 4 CSR 265-10.020. Emergency rule filed June 14, 1985, effective July 1, 1985, expired Oct. 28, 1985. Original rule filed Aug. 1, 1985, effective Oct. 29, 1985. For intervening history, please consult the* ***Code of State Regulations****. Moved to 7 CSR 265-10.020, effective July 11, 2002. Emergency amendment filed Aug. 15, 2005, effective Aug. 26, 2005, expires Feb. 23, 2006. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

EMERGENCY AMENDMENT

13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services. The division is amending sections (1), (3), (6), (8), (9), (10), (11), (12) and deleting section (7) and adding new sections (13), (14), (15) and (16).

PURPOSE: This amendment changes the copayment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services.

EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to change the copayment due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services, was published in the June 15, 2005 issue of the ***Missouri Register*** *(30 MoReg 1350–1353). The order of rulemaking for the proposed amendment, with changes resulting from comments sent to the Division of Medical Services during the thirty (30)-day comment period, was filed with the Joint Committee on Administrative Rules on August 3, 2005. The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to copayments due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The changes to Medicaid copayments due from Medicaid recipients for physician-related services and hospital outpatient clinic or emergency room services are estimated to save the Missouri Medicaid program approximately twenty-three (23) million dollars annually. The scope of this emergency amendment is limited to the circumstance creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) Recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. The services to be affected by the copayment or coinsurance requirements are—

(A) *[All audiological services and hearing aids provided through the Audiology Program]* **Dental services related to trauma or the treatment of a disease/medical condition**;

(B) *[All dental services and dentures provided through the Dental Program]* **Optical services related to trauma or the treatment of a disease/medical condition, and one (1) eye exam every two (2) years**;

(C) *[All optometric services, eyeglasses and artificial eyes provided through the Optical Program]* **Podiatry services provided through the podiatry program**;

(D) *[All podiatry services provided through the Podiatry Program]* **Inpatient hospital services**;

(E) *[Inpatient hospital services;]* **Hospital outpatient clinic/emergency room services; and**

(F) *[Outpatient hospital clinic/emergency room services; and]* **All physician-related services.**

[(G) Physician services rendered in a hospital outpatient clinic or emergency room.]

(3) Copayment charged shall be in accordance with 42 CFR 447.54 and, applicable to the services described in subsections (1)(A), (B) (excepting dentures), (C) *[and]***,** (D), **and (G),** based on the following schedule:

Medicaid Payment for Each Item of Service	**Recipient Copayment Amount**
$*[10.99]* **10** or less	$0.50
$*[11.00]* **10.01**–$25*[.99]*	$1.00
$*[26.00]* **25.01**–$50*[.99]*	$2.00
$*[51.00]* **50.01** or more	$3.00

(6) Co-payment to be charged for hospital outpatient clinic or emergency room services shall be *[two dollars ($2)]* **three dollars ($3)** for each date of service on which the recipient receives, either one (1) or both, outpatient clinic or emergency room services.

[(7) Co-payment to be charged for physician services provided in a hospital outpatient clinic or emergency room shall be one dollar ($1) for each date of service on which the recipient receives these services.]

[(8)] **(7)** *[With noted exceptions, t]***T**he following *[exemptions to the copayment requirement apply to the services described in subsections (1)(A)–(G)]* **is a list of exemptions to the Medicaid copayment requirement**:

(A) Services provided *[on or after December 1, 1984]* to recipients under *[eighteen (18)]* **nineteen (19)** years of age;

(B) Services **provided** to recipients residing within a skilled nursing *[home]* **facility**, an intermediate care *[nursing home]* **facility**, a residential care *[home]* **facility**, an adult boarding home or a psychiatric hospital;

(C) Services **provided** to recipients who have both Medicare and Medicaid entitlement if Medicare covers the service and provides payment for it;

(D) Emergency or transfer inpatient hospital admissions;

(E) Emergency services provided in an outpatient clinic or emergency room, *[such as—heart attack, hemorrhaging, poisoning, concussion, bone fractures or stroke;]* **after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:**

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

(F) Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

(G) Family planning services;

(H) Services provided to pregnant women *[which are directly related to the pregnancy or a complication of the pregnancy]*;

(I) Services provided to foster care recipients; *[and]*

(J) **Services identified as medically necessary through an** Early Periodic Screening, Diagnosis and Treatment **(EPSDT)** *[services.]* **screen;**

(K) Services provided through MC+ Managed Care Contracts;

(L) Personal Care services;

(M) Mental Health services;

(N) Services provided to the blind;

(O) Hospice services; and

(P) Medicaid waiver services.

