# Rules of
# Department of Health
## Division 40—Division of Maternal, Child and Family Health
## Chapter 1—Crippled Children's Service (CCS)


| Title | | Page |
|---|---|---|
| 19 CSR 40-1.010 | Definitions Relating to Crippled Children's Service (CCS) | 3 |
| 19 CSR 40-1.020 | Program Eligibility | 3 |
| 19 CSR 40-1.030 | Categories of Care | 4 |
| 19 CSR 40-1.040 | CCS Financial Eligibility | 5 |
| 19 CSR 40-1.050 | Client Responsibilities | 5 |
| 19 CSR 40-1.060 | Organization and Management | 6 |
| 19 CSR 40-1.070 | Service Providers | 7 |
| 19 CSR 40-1.080 | Sanctions | 8 |

# Title 19—DEPARTMENT OF HEALTH

## Division 40—Division of Maternal, Child and Family Health
## Chapter 1—Crippled Children's Service (CCS)

### 19 CSR 40-1.010 Definitions Relating to the Crippled Children's Service (CCS)

*PURPOSE: This rule defines terminology used throughout this chapter.*

(1) Administrator means the administrator of CCS as designated in section 201.050, RSMo (1986).

(2) Advisory committee means the general advisory committee, as defined in section 201.110, RSMo (1986). This committee shall be comprised of a majority of physicians, as licensed under Chapter 334, RSMo (1986), and the remainder of consumers, other health care personnel and interested parties. It shall meet at least once a year and shall select a chairperson among its members to voice the committee's collective advice.

(3) Care means specialized treatment services and does not include general medical care, which remains the responsibility of the client or the client's family and the referring health provider. Care does not include education or domiciliary care.

(4) Case finding means a method of locating children who can benefit from CCS. This shall be accomplished through close cooperation of local physicians, hospitals, other health providers, schools, official and voluntary agencies, parents and other interested individuals.

(5) Case management means management of resources across agency and professional lines to develop and attain the client's care plan with optimal participation of the client or the client's family or both.

(6) Central office means that portion of the CCS which has the responsibility and authority to administer the statewide program.

(7) Diagnostic services means services which include, but are not limited to, medical, social, psychological and other services necessary to identify the presence of a handicapping disability, its cause and complications and to determine the extent to which the disability limits or is likely to limit an individual's daily living and work activities.

(8) District and subdistrict office means that portion of CCS which includes case managers and personnel who interact directly with individual clients and providers of care.

(9) Financial eligibility means eligibility for those health services offered by CCS, based on the financial status of the client or the client's family or the client's guardians. Categories of financial eligibility have been established by CCS in 19 CSR 40-1.040.

(10) Habilitation means the continuous development of skills and abilities.

(11) Individual care plan (ICP) means a written statement developed by a provider of care, interdisciplinary team, case manager, parents or guardians and the child, if possible, which analyzes the child's achievement level, lists short-range and annual goals, describes specific services needed to meet those goals and develops a schedule for monitoring progress.

(12) Interdisciplinary team means a team of professionals representing a variety of disciplines which provides services to persons with physical handicaps.

(13) Services means services in hospitals, convalescent homes and clinics by physicians, chiropractors, dentists, nurses, medical social workers, nutritionists, dietitians, physical therapists, occupational therapists, speech pathologists and audiologists, technicians and other personnel whose services are needed in the CCS programs.

(14) Medical eligibility means eligibility for those health services offered by CCS as based on medical condition. Categories of medical conditions acceptable for services have been established in 19 CSR 40-1.030.

(15) Crippled Children's Service or CCS is the agency of the Department of Health for facilitating the early identification of physically handicapped children and of individuals who have the potential of producing physically handicapped children; the provision of preventive, diagnostic and treatment services, including case management services, for the restoration of optimum health for physically handicapped children; the development, strengthening and improvement of standards and techniques relating to the provision of those services; the training of personnel engaged in the provision of those services or the strengthening and improvement of services; and the necessary administration to provide services to physically handicapped children and individuals at risk of having physically handicapped children.

(16) Physically handicapped child means an individual below the age of twenty-one (21) years who has a disease, defect or condition which may hinder the achievement of normal physical growth and development.

