Rules of
Department of Health and Senior Services
Division 50—Division of Injury Prevention, Head Injury Rehabilitation and Local Health Services
Chapter 20—Head Injury Program

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 50—Division of Injury Prevention, Head Injury Rehabilitation and Local Health Services

Chapter 20—Head Injury Program

19 CSR 50-20.010 Service Providers

PURPOSE: This rule establishes the eligibility requirements and responsibilities of head injury service providers.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Any person, organization or agency wishing to provide services shall apply to the Office of Head Injury Services (OHIS). Interested individuals or facilities shall meet eligibility criteria outlined in the Provider Manual published by the Missouri Department of Health, Head Injury Program, June 1993. OHIS shall notify providers of application approval or disapproval and shall make contractual agreements with facilities approved to provide services.

(2) Approved providers shall agree to accept the amounts established by OHIS as payments in full.

(A) If a provider receives payment from any source other than the OHIS which is equal to or exceeds the amount of the program fee schedule for the authorized services rendered, the provider shall not accept any additional amount from either the client or the program. Claims shall be submitted to any third-party payer (see 19 CSR 40-1.010(22)) before submitting a claim to the OHIS.

(B) Approved providers shall submit bills on forms prescribed by the OHIS and within the billing time limits stated in the Provider Manual. Unless the provider receives a waiver of the time limit from the program administrator or designee, failure to comply with the time limits may result in denial of the claim.

(C) The OHIS shall reimburse for services only if a prior written authorization request has been approved. That request completed by the provider shall include a plan of care and assurance that the client/family participated in the plan and agree.

(3) Sanctions shall be imposed by the OHIS 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 OHIS any false or fraudulent claim of services or merchandise; submits or causes to be submitted false information for the purpose of obtaining compensation greater than that for which the provider is legally entitled; submits or causes to be submitted false information for the purpose of meeting prior approval status; or submits 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 violates the terms of the provider agreement;

(D) The provider is convicted of a criminal offense relating to performance of a provider agreement with the state or for a 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 for services for which the provider has billed OHIS;

(G) 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

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

(4) One (1) or more of the following sanctions may be invoked against a provider for any violation listed in section (3) of this rule: termination from participation in OHIS; suspension from participation in OHIS; 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.

AUTHORITY: sections 199.001 and 199.003, RSMo Supp. 1991 and 199.009, RSMo Supp. 1993. Original rule filed Feb. 2, 1994, effective July 30, 1994.*

**Original authority: 199.001 and 199.003, RSMo 1991 and 199.009, RSMo 1991, amended 1993.*

MISSOURI DEPARTMENT OF HEALTH
DIVISION OF INJURY PREVENTION, HEAD INJURY REHABILITATION
AND LOCAL HEALTH SERVICES

HEAD INJURY SERVICES INVOICE

		DATE	INVOICE NUMBER	PAGE NUMBER
SUBMIT TO: MISSOURI DEPARTMENT OF HEALTH DIVISION OF INJURY PREVENTION, HEAD INJURY REHABILITATION & LOCAL HEALTH SERVICES P.O. BOX 570 JEFFERSON CITY, MO 65102-0570	VENDOR		VENDOR NUMBER	FISCAL YEAR
	ADDRESS	CITY	AGREEMENT NUMBER	AGENCY CODE 597
	STATE / ZIP CODE	PHONE NUMBER	COST CENTER CODE 71836	OBJECT CODE 2445

SECTION A - TOTAL SERVICES BILLED FOR PERIOD OF INVOICE

SERVICE DESCRIPTION	SERVICE CODE	NUMBER OF CLIENTS	TOTAL NUMBER OF UNITS	MONTH	TOTAL($) SERVICE AMOUNT BILLED
				GRAND TOTAL ($) AMOUNT BILLED	$

I certify that the services have been rendered in accordance with the Provider Agreement and that I have not received prior payments for the services. If payment is received from another source, the Department of Health will be either reimbursed up to the amount involved or the amount received will be deducted from the amount billed to the state. I also certify that the services billed to the Department of Health are provided to clients who have suffered a head injury as defined in the Provider Manual and that the clients are Missouri residents.