[(9)] **(8) Providers are responsible for collecting the copayment or coinsurance amounts from individuals. The medical assistance program shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient. A provider shall collect a copayment from a recipient at the time each service is provided or at a later date.** Providers of services as described in this rule and as subject to a copayment or coinsurance requirement

may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment or coinsurance amount when charged.

[(10)] **(9)** A recipient's inability to pay a required coinsurance or copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient liability to pay the due amount **or prevent a provider from attempting to collect a copayment**.

[(11)] **(10)** Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any coinsurance or copayment amount required of the recipient.

[(12)] **(11)** Providers of services in the program areas named must charge copayment or coinsurance as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program.

[(13)] **(12)** Providers must maintain records of copayment or coinsurance amounts for five (5) years and must make those records available to the Department of Social Services upon request.

(13) If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

(14) A provider shall give a Medicaid recipient a reasonable opportunity to pay an uncollected copayment.

(15) A provider shall give a Medicaid recipient with uncollected debt advanced notice and a reasonable opportunity to arrange care with a different provider before services can be discontinued.

(16) If a provider is not willing to provide services to a recipient with uncollected copayments and the requirements of this regulation have been met, the provider may discontinue future services to an individual with uncollected copayments. In accordance with 42 *Code of Federal Regulations* (CFR) 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient and accept their ability/inability to pay the required copayments.

*AUTHORITY: sections [207.020] **208.152**, RSMo [1986] **Supp. 2004 and 208.215 as enacted by the 93rd General Assembly and 208.201, RSMo 2000**. This rule was previously filed as 13 CSR 40-81.054. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 16, 2005. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

EMERGENCY AMENDMENT

13 CSR 70-4.080 Children's Health Insurance Program. The division is amending sections (1), (5) through (9), and (13) through (15), adding a new section (10), and deleting sections (11) and (12).

PURPOSE: This amendment changes the copayment and premium requirements of the Children's Health Insurance Program pursuant to Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005. The amendment also changes the waiting period for coverage of any child identified as having special health care needs pursuant to House Bill 1453 enacted by the 92nd General Assembly, 2004.

*EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to change the copayment and premium requirements of the Children's Health Insurance Program, was published in the June 1, 2005 issue of the **Missouri Register** (30 MoReg 1131–1136). The order of rulemaking for the proposed amendment with changes resulting from comments sent to the Division of Medical Services during the thirty (30)-day comment period was filed with the Joint Committee on Administrative Rules on July 22, 2005. The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to the copayments and premium requirements of the Children's Health Insurance Program. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The changes to the copayment and premium requirements of the Children's Health Insurance Program are estimated to save the Missouri Medicaid program approximately $23,181,000 annually. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) Definitions.

[(A) Available income. For the purpose of this rule available income shall be defined as the household's total gross income compared to one hundred eighty-five percent (185%), two hundred twenty-five percent (225%) and three hundred percent (300%) of the federal poverty level for the household size.

(B) Cost sharing. Payment of co-payments and premiums.]

[(C)] **(A)** Children. Persons up to nineteen (19) years of age.

[(D)] **(B)** Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) Parent(s) and guardian(s) of uninsured children with *[available]* **gross** income above *[two hundred twenty-five percent (225%)]* **one hundred fifty percent (150%)** and below three hundred percent (300%) of the federal poverty level must certify, as a part of the application process, that the child does not have access to affordable employer-sponsored health insurance or other affordable health insurance available to the parent(s) or guardian(s) through their association with an identifiable group (for example, a trade association,

union, professional organization) or through the purchase of individual health insurance coverage.

[(6) An uninsured child/children with available income less than two hundred twenty-six percent (226%) of the federal poverty level shall be eligible for service(s) from the date the application is received. No service(s) will be covered prior to the date the application is received or September 1, 1998, whichever is later.]

[(7)] **(6)** An uninsured child/children with *[available]* **gross** income above *[two hundred twenty-five percent (225%)]* **one hundred fifty percent (150%)** and below three hundred percent (300%) of the federal poverty level shall be eligible for service(s) thirty (30) calendar days after the application is received if the required premium has been received.

