



Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation,
Reimbursement and Procedure of
General Applicability

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES**
Division 70—MO HealthNet Division
**Chapter 3—Conditions of Provider
Participation, Reimbursement and
Procedure of General Applicability**

**13 CSR 70-3.020 Title XIX Provider
Enrollment**

PURPOSE: This rule establishes the basis on which providers and vendors of health care services under the MO HealthNet program may be admitted to or denied enrollment in the program and lists the grounds upon which enrollment may be denied.

(1) The following definitions will be used in administering this rule:

(A) Affiliates—Persons having an overt, covert, or conspiratorial relationship so that any one of them directly or indirectly controls or has the power to control another;

(B) Applying provider—Any person who has submitted a provider enrollment application or request for enrollment in the MO HealthNet program;

(C) Closed-end provider agreement—An agreement that is for a specific period of time not to exceed twelve (12) months and that must be renewed in order for the provider to continue to participate in the MO HealthNet program;

(D) Fiscal agent—An organization under contract to the state MO HealthNet agency for providing services in the administration of the MO HealthNet program;

(E) Limited provider agreement—The granting of MO HealthNet enrollment to an applying provider by the single state agency upon the condition that the applying provider perform services, deliver supplies, or otherwise participate in the program only in adherence to or subject to specially set out conditions agreed to by the applying provider prior to enrollment;

(F) Medicaid agency or the agency—The single state agency administering or supervising the administration of a state Medicaid plan;

(G) Open-end provider agreement—An agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

(H) Participation—The ability and authority to provide services or merchandise to eligible MO HealthNet participants and to receive payment from the MO HealthNet program for the services or merchandise;

(I) Provider—Any person having an effective, valid, and current written provider enrollment application and application for

provider direct deposit with the MO HealthNet agency for the purpose of providing services to eligible participants and obtaining reimbursement excluding, for the purposes of this rule only, all persons receiving reimbursement in their capacity as owners or operators of a licensed nursing home;

(J) Provider enrollment application—A signed writing utilizing forms specified by the single state agency, containing all applicable information requested and submitted by a provider of medical assistance services for the purpose of enrolling in the MO HealthNet program;

(K) Person—Any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity;

(L) Termination from participation—The ending of participation in the Medicaid program; and

(M) Application for provider direct deposit—A signed writing utilizing forms specified by the single state agency containing all applicable information requested and submitted by a provider of medical assistance services for the purpose of having MO HealthNet checks automatically deposited to an authorized bank account.

(2) Duties of the Single State Agency.

(A) Upon receiving a provider enrollment application and application for provider direct deposit, the single state agency shall record receipt of the applications and conduct whatever lawful investigation which, in the discretion of the MO HealthNet agency, is necessary to verify, supplement, or change the information contained in the application.

(B) If, in the discretion of the MO HealthNet agency, further information is needed from the applying provider to verify or supplement a provider enrollment application or application for direct deposit, the MO HealthNet agency shall immediately make a clear and precise request to the provider for the information and inform the prospective provider whether or not the applications will be withheld pending receipt of the requested information.

(C) The single state agency, within ninety (90) calendar days after receiving an application, shall complete its investigation and determine whether to deny or allow enrollment of the applying provider. The MO HealthNet agency's decision shall be made known to the applying provider within ninety-five (95) calendar days after the application was received by the agency. A denial of enrollment shall be made known to an applying provider giving the reason(s) for the denial in writing. The written notice of denial

will be effective upon the date it is mailed by the single state agency to the address entered on the application by the provider.

(D) In the event that the applications cannot be fully investigated by the single state agency within ninety (90) days of receipt, the MO HealthNet agency, upon written notice to the applying provider, may extend the time for conducting the investigation for a period not to exceed one hundred twenty (120) calendar days from the date of receipt of the applications by the MO HealthNet agency. The MO HealthNet agency must send the notice of delay to the applying provider within sixty (60) calendar days from the time the application in question was received.

(3) The single state agency, at its discretion, may deny or limit an applying provider's enrollment and participation in the MO HealthNet program for any one (1) of the following reasons:

(A) A false representation or omission of any material fact or information required or requested by the single state agency pursuant to an applying provider making application to enroll. This shall include material facts or omissions about previous Medicaid participation in Missouri or any other state of the United States;

(B) Previous or current involuntary surrender, removal, termination, suspension, ineligibility, or otherwise involuntary disqualification of the applying provider's Medicaid participation in Missouri or any other state of the United States;

(C) Previous or current involuntary surrender, removal, termination, suspension, or otherwise involuntary disqualification from participation in Medicare;

(D) Previous or current involuntary surrender, removal, termination, suspension, ineligibility, or otherwise involuntary disqualification from participation in another governmental or private medical insurance program. This includes, but is not limited to, programs such as Workers' Compensation and Special Health Needs. For the purposes of subsections (3)(B)–(D), involuntary surrender, removal, termination, suspension, ineligibility, or other involuntary disqualification shall include withdrawal from medical assistance or medical insurance program participation arising from or as a result of any adverse action by a government agency, licensing authority, or criminal prosecution authority of Missouri or any other state or the federal government including Medicare;

(E) Regardless of changes in control or ownership, the existence of any amount due the single state agency which is the result of an overpayment under the MO HealthNet



program of which the applying provider or former owner, regardless of when the services were rendered, has had notice. Any amount due which is the subject of a plan of restitution shall not be considered in applying this section unless the applying provider is in default of the plan of restitution in which case enrollment may be denied or limited;

(F) Previous or current conviction of any crime relating to the applying provider's professional, business, or past participation in Medicaid, Medicare, or any other public or private medical insurance program;

(G) Any civil or criminal fraud against the MO HealthNet program or any other public or private medical insurance program;

(H) Any termination, removal, suspension, revocation, denial or consented surrender, or other involuntary disqualification of any license, permit, certificate, or registration related to the applying provider's business or profession in Missouri or any other state of the United States. Any such license, permit, certificate, or registration which has been denied or lost by the provider for reasons not related to matters of professional competence in the practice of the applying provider's profession, upon proof of reinstatement, shall not be considered by the agency in its decision to enroll the applying providers unless the conduct is harmful or dangerous to the mental or physical health of a patient;

(I) Any false representation or omission of a material fact in making application for any license, permit, certificate, or registration related to the applying provider's profession or business in Missouri or any other state of the United States;

(J) Any previous failure to correct deficiencies in provider operation after receiving written notice of the deficiencies from the single state agency;

(K) Any previous violation of any regulation or statute relating to the applying provider's participation in the MO HealthNet program;

(L) Failure to supply further information to the single state agency after receiving a written request for further information pursuant to a provider enrollment application or application for provider direct deposit;

(M) Failure to affix a proper signature to a provider enrollment application, application for provider direct deposit, or any other enrollment forms. Submission of any application bearing a signature that conceals the involvement in the provider's operation of a person who would otherwise be ineligible for Medicaid participation shall be grounds for denial of enrollment by the single state agency. Otherwise, the single state agency shall give the applying provider an opportunity to

provide a proper signature and, after that, consider the application as if the proper signature was originally affixed;

(N) A previous or current conviction or a plea of guilty to a misdemeanor or felony charge, including any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole relating to:

1. Endangering the welfare of a child;

2. Abusing or neglecting a resident, patient, or client;

3. Misappropriating funds or property belonging to a resident, patient, or client; or

4. Falsifying documentation verifying delivery of services to a personal care assistance services consumer;

(O) Placement on the "Family Care Safety Registry" as mandated by sections 210.900–210.936, RSMo;

(P) Placement on the "Missouri Sex Offender Registry" as mandated by sections 589.400–589.425 and 43.650, RSMo; or

(Q) Failure to complete an application for provider direct deposit as required by 13 CSR 70-3.140.

(4) After investigation and review of the applying provider's provider enrollment application and application for provider direct deposit and consideration of all the information, facts, and circumstances relevant to the applications, including, but not limited to, a review of the applying provider's affiliates, the single state agency, at its discretion, in the best interest of the MO HealthNet program, will make one (1) of the following determinations:

(A) Enroll the applying provider in an open-ended provider agreement;

(B) Deny or limit the application of an applying provider based on the abuse, fraud, or deficiencies of an affiliate, provided that each decision to deny or limit is based on a case-by-case evaluation, taking into consideration all relevant facts and circumstances known to the single state agency. The program abuse, fraud, regulatory violation, or deficiencies of a past or present affiliate of an applying provider may be imputed to the applying provider where the conduct of a past or present affiliate was accomplished with the knowledge or approval of the applying provider; or

(C) Deny or limit the applying provider's enrollment for one (1) or more of the reasons in subsections (3)(A)–(Q).

(5) Denial of enrollment shall preclude any person from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, affiliate,

partner, or any other association to the single state agency or its fiscal agents for any services or supplies delivered under the MO HealthNet program whose enrollment as a MO HealthNet provider has been denied. Any claims submitted by a nonprovider through any clinic, group, corporation, affiliate, partner, or any other association and paid shall constitute overpayments.

(6) No clinic, group, corporation, partnership, affiliate, or other association may submit claims for payment to the single state agency or its fiscal agent for any services or supplies provided by a person within each association who has been denied enrollment in the MO HealthNet program. Any claims for payment submitted and paid under these circumstances shall constitute overpayments.

(7) The provider shall advise the single state agency, in writing, on enrollment forms specified by the single state agency, of any changes affecting the provider's enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days. The Provider Enrollment Unit within the division is responsible for determining whether a current MO HealthNet provider record shall be updated or a new MO HealthNet provider record is created. A new MO HealthNet provider record is not created for any changes, including, but not limited to, change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacement facilities, whether they are at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued. If a new provider record is created in error due to change information being withheld at the time of application, the new MO HealthNet provider record shall be made inactive, the existing provider record will be made active, the existing provider record shall be updated, and the provider may be subject to sanction. The division shall issue payments to the entity identified in the current MO HealthNet provider enrollment application. Regardless of changes in control or ownership, the division shall recover from the entity identified in the current MO HealthNet provider enrollment application liabilities, sanctions, and penalties pertaining to the MO HealthNet program,



regardless of when the services were rendered.

(8) MO HealthNet provider identifiers are contingent upon the applying provider receiving a favorable determination of compliance with Civil Rights requirements from the Office of Civil Rights (OCR). If OCR approval is not obtained and maintained, any reimbursement received shall be recouped.

(9) The provider is responsible for all services provided and all claims filed using her/his MO HealthNet provider identifier regardless to whom the reimbursement is paid and regardless of whom in her/his employ or services produced or submitted the MO HealthNet claim, or both. The provider is responsible for submitting proper diagnosis codes, procedure codes, and billing codes. When the length of time actually spent providing a service (begin and end time) is required to be documented, the provider is responsible for documenting such length of time by documenting the starting clock time and the end clock time, except for services as specified pursuant to 13 CSR 70-91.010(4)(A), Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in the provider's employ or services produced or submitted the MO HealthNet claim.

(10) MO HealthNet provider identifiers shall not be released to any non-governmental entity, except the enrolled provider, by the MO HealthNet Division or its agents.

(11) MO HealthNet reimbursement shall not be made for any services performed by an individual not enrolled as a MO HealthNet provider, except for those services performed by the employee of the enrolled provider who is acting within their scope of practice and under the direct supervision of the enrolled provider. For example, an enrolled psychology or therapy provider may only bill for services that they actually perform. Psychology, therapy, and psychiatric services reimbursed through the physician program do not allow billing for supervised services.

(12) A provider that receives payment or makes payment of five (5) million dollars or more in a federal fiscal year under the MO HealthNet program must annually attest that the provider complies with the provisions of section 6032 of the federal Deficit Reduction Act of 2005. If a provider furnishes items or services at more than a single location or under more than one (1) contractual or other payment arrangement, the provisions apply to

that provider if the aggregate payments total five (5) million dollars or more. A provider meeting this dollar threshold and having more than one (1) federal tax identification number shall provide the single state agency written notification of each associated federal tax identification number, each associated provider name, and each associated MO HealthNet provider identifier by September 30 of each year. The provider's annual attestation must be made by March 1 of each year. The provider must provide a copy of the attestation within thirty (30) days upon the request of the single state agency. Any provider that claims an exemption from the provisions of section 6032 of the federal Deficit Reduction Act of 2005 must provide proof of such exemption within thirty (30) days upon the request of the single state agency.

AUTHORITY: sections 208.159, 208.164, and 210.924, RSMo 2000 and sections 208.153 and 208.201, RSMo Supp. 2009. This rule was previously filed as 13 CSR 40-81.165. Original rule filed June 14, 1982, effective Sept. 11, 1982. Amended: Filed July 30, 2002, effective Feb. 28, 2003. Amended: Filed April 29, 2005, effective Oct. 30, 2005. Amended: Filed Nov. 1, 2005, effective June 30, 2006. Amended: Filed March 30, 2007, effective Oct. 30, 2007. Amended: Filed June 1, 2010, effective Dec. 30, 2010.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; 208.159, RSMo 1979; 208.164, RSMo 1982, amended 1995; 208.201, RSMo 1987, amended 2007; and 210.924, RSMo 1999.*

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services

PURPOSE: This rule establishes the basis on which certain claims for MO HealthNet services or merchandise will be determined to be false or fraudulent and lists the sanctions which may be imposed and the method of imposing those sanctions.

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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The MO HealthNet program shall be administered by the Department of Social Services, MO HealthNet Division. The 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 and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.

(2) The following definitions will be used in administering this rule:

(A) "Adequate documentation" means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. "Adequate medical records" are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered. An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:

1. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;
2. An accurate, complete, and legible description of each service(s) provided;
3. Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to MO HealthNet. Services provided by an individual under the direction or supervision are not reimbursed by MO HealthNet. Services provided by a person not enrolled with MO



HealthNet are not reimbursed by MO HealthNet;

4. The name of the referring entity, when applicable;

5. The date of service (month/day/year);

6. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services American Medical Association Current Procedural Terminology procedure codes 99291-99292 and targeted case management services administered through the Department of Mental Health and as specified under 13 CSR 70-91.010 Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00-4:30 p.m.) must be documented;

7. The setting in which the service was rendered;

8. The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "nonhospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures;

9. The need for the service(s) in relationship to the MO HealthNet participant's treatment plan;

10. The MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes);

11. Long-term care facilities shall be exempt from the seventy-two (72)-hour documentation requirements rules applying to paragraphs (2)(A)9. and (2)(A)10. However, applicable documentation should be contained and available in the entirety of the medical record;

12. For applicable programs, it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and training records of staff; and

13. For targeted case management services administered through the Department of Mental Health, documentation shall include:

A. First name, last name, and either middle initial or date of birth of the MO HealthNet participant;

B. An accurate, complete, and legible case note of each service provided;

C. Name of the case manager providing the service;

D. Date the service was provided (month/day/year);

E. Amount of time in minutes/hour(s) spent completing the activity;

F. Setting in which the service was rendered;

G. Individual treatment plan or person centered plan with regular updates;

H. Progress notes;

I. Discharge summaries when applicable; and

J. Other relevant documents referenced in the case note such as letters, forms, quarterly reports, and plans of care;

(B) Affiliates means persons having an overt, covert, or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another;

(C) Closed-end provider agreement means an agreement that is for a specified period of time, not to exceed twelve (12) months, and that must be renewed in order for the provider to continue to participate in the MO HealthNet program;

(D) Contemporaneous means at the time the service was performed or within seventy-two (72) hours of the time the service was provided;

(E) Federal health care program means a program as defined in section 1128B(f) of the Social Security Act;

(F) Fiscal agent means an organization under contract to the state MO HealthNet agency for providing any services in the administration of the MO HealthNet program;

(G) MO HealthNet agency or the agency means the single state agency administering or supervising the administration of a state Medicaid plan;

(H) Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

(I) Participation means the ability and authority to provide services or merchandise to eligible MO HealthNet participants and to receive payment from the MO HealthNet program for those services or merchandise;

(J) Person means any natural person, company, firm, partnership, unincorporated association, corporation, or other legal entity;

(K) Provider means an individual, firm, corporation, pharmacy, hospital, long-term care facility, association, or institution which has a provider agreement to provide services to a participant pursuant to Chapter 208, RSMo;

(L) Record means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays, and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received. MO HealthNet claim for payment information,

appointment books, financial ledgers, financial journals, or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;

(M) Supervision means to direct an employee of the provider in the performance of a covered and allowable service such as under the MO HealthNet dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the MO HealthNet physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be cosigned by the enrolled billing provider;

(N) Suspension from participation means an exclusion from participation for a specified period of time;

(O) Suspension of payments means placement of payments due a provider in an escrow account;

(P) Termination from participation means the ending of participation in the MO HealthNet program; and

(Q) Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

(3) Program Violations.

