



Rules of
Department of Social Services
Division 65—Missouri Medicaid Audit and Compliance
Chapter 3—Providers and Participants—General Provider
and Participant Policies

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

**Division 65—Missouri Medicaid Audit
and Compliance**

**Chapter 3—Providers and Participants—
General Provider and Participant Policies**

**13 CSR 65-3.010 Participant Lock-In
Program**

PURPOSE: This rule establishes a process to safeguard against unnecessary or inappropriate utilization of care and services by MO HealthNet participants by identifying excessive use patterns in order to rectify overutilization practices of participants.

(1) Definitions applicable to the administration of this program are as follows:

(A) “Lock-In” means limiting or restricting a participant’s ability to access services to a single physician and/or a single pharmacy to reduce excessive MO HealthNet benefits usage;

(B) “Medically necessary” means health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine;

(C) “Misutilization” or “misuse” means overusing, underusing, or using MO HealthNet services in a way that is harmful, wasteful, and uncoordinated or using services provided under the MO HealthNet program in an improper or incorrect manner, whether that use is intentional or unintentional;

(D) “Overlap” means at least one (1) day of overlapping dispensing of prescriptions written by two (2) or more different prescribers; and

(E) “Therapeutic class” means a class of medications that are used to treat similar medical conditions.

(F) “MMAC approved pharmacy” means a licensed pharmacy that is currently enrolled with MO HealthNet and is not currently sanctioned or under investigation by any federal or state authority.

(G) “MMAC approved physician” means a licensed physician that is currently enrolled with MO HealthNet and is not currently sanctioned or under investigation by any federal or state authority.

(2) Unless a participant shows that the service or product provided to the participant was otherwise medically necessary, the Missouri Medicaid Audit and Compliance Unit (MMAC) may place the participant in the Lock-In Program if the participant’s utilization of benefits exceeds one (1) or more of the following parameters during a three- (3-)

month period:

(A) Use of three (3) or more drugs in the same therapeutic class such that the prescriptions of such drugs overlap;

(B) Use of three (3) or more pharmacies;

(C) Use of sixteen (16) or more prescriptions for therapeutic classes such as, but not limited to, analgesics, anticonvulsants, skeletal muscle relaxants, anxiolytics, or other potential drugs of misuse;

(D) Use of three (3) or more providers that specialize in a same or similar service or product;

(E) Use of three (3) or more different emergency departments; or

(F) Use by referral, review, or other analysis that indicates possible overutilization or that identifies a patient safety issue.

(3) Placement in the Lock-In Program.

(A) The decision to place a participant in the Lock-In Program is at MMAC’s discretion. MMAC is to consider the following factors when deciding whether to place the participant in the Lock-In Program:

1. Seriousness of the findings – MMAC will consider the seriousness of the findings including, but not limited to, overlaps of the same therapeutic class of prescription medications, the use of multiple pharmacies, the prescription of the same therapeutic class of prescription medications by multiple, like, or different prescribers, emergency department visits for non-emergent services, the use of multiple emergency departments in different locations, and the use of multiple primary care clinics;

2. Extent of Inappropriate Utilization of Services – MMAC will consider the extent as measured by, but not limited to, the number of overlapping prescriptions within the same therapeutic class prescribed by different prescribers and the number of emergency department visits and locations for diagnoses that are non-emergent such as back pain, lumbago, pain in limb, or toothache;

3. Prior History of Action Taken by the Lock-In Section – MMAC will consider whether or not the participant has been given prior education by the Lock-In Section which includes any education letters, warning letters, or previous placement in the Lock-In Program.

(4) A participant shall be placed in the Lock-In Program if the participant’s utilization of benefits was misused by any of the following methods:

(A) Lending or giving the participant’s Medicaid ID card to ineligible individuals who are not eligible for Medicaid;

(B) Submitting, or causing to be submit-

ted, forged documents to providers for medical benefits or services;

(C) Refusing to submit to, or failing to have predicted, urine or blood levels following testing for medications prescribed to the participant and covered by the MO HealthNet program while engaged in a pain management or substance use disorder treatment program; or

(D) Paying cash for prescribed medications covered by the MO HealthNet program.