(A) Parent(s) or guardian(s) of uninsured children with *[available]* **gross** income above *[two hundred twenty-five percent (225%)]* **one hundred fifty percent (150%)** and below *[three hundred percent (300%) of the federal poverty level are responsible for a monthly premium equal to the statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan]* **one hundred eighty-six percent (186%) of the federal poverty level are responsible for a monthly premium equal to the statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan not to exceed one percent (1%) of the family's gross income. Parent(s) or guardian(s) of uninsured children with gross income above one hundred eighty-five percent (185%) and below two hundred twenty-six percent (226%) of the federal poverty level are responsible for a monthly premium equal to the statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan not to exceed three percent (3%) of the family's gross income. Parent(s) or guardian(s) of uninsured children with gross income above two hundred twenty-five (225%) and below three hundred percent (300%) of the federal poverty level are responsible for a monthly premium equal to the statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan not to exceed five percent (5%) of the family's gross income.**

(B) The premium must be paid prior to service delivery.

(C) The premium notice shall include information on what to do if there is a change in *[available]* **gross** income.

(D) No service(s) will be covered prior to the effective date which is thirty (30) calendar days after the date the application is received.

[(8)] **(7)** If the parent or guardian discontinues payment of premiums, a past due notice shall be sent requesting remittance within twenty (20) calendar days from date of the letter. Failure to make payment shall result in the child's ineligibility for coverage for the following six (6) months.

[(9)] **(8)** Premium adjustments, based on changes in the Missouri Consolidated Health Care Plan, shall be calculated yearly in March with an effective date of July 1 of the same calendar year. Individuals shall be notified of the change in premium amount at least thirty (30) days prior to the effective date.

[(10)] **(9)** The six (6)-month waiting period and thirty (30)-calendar-day delay in service delivery is not applicable to a child/children already participating in the program when the parent's or guardian's income changes. Coverage shall be extended for thirty (30) calendar days to allow for premium collection and to ensure continuity in coverage. Eligibility shall be discontinued for the child/children if the premium payment is not made within the thirty (30)-day extension.

(10) Any child identified as having "special health care needs," defined as a condition which left untreated would result in the death or serious physical injury of a child, who does not have access to affordable employer-subsidized health care insurance shall not be required to be without health care coverage for six (6) months in order to be eligible for services under sections 208.631 to 208.657, RSMo and shall not be subject to the thirty (30)-day waiting period required under section 208.646, RSMo, as long as the child meets all other qualifications for eligibility.

[(11) Parent(s) or guardian(s) of uninsured children with available income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level are responsible for a co-payment at the time of professional service and for prescriptions.

(A) The co-payment is equal to the co-payment required by the Missouri Consolidated Health Care Plan.

(B) Co-payment adjustments, based on changes in the Missouri Consolidated Health Care Plan, shall be calculated yearly in March with an effective date of July 1 of the same calendar year.

(C) Individuals shall be notified of change(s) in the co-payment amount(s) at least thirty (30) days prior to the effective date.

(D) Providers may require payment of the co-payment prior to service delivery and service may be denied for failure to make co-payment. No co-payments shall be required for well-baby and well-child care including age-appropriate immunizations.

(12) Parent(s) or guardian(s) of uninsured children with income above one hundred eighty-five percent (185%) and at or below two hundred twenty-five percent (225%) of the federal poverty level for the household size are responsible for a five-dollar ($5) copayment at the time of professional service. Providers may require payment of the co-payment prior to service delivery and may deny services for failure to make co-payment. No co-payments shall be required for well-baby and well-child care including age-appropriate immunizations.]

[(13)] **(11)** The total aggregate *[cost-sharing]* **premiums** for a family covered by this rule shall not exceed five percent (5%) of the family's *[available]* **gross** income for a twelve (12)-month period of coverage beginning with the first month of service eligibility. *[Families responsible for cost-sharing shall be notified of their maximum liability for the twelve (12)-month period following service eligibility. When the total aggregate cost-sharing has reached five percent (5%) of the family's available income all co-payments and premiums shall be waived for the remainder of the twelve (12)-month period. Waiver in cost-sharing shall be made upon notification and documentation of co-payments from the family that payments have been made up to five percent (5%) of their yearly available income.]*

(A) The total aggregate premiums for a family covered by this rule with gross income above one hundred fifty percent (150%) and below one hundred eighty-six percent (186%) of the federal poverty level shall not exceed one percent (1%) of the family's gross income for a twelve (12)-month period of coverage beginning with the first month of service eligibility. When the total aggregate premiums have reached one percent (1%) of the family's gross income all premiums shall be waived for the remainder of the twelve (12)-month period. Waiver of premiums shall be made upon notification and documentation from the family that payments for premiums have been made up to one percent (1%) of their yearly gross income.