(A) Sanctions may be imposed by the MO HealthNet agency against a provider for any one (1) or more of the following reasons:

1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to MO HealthNet;

2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services or billing for higher level of service or increased number of units from those actually ordered or performed or both, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;



3. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements or for the purpose of obtaining payments in order to avoid the effect of those changes;

4. Failing to make available, and disclosing to the MO HealthNet agency or its authorized agents, all records relating to services provided to MO HealthNet participants or records relating to MO HealthNet payments, whether or not the records are commingled with non-Title XIX (Medicaid) records. All records must be kept a minimum of five (5) years from the date of service unless a more specific provider regulation applies. The minimum five (5)-year retention of records requirement continues to apply in the event of a change of ownership or discontinuing enrollment in MO HealthNet. Services billed to the MO HealthNet agency that are not adequately documented in the patient's medical records or for which there is no record that services were performed shall be considered a violation of this section. Copies of records must be provided upon request of the MO HealthNet agency or its authorized agents, regardless of the media in which they are kept. Failure to make these records available on a timely basis at the same site at which the services were rendered or at the provider's address of record with the MO HealthNet agency, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction. Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction;

5. Failing to provide and maintain quality, necessary, and appropriate services, including adequate staffing for long-term care facility MO HealthNet participants, within accepted medical community standards as adjudged by a body of peers, as set forth in both federal and state statutes or regulations. Failure shall be documented by repeat discrepancies. The discrepancies may be determined by a peer review committee, medical review teams, independent professional review teams, utilization review committees, or by Professional Standards Review Organizations (PSRO). The medical review may be conducted by qualified peers employed by the single state agency;

6. Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program or continuing the conduct following notification that the conduct should cease. This will include inappro-

priate or improper actions relating to the management of participants' personal funds or other funds;

7. Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Hower-ton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the MO HealthNet claim form;

8. Utilizing or abusing the MO Health-Net program as evidenced by a documented pattern of inducing, furnishing, or otherwise causing a participant to receive services or merchandise not otherwise required or requested by the participant, attending physician, or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs, or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered;

9. Rebating or accepting a fee or portion of a fee or charge for a MO HealthNet patient referral; or collecting a portion of the service fee from the participant, except this shall not apply to MO HealthNet services for which participants are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.050 and 13 CSR 70-4.051;

10. Violating any provision of the State Medical Assistance Act or any corresponding rule;

11. Submitting a false or fraudulent application for provider status which misrepresents material facts. This shall include concealment or misrepresentation of material facts required on any provider agreements or questionnaires submitted by affiliates when the provider knew or should have known the contents of the submitted documents;

12. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions, or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri, or any

other state or territory, where the violation is reasonably related to the provider's qualifications, functions, or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude, or an act of violence;

13. Failing to meet standards required by state or federal law for participation (for example, licensure);

14. Exclusion from the Medicare program or any other federal health care program;

15. Failing to accept MO HealthNet payment as payment in full for covered services or collecting additional payment from a participant or responsible person, except this shall not apply to MO HealthNet services for which participants are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.050 and 13 CSR 70-4.051;

16. Refusing to execute a new provider agreement when requested to do so by the single state agency in order to preserve the single state agency's compliance with federal and state requirements; or failure to execute an agreement within twenty (20) days for compliance purposes;

17. Failing to correct deficiencies in provider operations within ten (10) days or date specified after receiving written notice of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;

18. Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful, or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender, or other disqualification of all or part of any license, permit, certificate, or registration related to the provider's business or profession in Missouri or any other state or territory of the United States;

19. Being suspended or terminated from participation in another governmental medical program such as Workers' Compensation, Crippled Children's Services, Rehabilitation Services, Title XX Social Service Block Grant, or Medicare;

20. Using fraudulent billing practices arising from billings to third parties for costs of services or merchandise or for negligent practice resulting in death or injury or substandard care to persons including, but not limited to, the provider's patients;

21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments prior to the allowed forty-five (45) days



which the provider has to refund the requested amount;

22. Billing the MO HealthNet program more than once for the same service when the billings were not caused by the single state agency or its agents;

23. Billing the state MO HealthNet program for services not provided prior to the date of billing (prebilling), except in the case of prepaid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the MO HealthNet program;

24. Failing to reverse or credit back to the medical assistance program (MO HealthNet) within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the participant; for example, prescriptions that were returned to stock because they were not picked up;

25. Conducting any action resulting in a reduction or depletion of a long-term care facility MO HealthNet participant's personal funds or reserve account, unless specifically authorized in writing by the participant, relative, or responsible person;

26. Submitting claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the MO HealthNet dental, physician, or nurse midwife programs where such claims may be submitted only if the individually enrolled provider directly supervised the person who actually performed the service and the person was employed by the enrolled provider at the time the service was rendered. All claims for psychiatric, psychological counseling, speech therapy, physical therapy, and occupational therapy services may only be billed by the individually enrolled provider who actually performs the service, as supervision is noncovered for these services. Services performed by a nonenrolled person due to MO HealthNet sanction, whether or not the person was under supervision of the enrolled provider, is a noncovered service;

27. Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a MO HealthNet provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet is also prohibited. Payment includes, without limitation, any kickback, bribe, or rebate made,

either directly or indirectly, in cash or in-kind;

28. Billing for services through an agent, which were upgraded from those actually ordered, performed; or billing or coding services, either directly or through an agent, in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in MO HealthNet policy for payment in a total payment less than the aggregate of the improperly separated services; or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;

29. Conducting civil or criminal fraud against the MO HealthNet program or any other state Medicaid (medical assistance) program, or any criminal fraud related to the conduct of the provider's profession or business;

30. Having sanctions or any other adverse action invoked by another state Medicaid program;

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication, or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. For providers other than long-term care facilities, failing to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause;

34. Removing or coercing from the possession or control of a participant any item of

durable medical equipment which has reached MO HealthNet-defined purchase price through MO HealthNet rental payments or otherwise become the property of the participant without paying fair market value to the participant;

35. Failing to timely submit civil rights compliance data or information or failure to timely take corrective action for civil rights compliance deficiencies within thirty (30) days after notification of these deficiencies or failure to cooperate or supply information required or requested by civil rights compliance officers of the single state agency;

36. Billing the MO HealthNet program for services rendered to a participant in a long-term care facility when the resident resided in a portion of the facility which was not MO HealthNet-certified or properly licensed or was placed in a nonlicensed or MO HealthNet-noncertified bed;

37. Failure to comply with the provisions of the Missouri Department of Social Services, MO HealthNet Division Title XIX Participation Agreement with the provider relating to health care services;

38. Failure to maintain documentation which is to be made contemporaneously to the date of service;

39. Failure to maintain records for services provided and all billing done under his/her provider number regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both;

40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim;

41. Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program, regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both;

42. Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider. MO HealthNet will reimburse only one (1) provider for the exact same service;

43. Failing to make an annual attestation of compliance with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005 by March 1 of each year, or failing to



provide a requested copy of an attestation, or failing to provide written notification of having more than one (1) federal tax identification number by September 30 of each year, or failing to provide requested proof of a claimed exemption from the provisions of section 6032 of the federal Deficit Reduction Act of 2005; and

44. Failing to advise the single state agency, in writing, on enrollment forms specified by the single state agency, of any changes affecting the provider's enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days.

(4) Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (3) of this rule:

(A) Failure to respond to notice of overpayments or notice of deficiencies in provider operations within the specified forty-five (45)-day time limit shall be considered cause to withhold future provider payments until the situation in question is resolved;

(B) Termination from participation in the MO HealthNet program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the MO HealthNet program for a specified period of time;

(D) Suspension or withholding of payments to a provider;

(E) Referral to peer review committees including PSROs or utilization review committees;

(F) Recoupment from future provider payments;

(G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

(J) One hundred percent (100%) review of the provider's claims prior to payment;

(K) Referral to the state licensing board for investigation;

(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF), or ICF/mentally retarded (MR) that no longer meets the applicable conditions of participation (for SNFs)

or standards (for ICFs and ICF/MRs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

(5) Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the MO HealthNet agency. The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to MO HealthNet participants, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;

2. Extent of violations—The state MO HealthNet agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of MO HealthNet claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred. The MO HealthNet agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider's MO HealthNet claims. When records are examined pertaining to part of a provider's MO HealthNet claims, no random selection process in choosing the claims for review as set forth in 13 CSR 70-3.130 need be utilized by the MO HealthNet agency. But, if the random selection process is not used, the MO HealthNet agency may not construe violations found in the partial review to be an indication that the extent of the violations in any unreviewed claims would exist to the same or greater extent;

3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the

subsequent violations are of a different nature;

4. Prior imposition of sanctions—The MO HealthNet agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the MO HealthNet program, any other governmental medical program, Medicare, or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection;

5. Prior provision of provider education—In cases where sanctions are being considered for billing deficiencies only, the MO HealthNet agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions; and

6. Actions taken or recommended by peer review groups, licensing boards, or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

(B) Where a provider has been convicted of defrauding any Medicaid program, has been previously sanctioned due to program abuse, has been terminated from the Medicare program, the MO HealthNet agency shall terminate the provider from participation in the MO HealthNet program.

(C) When a sanction involving the collection, recoupment, or withholding of MO HealthNet payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result



from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

(D) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to an affiliate when the affiliate knew or should have known of the provider's actions.

(E) Suspension or termination of any provider shall preclude the provider from participation in the MO HealthNet program, either personally or through claims submitted by any clinic, group, corporation, or other association to the single state agency or its fiscal agents for any services or supplies provided under the MO HealthNet program except for those services or supplies provided prior to the suspension or termination.

(F) No clinic, group, corporation, or other association which is a provider of services shall submit claims for payment to the single state agency or its fiscal agents for any services or supplies provided by, or under the supervision of, a person within the organization who has been suspended or terminated from participation in the MO HealthNet program except for those services or supplies provided prior to the suspension or termination.

(G) When the provisions of the previously mentioned are violated by a provider of services which is a clinic, group, corporation, or other association, the single state agency may suspend or terminate the organization, the individual person, or both, within the organization who knew or should have known of the violation.

(H) When a provider has been sanctioned, the single state agency shall notify, as appropriate, the applicable professional society, board of registration or licensure, federal and state agencies of the finding made and the sanctions imposed.

(I) Where a provider's participation in the MO HealthNet program has been suspended or terminated, the single state agency shall notify the county offices of the suspensions or terminations.

(J) Except where termination has been imposed, a provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;

4. Instruction on the use and format of provider manuals;

5. Instruction on the use of procedure codes;

6. Key provisions of the MO HealthNet program;

7. Instruction on reimbursement rates; and

8. Instruction on how to inquire about coding or billing problems.

(K) Providers that have been suspended from the MO HealthNet program under subsections (4)(B) and (C) may be reenrolled in the MO HealthNet program upon expiration of the period of suspension from the program after making satisfactory assurances of future compliance. Providers that have been terminated from the MO HealthNet program under subsection (4)(B) may be reenrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

(6) Amounts Due the Department of Social Services From a Provider.

(A) If there exists an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. The notice shall be mailed to the address on the provider's enrollment record. If the amount due is not sooner paid to the Department of Social Services by or on behalf of the provider, the single state agency, forty-five (45) days from the date the provider receives the notice, established by a signed receipt of delivery or receipt of undelivered mail from the United States Post Office using the address on the provider's enrollment record, may take appropriate action to collect the overpayment. The single state agency may recover the overpayment by withholding from current MO HealthNet reimbursement. The withholding may be taken from one (1) or more payments until the funds withheld in the aggregate equal the amount due as stated in the notice.

(B) When a provider receives notice, established by a signed receipt of delivery, or receipt of undelivered mail from the United States Post Office using the address on the provider's enrollment record, of an overpayment and the amount due is in excess of one thousand dollars (\$1,000), the provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in

collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept, or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the provider receives notice of the overpayment, the MO HealthNet agency may take appropriate action to collect the balance of the amount due.

(C) If a plan agreed to and implemented under provisions of subsection (6)(B) for repayment of amounts due the Department of Social Services from a provider is breached, discontinued, or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, may begin to withhold payments or portions of payments until the entire amount due has been collected.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

(E) The single state agency may collect provider overpayments from any other enrolled provider when the other enrolled provider has received payment on behalf of the provider who incurred the overpayment (such as when a provider has directed payment to another enrolled provider). The single state agency may also collect provider overpayments from any enrolled provider with the same federal employer identification number (EIN) as the provider who incurred the overpayment. The state agency shall notify the other enrolled provider(s) forty-five (45) days prior to initiating the overpayment action. The notice shall be mailed to the address on the provider's(s') enrollment record. If the amount due is in excess of one thousand dollars (\$1,000), the other enrolled provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plan will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from the other enrolled provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and



reject, accept, or offer to accept a modified version of the other enrolled provider's plan for repayment. The single state agency shall notify the other enrolled provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the other enrolled provider receives notice of the overpayment, the Medicaid agency may take appropriate action to collect the balance of the amount due.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2008. This rule was previously filed as 13 CSR 40-81.160. Original rule filed Sept. 22, 1979, effective Feb. 11, 1980. Amended: Filed Nov. 25, 1981, effective March 11, 1982. Emergency amendment filed April 14, 1982, effective April 24, 1982, expired July 10, 1982. Amended: Filed April 14, 1982, effective July 11, 1982. Amended: Filed April 16, 1985, effective Sept. 1, 1985. Emergency amendment filed Dec. 5, 1986, effective Dec. 15, 1986, expired April 13, 1987. Amended: Filed Dec. 16, 1986, effective April 11, 1987. Amended: Filed Jan. 7, 1987, effective April 26, 1987. Emergency amendment filed April 15, 1988, effective April 25, 1988, expired Aug. 22, 1988. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Aug. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency amendment filed April 15, 1994, effective April 30, 1994, expired Aug. 13, 1994. Amended: Filed Feb. 16, 1994, effective Aug. 28, 1994. Amended: Filed May 16, 2005, effective Nov. 30, 2005. Amended: Filed July 3, 2006, effective Dec. 30, 2006. Amended: Filed Nov. 15, 2006, effective May 30, 2007. Amended: Filed March 30, 2007, effective Sept. 30, 2007. Amended: Filed Aug. 31, 2007, effective March 30, 2008. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.040 Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments

PURPOSE: This rule places a certain duty on Medicaid participating hospitals and other vendors to assist the Division of Family Services in making Medicaid third-party liability recoveries.

(1) All Medicaid participating hospitals or other vendors who have received reimbursement under Medicaid (Title XIX), or have made claim or anticipate making a claim for

reimbursement, and who shall receive a request from an attorney or insurance carrier for medical or other information pertaining to the Medicaid recipient for whom reimbursement has been received or claim made shall inform the attorney or insurance carrier that the Division of Family Services has the duty under section 208.153, RSMo to seek reimbursement from any source contractually or legally obligated to be primarily responsible to pay any moneys to or on behalf of the Medicaid recipient.

AUTHORITY: section 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.090. Original rule filed May 20, 1977, effective Sept. 11, 1977.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991.*

13 CSR 70-3.050 Obtaining Information From Providers of Medical Services

PURPOSE: This rule provides the basis for examination of the records of any provider who expects to receive payment from the Division of Family Services and for maintaining the confidentiality of any of those records.