(17) Pre-authorization means written permission obtained from CCS in advance of an action which would result in either the obligation or expenditure of funds or the performance of an activity.

(18) Program administrator means the person responsible for planning, developing, implementing and monitoring the program of special health services on a statewide basis for handicapped children.

(19) Program coordinator means the person responsible for coordinating a segment of the CCS and the duties assigned to that segment.

(20) Provider of care means an individual who is regulated under Chapters 331, 332, 334—338 and 344—346, RSMo (Supp. 1988); or an organization licensed under Chapter 197, RSMo (Supp. 1988) or approved by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

(21) Rehabilitation means the process of improving or reestablishing an individual's skill or level of adjustment by increasing the ability to maintain an optimum level of independent functioning.

(22) Third-party payer means any person, corporation, trust, association, the state of Missouri, any governmental subdivision or agency or any other legal entity which pays directly or indirectly for health care services provided to another person or reimburses or pays a benefit to or on behalf of another person for health care services in conformance to a contract, plan, employee benefit or member benefit.

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed as 13 CSR 50-160.010. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987. Amended: Filed Jan. 18, 1989, effective April 27, 1989.*

### 19 CSR 40-1.020 Program Eligibility

*PURPOSE: This rule establishes the criteria by which CCS accepts clients for service.*

(1) Conditions of eligibility for Crippled Children's Service (CCS) services include:

(A) A client must be under twenty-one (21) years of age. All expenditures by CCS on behalf of a child must be for services received prior to his/her twenty-first birthday;

(B) A client must be a resident of Missouri;

(C) A client must be financially eligible for CCS;

(D) A client must be medically eligible for CCS;

(E) Marital status is not a condition of eligibility; and

(F) Each client shall have a parent or an appointed guardian as a condition of eligibility, unless the client is legally emancipated and may sign on his/her own behalf.

(2) To qualify medically for services under the auspices of CCS, a client must meet the definition of a physically-handicapped child in 19 CSR 40-1.010(16) and have a medical condition which is included in 19 CSR 40-1.030.

(A) The following factors shall be considered in establishing categories of conditions eligible under CCS: severity; complexity; extent of significant dysfunction or disability that is present or expected; duration of the disorder; potential for habilitation or rehabilitation and also a reasonable expected longevity; amenability to limited standard medical intervention; and a strong likelihood the treatment will have a major impact upon the physically handicapping condition(s). There must be reasonable expectation or improvement to be eligible for CCS coverage.

(B) CCS may assist any child under twenty-one (21) years of age who resides in Missouri in obtaining a diagnostic evaluation if that child is possibly afflicted with a CCS-eligible condition.

(C) The medically-eligible client will be treated only for the eligible condition and for directly related conditions necessary to prepare the client for treatment of the eligible condition and to preserve the benefits derived from the treatment. An unrelated medical condition which is ineligible does not become eligible when the client is accepted for treatment of an eligible condition.

(D) On emergency cases that need to be referred to CCS but not previously known to the agency, it will be the responsibility of the attending physician or the hospital to contact CCS within seventy-two (72) hours for tentative oral approval for treatment at an approved CCS hospital. Final approval will be given only upon receipt of an official CCS application form and the medical report for establishing eligibility. The application process must be initiated no later than seven (7) calendar days after the time of admission.

(E) The client's medical condition shall be reviewed on a periodic basis by CCS to insure the continuing CCS eligibility.

(3) To receive medical or surgical services, the client must be medically eligible and the client's family must meet the current financial eligibility criteria which are included in 19 CSR 40-1.040. An applicant shall agree to participate in any cost-sharing that may be required.

(A) CCS is the last resource after all other available sources of payment have been exhausted.

(B) The financial situation of the client and of his/her family shall be reviewed on a periodic basis by CCS to insure the continuing CCS eligibility.