AUTHORIZED SIGNATURE	DATE	APPROVAL SIGNATURE	DATE

MO 580-1707 (5-93)

INSTRUCTIONS FOR COMPLETION

NOTE: The original and three copies of Section A and Section B must be complete and legible. Submit to Missouri Department of Health, Division of Injury Prevention, Head Injury Rehabilitation & Local Health Services, P.O. Box 570, Jefferson City, Missouri, 65102. Phone: (314) 751-6170.

DATE: Date form is completed.
INVOICE NUMBER: Assign an invoice number.
PAGE NUMBER: Sequentially numbered.
VENDOR: Name, address and phone number of vendor.
VENDOR NUMBER: 7 digit number assigned by OA to identify as specific vendor.
FISCAL YEAR: (already completed).
AGREEMENT NUMBER: Complete your agreement number.
AGENCY CODE: (already completed).
COST CENTER CODE: (already completed).
OBJECT CODE: (already completed).

SECTON A

SERVICE DESCRIPTION: Services being billed for (i.e., assessment, functional living rehabilitation, day program, recreation, etc.)
SERVICE CODE: Enter service code listed below.
NUMBER OF CLIENTS: Number of clients who received the service.
TOTAL NUMBER OF UNITS: Total number of units billed for this service.
MONTH: 2 digit month the services invoice applies.
TOTAL ($) SERVICE AMOUNT BILLED: Total amount due by service.
GRAND TOTAL ($) AMOUNT BILLED: Total amount due.
AUTHORIZED SIGNATURE: Authorized signature of person authorized to sign invoice and date signed.
APPROVAL SIGNATURE: Head Injury Program approval signature.

SECTION B

CLIENT NAME:
MONTH: 2 digit month the services invoice applies.
SERVICE CODE: Enter service code listed below.
TOTAL UNITS AUTHORIZED: Total number of units that have been approved.
TOTAL UNITS USED: Total number of approved units that have been used.
UNITS USED THIS MONTH: Units billed for client this month.
COST PER UNIT
TOTAL ($) BILLED THIS MONTH: Unit times (x) unit cost.
PAGE TOTAL: Total amount of services billed to the state on this page only.
AUTHORIZED SIGNATURE: Of person authorized to sign invoice and date signed.
APPROVAL SIGNATURE: Head Injury Program approval signature.

SERVICE CODE

001 Functional Living Rehabilitation
002 Day Activity Program
003 In-Home Support
004 Pre-Vocational-Pre-Employment Training
005 Recreation Services
006 Transportation-Program
007 Supported Employment-Long Term Extended Group Job Supervision
008 Supported Employment-Long Term Follow-Up
009 Community Support Services
010 Special Instruction
011 Physical Therapy Evaluation/Therapy
012 Occupational Therapy Evaluation/Therapy
013 Speech/Language Therapy Evaluation/Therapy
014 Psychologist/Neuropsychologist Evaluation
015 Counseling Psychologist
016 Counseling Social Worker
017 Counseling Licensed Counselor

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SECTION B - ITEMIZATION OF BILLING (Should correspond to Section A)

PAGE _____ OF _____

CLIENT NAME	MONTH	SERVICE CODE	TOTAL UNITS AUTHORIZED	TOTAL UNITS USED	UNITS USED THIS MONTH	COST PER UNIT	TOTAL ($) BILLED THIS MONTH
						PAGE TOTAL	$

I certify that the services have been rendered in accordance with the Provider Agreement and that I have not received prior payment for the services. If payment is received from another source, the Department of Health will be either reimbursed up to the amount involved or the amount received will be deducted from the amount billed to the state. I also certify that the services billed to the Department of Health are provided to clients who have suffered a head injury as defined in the Provider Manual and that the clients are Missouri residents.

AUTHORIZED SIGNATURE	DATE	APPROVAL SIGNATURE	DATE

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