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) Public Law 89-97, 1965 Amendment to the Social Security Act (42 U.S.C.A. Section 301), sections 201.151 and 208.153, RSMo, and other pertinent sections of Chapter 208, RSMo require Missouri to provide certain medical services to eligible individuals and further provide that these services may be obtained from any provider who has entered into an agreement for provision of medical services with the Missouri Division of Family Services. Therefore, to aid the Division of Family Services in determining the proper and correct payment for those services, the acceptance of these medical services and benefits by any applicant or recipient of public assistance benefits constitutes authorization

for the Division of Family Services, or its duly authorized representative, to examine all records pertaining to medical services provided the applicant or recipient in order that proper payment for the services may be made to the provider of services.

(2) Section 208.155, RSMo, regarding the confidentiality of all information concerning applicants for or recipients of medical services shall be confidential, shall be strictly adhered to.

AUTHORITY: section 207.020, RSMo Supp. 1993. This rule was previously filed as 13 CSR 40-81.060. Original rule filed Sept. 29, 1975, effective Oct. 9, 1975.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993.*

13 CSR 70-3.060 Medicaid Program Payment of Claims for Medicare Part B Services

(Rescinded August 11, 1988)

AUTHORITY: sections 208.153, RSMo 1986 and 208.201, RSMo Supp. 1987. Original rule filed March 2, 1988, effective May 12, 1988. Emergency rescission filed April 29, 1988, effective May 9, 1988. Rescinded: Filed May 17, 1988, effective Aug. 11, 1988.

13 CSR 70-3.100 Filing of Claims, MO HealthNet Program

PURPOSE: This rule establishes the general provisions for submission or resubmission of claims and adjustments of claims to MO HealthNet.

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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Claim forms used for filing MO HealthNet services as appropriate to the provider of services are—

(A) Nursing Home Claim—electronic claim submission or individualized provider software when authorized by the state's fiscal agent;



(B) Pharmacy Claim—MO-8803, Revision 11/00 or POS, on-line claim format—NCPDP current version or electronic claim submission;

(C) Outpatient Hospital Claim—UB-04 CMS-1450 or electronic claim submission;

(D) Professional Services Claim—CMS-1500, Revision 12/90, or electronic claim submission;

(E) Dental Claim—American Dental Association (ADA) 2002, 2004 revision, Dental Form or electronic claim submission; or

(F) Inpatient Hospital Claim—UB-04 CMS-1450 or electronic claim submission.

(2) Specific claims filing instructions are modified as necessary for efficient and effective administration of the program as required by federal or state law or regulation. Reference the appropriate MO HealthNet provider manual, provider bulletins, and claim filing instructions for specific claim filing instructions information, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.

(3) Time Limit for Original Claim Filing. Claims from participating providers that request MO HealthNet reimbursement must be filed by the provider and received by the state agency within twelve (12) months from the date of service. The counting of the twelve (12)-month time limit begins with the date of service and ends with the date of receipt.

(A) Claims that have been initially filed with Medicare within the Medicare timely filing requirement and which require separate filing of an electronic claim with MO HealthNet will meet timely filing requirements by being submitted by the provider and received by the state agency within twelve (12) months from the date of service or six (6) months from the date on the Medicare provider's notice of the allowed claim. Claims denied by Medicare must be filed by the provider and received by the state agency within twelve (12) months from the date of service. The counting of the twelve (12)-month time limit begins with the date of service and ends with the date of receipt. Medicare/Medicaid crossover claims must be submitted through an electronic media. Claims that have been initially filed with Medicare and which require separate filing of an electronic claim with MO HealthNet must include the Medicare internal control number or the Medicare claim identification number found on the

Medicare provider's notice. Paper billings for Medicare/Medicaid crossover claims will not be processed. Paper billings (claims) will not be returned to the provider. Paper billings will not be retained by the MO HealthNet Division or its contractors.

(B) Third-Party Resources.

1. Claims for participants who have a third-party resource that is primary to MO HealthNet must be submitted to the third-party resource for adjudication unless otherwise specified by the MO HealthNet Division. Documentation specified by the MO HealthNet Division which indicates the third-party resource's adjudication of the claim must be attached to the claim filed for MO HealthNet reimbursement. If the MO HealthNet Division waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the MO HealthNet timely filing requirement by being filed by the provider and received by the state agency within twelve (12) months from the date of service.

2. The twelve (12)-month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the twelve (12) months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the MO HealthNet state agency. Under this set of circumstances, the provider may file a claim with the MO HealthNet agency later than twelve (12) months from the date of services. The provider must submit this type of claim to the Third Party Liability Unit at Post Office Box 6500, Jefferson City, MO 65102-6500 for special handling. The MO HealthNet state agency may accept and pay this specific type of claim without regard to the twelve (12)-month timely filing rule; however, all claims must be filed for MO HealthNet reimbursement within twenty-four (24) months from the date of service in order to be paid.

(4) Time Limit for Resubmission of a Claim After Twelve (12) Months From the Date of Service.

(A) Claims which have been originally submitted and received within twelve (12) months from the date of service and denied

or returned to the provider may be resubmitted within twenty-four (24) months of the date of service. Those claims must be filed by the provider and received by the state agency within twenty-four (24) months from the date of service. The counting of the twenty-four (24)-month time limit begins with the date of service and ends with the date of receipt.

(B) Documentation specified by the MO HealthNet Division in MO HealthNet provider manuals which indicates the claim was originally received timely must be attached to the resubmission or entered on the claim form (electronic or paper).

(C) Claims will not be paid when filed by the provider and received by the state agency beyond twenty-four (24) months from the date of service.

(5) Denial. Claims that are not submitted in a timely manner and as described in sections (1) and (2) of this rule will be denied. Except that at any time in accordance with a court order, the agency may make payments to carry out hearing decision, corrective action, or court order to others in the same situation as those directly affected by it. The agency may make payment at any time when a claim was denied due to state agency error or delay, as determined by the state agency. In order for payment to be made, the state agency must be informed of any claims denied due to state agency error or delay within six (6) months from the date of the remittance advice on which the error occurred; or within six (6) months of the date of completion or determination in the case of a delay; or twelve (12) months from the date of service, whichever is longer.

(6) Time Limit for Filing an Adjustment. Adjustments to a paid claim must be filed within twenty-four (24) months from the date of the remittance advice on which payment was made. If an adjustment processed within the twenty-four (24) months from the date of the remittance advice limitation necessitates filing a corrected claim, the timely filing limit for resubmitting the corrected claim is limited to ninety (90) days from the date of the remittance advice indicating recoupment, or twelve (12) months from the date of service, whichever is longer.

(7) Definitions.

(A) Claim A—claim is each individual line item of service on a claim form, for which a charge is billed by a provider, for all claim form types except inpatient hospital. An inpatient hospital service claim is all the billed charges contained on one (1) inpatient claim document.

(B) Date of payment/denial—The date of



payment or denial of a claim is the date on the remittance advice at the top center of each page under the words remittance advice.

(C) Date of receipt—The date of receipt of a claim is the date the claim is received by the state agency. For a claim which is processed, this date appears as a Julian date in the internal control number (ICN). For a claim which is returned to the provider, this date appears on the Return to Provider form letter.

(D) Date of service—The date of service which is used as the beginning point for determining the timely filing limit applies to the various claim types as follows:

1. Nursing home—The through date or ending date of service for each line item for each participant listed on the claim;

2. Pharmacy—The date dispensed for each line item for each individual participant listed on the paper claim form, or on electronically submitted claims through point of service (POS) or the Internet;

3. Outpatient hospital—The ending date of service for each individual line item on the claim;

4. Professional services (CMS-1500)—The ending date of service for each individual line item on the claim;

5. Dental—The date service was performed for each individual line item on the claim;

6. Inpatient hospital—The through date of service in the area indicating the claimed period of service; and

7. For service which involves the providing of dentures, hearing aids, eyeglasses, or items of durable medical equipment; for example, artificial larynx, braces, hospital beds, wheelchairs, the date of service will be the date of delivery or placement of the device or item.

(E) Internal control number (ICN)—The fiscal agent prints a thirteen (13)-digit number on each document it processes through the Medicaid Management Information System (MMIS). The year of receipt is indicated by the third and fourth digits and the Julian date appears as the fifth, sixth, and seventh digits. In an example ICN, 490600152006, 06 is the year 2006 and 001 is the Julian date for January 1.

(F) Medicare internal control number—The number assigned to a Medicare claim by the Medicare provider which is used for identification purposes. The Medicare internal control number is also referred to as the Medicare claim identification number.

(G) Julian date—In a Julian system, the days of a year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 1984, a leap year, June 15 is the 167th day of that

year, thus, 167 is the Julian date for June 15, 1984.

(H) Twelve (12)-month time limit—This unit is defined as three hundred sixty-six (366) days.

(I) Twenty-four (24)-month time limit—This unit is defined as seven hundred thirty-one (731) days.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2008. This rule was previously filed as 13 CSR 40-81.070 and 13 CSR 40-81.071. Original rule filed June 2, 1976, effective Oct. 11, 1976. Emergency rescission filed July 18, 1979, effective July 31, 1979, expired Nov. 10, 1979. Emergency rule filed July 18, 1979, effective Aug. 1, 1979, expired Nov. 10, 1979. Rescinded and readopted: Filed July 18, 1979, effective Nov. 11, 1979. Rescinded and readopted: Filed Sept. 12, 1984, effective Jan. 12, 1985. Amended: Filed April 21, 1992, effective Jan. 15, 1993. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed Sept. 23, 1993, effective May 9, 1994. Amended: Filed Sept. 28, 2001, effective March 30, 2002. Amended: Filed June 15, 2006, effective Dec. 30, 2006. Amended: Filed Jan. 2, 2008, effective June 30, 2008. Amended: Filed July 31, 2008, effective Jan. 30, 2009. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.105 Timely Payment of MO HealthNet Claims

PURPOSE: This rule advises MO HealthNet providers of the time frames in which they can expect payment for the service(s) they provide to MO HealthNet participants. This rule implements Section 1902(a)(37) of the federal Social Security Act.

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) As used in this rule, unless the context clearly indicates otherwise, the following terms shall mean:

(A) Claim A—bill submitted by a provider to the MO HealthNet Division for MO HealthNet reimbursement for a procedure, a set of procedures, or a service rendered a MO HealthNet participant for a given diagnosis or a set of related diagnoses;

(B) Clean claim—A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the state's claim system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(C) Date of payment—The date of the check or other form of payment;

(D) Date of receipt—The date the MO HealthNet Division receives the claim, as indicated by its date stamp on the claim;

(E) Nonpractitioner claim—Claims for the following services: inpatient hospital, state-operated mental health facility, outpatient hospital, inpatient psychiatric facility for individuals age twenty-one (21) and under, intermediate care facility for the mentally retarded (ICF/MR), home health services (personal care home and community-based services), family planning (rendered by a hospital—inpatient or outpatient), sterilization (rendered by a hospital—inpatient or outpatient), nursing facility; and durable medical equipment; and

(F) Practitioner claim—Claims for the following services: physician, dental, clinic, family planning (rendered by a physician, clinic or other practitioner), laboratory and X-ray services, prescribed drugs, early and periodic screening, rural health clinic, sterilization services (rendered by a physician, clinic or other practitioner), and other (chiropractors, podiatrists, psychologists, registered or licensed practical nurses providing private duty nursing services, optometrists, physical therapists, occupational therapists, speech pathologists, audiologists and Christian Science practitioners).

(2) In accordance with Title 42 of the Code of Federal Regulations part 447 section 45, the MO HealthNet Division, each fiscal year, will process and pay within thirty (30) days of the date of receipt, ninety percent (90%) of all clean claims from practitioners who are in individual or group practice, or who practice in shared health facilities and nonpractitioners.

(3) The MO HealthNet Division, each fiscal year, will process and pay within ninety (90)



days of the date of receipt, ninety-nine percent (99%) of all clean claims from practitioners who are in individual or group practice, or who practice in shared health facilities and nonpractitioners.

(4) The MO HealthNet Division must pay all other claims within twelve (12) months of the date of receipt. The time limitation does not apply to—

(A) Retroactive adjustments;

(B) Claims submitted by providers who are under investigation for fraud or abuse; and

(C) Claims submitted to both Medicare and Medicaid.

(5) The MO HealthNet Division may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

AUTHORITY: section 208.201, RSMo Supp. 2007. Original rule filed Dec. 11, 1991, effective June 25, 1992. Amended: Filed July 31, 2008, effective Jan. 30, 2009.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.110 Second Opinion Requirement Before Nonemergency Elective Surgical Operations

(Rescinded June 30, 2011)

AUTHORITY: section 207.020, RSMo Supp. 1993. This rule was previously filed as 13 CSR 40-81.052. Emergency rule filed Sept. 18, 1981, effective Sept. 28, 1981, expired Jan. 13, 1982. Original rule filed Sept. 18, 1981, effective Jan. 14, 1982. Rescinded: Filed Dec. 1, 2010, effective June 30, 2011.

13 CSR 70-3.120 Limitations on Payment of Out-of-State Nonemergency Medical Services

PURPOSE: This rule establishes a regulatory basis for implementation of prior authorization on all out-of-state nonemergency MO HealthNet-covered services.

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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made

available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) All nonemergency, MO HealthNet-covered services, except for those services exempted in section (6) of this rule, which are to be performed or furnished out-of-state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, must be prior authorized in accordance with policies and procedures established by the MO HealthNet Division before the services are provided.

(2) Nonemergency services, for the purpose of the prior authorization requirement, are those services which do not meet the definition of emergency. Emergency services are defined as those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after 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 a) placing the patient's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

(3) Out-of-state is defined as not within the physical boundaries of Missouri nor within the boundaries of any state which physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma, Tennessee) will be considered as being on the same MO HealthNet participation basis as providers of services located within Missouri for purposes of administration of this rule.

(4) The out-of-state provider of services must meet the requirements for participation in the MO HealthNet program and have a state-approved participation agreement in effect in order to receive reimbursement for any covered service, emergency or nonemergency.

(5) The patient's attending physician is responsible for obtaining prior authorization of the services s/he believes to be medically necessary.

(A) Failure to obtain prior authorization for the services shall result in no payment by the MO HealthNet program.

(B) All prior authorization requests must be submitted in accordance with policies and procedures established by the MO HealthNet

Division as stated in the respective *MO HealthNet Provider Manual* and provider bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, June 15, 2009. This rule does not incorporate any subsequent amendments or additions.

(C) Prior authorization by the MO HealthNet agency shall approve the medical necessity of the covered services to be performed only. It shall not guarantee payment as the participant must be eligible on the date the service was provided.

(D) Prior authorization expires one hundred eighty (180) days from the date a specific service was approved by the state.

(E) All requests for prior authorization must be submitted to the Participant Services Unit of the MO HealthNet Division. The physician who is referring the patient for the nonemergency services must call or write the MO HealthNet Division for authorization.

(F) Telephone prior authorizations may be granted.

(6) The following are exempt from the requirement for prior authorization of non-emergency MO HealthNet-covered services for out-of-state providers:

(A) All services provided individuals having both Medicare and MO HealthNet coverage for which Medicare does provide coverage and is the primary payer (crossover claims);

(B) All border state providers as defined in section (3) of this rule;

(C) All foster care children living outside Missouri. Nonemergency services which routinely require prior authorization will continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child. Foster care children are identified on the MO HealthNet ID card with a Type of Assistance (TOA) indicator of "D" or "Z"; and

(D) All independent laboratory and emergency ambulance services.

(7) All other policies and procedures applicable to the MO HealthNet program will be in effect for services provided by out-of-state providers.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2008. This rule was previously filed as 13 CSR 40-81.190. Emergency rule filed Sept. 18, 1981, effective Sept. 28, 1981, expired Jan. 13, 1982. Original rule filed Sept. 18, 1981, effective Jan. 14, 1982.*



Amended: Filed Oct. 21, 1994, effective June 30, 1995. Amended: Filed May 14, 2009, effective Nov. 30, 2009.