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed 13 CSR 50-160.020. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987.*

## 19 CSR 40-1.030 Categories of Care

*PURPOSE: This rule defines the medical conditions for which MCCS will provide service and funding.*

(1) Category I shall include those eligible applicants whose medical conditions require immediate life-saving medical treatment. The conditions include, but are not necessarily limited to:

(A) Burn care—any burns requiring seven (7) days or more inpatient care and burns requiring skin grafting;

(B) Cardiac care—congenital heart disease requiring surgical intervention or presenting with congestive heart failure; and acute rheumatic fever with congestive heart failure or requiring cardiac surgery;

(C) Cleft lip and palate care—initial lip or palate closure or both;

(D) Genito-urinary (GU) care—bladder extrophy, vesico-ureteral reflux and ureteropelvic junction obstruction;

(E) Myelomeningocele care (spina bifida)—surgical closure of myelocele;

(F) Neurology care—depressed skull fracture, subdural hematoma and uncontrolled seizures;

(G) Neurosurgery care—shunting procedures;

(H) Orthopedic care—acquired amputations, fractures and fracture dislocations of the vertebral column with or without associated spinal cord injury except for closed coccygeal fractures, open fractures, osteogenesis imperfecta, osteomyelitis or pyarthrosis presenting with sepsis; and

(I) Pediatric surgery care—diaphragmatic hernia with accompanying respiratory distress; Hirschsprung's disease; multiple surgically-staged imperforate anus; duodenal atresia; jejunal atresia; tracheoesophageal fistula; gastroschisis; omphalocele; intestinal obstruction in neonates; lacerated tendons; electrical burns to the mouth; surgical procedures for subglottic stenosis; laryngeal webs; choanal atresia; and ingestion burns; and

(J) The following are not covered under Category I: arthritis care; cerebral palsy care; ear; nose and troat (ENT)/hearing care; ENT/surgical care; and physical, medical and rehabilitation (PM&R) care.

(2) Category II shall include those medical conditions which, if not treated, could grow worse or cause a crippling disability. A limited term of hospitalization and a good prognosis should be expected. The conditions may include, but are not necessarily limited to:

(A) Arthritis care—acute juvenile rheumatoid arthritis;

(B) Burn care—follow-up and rehabilitation services;

(C) Cardiac care—congenital heart disease (CHD) not requiring immediate surgical intervention and CHD not presenting with congestive heart failure;

(D) Cerebral palsy care—surgical procedures and bracing;

(E) Cleft lip and palate care—surgical procedures;

(F) Ear, nose and throat (ENT) surgical care—surgical procedures for chronic otitis media, tympanic membrane perforation, cholesteatoma and other otologic conditions requiring specialty care;

(G) Genito-urinary care—bladder extrophy, vesicoureteral reflux, utreteropelvic junction obstruction, hypospadias and ambiguous genitalia;

(H) Myelomeningocele care (spinal bifida)—follow-up and rehabilitation services:

(I) Neurology care—residuals of meningitis, Guillain-Barre syndrome, Reye's syndrome, poliomyelitis, seizure disorders and stalic encephalopathies;

(J) Neurosurgery care—hydrocephanlus, diastematomyelia, enecephalocele and vascular lesions affecting the central nervous system;

(K) Orthopedic care—congenital deformities; arthrogryposis congenital dysplasia of the hip; complicated fractures of the limbs, pelvis and shoulder girdle; scoliosis and kyphosis; surgical treatment of late effects of epiphyseal injury; osteomyelitis; closed spinal

fracture without neurologic deficit, excluding coccygeal fractures; rickets; Legg-Calve-Perthes disease; club feet; nonmalignant bone tumors and acquired injury to limbs;

(L) Pediatric surgery care—benign tumors, hemangiomas, lymphangiomas and neurofibromas which cause functional impairment or disfigurement and surgical correction of laryngeal papillomas;

(M) Physical, medical and rehabilitation (PM&R) care—rehabilitation for spinal cord injuries; and

(N) The following are not covered under Category II: ear, nose and throat (ENT)/hearing care.