(5) Once MMAC identifies a participant that falls under subsection (2) or (3) of this rule and notifies the participant of its decision to place the participant in the Lock-In Program, the participant is to provide MMAC with the following:

(A) Notification within twenty (20) days of the participant’s selection of a single physician and a single pharmacy that must be approved by MMAC. In the event the participant fails to select an MMAC approved physician and pharmacy, MMAC will select a single physician and a single pharmacy on behalf of the participant;

(B) Notification if the participant requires more than one (1) physician or pharmacy for the purposes of specialized medical treatment. MMAC may permit a participant to select more than one (1) physician or pharmacy upon showing of such need; and

(C) Notification of any request to change a selected physician and/or pharmacy. A participant may not request to change selection of physician and/or pharmacy more than once within a three (3) consecutive month period unless additional provider changes within that three (3) consecutive month period are approved upon verification of just cause. A participant may only change a selected physician and/or pharmacy if any of the following occur:

1. The physician or pharmacy moves, retires, dies, discontinues MO HealthNet participation, or refuses to provide care to the participant; or

2. The participant moves from the physician’s service area.

(6) A participant who is subject to the Lock-In Program may not select a single physician and single pharmacy if the single physician and/or single pharmacy decline to serve as the participant’s single physician or pharmacy.

(7) A participant who is subject to the Lock-In Program may only receive services from a provider who is not the designated physician and/or a pharmacy that is not the designated pharmacy in the following circumstances:



- (A) Documented medical emergencies;
- (B) Upon referral by the participant's designated Lock-In provider; or
- (C) As otherwise authorized by MMAC.

(8) A participant who is placed in the Lock-In Program will be subject to Lock-In for a minimum of twenty-four (24) months. If after twenty-four (24) months, MMAC determines that the participant is continuing to misuse the MO HealthNet program as set forth in this rule, MMAC may impose an additional Lock-In period for up to twenty-four (24) additional months.

(9) Any participant who is aggrieved by a decision made under this regulation may seek administrative review under section 208.080, RSMo.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed July 19, 2018, effective Feb. 28, 2019.*

**Original authority: 208.201, RSMo 1987, amended 2007 and 660.017, RSMo 1993, amended 1995.*

13 CSR 65-3.050 Electronic Signatures for Mo HealthNet Program

PURPOSE: This rule establishes the basis on which Health Care Providers and participants under Missouri Medicaid Title XIX Programs may utilize electronic signatures when validating services rendered and received.

(1) As used in this rule, the following terms shall mean:

(A) "Electronic Medical Record" means a record 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. Electronic Medical Records may be referred to as "Electronic Health Records;"

(B) "Electronic Record" means an electronic record of health-related information on an individual, from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty;

(C) "Electronic Signature" means a computer data compilation of any symbol or series of symbols executed, adopted, or authorized by an individual with the intent to be the legally binding equivalent of the individual's handwritten signature. The use of biometrics does not constitute an electronic signature; however, biometrics may be used as part of electronic signature verification. A signature stamp does not constitute an electronic signature;

(D) "Participant" means any individual who is a participant in the Missouri Medicaid Title XIX or Title XXI programs;

(E) "Provider" means any health care provider that participates or provides services under Title XIX and under Title XXI of the federal Social Security Act.

(2) This rule applies to any Electronic Record, Electronic Health Record or Electronic Medical Record, or Electronic Signature, as defined herein.

(3) If a law or regulation requires a record to be in writing, an electronic record shall satisfy such law for MO HealthNet purposes. If a law or regulation requires a signature to be in writing, an electronic signature shall satisfy such law for MO HealthNet purposes.

(4) An electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

(5) Electronic records and electronic medical records are subject to the retention requirements set forth in 13 CSR 70-3.030 and 13 CSR 70-3.210.