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.130 Computation of Provider Overpayment by Statistical Sampling

PURPOSE: This rule establishes the method where the billing forms or claims for payment submitted by Medicaid providers will be examined to determine compliance with Title XIX (Medicaid) Program requirements and proper payment, and sets forth the statistical methodology to be employed and the manner in which providers may challenge the results.

(1) The following definitions will be used in administering this rule:

(A) Adequate records means records from which services rendered and the amount of reimbursement received for services by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form required of good medical practice;

(B) Amount due means an amount of money owed to the Medicaid agency by a provider resulting from a finally determined overpayment;

(C) Claim for payment or claim means a document or electronically transmitted data submitted to the Medicaid agency for the purpose of obtaining payment by the Title XIX Medicaid Program. A claim for payment means any one (1) document regardless of how many services, dates of service or recipients to which it pertains. In the case of electronically transmitted claims for payment, a claim for payment means all services for each recipient for which reimbursement is sought in the transmitted information;

(D) Medicaid agency or the agency means the single state agency administering or supervising the administration of the state Medicaid plan;

(E) Overpayment means an amount of money paid to a provider by the Medicaid agency to which s/he was not entitled by reason of improper billing, error, fraud, abuse, lack of verification, or insufficient medical necessity;

(F) Participation means the ability and authority to provide services or merchandise to eligible Medicaid recipients and to receive payment from the Medicaid program for services or merchandise;

(G) Provider means any person, partner-

ship, corporation, not-for-profit corporation, professional corporation, or other business entity that enters into a contract or provider agreement with the Department of Social Services for the purpose of providing services to eligible persons and obtaining from the department or its divisions reimbursement for services;

(H) Records means any books, papers, journals, charts, treatment histories, medical histories, test and laboratory results, photographs, X rays, and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to Medicaid recipients and payments charged or received for services. Medicaid claim for payment information does not constitute adequate records. A provider must retain all records for five (5) years;

(I) Review group means all claims for payment or all claims relating to a specific service or a specific item or merchandise submitted by a provider between two (2) certain dates. To be valid, the review group beginning and ending dates must be established before the statistical sample is selected. If the dates are changed, a new statistical sample must be identified;

(J) Selected at random means the process where claims in a review group are assigned consecutive numbers and after the assignment, twenty-five percent (25%) of those numbers identified as the statistical sample by use of a random numbers table or computer-generated random numbers;

(K) Statistical sample means twenty-five percent (25%) of a review group of claims for payment submitted by a provider. The sample must be selected at random to be valid; and

(L) Supervision means the service was performed while the provider was physically present during the service or the provider was on the premises and readily available to give direction to the person actually performing the service.

(2) When the Medicaid agency determines that claims for payment submitted by a provider shall be reviewed, the following actions will be taken:

(A) A Review Group Selected. All claims for which the provider was not paid or for which a particular service or item of merchandise under review was not paid will be removed from the review group before a statistical sample is identified. The agency shall not use statistical sampling to determine overpayment where the review group consists of fewer than one hundred (100) claims for payment;

(B) A Statistical Sample Selected From the Review Group.

1. When the review group selected by the state agency exceeds five hundred (500) claims, the agency, at its discretion, may request that the provider whose claims are under review waive examination of a portion of the claims in a statistical sample. If a request results in a waiver, the state agency will not review claims in the randomly selected statistical sample in which the total aggregate amount paid for the claim document is less than a fixed amount specified in the waiver request. A waiver will not reduce the number of claims in the review group and calculations of underpayments or overpayments shall be made as if all claims in the randomly selected statistical sample had been reviewed.

2. At the sole discretion of the state agency, any request for waiver of a full statistical sample review may offer the provider the further option that it may elect to have the statistical sample selected from the review group by the following statistical sampling formula:

$$\text{Sample Size} = \frac{96}{1 + (96 \div \text{Review Group Size})}$$

The request for waiver shall contain the formula with the calculations completed for the size of the review group selected for the provider in question.

3. When a statistical sample has been selected by formula, the number of claims in the review group remains the same in calculating total overpayments or underpayments. A statistical sample selected by formula replaces the twenty-five percent (25%) statistical sample in calculating total overpayments or underpayments.

4. The state agency has the sole discretion both to request a waiver and whether to offer in this request an election to the provider to use a sample selected by statistical sampling formula. If a waiver is requested, the provider has the sole discretion whether to have the full twenty-five percent (25%) statistical sample reviewed or to waive examination of a portion of claims in a statistical sample. If the provider elects the waiver, only claims paid above a fixed amount will be reviewed or, if a statistical sampling formula option has been offered by the state agency, the provider has the sole discretion to elect the statistical sampling formula.

5. Once a provider has waived a full statistical sample review or has elected to have a sample selected by statistical sampling formula, the provider's decision may not be revoked or rescinded by the provider; and



(C) Each claim or each portion of a claim relating to a particular service or item of merchandise reviewed. The review process may include any one (1) or more of the following:

1. Determination of medical necessity by a qualified consultant or employee of the agency. The reimbursement received by the provider for services or merchandise determined to be medically unnecessary shall constitute an overpayment. Medically unnecessary includes services that are inappropriate or excessive for the diagnosis tested;

2. Determination of proper billing codes as required under program benefit limitations. The reimbursement received by the provider for services or merchandise through the use of improper billing codes or billing codes in excess of program benefit limitations shall constitute an overpayment;

3. Determination that services or merchandise were delivered by the provider in compliance with the requirements of 13 CSR 70-3.030(3)(A). The reimbursement received by the provider for services or merchandise delivered in violation of any provision of 13 CSR 70-3.030(3)(A) shall constitute an overpayment;

4. Determination that delivery of services or merchandise appearing on the reviewed claims is verified by adequate records kept by the provider. Reimbursement received by the provider for services or merchandise not verified by adequate records shall constitute an overpayment;

5. Determination that services or merchandise delivered by the provider were performed or delivered by the provider for services performed or merchandise delivered by another or without proper supervision shall constitute an overpayment;

6. Determination that services performed or merchandise delivered by the provider are verified by statements of the eligible recipients of the services or merchandise. Reimbursement received for services or merchandise not verified by the recipients shall constitute an overpayment; and

7. Determination that information submitted by the provider accompanying the claims for payment was adequate. This includes, but is not limited to, physician examination certifications, medical necessity forms, and test results. Reimbursement received by the provider for services or merchandise not accompanied by adequate information of this type shall constitute an overpayment.

(3) When a review of a provider's claims by statistical sampling has been completed, a total overpayment shall be computed by totaling all overpayments for the statistical sample

and subtracting all underpayments found in the sample to obtain a total overpayment. This total is then divided by the number of claims contained in the statistical sample to obtain an average overpayment for the sample. The total overpayment for the review will then be determined by multiplying the average sample overpayment by the number of claims in the review group. If there exists a net underpayment for the sample, then the average underpayment shall be computed in the same manner and the provider notified of the results.

(4) When a total overpayment has been computed by statistical sampling, the Medicaid agency may proceed to recover the full amount of the overpayment from the provider as an amount due. Recovery of the overpayment shall be accomplished according to the provisions of 13 CSR 70-3.030(6), except that in cases where the amount due was computed by statistical sample, the notice informing the provider of the amount due required by 13 CSR 70-3.030(6)(A) and (B) shall also contain the following information:

(A) The dates encompassed by the review group;

(B) The number of claims in the review group and, if applicable, what particular service or item or merchandise pertained to the review group;

(C) The number of claims in the statistical sample; and

(D) A generally summarized description of the reasons for the overpayment determinations with all claims in the statistical sample identified as to which overpayment description applies to each.

*AUTHORITY: section 208.165, RSMo 2000 and sections 208.153 and 208.201, RSMo Supp. 2010. * This rule was previously filed as 13 CSR 40-81.161. Original rule filed April 14, 1983, effective Oct. 13, 1983. Amended: Filed Sept. 17, 1986, effective Dec. 11, 1986. Emergency amendment filed Feb. 4, 1987, effective Feb. 14, 1987, expired April 25, 1987. Amended: Filed Feb. 4, 1987, effective June 11, 1987. Amended: Filed July 30, 2010, effective Feb. 28, 2011.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; 208.165, RSMo 1982; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.140 Direct Deposit of Provider Reimbursement

PURPOSE: This rule describes the procedures for the direct deposit of MO HealthNet provider payments. This requirement is being

implemented due to the reduction and consolidation of Department of Social Services' mail room staff with the Office of Administration; handling, cost for postage, printing, and mailing paper checks; and will eliminate the cost of returned or lost checks.

(1) Effective October 1, 2010, the MO HealthNet Division will require enrolled providers to have their MO HealthNet checks automatically deposited to an authorized bank account.

(2) MO HealthNet providers must complete the Application for Provider Direct Deposit Form MO 886-3089 available on the MO HealthNet Division website at www.dss.mo.gov/mhd, unless otherwise agreed upon by the Department of Social Services.

(A) The completed application authorizes the Office of Administration to deposit MO HealthNet payments into an authorized checking or savings account.

(B) A provider's account may only be debited when an error has occurred resulting in an erroneous payment to the provider.

(C) Direct deposit will begin following:

1. Submission of a properly completed application form to the Department of Social Services, MO HealthNet Division;

2. The successful processing of a test transaction through the banking system; and

3. Authorization to make payment using the direct deposit option by the MO HealthNet Division.

(D) The state will conduct direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Automated Clearing House Association and its member local Automated Clearing House Associations shall apply, as limited or modified by law.

(3) All direct deposit applications must be signed with an original signature by the provider enrolled in the MO HealthNet program when that provider is an individual. Applications on behalf of groups or businesses (except those described in this rule) must be signed with an original signature by the individual (officer) with fiscal responsibility for the group or business. Signature stamps or other facsimiles will not be accepted.

(4) The MO HealthNet Division will terminate or suspend the direct deposit option for administrative or legal actions, including, but not limited to, ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for



the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

AUTHORITY: section 208.201, RSMo Supp. 2009. Original rule filed Oct. 4, 1993, effective June 6, 1994. Amended: Filed June 1, 2010, effective Dec. 30, 2010.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.150 Authorization To Receive Payment for Medicaid Services

PURPOSE: This rule establishes who may receive payment for services furnished to a recipient of medical assistance by a provider who is subject to either the Federal Reimbursement Allowance (FRA) or the Nursing Facility Reimbursement Allowance (NFRA). This rule is necessary to comply with the terms and conditions required by the Health Care Financing Administration for approval of Missouri's III15 Demonstration Waiver.

(1) Authorization To Receive Payment. Payment for any services covered by the Missouri Medicaid program to a recipient eligible for medical assistance by an enrolled Medicaid provider who is subject to either the Federal Reimbursement Allowance (FRA) or the Nursing Facility Reimbursement Allowance (NFRA) shall be—

(A) By direct deposit to the provider's account at a bank or other financial institution;

(B) To a person or entity affiliated with the enrolled provider; or

(C) To a business agent, or to a government agency or a recipient specified by a court order, as permitted under federal regulations at 42 *Code of Federal Regulations* section 447.10(e) and (f).

(2) Two (2) or more unaffiliated providers may not by agreement or other joint action designate a common business agent or other recipient of their payments under the Missouri Medicaid program.

(3) Authorizations to receive payment that do not meet the foregoing requirements of section (1) of this rule shall be void upon the effective date of this rule.

AUTHORITY: sections 208.158 and 208.201, RSMo 1994. Original rule filed July 15, 1998, effective Jan. 30, 1999.*

**Original authority: 208.158, RSMo 1967 and 208.201, RSMo 1987.*

13 CSR 70-3.160 Electronic Submission of MO HealthNet Claims and Electronic Remittance Advices

PURPOSE: This rule implements the requirement that claims for reimbursement by the MO HealthNet program be submitted electronically and remittance advices be retrieved electronically.

(1) "Electronic claim" means a claim that is submitted via electronic media.

(2) Electronic submission of MO HealthNet claims for services rendered under the MO HealthNet program is required. A MO HealthNet claim may be paid only if submitted as an electronic claim for processing by the Medicaid Management Information System.

(A) To utilize the Internet for electronic claim submissions, the provider must apply online via the Application for MO HealthNet Internet Access Account link.

(B) Each user is required to complete this online application to obtain a user ID and password.

(C) The enrolled MO HealthNet provider shall be solely responsible for the accuracy and authenticity of said electronic media claims submitted, whether submitted directly or by an agent.

(D) The enrolled MO HealthNet provider shall agree that services described on the electronic media claim are true, accurate, and complete.

(E) The enrolled MO HealthNet provider certifies that services described on the electronic media claim are personally rendered by the provider.

(3) State-required supporting documentation (paper attachments) must be maintained at the place of service for auditing purposes.

(A) The failure of the enrolled MO HealthNet provider to keep or furnish, or both, such information shall constitute grounds for the disallowance and recoupment of all applicable charges or payments.

(B) The enrolled MO HealthNet provider shall be responsible for refund of any payments that result from claims being paid inappropriately or inaccurately.

(C) The records shall be maintained for five (5) years, unless the records are the subject of an audit or litigation. Records that are the subject of an audit or litigation shall be maintained until the conclusion of the audit or litigation.

(4) Medical record documentation shall support the medical necessity of the service

being provided as well as the frequency of the service. The provider shall establish and maintain a record containing the signature of each participant of service furnished by the MO HealthNet enrolled provider or, when applicable, the signature of a responsible person made on behalf of the participant. Clinical laboratories, radiologists, and pathologists are exempt from the requirement that a MO HealthNet enrolled provider establish and maintain a record containing the signature of each participant of service. A physician's order shall be documented in the medical record. Clinical laboratories, radiologists, and pathologists shall maintain a record of the ordering physician for a MO HealthNet service for which they request reimbursement.

(A) The failure of the enrolled MO HealthNet provider to keep or furnish, or both, such information shall constitute grounds for the disallowance and recoupment of all applicable charges or payments.

(B) The enrolled MO HealthNet provider shall be responsible for refund of any payments that result from claims being paid inappropriately or inaccurately.

(C) The records shall be maintained for five (5) years, unless the records are the subject of an audit or litigation. Records that are the subject of an audit or litigation shall be maintained until the conclusion of the audit or litigation.

(5) The provider shall keep such records, including original source documents, as are necessary to disclose fully the nature and extent of services provided to participants under the MO HealthNet program and to furnish information regarding any payment of claims for providing such services as the MO HealthNet Division, or its designee, may request. The enrolled MO HealthNet provider agrees that the service was medically necessary for the treatment of the condition as indicated by the diagnosis and shall maintain records, including source documents, to verify such.

(A) The failure of the enrolled MO HealthNet provider to keep or furnish, or both, such information shall constitute grounds for the disallowance and recoupment of all applicable charges or payments.

(B) The enrolled MO HealthNet provider shall be responsible for refund of any payments that result from claims being paid inappropriately or inaccurately.

(C) The records shall be maintained for five (5) years, unless the records are the subject of an audit or litigation. Records that are the subject of an audit or litigation shall be



maintained until the conclusion of the audit or litigation.

(6) The enrolled MO HealthNet provider must identify and bill third party insurance and Medicare coverage prior to billing MO HealthNet.

(7) Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect participant specific data from improper access.

(8) The provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the MO HealthNet program and shall be responsible for modifications necessary to meet electronic billing standards.

(9) The enrolled MO HealthNet provider agrees to accept as payment in full the amount paid by MO HealthNet for the electronic media claims submitted for payment.

(10) The submission of an electronic media claim is a claim for MO HealthNet payment.

(A) Any person who, with intent to defraud or deceive, makes, causes to be made, or assists in the preparation of any false statement, misrepresentation, or omission of a material fact in any claim or application for any claim, regardless of amount, knowing the same to be false, is subject to civil or criminal sanctions, or both, under all applicable state and federal statutes.