(3) Category III shall include those eligible applicants whose conditions may require prolonged outpatient care and may require hospitalization at some time. The conditions have a fair prognosis if treated and may include, but are not necessarily limited to:

(A) Arthritis care—juvenile sheumatoid arthritis follow-up as needed;

(B) Burn care—covered under Category I and II;

(C) Cardiac care—congenital heart disease follow-up and resistant dysrhythmias;

(D) Cerebral palsy care—rehabilitation services;

(E) Cleft lip and palate care—surgical revisions, dental care and speech therapy;

(F) Ear, nose and throat (ENT)/hearing care—all eligible services;

(G) Ear, nose and throat (ENT)/surgical care—surgical care follow-up;

(H) Genitourinary care—follow-up care as needed;

(I) Myelomeningocele care—covered under Categories I and II;

(J) Neurology care—residuals of meningitis, seizure disorders, Guillain-Barre syndrome, Reye's syndrome, poliomyelitis and stalic encephalopathies;

(K) Neurosurgery care—hydrocephalus, diastematomyelia, encephalocele and vascular lesions affecting the central nervous system;

(L) Orthopedic care—claw foot, calcaneovalgus and other acquired congenital deformities and rehabilitation services;

(M) Pediatric surgery care—follow-up care as needed; and

(N) Physical, medical and rehabilitation (PM&R) care—covered under Category II.

(4) Category IV shall include those eligible applicants whose medical conditions have a poor to fair prognosis or uncertain restoration to a useful or productive life regardless of the treatment provided. The conditions are considered to be maintained by the services that are provided for them and thus are put in this category of maintenance. This is primarily a category of case management and covers the entire spectrum of CCS-eligible conditions.

(5) Category V shall include all those eligible applicants whose medical conditions have variable prognosis; enhancement allows improvements in activities of daily living (ADL), physical appearance for psychological reasons, with plastic surgical procedures, etc. This also includes exotic conditions such as craniofacial anomalies which are not ordinarily eligible for CCS services due to budgetary limitations; if funding allows, these conditions would be included under this category. Cosmesis, inborn errors of metabolism, exotic drugs and special counseling are some of the miscellaneous items that would be funded in this category.

(6) The categories in sections (1)—(5) of this rule may have funding ceilings or limitations imposed on them or may be categorically suspended, as stipulated in 19 CSR 40-1.060(1)(B).

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed 13 CSR 50-160.030. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Emergency amendment filed Feb. 20, 1985, effective March 2, 1985, expired June 30, 1985. Emergency amendment filed April 11, 1985, effective April 21, 1985, expired June 30, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987.*

## 19 CSR 40-1.040 CCS Financial Eligibility

*PURPOSE: This rule establishes guidelines for determining financial eligibility for enrollment in Crippled Children's Service.*

(1) Financial eligibility guidelines for enrollment in Crippled Children's Services (CCS) shall be based upon the Poverty Income Guidelines in section (2) of this rule, as established by the United States Department of Health and Human Services. The determination of individual client eligibility shall be based upon the following factors:

(A) Total adjusted gross income shall not exceed one hundred eighty-five percent (185%) of the federal poverty income guideline for the family size;

(B) Size of family unit shall be the number of persons in the household, including the responsible party(ies) and dependents allowable by the Internal Revenue Service as federal income tax exemptions. If there is more than one (1) eligible CCS client in the household, the total family size shall be increased by one (1) unit for each additional client; and

(C) Families or individuals whose income exceeds the one hundred eighty-five percent (185%) poverty level shall be given consideration if the medical cost of an eligible condition, regardless of third-party payment, would bring the income below the one hundred eighty-five percent (185%) poverty level.

(2) Poverty Income Guidelines.

**1990 Poverty Income Guidelines for All States (Except Alaska and Hawaii) and the District of Columbia**

| Size of Family Unit | Poverty Guidelines |
|---|---|
| 1 | $ 6280 |
| 2 | $ 8420 |
| 3 | $ 10,560 |
| 4 | $ 12,700 |
| 5 | $ 14,840 |
| 6 | $ 16,980 |
| 7 | $ 19,120 |
| 8 | $ 21,260 |

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed as 13 CSR 50-160.040. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987. Rescinded and readopted: Filed Nov. 2, 1990, effective April 29, 1991.*

## 19 CSR 40-1.050 Client Responsibilities

*PURPOSE: This rule establishes the way in which clients maintain their program eligibility.*

(1) Clients and their families are responsible for providing Crippled Children's Service (CCS) with accurate information concerning their financial status.