(B) The total aggregate premiums for a family covered by this rule with gross income above one hundred eighty-five percent (185%) and below two hundred twenty-six percent (226%) of the

federal poverty level shall not exceed three percent (3%) of the family's gross income for a twelve (12)-month period of coverage beginning with the first month of service eligibility. When the total aggregate premiums have reached three percent (3%) of the family's gross income all premiums shall be waived for the remainder of the twelve (12)-month period. Waiver of premiums shall be made upon notification and documentation from the family that payments for premiums have been made up to three percent (3%) of their yearly gross income.

(C) The total aggregate premiums for a family covered by this rule with gross income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level shall not exceed five percent (5%) of the family's gross income for a twelve (12)-month period of coverage beginning with the first month of service eligibility. When the total aggregate premiums have reached five percent (5%) of the family's gross income all premiums shall be waived for the remainder of the twelve (12)-month period. Waiver of premiums shall be made upon notification and documentation from the family that payments for premiums have been made up to five percent (5%) of their yearly gross income.

[(14)] **(12)** Parents of uninsured children must certify that their total net worth does not exceed two hundred fifty thousand dollars ($250,000) to be eligible for health insurance under this rule.

[(15)] **(13)** For the purposes of this rule, children participating in the Missouri Health Insurance Pool and child/children whose annual maximum benefits on a particular medical service under their private insurance have been exhausted are considered insured. Child/children whose parent(s) or guardian(s) drop Missouri Health Insurance Pool coverage in order to qualify under this rule shall not be eligible for six (6) months from the month coverage was terminated.

*AUTHORITY: sections 208.633, 208.636, 208.640, 208.643, 208.646, 208.650, 208.655, 208.657 and [208.660, RSMo Supp. 1998 and] 208.201, RSMo [1994] **2000, and** 208.631 **and 208.647, RSMo Supp. 2004**. Original rule filed July 15, 1998, effective Feb. 28, 1999. Amended: Filed April 29, 2005. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

EMERGENCY RULE

13 CSR 70-4.110 Placement of Liens on Property of Certain Institutionalized Medicaid Eligible Persons

PURPOSE: This rule implements the guidelines for placement of liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

*EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed rule, which covers the same material as this emergency rule to implement the guidelines for placement of liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended, was published in the June 15, 2005 issue of the **Missouri Register** (30 MoReg 1354–1356). No comments were received on the rule. The order of rulemaking for the proposed rule was filed with the Joint Committee on Administrative Rules on July 22, 2005. The proposed rule will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to place liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the federal Tax Equity and Fiscal Responsibility Act of 1982, as amended. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The liens on the property of certain institutionalized Medicaid eligible persons, in accordance with the authority given to states in the federal Tax Equity and Fiscal Responsibility Act of 1982, as amended are estimated to save the Missouri Medicaid program approximately one hundred thousand dollars ($100,000) in the aggregate over the first two (2) years of the rule. In following years the medical assistance program will recover approximately one (1) million dollars a year from property with these liens annually. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 15, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) When an applicant for Medicaid or a Medicaid recipient is a patient, or will become a patient, in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, the Department of Social Services will determine if the placement of a lien against the property of the applicant or recipient is applicable. A lien is imposed on the property of an individual, in accordance with the authority given states in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), when:

(A) The Medicaid recipient is or has made application to become a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his income required for personal needs;

(B) The institutionalized Medicaid recipient owns property. Property includes the homestead and all other real property in which the person has a sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than fair market value within thirty-six (36) months prior to the person entering the nursing facility;

(C) The department has determined after notice and opportunity for hearing that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home. The hearing, if requested, will proceed under the provision of Chapter 536, RSMo, before a hearing officer designated by the director of the Department of Social Services. The fact that there is no reasonable expectation that the person can be discharged from the facility within one hundred twenty (120) days and return home may be substantiated by one (1) of the following:

1. Applicant/recipient states in writing that he/she does not intend to return home within one hundred twenty (120) days;

2. Applicant/recipient has been in the institution for longer than one hundred twenty (120) days; and

3. A physician states in writing that the applicant/recipient cannot be expected to be discharged within one hundred twenty (120) days of admission; and

(D) A lien is imposed on the property unless one (1) of the following persons lawfully resides in the property:

1. The institutionalized person's spouse;

2. The institutionalized person's child who is under twenty-one (21) years of age or is blind or permanently and totally disabled;

3. The institutionalized person's sibling who has an equity interest in the property and who was residing in such individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the institution.