(11) "Electronic remittance advice" means a remittance that is retrieved via electronic media.

(12) The enrolled MO HealthNet provider agrees to retrieve his/her remittance advice via electronic media.

(A) To utilize the Internet for electronic remittance advice retrieval, the provider must apply online via the Application for MO HealthNet Internet Access Account link.

(B) Each user is required to complete this online application to obtain a user ID and password.

(C) Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect participant specific data from improper access.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2009. Original rule filed April 29, 2005, effective Nov. 30, 2005. Amended: Filed June 1, 2010, effective Dec. 30, 2010.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.170 Medicaid Managed Care Organization Reimbursement Allowance

PURPOSE: This rule establishes the formula for determining the Medicaid Managed Care Organizations' Reimbursement Allowance each Medicaid Managed Care Organization is required to pay for the privilege of engaging in the business of providing health benefit services in this state as required by sections 208.431 to 208.437, RSMo.

(1) Medicaid Managed Care Organization Reimbursement Allowance (MCORA) shall be assessed as described in this section.

(A) Definitions.

1. Medicaid Managed Care Organization (MCO). A health benefit plan, as defined in section 376.1350, RSMo, with a contract under 42 U.S.C. section 1396b(m) to provide health benefit services to MO HealthNet managed care program eligibility groups.

2. Department. Department of Social Services.

3. Director. Director of the Department of Social Services.

4. Division. MO HealthNet Division.

5. Health annual statement. The National Association of Insurance Commissioners (NAIC) annual financial statement filed with the Missouri Department of Insurance, Financial Institutions and Professional Registration.

6. Effective July 1, 2005 through June 30, 2006, Total Revenues. Total Revenues reported for Title XIX—Medicaid on the NAIC annual statement schedule "Analysis of Operations by Lines of Business." Column No. 8, Line 7.

7. Engaging in the business of providing health benefit services. Accepting payment for health benefit services.

8. Effective July 1, 2006, Total Revenues. Total capitated payments a Medicaid managed care organization receives from the division for providing, or arranging for the provision of, health care services to its members or enrollees.

(B) Beginning July 1, 2005, each Medicaid MCO in this state shall, in addition to all other fees and taxes now required or paid, pay a Medicaid Managed Care Organization Reimbursement Allowance (MCORA) for the privilege of engaging in the business of providing health benefit services in this state. Collection of the MCORA shall begin upon Centers for Medicare and Medicaid Services

(CMS) approval of the changes in Medicaid capitation rates that are effective July 1, 2005.

1. Effective July 1, 2005 through June 30, 2006, the Medicaid MCORA owed for existing Medicaid MCOs shall be calculated by multiplying the Medicaid MCORA tax rate by the Total Revenues, as defined above. The most recent available NAIC Health Annual Statement shall be used. The Medicaid MCORA shall be divided by and collected over the number of months for which each Medicaid MCORA is effective. The Medicaid MCORA rates, effective dates, and applicable NAIC Health Annual Statements are set forth in section (2).

A. Exceptions.

(I) If an existing Medicaid MCO's applicable NAIC Health Annual Statement, as set forth in section (2), does not represent a full calendar year worth of revenue due to the Medicaid MCO entering the Medicaid market during the calendar year, the Total Revenues used to determine the MCORA shall be the partial year Total Revenues reported on the NAIC Health Annual Statements schedule titled Analysis of Operations by Lines of Business annualized.

(II) If an existing Medicaid MCO did not have Total Revenues reported on the applicable NAIC Health Annual Statement due to the Medicaid MCO not entering the Medicaid market until after the calendar year, the Total Revenue used to determine the Medicaid MCORA shall be the MC+ regional weighted average per member per month net capitation rate in effect during the same calendar year multiplied by the Medicaid MCO's estimated annualized member months based on the most recent complete month.

2. Effective July 1, 2006, the Medicaid MCORA owed for existing Medicaid MCOs shall be calculated by multiplying the Medicaid MCORA tax rate by the prior month Total Revenue, as defined above.

A. Exceptions.

(I) For the month of July 2006, the Medicaid MCORA owed for existing Medicaid MCOs shall be calculated by multiplying the Medicaid MCORA tax rate by the current month Total Revenue, as defined above.

(C) Effective July 1, 2005 through June 30, 2006, the Department of Social Services shall prepare a confirmation schedule of the information from each Medicaid MCO's NAIC Health Annual Statement Analysis of Operations by Lines of Business. Effective July 1, 2006, the Department of Social Services shall prepare a confirmation schedule of the Medicaid MCORA calculation. The Department of Social Services shall provide each Medicaid MCO with this schedule.



1. Effective July 1, 2005 through June 30, 2006, the schedule shall include:

- A. Medicaid MCO name;
- B. Medicaid MCO provider number;
- C. Calendar year from the NAIC Health Annual Statement; and
- D. Total Revenues reported on the Analysis of Operations by Lines of Business schedule.

2. Effective July 1, 2006, the schedule shall include:

- A. Medicaid MCO name;
- B. Medicaid MCO provider number; and
- C. Medicaid MCORA tax rate.

3. Each Medicaid MCO required to pay the Medicaid MCORA shall review the information in the schedule referenced in paragraph (1)(C)1. of this regulation and if necessary, provide the department with correct information. If the information supplied by the department is incorrect, the Medicaid MCO, within fifteen (15) calendar days of receiving the confirmation schedule, must notify the division and explain the corrections. If the division does not receive corrected information within fifteen (15) calendar days, it will be assumed to be correct, unless the Medicaid MCO files a protest in accordance with subsection (1)(E) of this regulation.

(D) Payment of the Medicaid MCORA.

1. Offset. Each Medicaid MCO may request that their Medicaid MCORA be offset against any Missouri Medicaid payment due to that MCO. A statement authorizing the offset must be on file with the division before any offset may be made relative to the Medicaid MCORA by the MCO. Assessments shall be allocated and deducted over the applicable service period. Any balance due after the offset shall be remitted by the Medicaid MCO to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the Medicaid MCORA Fund. If the remittance is not received before the next MO HealthNet payment cycle, the division shall offset the balance due from that check.

2. Check. If no offset has been authorized by the Medicaid MCO, the division will begin collecting the Medicaid MCORA on the first day of each month. The Medicaid MCORA shall be remitted by the Medicaid MCO to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the Medicaid MCORA Fund.

3. Failure to pay the Medicaid MCORA. If a Medicaid MCO fails to pay its Medicaid

MCORA within thirty (30) days of notice, the Medicaid MCORA shall be delinquent. For any delinquent Medicaid MCORA, the department may compel the payment of such reimbursement allowance in the circuit court having jurisdiction in the county where the main offices of the Medicaid MCO is located. In addition, the director of the Department of Social Services or the director's designee may cancel or refuse to issue, extend, or reinstate a MO HealthNet contract agreement to any Medicaid MCO that fails to pay such delinquent reimbursement allowance required unless under appeal. Furthermore, except as otherwise noted, failure to pay a delinquent reimbursement allowance imposed shall be grounds for denial, suspension, or revocation of a license granted by the Department of Insurance, Financial Institutions and Professional Registration. The director of the Department of Insurance, Financial Institutions and Professional Registration may deny, suspend, or revoke the license of the Medicaid MCO with a contract under 42 U.S.C. section 1396b(m) that fails to pay a MCO's delinquent reimbursement allowance unless under appeal.

(E) Each Medicaid MCO, upon receiving written notice of the final determination of its Medicaid MCORA, may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the Medicaid MCO so requested, the director or the director's designee shall grant the Medicaid MCO a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the Medicaid MCO and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a Medicaid MCO's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo and 621.055, RSMo.

(2) Medicaid MCORA Rates for SFY 2006. The Medicaid MCORA rates for SFY 2006 determined by the division, as set forth in (1)(B) above, are as follows:

(A) The Medicaid MCORA will be five and ninety-nine hundredths percent (5.99%) of the Total Revenues reported by each Medicaid MCO on the calendar year 2004 NAIC Health Annual Statement Analysis of Operations by Lines of Business, for the six (6)-month period of July 2005 through December 2005, and five percent (5.00%) of the Total

Revenues reported by each Medicaid MCO on the calendar year 2004 NAIC Health Annual Statement Analysis of Operations by Lines of Business for the six (6)-month period of January 2006 through June 2006. The Medicaid MCORA will be collected over twelve (12) months (July 2005 through June 2006). No Medicaid MCORA shall be collected by the Department of Social Services if the federal Center for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act. If CMS approval of the reimbursement allowance occurs after July 2005, the total Medicaid MCORA for SFY 2006 will be collected over the number of months remaining in the fiscal year.

(3) Medicaid MCORA Rates for SFY 2007. The Medicaid MCORA rates for SFY 2007 determined by the division, as set forth in (1)(B) above, are as follows:

(A) The Medicaid MCORA will be five and ninety-nine hundredths percent (5.99%) of the prior month Total Revenue received by each Medicaid MCO. The Medicaid MCORA will be collected each month for SFY 2007 (July 2006 through June 2007). No Medicaid MCORA shall be collected by the Department of Social Services if the federal Centers for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act.

(4) Medicaid MCORA Rates for SFY 2008. The Medicaid MCORA rates for SFY 2008 determined by the division, as set forth in (1)(B) above, are as follows:

(A) The Medicaid MCORA will be five and ninety-nine hundredths percent (5.99%) of the prior month Total Revenues received by each Medicaid MCO for each month of the six (6)-month period of July 2007 through December 2007, and five and forty-nine hundredths percent (5.49%) of the prior month Total Revenues received by each Medicaid MCO for each month of the six (6)-month period of January 2008 through June 2008. The Medicaid MCORA will be collected each month for SFY 2008 (July 2007 through June 2008). No Medicaid MCORA shall be collected by the Department of Social Services if the federal Centers for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act.

(5) Medicaid MCORA Rates for SFY 2009. The Medicaid MCORA rates for SFY 2009



determined by the division, as set forth in (1)(B) above, are as follows:

(A) The Medicaid MCORA will be five and forty-nine hundredths percent (5.49%) of the prior month Total Revenue received by each Medicaid MCO. The Medicaid MCORA will be collected each month for SFY 2009 (July 2008 through June 2009). No Medicaid MCORA shall be collected by the Department of Social Services if the federal Centers for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act.

(6) Medicaid MCORA Rates for SFY 2010. The Medicaid MCORA rates for SFY 2010 determined by the division, as set forth in subsection (1)(B) above, are as follows:

(A) The Medicaid MCORA will be five and forty-nine hundredths percent (5.49%) of the prior month Total Revenue received by each Medicaid MCO for the three (3)-month period of July 1, 2009, through September 30, 2009. The Medicaid MCORA will be collected for the three (3)-month period of July 1, 2009, through September 30, 2009. No Medicaid MCORA shall be collected by the Department of Social Services if the federal Centers for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act.

AUTHORITY: sections 208.201, 208.431, and 208.435, RSMo Supp. 2008. Original rule filed June 1, 2005, effective Dec. 30, 2005. Emergency amendment filed May 5, 2006, effective May 15, 2006, expired Nov. 10, 2006. Emergency amendment filed June 15, 2006, effective July 1, 2006, expired Dec. 28, 2006. Amended: Filed June 15, 2006, effective Dec. 30, 2006. Emergency amendment filed June 20, 2007, effective July 1, 2007, expired Dec. 27, 2007. Amended: Filed June 20, 2007, effective Jan. 30, 2008. Emergency amendment filed June 18, 2008, effective July 1, 2008, expired Dec. 28, 2008. Amended: Filed March 17, 2008, effective Sept. 30, 2008. Emergency amendment filed June 19, 2009, effective July 1, 2009, expired Sept. 30, 2009. Amended: Filed July 1, 2009, effective Jan. 30, 2010.*

**Original authority: 208.201, RSMo 1987, amended 2007; 208.431, RSMo 2005; and 208.435, RSMo 2005.*

13 CSR 70-3.180 Medical Pre-Certification Process

PURPOSE: This rule establishes the medical pre-certification process of the MO HealthNet

Program for certain covered diagnostic and ancillary procedures and services prior to provision of the procedure or service as a condition of reimbursement. This rule shall only apply to those diagnostic and ancillary procedures or services that are listed in the provider manuals, provider bulletins, or clinical edits criteria which are incorporated by reference and made a part of this rule. The medical pre-certification process serves as a utilization management tool, allowing payment for services that are medically necessary, appropriate, and cost-effective without compromising the quality of care provided to MO HealthNet participants.

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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Providers are required to seek pre-certification for certain specified services listed in the provider manuals, provider bulletins, or clinical edits criteria before delivery of the services. This rule shall apply to diagnostic and ancillary procedures and services listed in the provider manuals, provider bulletins, or clinical edits criteria when ordered by a healthcare provider unless provided in an inpatient hospital or emergency room setting. This pre-certification process shall not include primary services performed directly by the provider. In addition to services and procedures that are available through the traditional medical assistance program, expanded services are available to children twenty (20) years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require pre-certification. Certain services require pre-certification only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in subsections 13(3) and 14(4) of the applicable provider manuals, provider bulletins, or clinical edits criteria, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, April 1, 2009. The rule does not incorporate any subsequent

amendments or additions. This rule shall only apply to those diagnostic and ancillary procedures or services that are listed in the provider manuals, provider bulletins, or clinical edits criteria which are incorporated by reference and made a part of this rule.

(2) All requests for pre-certification must be initiated by an enrolled medical assistance provider and approved by the MO HealthNet Division. A covered service for which pre-certification is requested must meet medical criteria established by the MO HealthNet Division's medical consultants or medical advisory groups in order to be approved.

(3) An approved pre-certification request does not guarantee payment. The provider must be enrolled and verify participant eligibility on the date of service.

(4) Approved services/procedures must be initiated within six (6) months of the date the pre-certification approval is issued. Services/procedures initiated after the six (6)-month approval period will be void and payment denied.

(5) The pre-certification for a specific service is time and patient status and/or diagnosis sensitive. A denial at any given time shall not prejudice or impact the decision to grant a future request for the same or similar service.

(6) Pre-certifications for exactly the same service may be granted to allow provision over an extended period of time and may be granted for a term of not more than one (1) year.

(7) If a pre-certification request is denied, the medical assistance participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The MO HealthNet participant must contact the Participant Services Unit within ninety (90) days of the date of the denial letter if they wish to request a hearing. After ninety (90) days a request to appeal the pre-certification decision is denied.

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2008. Original rule filed July 3, 2006, effective Feb. 28, 2007. Amended: Filed March 2, 2009, effective Aug. 30, 2009.*

**Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.190 Telehealth Services

PURPOSE: This rule establishes coverage of the Telehealth spoke site facility fee and to



define services considered appropriate for this form of interactive technology from a hub site to a participant at a spoke site.

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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration.

(A) This rule is established pursuant to the authority granted to the Missouri Department of Social Services, MO HealthNet Division, to promulgate rules governing the practice of Telehealth in the MO HealthNet Program.

(B) Definitions.

1. Community Mental Health Center (CMHC) means a legal entity through which comprehensive mental health services are provided to individuals residing in a certain service area.

2. Consultation means a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association.

3. Consulting provider means a provider who evaluates the patient and appropriate medical data or images through a Telehealth mode of delivery, upon recommendation of the referring provider.

4. Comprehensive Substance Treatment and Rehabilitation (CSTAR) means a MO HealthNet qualified and enrolled outpatient substance abuse treatment program. Coverage is targeted to MO HealthNet-eligible participants who are assessed as requiring substance abuse treatment.

5. Department means the Department of Social Services.

6. Distant site means a Telehealth site where the health care provider providing the Telehealth service is physically located at the time the Telehealth service is provided and is considered the place of service.

7. Division means the MO HealthNet Division, within the Department of Social Services.

8. GT modifier means a modifier that identifies a Telehealth service which is approved by the Healthcare Common Procedure Coding System (HCPCS).