(2) The client or the client's family shall use all available health insurance benefits, Medicaid or other third-party payment mechanism—including recoveries specifically awarded for medical expenses from third-party insurance sources through settlement of personal injury claims attributable to the

condition being treated—for payment toward medical expenses.

(3) The client or the client's family shall enroll in any state or other public programs for which they are eligible in order to provide maximum comprehensive services.

(4) The client or the client's family shall report any major changes in income, household composition, insurance, Medicaid coverage or address within ten (10) working days after the date the client or the client's family becomes aware of the change.

(5) The client or the client's family shall keep the CCS case manager updated on the medical progress of the client's individual care plan.

(6) The client or the client's family shall take the client's CCS service authorization to all diagnostic and therapeutic appointments being covered by CCS.

(7) To maintain eligibility, an applicant shall complete and have approved another application at the end of the eligibility period. An eligibility period shall be the year following the anniversary date of original application or the year following the date of the filing of a new 1040 tax form.

(8) Provisions of sections (1)—(7) of this rule are considered mandatory, and if not followed by the client or the client's family, CCS may discontinue services.

(9) An applicant who is determined ineligible for CCS may reapply when s/he feels there have been changes which may make the applicant eligible.

(10) When an application is denied, the applicant shall be informed of his/her right to appeal.

(11) Information shall be released by CCS only upon receipt of a release of information form signed by the client or the client's parent or appointed guardian indicating the client's approval of the release of information to the party seeking the information. Information shall not be released to the client unless the client requests the information from CCS.

*Auth: sections 192.005.2. and 201.120, RSMo (1986). This rule was previously filed 13 CSR 50-160.050. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987.*

## 19 CSR 40-1.060 Organization and Management

*PURPOSE: This rule establishes the components of CCS. It also delineates central office and district and subdistrict office roles in the components of the program.*

(1) Central Office Role.

(A) The Department of Health shall see that Crippled Children's Service (CCS) is administered strictly within the states' fiscal guidelines.

1. The line of authority by which the Department of Health administers CCS shall be through the Division of Personal Health Services.

2. The program administrator shall be held accountable to the division director, who in turn shall be held accountable to the director of the Department of Health.

3. The program administrator shall work with the CCS advisory committee, informing committee members of issues pertinent to the operation of the program and giving due consideration to the committee's collective advice.

(B) Central office may administratively revise limitations on CCS programs. CCS, for budgetary reasons, may suspend one (1) or more of the categories of care in 19 CSR 40-1.030(1)—(5) or impose or revise funding ceilings for services throughout the state.

(C) Central office may develop and implement demonstration or special projects to provide services to groups in special need. The development of the projects shall include development of policies, standards and criteria applicable to provision of the services and to the selection of groups in special need. Special funds may be set aside for these projects and shall be limited to no more than ten percent (10%) of the general service budget.

(D) Central office shall attempt to formulate written agreements with any other governmental agencies and their respective departments in order to carry out the mandates stipulated in section 201.030, RSMo (1986).

(E) Central office shall consult with the district and subdistrict staff on complicated individual care plans and shall monitor the case management function of the staff.

(F) Central office shall maintain statistics of children in Missouri who have congenital anomalies, birth defects and physically-handicapping conditions.

(G) Central office shall review the qualifications of CCS-approved providers. Notification of any changes of status or revisions will be sent to the district and subdistrict offices.

(2) District and Subdistrict Office Role.

(A) Case finding is a primary function of the CCS staff at the district and subdistrict level. The staff, in conjunction with providers of care and other public and private agencies and concerned individuals, shall actively seek out children and families who may be eligible for CCS services.

(B) Services shall be initiated at the district and subdistrict level.

1. The staff shall monitor requests for diagnostic services from all providers of care and other public and private agencies and concerned individuals who may refer a child or family for the services.

2. The staff shall reject or bring up for further review with the central CCS office any referrals and requests for services for children with conditions not included in 19 CSR 40-1.030(1)—(5).

3. Referral from district and subdistrict staff to an appropriate provider of care and other public and private agencies and concerned individuals shall be made for all children or families referred to CCS.