(2) After determining the applicability of the lien, the Medicaid recipient is given an Explanation of TEFRA Lien. A person who objects to the imposition of a lien is ineligible for medical assistance. Ineligibility is based on the person's objection without good cause to the imposition of the lien, which impedes the department's ability to implement its lien requirements.

(3) The director of the department or the director's designee will file for record, with the recorder of deeds of the county in which any real property is situated, a written Certificate of TEFRA Lien. The lien will contain the name of the Medicaid recipient and a description of the property. The recorder will note the time of receiving such notice and will record and index the certificate of lien in the same manner as deeds of real estate are required to be recorded and indexed. The county recorder shall be reimbursed by presenting a statement showing the number of certificates and releases filed each calendar quarter to the Department of Social Services.

(4) The TEFRA lien will be for the debt due the state for medical assistance paid or to be paid on behalf of the Medicaid recipient. The amount of the lien will be for the full amount due the state at the time the lien is enforced. Fees paid to county records of deeds for filing of the lien will be included in the amount of the lien.

(5) The TEFRA lien does not affect ownership interest in a property until it is sold, transferred, or leased, or upon the death of the individual, at which time the lien must be satisfied.

(6) The lien will be dissolved in the event the individual is discharged from the institution and returns home. A Notice of TEFRA Lien Release will be filed within thirty (30) days with the recorder of deeds of the county in which the original Certificate of TEFRA Lien was filed.

AUTHORITY: sections 208.201, RSMo 2000 and 208.215 as enacted by the 93rd General Assembly. Original rule filed May 16, 2005. Emergency rule filed Aug. 15, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 40—Optical Program

EMERGENCY AMENDMENT

13 CSR 70-40.010 Optical Care Benefits and Limitations—Medicaid Program. The Division of Medical Services is amending sections (1), (2), and (7).

PURPOSE: This amendment updates the Department of Social Services, Division of Medical Services Internet address and revises the eye examination benefit to every two (2) years and eliminates coverage of eyeglasses for all recipients who are not eligible needy children, pregnant women or blind persons as approved through Senate Bill 539 enacted by the 93rd General Assembly.

*EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to amend the optical care benefits and limitation of the Medicaid program, was published in the July 1, 2005 issue of the **Missouri Register** (30 MoReg 1448–1449). No written comments were received during the thirty (30)-day public comment period. The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to limit the eye examination benefit to every two (2) years for all Medicaid recipients who are not eligible needy children, pregnant women or blind persons and eliminate coverage of eyeglasses for all recipients who are not eligible needy children, pregnant women or blind persons. The changes to the Medicaid optical program are estimated to save the Missouri Medicaid program approximately $7,754,000 annually. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) Administration. The Optical Care program shall be administered by the **Department of Social Services,** Division of Medical Services*[, Department of Social Services]*. The optical care services covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services and shall be made available through the Department of Social Services, Division of Medical Services website at *[www.dss.state.mo.us/dms]* **www.dss.mo.gov/dms**, provider bulletins, and updates to the provider manual. Services covered shall include only those which are clearly shown to be medically necessary.

(2) Persons Eligible. Any person who is eligible for Title XIX benefits from the **Family Support** Division *[of Family Services]* and who is found to be in need of optical care services as described in this regulation **subject to the limitations set forth in subsections (7)(A)–(Y)**.

(7) Program Limitations.

(A) One (1) comprehensive or one (1) limited eye examination is allowed per **two (2)** years (within a *[twelve (12)-]***twenty-four (24)-**month period of time) under the Medicaid program. **Eligible needy children, pregnant women, and blind persons are allowed one (1) comprehensive or one (1) limited eye examination per year (within a twelve (12)-month period of time) under the Medicaid program.** Payment for a comprehensive eye examination will be made only if six (6) or more of the following procedures have been performed:

1. Refraction far point and near point;
2. Case history;
3. Visual acuity testing;
4. External eye examination;
5. Pupillary reflexes;
6. Ophthalmoscopy;
7. Ocular motility testing;
8. Binocular coordination;
9. Vision fields;
10. Biomicroscopy (slit lamp);
11. Tonometry;
12. Color vision; and
13. Depth perception.