9. Health care provider means a:

- A. Missouri licensed physician;
- B. Missouri licensed advanced registered nurse practitioner;
- C. Missouri licensed dentist or oral surgeon;
- D. Missouri licensed psychologist or provisional licensee;
- E. Missouri licensed pharmacist; or
- F. Missouri licensed speech, occupational, or physical therapist.

10. MTN means the Missouri Telehealth Network.

11. Originating site means a Telehealth site where the MO HealthNet participant receiving the Telehealth service is located for the encounter. The originating site must ensure immediate availability of clinical staff during a Telehealth encounter in the event a participant requires assistance. An originating site must be one (1) of the following locations:

- A. Office of a physician or health care provider;
- B. Hospital;
- C. Critical access hospital;
- D. Rural health clinic;
- E. Federally Qualified Health Center;
- F. Nursing home;
- G. Dialysis center;
- H. Missouri state habilitation center or regional office;
- I. Community mental health center;
- J. Missouri state mental health facility;

K. Missouri state facility;

L. Missouri residential treatment facility—licensed by and under contract with the Children's Division (CD) and has a contract with the CD. Facilities must have multiple campuses and have the ability to adhere to technology requirements addressed in this rule. Only Missouri licensed psychiatrists, licensed psychologists or provisionally licensed psychologists, and advanced registered nurse practitioners who are enrolled MO HealthNet providers may be consulting providers at these locations; or

M. Comprehensive Substance Treatment and Rehabilitation (CSTAR) program.

12. Participant means an individual eligible for medical assistance benefits on behalf of needy persons through MO HealthNet, under section 208.151, RSMo.

13. Presenting provider means a provider who:

- A. Introduces a patient to a consulting provider for examination, observation, or consideration of medical information; and
- B. May assist in the Telehealth encounter.

14. Telepresenter means a person who is an employee of the originating site and is with

the patient during the time of the encounter who aids in the examination by following the orders of the consulting clinician, including the manipulation of cameras and appropriate placement of other peripheral devices used to conduct the patient examination.

15. Referring provider means a provider who evaluates a patient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment.

16. Telehealth means the use of medical information exchanged from one (1) site to another via electronic communications to improve the health status of a patient. Telehealth means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of medical data, audio visual, or data communications that are performed over two (2) or more locations between providers who are physically separated from the patient or from each other.

17. Telehealth service means a medical service provided through advanced telecommunications technology from a distant site to a participant at an originating site.

18. Two (2)-way interactive video means a type of advanced telecommunications technology that permits a real time service to take place between a participant and a presenting provider or a Telepresenter at the originating site and a health care provider at the distant site.

(2) Covered Services.

(A) A Telehealth service shall be covered only if it is medically necessary.

(B) A Telehealth service shall require use of two (2)-way interactive video and shall not include store and forward services. The participant must be able to see and interact with the off-site provider at the time services are provided via Telehealth.

(C) The distant site is the location where the physician or practitioner is physically located at the time of the Telehealth service. Coverage of services rendered through Telehealth at the distant site is limited to:

- 1. Consultations made to confirm a diagnosis; or
- 2. Evaluation and management services; or
- 3. A diagnosis, therapeutic, or interpretive service; or
- 4. Individual psychiatric or substance abuse assessment diagnostic interview examinations; or
- 5. Individual psychotherapy; or
- 6. Pharmacologic management.

(D) The participant must be present for the encounter.



(3) Eligible Providers.

(A) A health care provider utilizing Telehealth at either a distant site or an originating site shall be enrolled as a MO HealthNet provider pursuant to 13 CSR 70-3.020 and licensed for practice in Missouri. A health care provider utilizing Telehealth must do so in a manner that is consistent with the provisions of all laws governing the practice of the provider's profession.

(B) A provider agrees to conform to MO HealthNet program policies and instructions as specified in the provider manuals and bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, April 1, 2009. This rule does not incorporate any subsequent amendments or additions.

(4) Prior Authorization and Utilization Review. All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made.

(A) Prior Authorization. Certain procedures or services can require prior authorization from the MO HealthNet Division or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through Telehealth is subject to the same prior authorization and utilization review requirement which exist for the service when not provided through Telehealth.

(B) Eligibility Determination. Prior authorization of services does not guarantee an individual is eligible for a MO HealthNet service. Providers must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the participant has other health insurance.

(5) Reimbursement.

(A) Reimbursement to the health care provider delivering the medical service at the distant site is made at the same amount as the current fee schedule for the service provided without the use of a telecommunication system.

(B) The claim for service will use the appropriate procedure code for the covered services addressed in (2)(C) and the GT modifier indicating interactive communication was used.

(C) The originating site is eligible to receive a facility fee. Facility fees are not

payable to the distant site.

(D) Services provided by practitioners must be within their scope(s) of practice and according to MO HealthNet policy.

(E) Reimbursement for services furnished by interns or residents in hospitals with approved teaching program or services furnished in other hospitals that participate in teaching programs is made through institutional reimbursement. The division cannot be billed directly by interns or residents for Telehealth services.

(6) Documentation for the Encounter. Patient records at the distant and originating sites are to document the Telehealth encounter consistent with the service documentation described in MO HealthNet provider manuals and bulletins.

(A) A request for a Telehealth service from a referring provider and the medical necessity for the Telehealth service shall be documented in the participant's medical record.

(B) A health care provider shall keep a complete medical record of a Telehealth service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.030 and 13 CSR 70-98.015.

(C) Documentation of a Telehealth service by the health care provider shall be included in the participant's medical record maintained at the participant's location and shall include:

1. The diagnosis and treatment plan resulting from the Telehealth service and progress note by the health care provider;

2. The location of the distant site and originating site;

3. A copy of the signed informed consent form; and

4. Documentation supporting the medical necessity of the Telehealth service.

(7) Confidentiality and Data Integrity. All Telehealth activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and all other applicable state and federal laws and regulations.

(A) A Telehealth service shall be performed on a private, dedicated telecommunication line approved through the Missouri Telehealth Network (MTN). The telecommunication line must be secure and utilize a method of encryption adequate to protect the confidentiality and integrity of the Telehealth service information. The Missouri Telehealth Network must also approve the equipment that will be used in Telehealth service.

(B) Both a distant site and an originating

site shall use authentication and identification to ensure the confidentiality of a Telehealth service.

(C) A provider of a Telehealth service shall implement confidentiality protocols that include:

1. Identifying personnel who have access to a Telehealth transmission; and

2. Preventing unauthorized access to a Telehealth transmission.

(D) A provider's protocols and guidelines shall be available for inspection by the department upon request.

(8) Informed Consent.

(A) Before providing a Telehealth service to a participant, a health care provider shall document written informed consent from the participant or the participant's legal guardian and shall ensure that the following written information is provided to the participant in a format and manner that the participant is able to understand:

1. The participant shall have the option to refuse the Telehealth service at anytime without affecting the right to future care or treatment and without risking the loss or withdrawal of a MO HealthNet benefit to which the participant is entitled;

2. The participant shall be informed of alternatives to the Telehealth service that are available to the participant;

3. The participant shall have access to medical information resulting from the Telehealth service as provided by law;

4. The dissemination, storage, or retention of an identifiable participant image or other information from the Telehealth service shall not occur without the written informed consent of the participant or the participant's legally authorized representative;

5. The participant shall have the right to be informed of the parties who will be present at the originating site and the distant site during the Telehealth service and shall have the right to exclude anyone from either site; and

6. The participant shall have the right to object to the videotaping or other recording of a Telehealth service.

(B) A copy of the signed informed consent shall be retained in the participant's medical record and provided to the participant or the participant's legally authorized representative upon request.

(C) The requirement to obtain informed consent before providing a service shall not apply to an emergency situation if the participant is unable to provide informed consent and the participant's legally authorized representative is unavailable.

AUTHORITY: section 208.201, RSMo Supp.



2008.* Original rule filed Jan. 2, 2008, effective Aug. 30, 2008. Amended: Filed Feb. 17, 2009, effective Aug. 30, 2009.

*Original authority: 208.201, RSMo 1987, amended 2007.

13 CSR 70-3.200 Ambulance Service Reimbursement Allowance

PURPOSE: This rule establishes the formula for determining the Ambulance Service Reimbursement Allowance each ground emergency ambulance service must pay, except for any ambulance service owned and operated by an entity owned or operated by the board of curators, as defined in Chapter 172, RSMo, or any department of the state, in addition to all other fees and taxes now required or paid, for the privilege of engaging in the business of providing ground emergency ambulance services in Missouri.

(1) Ambulance Service Reimbursement Allowance shall be assessed as described in this section.

(A) Definitions.

1. Ambulance. Ambulance shall have the same meaning as such term is defined in section 190.100, RSMo.

2. Department. Department of Social Services.

3. Director. Director of the Department of Social Services.

4. Division. MO HealthNet Division.

5. Gross receipts. Emergency ambulance revenue from Medicare, Medicaid, insurance, and private payments received by an ambulance service licensed under section 190.109, RSMo (or by its predecessor in interest following a change of ownership). Revenue from CPT Code A0427/A0425 ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency), and associated ground mileage; CPT Code A0429/A0425 ambulance services, basic life support, emergency transport (BLS-emergency), and associated ground mileage; and CPT Code A0433/A0425 advanced life support, level 2 (ALS2), and associated ground mileage.

6. Engaging in the business of providing ambulance services. Accepting payment for ambulance services as such term is defined in section 190.100, RSMo.

(B) Beginning July 1, 2009, each ground emergency ambulance services provider in this state, except for any ambulance service owned and operated by an entity owned and operated by the state of Missouri, including but not limited to any hospital owned or operated by the board of curators, as defined in

Chapter 172, RSMo, or any department of the state, shall, in addition to all other fees and taxes now required or paid, pay an ambulance service reimbursement allowance for the privilege of engaging in the business of providing ambulance services as defined in section 190.100, RSMo. Gross receipts shall be obtained by the division from a survey conducted six (6) months after calendar year end (i.e., calendar year 2009 revenue will be obtained through survey sent out by the state in June 2010). Collection of the ambulance service reimbursement allowance shall begin in state fiscal years 2010 and 2011 based on gross receipts collected in calendar year 2008. Collection of the ambulance service reimbursement allowance beginning with state fiscal year (SFY) 2012 and thereafter shall be based on gross receipts collected in a third prior calendar year (i.e., state fiscal year 2012 shall be based on gross receipts collected in calendar year 2009).

1. The ambulance service reimbursement allowance owed for currently licensed emergency ambulance providers as defined in section 190.100, RSMo, shall be calculated by multiplying the ambulance service reimbursement allowance tax rate by the gross receipts, as defined above in paragraph (1)(A)5.

A. Exceptions.

(I) For emergency ambulance providers without reported survey data, the gross receipts used to determine the ambulance service reimbursement allowance shall be estimated as follows:

(a) Emergency ambulance providers shall be divided into quartiles based on total emergency ambulance transports;

(b) Gross receipts shall be individually summed and divided by the total emergency ambulance transports in the quartile to yield an average gross receipt per emergency ambulance transport; and

(c) The number of emergency ambulance transports as reported to the Department of Health and Senior Services (Bureau of Emergency Medical Services (BEMS) data) as required by 19 CSR 30-40.375(3) for the emergency ambulance provider without reported survey data shall be multiplied by the average gross receipts per emergency ambulance transport.

(C) The Department of Social Services shall provide each emergency ambulance provider with a final determination letter. The letter shall include emergency ambulance provider name, National Provider Identifier (NPI) number, total emergency ambulance gross receipts, ambulance service reimbursement allowance tax rate, and annual tax amount.

1. Each emergency ambulance provider required to pay the ambulance service reimbursement allowance shall review the information in the letter and, if necessary, provide the department with correct information. If the information supplied by the department is incorrect, the emergency ambulance provider, within fifteen (15) calendar days of receiving the confirmation schedule, must notify the division and explain the corrections. If the division does not receive corrected information within fifteen (15) calendar days, it will be assumed to be correct, unless the emergency ambulance provider files a protest in accordance with subsection (1)(E) of this regulation.

(D) Payment of the Ambulance Service Reimbursement Allowance.

1. Offset. Each emergency ambulance provider may request that its ambulance service reimbursement allowance be offset against any Missouri Medicaid payment due to that emergency ambulance provider. A statement authorizing the offset must be on file with the division before any offset may be made relative to the ambulance service reimbursement allowance by the emergency ambulance provider. Assessments shall be allocated and deducted over the applicable service period. Any balance due after the offset shall be remitted by the emergency ambulance provider to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the ambulance service reimbursement allowance fund. If the remittance is not received before the next MO HealthNet payment cycle, the division shall offset the balance due from that check.

2. Check. If no offset has been authorized by the emergency ambulance provider, the division will begin collecting the ambulance service reimbursement allowance on the first day of each month. The ambulance service reimbursement allowance shall be remitted by the emergency ambulance provider to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the ambulance service reimbursement allowance fund.

3. Failure to pay the ambulance service reimbursement allowance. If an emergency ambulance provider fails to pay its ambulance service reimbursement allowance within thirty (30) days of notice, the ambulance service reimbursement allowance shall be delinquent. For any delinquent ambulance service reimbursement allowance, the department may compel the payment of such reimbursement allowance in the circuit court having jurisdiction in the county where the main office of



the emergency ambulance provider is located. In addition, the director of the Department of Social Services or the director's designee may cancel or refuse to issue, extend, or reinstate an emergency ambulance provider agreement to any emergency ambulance provider that fails to pay such delinquent reimbursement allowance required unless under appeal.

(E) Each emergency ambulance provider, upon receiving written notice of the final determination of its ambulance service reimbursement allowance, may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the emergency ambulance provider so requested, the director or the director's designee shall grant the emergency ambulance provider a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the emergency ambulance provider and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, an emergency ambulance provider's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156 and 621.055, RSMo.

(2) Ambulance Service Reimbursement Allowance Rate for SFY 2010 and SFY 2011. The ambulance service reimbursement allowance rate for SFY 2010 and SFY 2011 determined by the division, as set forth in subsection (1)(B) above, is as follows:

(A) The ambulance service reimbursement allowance rate shall be four and four hundred seventeen thousandths percent (4.417%) of gross receipts as determined in paragraph (1)(A)5. above with an aggregate annual adjustment, by the MO HealthNet Division, not to exceed five-tenths percent (0.5%) based on the ambulance services total gross receipts. No ambulance service reimbursement allowance shall be collected by the Department of Social Services if the federal Centers for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act.

AUTHORITY: sections 190.836 and 208.201, RSMo Supp. 2009. Original rule filed March 19, 2010, effective Nov. 30, 2010.*

**Original authority: 190.836, RSMo 2009 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.210 Electronic Retention of Records

PURPOSE: This rule advises MO HealthNet providers of the opportunity to store records on an electronic medium to save resources when storing records.

(1) Records required to be maintained by the Department of Social Services may be maintained in an electronic medium. Records means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays, and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received.

(2) Upon transfer of an original paper record to an electronic medium, the enrolled provider may destroy the original paper record after assuring that all information contained in the original record, including signatures, handwritten notations, or pictures, is contained in the durable medium.

(3) If the provider does not retain the original paper record, or if there was no original paper record, a duplicate or back-up system sufficient to permit reconstruction of the electronic records shall be established at a separate location.

(4) Nothing in this regulation shall be construed as requiring the utilization of any particular method of record retention by an enrolled provider. Records may be retained in any form that can be made available for review at the same site at which the service was provided or at the provider's address of record with the Department of Social Services. Copies of records must be provided upon request of the Department of Social Services, Department of Health and Senior Services, and/or Department of Mental Health or its authorized agents, regardless of the media in which they are kept. Failure to make these records available at the same site at which the services were rendered or at the provider's address of record with the Department of Social Services, or failure to provide copies when and as requested, or failure to keep and make available records which document the services and payments as required in 13 CSR 70-3.030 shall constitute a violation of this section and shall be a reason for sanction.