(C) Case management shall be a primary function at the district and subdistrict level. It includes all activities related to the monitoring of the client's medical progress and the individual care plan (ICP) outlined for the client by the provider(s) of service, case manager, client's parents and the client.

1. The staff shall provide feedback on the client to service providers and shall work with providers and other community resources to create an appropriate ICP for CCS clients.

2. The staff shall also work together as an interdisciplinary team when necessary to review and implement complicated ICPs and, when necessary, to see that ICPs are periodically being reviewed by the providers of care.

3. The staff shall provide feedback on the client's CCS status within twenty (20) working days after the client or client's family reports any major changes in income, household composition, insurance, Medicaid coverage, medical condition or the client's care plan; and work with the client and the client's family to insure the client's ICP is appropriate.

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed 13 CSR 50-160.060. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987.*

## 19 CSR 40-1.070 Service Providers

*PURPOSE: This rule establishes the responsibilities of service providers and outlines the framework of who is eligible to provide care; this includes hospitals and clinics, as well as individual providers of care.*

(1) Provider Specifications.

(A) Eligible children may be approved for hospitalization by contractual agreement in treatment centers.

1. Treatment centers shall have a pediatric unit which meets the requirements of 19 CSR 30-20.021(4)(F)1.—7.

2. Treatment centers shall have open heart surgical facilities and facilities for cardiac catheterization.

3. Treatment centers shall have the capacity for dealing appropriately with neurosurgical conditions requiring emergency services.

4. Treatment centers shall have the capacity for dealing appropriately with all pediatric surgical procedures.

5. Treatment centers shall have the capacity to be designated as pediatric trauma centers.

6. Treatment centers shall have the capacity to provide pediatric specialty outpatient clinics.

7. Treatment centers shall be approved by the Joint Commission on the Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA).

(B) Special condition centers (SCC) include pediatric rehabilitation units, burn units, orthopedic units, dental units, plastic surgery units and otolaryngologic units and other pediatric facilities which do not have the full capacity of a treatment center, but have the capacity to provide limited or specialized services for Crippled Children's Service (CCS)-eligible clients.

1. SCCs shall be limited in number, based on geographic and demographic considerations of any given part of Missouri.

2. Eligible children may be approved for hospitalization or outpatient care by contractual agreement for those specific conditions for which the SCCs provide services.

3. Emergency hospital admissions shall be handled as required by 19 CSR 40-1.020(2)(D). In the event that the SCC is not able to provide adequate hospitalization, the patient shall be stabilized and subsequently transferred to a treatment center which is more fully equipped to deal with the emergency.

4. SCCs shall be approved by JCAH or AOA.

(C) CCS-approved physicians shall be certified by or eligible for certification by a specialty or subspecialty practice board recognized by and affiliated with the American Medical Association (AMA) or the AOA. Chiropractors shall be certified by or eligible for certification by a specialty or subspecialty practice board recognized by and affiliated with the Council of Chiropractic Education, the American Chiropractic Association or the International Chiropractic Association. Physicians or chiropractors who are board-eligible shall have two (2) years from the time they are approved to obtain board certification before being discontinued from the CCS list of approved physicians or chiropractors. For certain conditions, the physician or chiropractor is expected to act as an integral part of an interdisciplinary team of physicians or chiropractors and other health professionals to deal with the medical aspects of the condition. These conditions include spina bifida, cleft lip and palate, severe and extensive burns, spinal cord injuries and head trauma with loss of consciousness for more than twenty-four (24) hours. Services shall be provided or supervised by a CCS-approved physician or chiropractor who is a specialist in the condition for which the child is CCS-approved.

(D) Therapists include speech therapists, physical therapists and occupational therapists.

1. Therapy must be approved in advance by CCS. When therapy is recommended by the attending physician or interdisciplinary team, CCS authorization is necessary for therapy services not covered by another agency.

2. Therapy services are provided by a CCS-approved therapist.

3. Therapy personnel shall be licensed by their respective boards in Missouri.

(E) General dental services are not approved by CCS, except as specified in 19 CSR 40-1.020(2)(C). Specialized dental services are approved for cleft lip and palate and gengevectomy for patients receiving dilantin therapy. CCS-approved specialty dentists must be board-certified or board-eligible and licensed to practice in their specialty areas under section 332.171, RSMo (1986). Dentists who are board-eligible shall have two (2) years from the time they are approved to obtain board certification before being discontinued from the CCS list of approved dentists.