(6) Nothing herein shall require a provider to conduct business electronically, but if a provider chooses to conduct business electronically, the following requirements shall apply:

(A) Only employees or agents designated by the provider may make entries in a participant's electronic record or electronic medical record;

(B) All entries in a participant's electronic record or electronic medical record must be authenticated with a method established to identify the author. The method utilized may include computer keys/codes or biometric identification systems that utilize a personal identification number (PIN). When computer key/code(s), biometric identification systems, or other codes are used, these methods must be under the sole control of the employee or agent using them. Providers must be able to demonstrate that adequate safeguards are maintained to protect against improper or unauthorized use of these methods;

(C) A provider shall have a process in place to deactivate and disable an employee's or an agent's access to electronic records and electronic medical records upon suspension or termination of an employee's or agent's employment or agency relationship;

(D) Providers' electronic records and electronic medical records systems shall maintain an activity tracking system to monitor and record user activity for all documents in a

participant's record that are viewed, created, updated, or modified. The tracking system must record the following for each activity:

1. User log-in and log-out dates and times;
2. User identification;
3. Device identification, such as a Media Assigned Control (MAC) address; and
4. Dates and times when records are viewed, created, updated, or modified; and

(E) Providers shall ensure measures are in place to assure that the signer cannot deny having signed the record.

(7) Electronic medical records shall contain the following:

(A) The name, title, and electronic signature of the MO HealthNet enrolled provider delivering the service; and

(B) The date the electronic signature was executed.

(8) The process of affixing an electronic signature shall require at least two (2) distinct identification components, such as an identification code and a password.

(9) When a change is made to an electronic record or electronic health record, the following requirements apply:

(A) All original records shall be maintained; and

(B) Any edits or changes to the record shall be saved, and the record shall contain the date of the edit or change, the reason for the edit or change, and the author of the edit or change.

AUTHORITY: sections 208.159 and 660.017, RSMo 2016. Original rule filed April 6, 2017, effective Nov. 30, 2017.*

**Original authority: 208.159, RSMo 1979 and 660.017, RSMo 1993, amended 1995.*

13 CSR 65-3.060 Computation of Provider Overpayment by Statistical Sampling

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

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

(A) "Claim for payment" or "claim" means the Internal Control Number (ICN) and the associated data submitted to the



Medicaid agency for the purpose of obtaining payment by the Title XIX Medicaid Program;

(B) “Disproportionate Stratified Random Sampling Technique” means a sampling method in which the size of the sample drawn from a particular stratum is not proportional to the relative size of that stratum;

(C) “Medicaid agency” or “the agency” means the single state agency administering or supervising the administration of the state Medicaid plan;

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

(E) “Provider” means any person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity that enters into a contract or provider agreement with the Medicaid agency for the purpose of providing services to Medicaid-eligible persons and obtaining from the Medicaid agency reimbursement for services;

(F) “Sampling Unit” means one (1) of the units into which an aggregate (e.g. total paid on claims) is divided for the purpose of sampling. For example a sampling unit may be ICNs, a specific procedure code or codes, or participant DCNs (Document Control Numbers);

(G) “Stratum” refers to a sampling method in which the universe is divided into non-overlapping subgroups. Each of the subgroups is called a stratum, and two (2) or more subgroups are called strata; and

(H) “Universe” 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.

(2) The Medicaid agency may use a Disproportionate Stratified Random Sampling Technique to establish provider overpayments. This technique is an extrapolation of a statistical sampling of claims used to determine the total overpayment for recoupment.

(3) 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 sampling, 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 of service and total paid for the Universe;

(B) Definition of the sampling unit;

(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.

(4) The extrapolated overpayment is a final decision regarding administration of the state Medicaid plan and is subject to appeal in accordance with section 208.156, RSMo.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed Aug. 28, 2018, effective April 30, 2019.*

**Original authority: 208.201, RSMo 1987, amended 2007 and 660.017, RSMo 1993, amended 1995.*