AUTHORITY: section 208.201, RSMo Supp. 2010. Original rule filed July 1, 2011, effective Dec. 30, 2011.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.220 Electronic Health Record Incentive Program

PURPOSE: The Health Information Technology and Clinical Health Act (HITECH) offers incentive payments to encourage eligible professionals and hospitals to adopt certified Electronic Health Records (EHRs). This rule establishes the basis on which eligible hospitals and professionals participating in the MO HealthNet Program will be eligible to receive payments when they successfully demonstrate that they have adopted, implemented, or upgraded to certified EHR technology in the first year and meaningfully use certified electronic health record technology in subsequent years.

(1) Definitions. Patient volume shall be calculated as outlined in 42 CFR 495.302-495.306.

(2) Eligible Providers. To qualify for Medicaid incentive payments during the first year, eligible professionals and hospitals must complete registration and attestation requirements, meet volume thresholds for Medicaid patients, and show that they have adopted, implemented, or upgraded to certified electronic health record (EHR) technology. In subsequent years, payments require demonstration of meaningful use of certified EHR technology. To be deemed an "eligible professional or hospital" for the electronic health record incentive program, a professional or hospital must satisfy the following criteria:

(A) The eligible professional or hospital must be currently enrolled as a MO HealthNet provider, either in the fee for service program or a managed care organization which has a contract with the state of Missouri;

(B) The provider must be one (1) of the following:

1. An eligible professional, listed as—
 - A. A physician;
 - B. A dentist;
 - C. A certified nurse midwife;
 - D. A nurse practitioner; or
 - E. A physician assistant practicing in a federally-qualified health center or rural health clinic when a physician assistant is the primary provider, director, or owner of the site;

2. An acute care hospital, defined as a health care facility where the average length of stay is twenty-five (25) days or fewer, which has a Centers for Medicare and Medicaid Services (CMS) certification number with the last four digits in the series 0001-0879 or 1300-1399; or

3. A children's hospital, defined as a separately certified children's hospital, either



freestanding or a hospital-within-hospital, that predominately treats individuals under twenty-one (21) years of age and has a CMS certification number with the last four digits in the series 3300-3399;

(C) For the year for which the provider is applying for an incentive payment—

1. An eligible professional must have at least thirty percent (30%) of the professional's patient volume covered by Medicaid, except that—

A. A pediatrician must have at least twenty percent (20%) Medicaid patient volume;

B. A professional practicing at a federally-qualified health center or rural health clinic must have at least fifty percent (50%) of patient encounters in a federally-qualified health center or rural health clinic, with a minimum thirty percent (30%) patients who are medically needy, defined as those furnished uncompensated care, or services either at no cost or at a reduced cost based on a sliding scale or ability to pay, or patients covered by the MO HealthNet program or the state's Children's Health Insurance Program (CHIP); and

C. Professionals have the option to base their volume on either—

(I) Their individual Medicaid patient encounters as a percentage of their total individual encounters; or

(II) The practice's total Medicaid encounters as a percentage of the practice's total patient encounters;

2. An acute care hospital must have ten percent (10%) Medicaid patient volume; and

3. A children's hospital is presumed to meet the Medicaid patient volume requirement;

(D) Application and Agreement. Any eligible provider who wants to participate in the Missouri electronic health record incentive program must declare the intent to participate by electronically registering with the Centers for Medicare and Medicaid Services (CMS) using the Medicare and Medicaid electronic health record incentive program registration and attestation website. CMS will notify the Department of Social Services of an eligible provider's registration for the Medicaid incentive payment program.

1. The department will maintain a website and secure portal with instructions for submitting documentation of patient volume, certified technology, and other information required to apply for the Medicaid EHR incentive at the website, <http://mo.arraincentive.com>.

2. The applicant shall use the website to—

A. Attest to the applicant's qualifica-

tions to receive the incentive payment; and

B. Submit an electronic copy of a signed attestation form.

3. The department may request any missing or additional information from the provider. If missing or additional information is required, the department will notify the provider by electronic mail of the specific information needed. If the provider fails to submit the required information, the department will determine the registration incomplete and application will remain in an incomplete status until the required information is submitted.

4. The department may request additional information from sources other than the provider to validate the provider's attestation submitted as a result of this rule;

(E) Record Retention. Providers must retain records to support their eligibility for the incentive payment for a minimum of six (6) years. The department will select providers for audit after issuance of an incentive payment. Incentive payment recipients shall cooperate with the department by providing proof of—

1. Eligibility for the incentive program;

2. Medicaid patient volume thresholds;

3. Purchase of certified electronic health record technology; and

4. Meaningful use of electronic health record technology;

(F) Patient Consent Form. Providers must retain records to support the disclosure of patient health information to all treating providers; and

(G) Administrative Appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to adverse actions related to the electronic health record incentive program may seek review of the department's action pursuant to section 621.055, RSMo. Appealable issues include:

1. Provider eligibility determination;

2. Medicaid patient volume thresholds;

3. Incentive payment amounts; or

4. Demonstration of adopting, implementing, upgrading, and meaningful use of technology.

(3) The department will make an incentive payment to a provider as a result of this rule in accordance with the requirements of 42 CFR 495.308-495.312. A provider who has received an incentive payment as a result of this rule must continue to meet the eligibility standards for that payment through the entire payment year. If the department finds that a provider is deficient, the department may take any of the following actions:

(A) Suspend an incentive payment until the provider has removed the deficiency to the

satisfaction of the department;

(B) Require full repayment of all or a portion of an incentive payment; or

(C) Terminate participation in the MO HealthNet electronic health record incentive program.

AUTHORITY: section 208.201, RSMo Supp. 2010. Original rule filed July 1, 2011, effective Dec. 30, 2011.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.230 Payment Policy for Provider Preventable Conditions

PURPOSE: This rule establishes the MO HealthNet payment policy for services provided by acute care hospitals or ambulatory surgical centers that result in Provider Preventable Conditions, errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients.

(1) Definitions.

(A) Provider Preventable Conditions (PPC). An umbrella term for hospital and non-hospital acquired conditions identified by the state for nonpayment to ensure the high quality of Medicaid services. PPCs include two (2) distinct categories, Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

(B) Health Care-Acquired Conditions (HCAC). Apply to conditions that occurred during a Medicaid inpatient hospital stay. HCACs are defined as the full list of Medicare Hospital Acquired Conditions, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee replacement or hip replacement in pediatric and obstetric patients, as the minimum requirements for states' PPC nonpayment program.

(C) Other Provider-Preventable Conditions (OPPC). This includes the list of Serious Reportable Events in Healthcare as published by the National Quality Forum. These conditions apply broadly to Medicaid inpatient and outpatient health care settings where these events may occur.

(D) Adverse event. A discrete, auditable, and clearly defined occurrence as identified by the National Quality Forum in its list of serious adverse events in health care, as of December 15, 2008 (and as further defined by the criteria and implementation guidance of Table 1 of the National Quality Forum's publication "Serious Reportable Events in Healthcare: 2006 Update" which is available at http://www.qualityforum.org/publications/reports/sre_2006.asp), or an event



identified by the Centers for Medicare and Medicaid Services, as of December 15, 2008, that leads to a negative consequence of care resulting in an unintended injury or illness which was preventable.

(E) Preventable. An event that reasonably could have been anticipated and avoided by the establishment and implementation of appropriate policies, procedures, and protocols by a hospital or by staff conformance to established hospital policies, procedures, and protocols.

(F) Serious. An adverse event that results in death or loss of a body part, disability, or loss of bodily function lasting more than seven (7) days or, for a hospital patient, the loss of bodily function is still present at the time of discharge from a hospital.

(G) Healthcare facility. For purposes of the regulation shall mean a hospital or ambulatory surgical center.

(2) Payment to hospitals enrolled as MO HealthNet providers for care related only to the treatment of the consequences of a HCAC will be denied or recovered by the MO HealthNet Division when the HCAC is determined to have occurred during an inpatient hospital stay.

(A) HCAC conditions include:

- 1. Foreign object retained after surgery;
- 2. Air embolism;
- 3. Blood incompatibility;
- 4. Stage III and IV pressure ulcers;
- 5. Falls and trauma—
 - A. Fractures;
 - B. Dislocations;
 - C. Intracranial Injuries;
 - D. Crushing Injuries;
 - E. Burns; or
 - F. Electric Shock;
- 6. Catheter-associated Urinary Tract Infection;
- 7. Vascular catheter-associated infection;
- 8. Manifestations of poor glycemic control—
 - A. Diabetic Ketoacidosis;
 - B. Nonketotic Hyperosmolar coma;
 - C. Hypoglycemic coma;
 - D. Secondary diabetes with ketoacidosis; or
 - E. Secondary diabetes with hyperosmolarity;
- 9. Surgical site infection following:
 - A. Coronary Artery Bypass Graft (CABG)—Mediastinitis;
 - B. Bariatric surgery—
 - (I) Laparoscopic gastric Bypass;
 - (II) Gastroenterostomy; or
 - (III) Laparoscopic gastric restrictive surgery; or

- C. Orthopedic procedures—
 - (I) Spine;
 - (II) Neck;
 - (III) Shoulder; or
 - (IV) Elbow; and
- 10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) excluding those in pediatric and obstetric patients following:
 - A. Total knee replacement; or
 - B. Hip replacement.
- (B) Hospitals enrolled as MO HealthNet providers shall include the “Present on Admission” (POA) indicator on the CMS 1450 UB-04 or electronic equivalent when submitting inpatient claims for payment beginning July 1, 2010. The POA indicator is to be used according to the Official Coding Guidelines for Coding and Reporting and the CMS guidelines. The POA indicator will prompt review of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines.

(C) HCACs are based on Medicare inpatient prospective payment system rules effective October 1, 2010 (FY 2011), published in the *Federal Register*, 75:157 (Aug. 16, 2010), pp. 50084–50085, with the inclusion of present on admission (POA) indicators as provided by the final regulation published in the *Federal Register*, 76:108 (June 6, 2011), pp. 32816–32838. Unlike Medicare, all MO HealthNet enrolled hospitals must report the above mentioned HCACs on claims submitted to MO HealthNet for consideration of payment.

(3) Payment to hospitals or ambulatory surgical centers enrolled as MO HealthNet providers for care related only to the treatment of the consequences of an Other Provider-Preventable Condition such as a serious adverse event will be denied or recovered by the MO HealthNet Division when the serious adverse event is determined to—

- (A) Be preventable;
- (B) Be within the control of the hospital or ambulatory surgical center;
- (C) Have occurred during an inpatient hospital admission, outpatient hospital care, or care in an ambulatory surgical center;
- (D) Have resulted in serious harm; and
- (E) Be included on the National Quality Forum list of Serious Reportable Events as of December 15, 2008, non-payable by Medicare as of December 15, 2008. The National Quality Forum list of serious reportable events as of December 15, 2008, includes:
 - 1. Surgery performed on the wrong body part;
 - 2. Surgery performed on the wrong patient;

- 3. Wrong surgical procedure on a patient;
- 4. Foreign object left in a patient after surgery or other procedure;
- 5. Intraoperative or immediately post-operative death in a normal health patient;
- 6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility;
- 7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended;
- 8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility;
- 9. Infant discharged to the wrong person;
- 10. Patient death or serious disability associated with patient elopement (disappearance) for more than four (4) hours;
- 11. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility;
- 12. Patient death or serious disability associated with a medication error (error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
- 13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
- 14. Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility;
- 15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;
- 16. Death or serious disability (Kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;
- 17. Stage III or IV pressure ulcers acquired after admission to a healthcare facility;
- 18. Patient death or serious disability due to spinal manipulative therapy;
- 19. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;
- 20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- 21. Patient death or serious disability associated with a burn incurred from any



source while being cared for in a healthcare facility;

22. Patient death associated with a fall while being cared for in a healthcare facility;

23. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility;

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;

25. Abduction of a patient of any age; or

26. Sexual assault on a patient within or on the grounds of a healthcare facility;

(F) Other Provider-Preventable Conditions (OPPC) or serious adverse events are to be billed as follows:

1. Medical claims using the CMS 1500 claim form, must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event: modifier PA (wrong body part), PB (wrong patient), or PC (wrong surgery), AND/OR at least one (1) of the diagnosis codes indicating wrong surgery, wrong patient, or wrong body part must be present as one of the first four (4) diagnosis codes on the claim;

2. Outpatient hospital claims using the CMS 1450 UB-04 claim form or its electronic equivalent must be billed with at least one (1) of the diagnosis codes indicating wrong surgery, wrong patient, or wrong body part within the first five (5) diagnosis codes listed on the claim; and

3. Inpatient hospital claims, using the CMS 1450 UB-04 claim form or its electronic equivalent must be billed with a type of bill 0110.

A. If there are covered services or procedures provided during the same stay as the serious adverse event service, then the facility must submit two (2) claims; one (1) claim with covered services unrelated to the OPPC event and the other claim for any and all services related to the OPPC event.

B. The Type of Bill 0110 claim must also contain one (1) of the diagnosis codes indicating wrong surgery, wrong patient, or wrong body part within the first five (5) diagnosis codes listed on the claim.

(4) A MO HealthNet participant shall not be liable for payment for an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the MO HealthNet Division.

(5) The review process for Provider Preventable Conditions (PPC) will include a review of the claim and, if applicable, any informa-

tion provided during the inpatient certification review to determine if the length of stay was extended by the PPC. Medical records will be requested from the provider as needed to complete the review. Providers will be required to submit the medical records to the MO HealthNet Division within thirty (30) days of receipt of the request for records. Medical records will be reviewed by clinically appropriate medical professionals within the MO HealthNet Division or its contracted medical consultants to assess the quality of medical care provided and the circumstances surrounding that care. MO HealthNet payment denials or recoupments will be calculated by the MO HealthNet Division based on the facts of each OPPC or HCAC. The calculation of the denial of payment or recoupment will be reviewed by the MO HealthNet Division Medical Director and the MO HealthNet Division Director after consideration of the review findings provided by the clinical staff who completed the review. The final decision of the division regarding the denial of payment or recoupment shall be subject to review by the Administrative Hearing Commission pursuant to the provisions of section 208.156, RSMo. Such payment limitation shall only apply to the hospital or ambulatory surgical center where the OPPC or HCAC occurred and shall not apply to care provided by other hospitals should the patient subsequently be transferred or admitted to another hospital for needed care.

(6) A MO HealthNet participant shall not be liable for payment, and must not be billed, for any item or service related to a PPC.

*AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2011. * Material in this rule originally filed as 13 CSR 70-15.200. Original rule filed Nov. 30, 2011, effective June 30, 2012.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-3.240 MO HealthNet Primary Care Health Homes

PURPOSE: This rule establishes the MO HealthNet Primary Care Health Home program for MO HealthNet participants with chronic conditions.

(1) Definitions.

(A) EMR—Electronic Medical Records, also referred to as Electronic Health Records (EHR).

(B) Health Home—A primary care practice

or site that provides comprehensive primary physical and behavioral health care to MHD patients with chronic physical and/or behavioral health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary care and to avoid preventable hospitalization or emergency department use for conditions treatable by the Health Home.

(C) Learning Collaborative—Group training sessions that primary care providers must attend if they are chosen to participate in the MO HealthNet Health Home program. The training will include meetings with mandatory attendance by certain officers and medical staff of the Health Home site and monthly conference calls.

(D) Meaningful Use Stage One—The American Recovery and Reinvestment Act (ARRA) of 2009 created the Electronic Health Records (EHR) incentive payments program to provide Medicare or Medicaid incentive payments to eligible professionals in primary care practices. Meaningful use means that the eligible professionals or providers document that they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. Stage one of meaningful use means the eligible professionals meet twenty (20) out of twenty-five (25) meaningful use objectives as specified by the Centers for Medicare and Medicaid Services (CMS).

(E) MHD—MO HealthNet Division, Department of Social Services.

(F) NCQA—National Committee of Quality Assurance, the entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.