(F) Appliances, prostheses and equipment that are approved by CCS are provided by contractual agreement with direct service vendors; approved repairs and replacements are also provided by contractual agreement with direct service vendors. Appliances, prostheses and equipment authorized by CCS include artificial limbs, artificial stock eyes, braces, catheterization supplies, communication devices, dental appliances within orthondontic and prosthodontic limitations, ear molds, hearing aids, ostomy supplies and feeding tubes, respirator equipment, shoes for specific diagnostic criteria, tracheostomy tubes and supplies, wheelchairs, walkers, ambulatory aids and universal cuffs and splints.

(G) Outpatient x-ray and laboratory services are authorized if they are directly related to the medical condition the client has been enrolled under. They may be requested by the patient's attending physician, chiropractor, dentist or interdisciplinary team. Whenever possible, they should be included in the client's individual care plan (ICP).

(H) All outpatient drugs, supplies and equipment costing more than three hundred dollars ($300) must be pre-authorized by CCS. Medication, nutritional formulas and supplies necessary for the treatment of a disease or condition may be provided.

(I) Payment for medical services shall be limited to those services available in Missouri, except when a client develops specialized needs which cannot be treated in Missouri and must be referred out-of-state.

(2) Any person or facility wishing to provide health care for CCS shall complete a provider application. CCS shall notify providers of application approval and make contractual agreements with facilities approved to provide health care.

(A) Approved providers shall agree to accept as payments in full, the amounts established by CCS.

1. If a provider receives payment from a source other than CCS which is equal to or exceeds the amount of the program fee schedule for the authorized services rendered, the provider may not seek any additional amount from either the client or the program.

2. Approved providers shall submit bills on forms prescribed by CCS and within the billing time limits negotiated between CCS and its providers. Unless the provider receives a waiver of the time limit from the program administrator or designee, failure to comply with time limits may result in denial of the claim.

(B) Approved providers shall submit to the case manager legible and complete medical or chiropractic reports for each service or set of related services authorized by CCS. Failure to submit medical reports may result in termination of provider agreement.

1. Medical reports submitted to CCS are the property of CCS. CCS shall not release the reports except under the following circumstances:

A. Reports shall be given to other providers when necessary to assure continuity of treatment or provision of services to the client, if the client consents to the release; and

B. Reports shall be used by CCS as necessary to collect for services paid for by CCS from liable third parties.

2. For a client to receive and continue receiving services, the client's CCS-approved physician or chiropractor shall initiate a proposal for services to be incorporated into the ICP.

(C) CCS shall reimburse for diagnostic evaluations or treatment services only if a prior written authorization has been provided.

1. Emergency authorization of reimbursement for treatment service(s) shall be provided by CCS in situations which are determined by the CCS program administrator or designee to have the potential for irrevocable damage, injury or long-term consequences if treatment is not provided immediately. In these instances, CCS shall be notified by the attending physician or hospital within seventy-two (72) hours after admission to a CCS-approved hospital. Eligibility for further authorization shall be determined according to criteria in 19 CSR 40-1.020(2)(D).

2. Purchase of services related to psychosocial disturbances are excluded, except when attributable to a medical condition for which the client is enrolled. Requests for these services are subject to review by the program administrator or designee.

3. Purchase of services related to educational activities or educational disabilities are excluded.

4. Out-of-state providers are subject to the same fee schedule, time limitations, standards and requirements as in-state providers.