(C) **Eligible needy children, pregnant women, and blind persons may be allowed** *[A]***a**dditional eye examinations *[may be allowed]* during the year (within a twelve (12)-month period of time) if medically necessary (that is, cataract examination, prescription change of 0.50 diopters or greater). A Medical Necessity Form must

be *[attached to the claim form]* **completed** for eye examinations in excess of one (1) per year.

(D) Eyeglasses are **only** covered by Medicaid **for eligible needy children, pregnant women, and blind persons** when the prescription is at least 0.75 diopters for one (1) eye or 0.75 diopters for each eye. **Eyeglasses (any type of frame and/or lens) are not covered for any other Medicaid eligibles.**

(E) Only one (1) pair of eyeglasses is allowed every two (2) years (within any twenty-four (24)-month period of time) for *[all Medicaid recipients]* **eligible needy children, pregnant women, and blind persons** regardless of age.

AUTHORITY: sections 208.152, ***RSMo Supp. 2004,*** *208.153 and 208.201, RSMo 2000,* ***and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005.*** *This rule was previously filed as 13 CSR 40-81.170. Emergency rule filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 10, 1981, effective July 11, 1981. Emergency amendment filed June 27, 2002, effective July 7, 2002, terminated Feb. 23 2003. Amended: Filed July 15, 2002, effective Feb. 28, 2003. Amended: Filed March 3, 2003, effective Oct. 30, 2003. Amended: Filed June 1, 2005. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 45—Hearing Aid Program

EMERGENCY AMENDMENT

13 CSR 70-45.010 Hearing Aid Program. The Division of Medical Services is amending section (2) and deleting the form which follows the rule in the *Code of State Regulations*.

PURPOSE: This amendment eliminates hearing aid services for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or the blind as approved through Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly.

EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to eliminate coverage of hearing aid services for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons, was published in the August 1, 2005 issue of the ***Missouri Register*** *(30 MoReg 1649–1650). The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to eliminate coverage of hearing aid services for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons. The changes to the Medicaid hearing aid program are estimated to save the Missouri Medicaid program approximately 1.6 million dollars annually. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(2) *[Eligibility]* **Persons Eligible**. *[Any person who is eligible for Title XIX benefits as determined by the Division of Family Services and who is found to be in need in accordance with the procedures listed in section (5) is eligible for a hearing aid.]* **The Missouri Medicaid Program pays for approved Medicaid services for hearing aid services when furnished within the provider's scope of practice to Medicaid eligible needy children or persons receiving Medicaid under a category of assistance for pregnant women or the blind. The recipient must be eligible on the date the service is furnished. Recipients may have specific limitations for hearing aid services according to the type of assistance for which they have been determined eligible. It is the provider's responsibility to determine the coverage benefits for a recipient based on their type of assistance as outlined in the provider program manual. The provider shall ascertain the patient's Medicaid/MC+ and managed care or other lock-in status before any service is performed. The recipient's eligibility shall be verified in accordance with methodology outlined in the provider program manual.**

AUTHORITY: sections 208.153[, RSMo 1986] and 208.201, RSMo [Supp. 1988] ***2000, and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005****. This rule was previously filed as 13 CSR 40-81.120. Emergency rule filed June 1, 1979, effective June 11, 1979, expired Sept. 13, 1979. Original rule filed June 1, 1979, effective Sept. 14, 1979. Emergency amendment filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Amended: Filed April 10, 1981, effective July 11, 1981. Rescinded and readopted: Filed July 18, 1989, effective March 1, 1990. Amended: Filed June 29, 2005. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 60—Durable Medical Equipment Program

EMERGENCY AMENDMENT

13 CSR 70-60.010 Durable Medical Equipment Program. The Division of Medical Services is amending the Purpose and sections (1), (2), (6), and (8).

PURPOSE: This amendment eliminates coverage of certain items of durable medical equipment for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or the blind.

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

EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to eliminate coverage of certain items of durable medical equipment for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons, was published in the July 15, 2005 issue of the ***Missouri Register*** *(30 MoReg 1566–1568). The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to eliminate coverage of certain items of durable medical equipment for individuals who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons. The changes to the Medicaid durable medical equipment program are estimated to save the Missouri Medicaid program approximately 24.9 million dollars annually. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) Administration. The Medicaid durable medical equipment (DME) program shall be administered by the Department of Social Services, Division of Medical Services. The services and items covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, Division of Medical Services and shall be included in the DME provider manual, which is incorporated by reference *[in]* **and made a part of** this rule *[and available through]* **as published by** the Department of Social Services, Division of Medical Services**, 615 Howerton Court, Jefferson City, MO 65109 at its** website at *[www.medicaid.state.mo.us. The division reserves the right to affect changes in services, limitations and fees with notification to DME providers.]* **www.dss.mo.gov/dms, July 15, 2005. This rule does not incorporate any subsequent amendments or additions.**