(G) Needy Individuals—Patients whose primary care services are either reimbursed by MHD or the Children's Health Insurance Program (CHIP), or are provided as uncompensated care by the primary care practice, or are furnished at no cost or at reduced cost to patients without insurance.

(H) Patient Panel—The list of patients for whom each provider at the practice site serves as the primary care provider.

(I) CMS—Centers for Medicare and Medicaid Services.

(2) A primary care practice site shall meet the following requirements at the time of the site's application to be considered for selection as a Health Home site by MHD and for participation in a Health Home learning collaborative:



(A) It must have substantial Medicaid utilization in its patient population, with needy individuals comprising no less than twenty-five percent (25%) of its patient population;

(B) It must demonstrate that it has strong engaged leadership committed to, and capable of, leading the practice site through a continuing Health Home transformation process and sustaining transformed practice processes;

(C) It must have patient panels assigned to each primary care clinician;

(D) It must actively utilize MHD's comprehensive electronic health record for care coordination and prescription monitoring for MHD participants;

(E) It must utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;

(F) It must meet the minimum access requirements of third-next-available appointment within thirty (30) days and same-day urgent care;

(G) It must have completed EMR implementation and have been using EMR at stage one of meaningful use for at least six (6) months prior to the beginning of Health Home services; and

(H) It must comply with established time frames for Health Home applications, inquiry submission, learning collaborative attendance, and any reporting deadlines.

(3) Health Home Responsibilities After Selection.

(A) Health Home practice sites will be physician- or nurse practitioner-led and shall form a health team comprised of, at a minimum, a primary care physician (i.e., family practice, internal medicine, or pediatrics) or nurse practitioner, a licensed nurse or medical assistant, a behavioral health consultant, a nurse clinical care manager, and the practice administrator or office manager. The team will be supported as needed by the care coordinator and Health Home Director. Other team members may include, for example, dietitians, nutritionists, pharmacists, or social workers.

(B) Practice sites selected to be MHD Health Homes shall participate in Health Home learning collaboratives. MHD will announce the dates and locations for learning collaborative meetings.

1. At a minimum, each Health Home practice site shall send to the learning collaborative meetings a team consisting of a senior clinician, another clinician, and a non-clinician member of the practice (site) such as the practice manager or practice administrator.

2. A Health Home will participate in monthly learning collaborative conference calls or webinars.

3. A Health Home will participate in topical work groups as requested by MHD.

4. A practice organization that has more than one (1) of its practice sites recognized by MHD as Health Homes, but not all of its sites selected for learning collaborative participation, shall designate a trainer to participate in a "train the trainer" program. The trainer shall attend the learning collaborative as a member of a practice's core practice team and then train all of the organization's other Health Home practice sites that were not selected for learning collaborative participation. MHD or its designee shall identify content that the practice organization trainer will teach to the Health Home practice sites that do not participate in the learning collaborative.

(C) Health Homes shall convene practice team meetings at regular intervals to assist with the practice's transformation into a Health Home and to support continual Health Home evolution.

(D) A Health Home shall create and maintain a patient registry using EHR software, a stand-alone registry, or a third-party data repository and measures reporting system. The patient registry is the system used to obtain information critical to the management of the health of a primary care practice's patient population, including dates of services, types of services, and laboratory values needed to track chronic conditions. The Health Home's patient registry will be used for—

1. Patient tracking;
2. Patient risk stratification;
3. Analysis of patient population health status and individual patient needs; and
4. Reporting as specified by MHD.

(E) Primary care practice sites must transform how they operate in order to become Health Homes. Transformation involves mastery of thirteen (13) Health Home core competencies to be taught through the learning collaborative. The thirteen (13) core competencies are—

1. Patient/family/peer/advocate/care-giver-centeredness or a whole-patient orientation to care;
2. Multi-disciplinary team-based approach to care;
3. Personal patient/primary care clinician relationships;
4. Planned visits and follow-up care;
5. Population-based tracking and analysis with patient-specific reminders;
6. Care coordination across settings, including referral and transition management;

7. Integrated clinical care management services focused on high-risk patients including medication management, such as medication histories, medication care plans, and medication reconciliation;

8. Patient and family education;

9. Self-management support by members of the practice team;

10. Involvement of the patient in goal setting, action planning, problem solving, and follow-up;

11. Evidence-based care delivery, including stepped care protocols;

12. Integration of quality improvement strategies and techniques; and

13. Enhanced access.

(F) By the eighteenth month following the receipt of the first MHD Health Home payment, a practice site participating in the Health Home program shall demonstrate to MHD that the practice site has either—

1. Submitted to the National Committee of Quality Assurance (NCQA) an application for Health Home status and has obtained NCQA recognition of Health Home status at "Level 1 Plus." "Level 1 Plus" recognition is defined for these purposes as meeting 2011 NCQA Level 1 standards, plus recognition for achieving the following 2011 NCQA patient-centered medical home standard at the specified level of performance: Standard 3C at one hundred percent (100%), or at seventy-five percent (75%) with an acceptable plan of correction; or

2. Submitted to NCQA an application for Health Home status and has obtained NCQA recognition of Health Home status at "Level 1 Plus," defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus recognition for achieving the following NCQA 2008 PPC-PCMH standards at the specified levels of performance: Standard 3C at seventy-five percent (75%), Standard 3D at one hundred percent (100%), and Standard 4B at fifty percent (50%).

(G) A Health Home shall submit to MHD or its designee the following information, as further specified by MHD or its designee, within the specified time frames:

1. Monthly narrative practice reports that describe the Health Home's efforts and progress toward implementing Health Home practices;

2. Monthly clinical quality indicator reports utilizing clinical data obtained from the Health Home's patient registry or third-party data repository;

3. Periodic submission of Medicaid Home Implementation Quotient (MHIQ) survey scores, as specified by MHD; and

4. Other reports as specified by MHD.

(H) Practices selected to participate in the



Health Home program must provide evidence of Health Home practice transformation on an ongoing basis using measures and standards established by MHD. Evidence of Health Home transformation includes:

1. Development of fundamental Health Home functionality at six (6) months and at twelve (12) months of entering the Health Home program, based on an assessment process to be applied by MHD or its designee;
2. Significant improvement on clinical indicators specified by and reported to MHD or its designee; and
3. Development of quality improvement plans to address gaps and opportunities for improvement identified during and after the Health Home application process.

(I) A Health Home must notify MHD within five (5) working days of the following changes:

1. If the employment or contract of a clinical care manager is terminated after the initiation of clinical care management payments;
2. If the Health Home experiences substantive changes in practice ownership or composition, including:
 - A. Acquisition by another practice;
 - B. Acquisition of another practice; or
 - C. Merger with another practice.

(J) Health Homes shall participate in evaluations determined necessary by CMS and/or MHD. Participation in evaluations may require responding to surveys and requests for interviews of Health Home practice staff and patients. Health Homes shall provide all requested information to an evaluator in a timely fashion.

(K) Within three (3) months of selection to be a Health Home, a practice site will develop agreements or memorandums of understanding to formalize traditional care planning with area hospitals, in which the hospitals agree to—

1. Notify the Health Home when Health Home patients are admitted to inpatient hospital departments;
2. Identify for the Health Home individuals seeking emergency department services who might benefit from connection with the Health Home;
3. Notify the Health Home when Health Home patients seek treatment in the hospitals' emergency departments; and
4. Refer patients to the Health Home for follow-up care.

(4) Health Home Patient Requirements.

(A) To become a MO HealthNet Health Home patient, an individual—

1. Must be an MHD participant or a participant enrolled in an MHD managed

care health plan; and

2. Must have at least—

A. Two (2) of the following chronic health conditions:

- (I) Asthma;
- (II) Diabetes;
- (III) Cardiovascular disease;
- (IV) A developmental disability; or
- (V) Be overweight, as evidenced by

having a body mass index (BMI) over twenty-five (25); or

B. One (1) chronic health condition and be at risk for a second chronic health condition as defined by MHD. In addition to being a chronic health condition, diabetes shall be a condition that places a patient at risk for a second chronic condition. Smoking or regular tobacco use shall be considered at-risk behavior leading to a second chronic health condition.

(B) A participant eligible for Health Home services and identified by MHD as an existing user of Health Home services will be auto-assigned to a Health Home based on qualifying chronic health conditions. A participant not enrolled in an MHD managed care health plan will be attributed to a Health Home using a standard patient algorithm adopted by MHD. A participant enrolled in an MHD managed care health plan will be attributed to a Health Home practice site that the participant has selected or to which the participant has been assigned by the health plan.

(C) After being assigned to Health Homes, participants will be granted the option at any time to change their Health Homes if desired. A participant assigned to a Health Home will be notified by MHD of all available Health Home sites throughout the state. The notice will—

1. Describe the participant's choice in selecting a Health Home;
2. Provide a brief description of Health Home services, including the role of care managers and coordinators; and
3. Describe the process for the participant to opt out of receiving services from the assigned Health Home provider.

(D) Participants eligible for Health Home services who receive inpatient hospital or hospital emergency department services will be notified of eligible Health Homes and will be referred to Health Homes based on their choice of providers. Participants who are admitted to a hospital or who receive hospital emergency department services will be identified as eligible for Health Home services through the MHD comprehensive Medicaid electronic health record.

(E) Health Home providers to which patients have been auto-assigned will be noti-

fied by MHD of patients' enrollment for Health Home services. The Health Homes will notify their patients' other treatment providers in order to explain Health Home goals and services, and to encourage their patients' other treatment providers to participate in care coordination efforts.

(5) Required Health Home Services.

(A) All Health Homes shall provide clinical care management services for enrolled patients, including those who are at high risk for future hospital inpatient admissions or hospital emergency department use.

1. Essential clinical care management services include:

A. Identification of high-risk patients and use of patient information to determine the level of participation in clinical care management services;

B. Assessment of preliminary service needs;

C. Individual treatment plan development for each patient, including patient goals, preferences, and optimal clinical outcomes;

D. Intensive monitoring, follow-up, and clinical management of high-risk patients;

E. Assignment of health team roles and responsibilities by the clinical care manager;

F. Monitoring of individual and population health status and service use to determine adherence to, or variance from, treatment guidelines;

G. Development of treatment guidelines for health teams to follow across risk levels or health conditions; and

H. Development and dissemination of reports that indicate progress toward meeting desired outcomes for client satisfaction, health status, service delivery, and costs.

2. Clinical care management activities generally include frequent patient contact, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.

3. A Health Home shall employ or contract with at least one (1) licensed nurse as the Health Home clinical care manager responsible for providing clinical care management services. The clinical care manager shall function as a member of the Health Home practice team whenever patients of the practice team are receiving clinical care management services.

4. Health Homes shall ensure and document that funding for clinical care management services is used exclusively to provide clinical care management services.



5. Recognized Health Homes may collaborate in the provision of clinical care management services.

(B) Health Homes shall provide health promotion services for their patients. Health promotion services include:

- 1. Providing health education specific to a patient's chronic conditions;
- 2. Emphasizing patient self-direction, planning, and skill development so patients can help manage and monitor their chronic health conditions;
- 3. Providing support for improving social networks; and
- 4. Providing health-promoting lifestyle interventions, including but not limited to:
 - A. Substance abuse prevention;
 - B. Smoking prevention and cessation;
 - C. Nutritional counseling;
 - D. Obesity prevention and reduction;

and

E. Physical exercise activities.

(C) All Health Homes shall provide comprehensive care coordination services necessary to implement individual treatment plans, reduce hospital inpatient admissions, and interrupt patterns of frequent hospital emergency department use.

1. Care coordination requires that a member of the Health Home team assist patients in the development, revision, and implementation of their individual treatment plans.

2. Care coordination also includes appropriate linkages, referrals, and follow-ups to needed services and supports.

3. Health Homes that specialize in primary physical health care shall obtain the services of a licensed behavioral health professional to assist with care coordination services.

4. Other essential care coordination activities include:

- A. Appointment scheduling;
- B. Arranging transportation for medically-necessary services;
- C. Monitoring referrals and follow-ups;
- D. Providing comprehensive transitional care by collaborating with physicians, nurses, social workers, discharge planners, pharmacists, and other health care professionals to continue implementation of patients' treatment plans;

E. For patients with developmental disabilities (DD), coordinating with DD case managers for services more directly related to habilitation and other DD-related services;

F. Referring Health Home patients to social and community resources for assistance in areas such as legal services, housing, and disability benefits; and

G. Providing individual and family support services by working with patients and their families to increase their abilities to manage the patients' care and live safely in the community.

(6) Hospitals and participating Health Home sites shall communicate transitional care planning for Health Home participants, including inpatient discharge planning, such that effective patient-centered, quality-driven provider coordination is ensured.

(7) Health Home Payment Components.

(A) General.

1. All Health Home payments to a practice site are contingent on the site meeting the Health Home requirements set forth in this rule. Failure to meet these requirements is grounds for revocation of a site's Health Home status and termination of payments specified within this rule.

2. MO HealthNet Health Home reimbursement will be in addition to a provider's existing MHD reimbursement for services and procedures and will not change existing reimbursement for a provider's non-Health Home services and procedures.

3. No Health Home payments will be made to an MHD Health Home until the calendar month immediately following the Health Home's first learning collaborative session.

4. Should experience reveal to MHD that elements of the Health Home payment methodology will not function, or are not functioning, as MHD intended, MHD reserves the right to make changes to the payment methodology after consultation with recognized Health Homes and receipt of required federal approvals.

(B) MHD Health Homes shall receive per-member-per-month (PMPM) payments to reimburse Health Home sites for costs incurred for patient clinical care management services, comprehensive care coordination services, health promotion services, and Health Home administrative and reporting costs.

1. A Health Home's PMPM reimbursement will be determined from the number of patients that choose, or are assigned to, the Health Home site.

2. A current month's PMPM payments to a Health Home site will be based on—

A. The number of Health Home-eligible patients receiving Health Home services at the Health Home in the month considered for payment;

B. The number of Health Home-eligible patients in subparagraph (7)(B)2.A. who are assigned to the Health Home at the begin-

ning of the month considered for payment; and

C. The number of Health Home-eligible patients in subparagraphs (7)(B)2.A. and (7)(B)2.B. who are Medicaid-eligible at the end of the month considered for payment.

3. During the first year of participation in the Health Home program, a Health Home will receive PMPM payments only for MHD or MHD managed care participants—

A. With two (2) or more of the following chronic conditions:

- (I) Asthma;
- (II) Diabetes;
- (III) Cardiovascular disease, including hypertension;
- (IV) Overweight (BMI > 25); or
- (V) Developmental disabilities; or

B. With one (1) of the conditions in subparagraph (7)(C)3.A. and be at risk for a second chronic condition because of diabetes or tobacco use.

4. In order to generate a PMPM payment to a Health Home, a patient assigned to the Health Home must have received at least one (1) non-Health Home service based on paid Medicaid fee for service or managed care claims.

5. In order to receive PMPM payments, a Health Home must demonstrate to MHD that the Health Home has hired, or has contracted with, a clinical care manager to provide services at the Health Home site.

(8) Health Home Corrective Action Plans.

(A) Health Homes shall undergo an assessment process to be applied by MHD or its designee at six (6) months and at twelve (12) months of entering the Primary Care Health Home program. If the assessment shows that a Health Home practice site fails to meet the Health Home requirements as set forth in section (3) of this rule, or fails to provide the required Health Home services as set forth in section (5) of this rule, the Health Home practice site shall participate in a corrective action plan to address any such failures disclosed as a result of the assessment process. The corrective action plan will last for six (6) months and may be extended or renewed at MHD's discretion. At the end of the corrective action plan period, the Health Home practice site will be reassessed to determine its compliance with the requirements of this rule.

(B) The Health Home practice site will be reassessed at the end of the corrective action plan period, including any extensions and renewals granted by MHD. If the reassessment shows that the Health Home still fails to meet Health Home requirements or provide required Health Home services, MHD shall



terminate the Health Home practice site from the Primary Care Health Home program.

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**Original authority: 208.201, RSMo 1987, amended 2007.*