*Auth: sections 192.005.2., 201.060, 201.100 and 201.120, RSMo (1986). This rule was previously filed as 13 CSR 50-160.070. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987. Amended: Filed Jan. 18, 1989, effective April 27, 1989.*

## 19 CSR 40-1.080 Sanctions

*PURPOSE: This rule establishes the violations for which providers and clients will be penalized and those actions which will be taken against them.*

(1) Sanctions will be imposed by Crippled Children's Service (CCS) against a provider for any one (1) or more of the following reasons:

(A) The provider knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact by presenting or causing to be presented for payment under CCS any false or fraudulent claim for services or merchandise; submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that which the provider is legally entitled; submitting or causing to be submitted false information for the purpose of meeting prior approval status; or submitting a false or fraudulent application for provider status;

(B) The provider fails to provide and maintain quality services which meet professionally recognized standards of care;

(C) The provider breaks the terms of the provider agreement or fails to comply with the terms of the provider certification on the CCS claim form;

(D) The provider is convicted of a criminal offense relating to performance of a provider agreement with the state or for negligent or abusive practice resulting in the death or injury of a client;

(E) The provider fails to meet licensure or certification standards for participation as a given type of provider;

(F) The provider solicits, charges or receives payments from recipients for services for which the provider has billed CCS;

(G) The provider is suspended or terminated from participation in another governmental medical program such as, but not limited to, Workers' Compensation, Medicaid and Medicare;

(H) The provider is indicted for fraudulent billing practices or for negligent practice resulting in physical, emotional or psychological injury or death to the provider's client; or

(I) The provider fails to repay or to make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(2) One (1) or more of the following sanctions may be invoked against a provider for any violation listed in section (1) of this rule: termination from participation in CCS; suspension from participation in CCS; suspension or withholding of payments; or referral for investigation to the State Board of Registration for the Healing Arts or other appropriate state licensing agency.

(3) A client may be dismissed or an application cancelled for any of the following reasons: financial ineligibility; medical ineligibility; death of registrant; failure to keep scheduled appointments; failure to reply to CCS correspondence; residency established out-of-state; return appointment more than twelve (12) months away; no treatment recommended; unable to locate; age twenty-one (21) reached; failure to supply requested information; unwillingness to follow medical recommendations; medical recommendations indicate care needed is below current acceptable minimum to meet eligibility criteria for the diagnosis; or failure to properly use third-party coverage benefits.

(4) In cases where CCS intends to discontinue, terminate, suspend or reduce benefits to clients, providers or applicants, the program must give written notice that the proposed action will occur no sooner than fourteen (14) calendar days after the notice is dated. The notice must include a statement of what action the program intends to take; the reasons for the intended action; and a statement of the right to appeal. Further information is available by contacting the nearest district or subdistrict office or the CCS central office.

(5) An opportunity for a hearing is granted upon request to—an applicant whose application is denied; a client who is aggrieved by any CCS decision resulting in suspension, reduction, discontinuance or termination of benefits; or a provider who is aggrieved by any program decision resulting in suspension, reduction, discontinuance or termination of benefits.

(A) A hearing shall be conducted at a reasonable time, date and place. The notice of the time, date and place of a hearing shall be mailed to the requesting applicant, client or provider at least twenty (20) days prior to the hearing.

(B) An officer appointed by the director of the Department of Health shall preside at the hearing. The officer shall not have been involved in the initial determination of the action in question. The hearing officer shall prepare a report consisting of a statement of issues, findings of fact, conclusions and recommendations.

(C) The appellant shall have adequate opportunity to record the hearing proceedings, examine the contents of his/her case file, bring witnesses, establish all pertinent facts, advance arguments without undue interference and question or refute any testimony or evidence.

(D) The final decision shall be made by the director of the Department of Health, based upon the evidence and other material introduced at the hearing and the hearing officer's report. This decision shall be mailed to the appellant within ninety (90) calendar days after the hearing date.

(6) Any person who has exhausted all administrative remedies provided by law and sections (4) and (5) and subsections (5)(A) and (B) of this rule and who is aggrieved by a final decision in a contested case, whether this decision is affirmative or negative, shall be entitled to judicial review as provided in sections 536.100—536.140, RSMo (1986).

*Auth: sections 192.005.2. and 201.060, RSMo (1986). This rule was previously filed 13 CSR 50-160.080. Emergency rule filed Dec. 12, 1984, effective Dec. 22, 1984, expired April 20, 1985. Original rule filed Dec. 12, 1984, effective April 11, 1985. Amended: Filed June 2, 1987, effective Aug. 13, 1987.*