(2) Persons Eligible. Any person who is eligible for Title XIX benefits as determined by the **Family Support** Division *[of Family Services]* is eligible for DME when the DME is medically necessary as determined by the treating physician or advanced practice nurse in a collaborative practice arrangement. **Covered services are limited as specified in section (6) of this rule.**

(6) Covered Services. It is the provider's responsibility to determine the coverage benefits for a Medicaid eligible recipient based on his or her type of assistance as outlined in the DME manual. Reimbursement will be made to qualified participating DME providers only for DME items, determined by the recipient's treating physician or advanced practice nurse in a collaborative practice arrangement to be medically necessary*[, and]***. Covered services include the following items: prosthetics, excluding an artificial larynx; ostomy supplies; diabetic supplies and equipment; oxygen and respiratory equipment, excluding CPAPs, BiPAPs, nebulizers, IPPB machines, humidification items, suction pumps and apnea monitors; and wheelchairs, excluding wheelchair accessories and scooters. Covered services for Medicaid eligible needy children or persons receiving Medicaid under a category of assistance for pregnant women or the blind** shall include but not be limited to: prosthetics; orthotics; oxygen and respiratory care equipment; parenteral nutrition; ostomy supplies; **diabetic supplies and equipment;** ***decubitus*** **care equipment;** wheelchairs; **wheelchair accessories and scooters;** augmentative communication devices; and hospital beds. Specific procedure codes that are covered under the DME program are listed in Section 19 of the DME provider manual, which is incorporated by reference *[in]* **and made a part of** this rule **as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, July 15, 2005. This rule does not incorporate any subsequent amendments or additions**. These items must be for use in the recipient's home when ordered in writing by the recipient's physician or advanced practice nurse in a collaborative practice arrangement. Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of the illness or injury, or to improve the functioning of a malformed or permanently inoperative body part and the equipment meets the definition of DME. Even though a DME item may serve some useful, medical purpose, consideration must be given by the physician or advanced practice nurse in a collaborative arrangement and the DME supplier to what extent, if any, it is reasonable for Medicaid to pay for the item as opposed to another realistically feasible alternative pattern of care. Consideration should be given by the physician or advanced practice nurse in a collaborative practice arrangement and the DME supplier as to whether the item serves essentially the same purpose as equipment already available to the recipient. If two (2) different items each meet the need of the recipient, the less expensive item must be employed, all other conditions being equal.

(8) Durable medical equipment for recipients who are in a nursing facility or inpatient hospital. DME is not covered for those recipients residing in a nursing home. DME is included in the nursing home per diem rate and not paid for separately with the exception of *[augmentative communication devices,]* custom and power wheelchairs, *[orthotic and]* prosthetic devices, *[total parenteral nutrition,]* and volume ventilators. DME that is used while the recipient is in inpatient hospital care is not paid for separately under the DME program. These costs are recognized as part of the hospital's inpatient per diem rate.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000, ***and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005****. Original rule filed Nov. 1, 2002, effective April 30, 2003. Amended: Filed June 15, 2005. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 90—Home Health Program

EMERGENCY AMENDMENT

13 CSR 70-90.010 Home Health-Care Services. The Division of Medical Services is amending sections (1), (2), and (4).

PURPOSE: This amendment eliminates coverage of physical, occupational and speech therapy for adult Medicaid recipients receiving those services through home health care who are not pregnant or blind as approved through Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005.

EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed amendment, which covers the same material to eliminate coverage of physical, occupational and speech

therapy for Medicaid recipients receiving those services through home health care who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons, was published in the July 1, 2005 issue of the ***Missouri Register*** *(30 MoReg 1450). The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to eliminate coverage of physical, occupational and speech therapy for adult Medicaid recipients receiving those services through home health care who are not Medicaid eligible needy children or receiving Medicaid under a category of assistance for pregnant women or blind persons. The changes to the Medicaid home health care services program are estimated to save the Missouri Medicaid program approximately seven hundred fifty-one thousand three hundred forty-five dollars ($751,345). This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The scope of this emergency amendment is limited to the circumstance creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 15, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) An otherwise eligible Medicaid recipient is eligible for Medicaid reimbursement on his/her behalf for home health services if all the conditions of subsections (1)(A)–(D) are met—

(A) The recipient requires—

1. Intermittent skilled nursing care which is reasonable and necessary for the treatment of an injury or illness; **or**

2. Physical**,** *[or]* occupational **or speech** therapy **when the following conditions are met—**

A. The recipient is a needy child, pregnant woman or blind person; and

B. Physical, occupational or speech therapy is reasonable and necessary for restoration to an optimal level of functioning following an injury or illness, in accordance with limitations set forth in section (8) of this rule**.***[; or*

3. Speech therapy reasonable and necessary for restoration to an optimal level of functioning following an injury or illness, in accordance with limitations set forth in section (8) of this rule.]

(2) To qualify as skilled nursing care or as physical, occupational or speech therapy under paragraph*[s]* (1)(A)1.*[–3.]* **or subparagraph (1)(A)2.B.** and to be reimbursable under the Medicaid Home Health Program, a service must meet the following criteria:

(C) The service must constitute active treatment for an illness or injury and be reasonable and necessary. To be considered reasonable and necessary, services must be consistent with the nature and severity of the individual's illness or injury, his/her particular medical needs and accepted standards of medical practice. Services directed solely to the prevention of illness or injury will neither meet the conditions of paragraph*[s]* (1)(A)1.*[–3.]* **or subparagraph (1)(A)2.B.** nor be reimbursed by the Medicaid Home Health Program.

(4) Services included in Medicaid home health coverage are those set forth in paragraph*[s]* (1)(A)1.*[–3.]* **or subparagraph (1)(A)2.B.** and, in addition, the intermittent services of a home health aide and the provision of nonroutine supplies identified as specific and necessary to the delivery of a recipient's nursing care and prescribed in the plan of care. These additional services are covered only if all the conditions of subsections (1)(A)–(D) are met. Necessary items of durable medical equipment prescribed by the physician **as a part of the home health service** are available to recipients of home health services through *[the]* Medicaid *[Durable Medical Equipment Program]* subject to the limitations of amount, duration and scope where applicable. **The home health agency must coordinate with the durable medical equipment provider to ensure the durable medical equipment provider has a copy of the home health plan of care for provision of the durable medical equipment prescribed.**

AUTHORITY: sections 208.153 and 208.201, RSMo 2000, ***and Senate Substitute for Senate Bill 539 enacted by the 93rd General Assembly, 2005****. This rule was previously filed as 13 CSR 40-81.056. Original rule filed April 14, 1982, effective July 11, 1982. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 1, 2005. Emergency amendment filed Aug. 15, 2005, effective Sept. 1, 2005, expires Feb. 27, 2006.*

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

EMERGENCY RULE

13 CSR 70-99.010 Comprehensive Day Rehabilitation Program

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

EMERGENCY STATEMENT: The 93rd Missouri General Assembly truly agreed and finally passed Senate Substitute for Senate Bill 539. The governor signed Senate Bill 539. Senate Bill 539 is effective August 28, 2005. A proposed rule, which covers the same material to establish the regulatory basis for the administration of the Medicaid Comprehensive Day Rehabilitation Program, was published in the July 1, 2005 issue of the ***Missouri Register*** *(30 MoReg 1451–1454). No written comments were received during the thirty (30)-day public comment period. The proposed amendment will not be effective September 1, 2005 when the Department of Social Services, Division of Medical Services is required by Senate Bill 539 and House Bill 11 to implement the program changes to limit the comprehensive day rehabilitation program to Medicaid recipients who are eligible needy children, pregnant women or blind persons. The changes to the Medicaid Comprehensive Day Rehabilitation Program are estimated to save the Missouri Medicaid program approximately one (1) million dollars annually. This emergency amendment is necessary to implement Senate Bill 539 and House Bill 11 as passed by the Missouri General Assembly and signed by the governor. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 11, 2005, effective September 1, 2005, expires February 27, 2006.*

(1) Administration. The Missouri Medicaid Comprehensive Day Rehabilitation Program shall be administered by the Department of Social Services, Division of Medical Services. The Comprehensive Day Rehabilitation services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services and shall be included in the Medicaid provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/dms, July 1, 2005. This rule does not incorporate any subsequent amendments or additions. Comprehensive Day Rehabilitation program shall include only those that are prior authorized by the Division of Medical Services.

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

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

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

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

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

(7) Documentation Requirements for Comprehensive Day Rehabilitation Program.

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

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

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

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