



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**
(Rescinded March 30, 2022)

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. Rescinded: Filed Aug. 20, 2021, effective March 30, 2022.

**13 CSR 70-3.030 Sanctions for False or
Fraudulent Claims for MO HealthNet Ser-
vices**

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.

(A) 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 pub-

lished by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website dss.mo.gov/mhd, October 1, 2017. This rule does not incorporate any subsequent amendments or additions.

(B) When a rule published in the *Missouri Code of State Regulations* relating to a specific provider type or service incorporates by reference a MO HealthNet provider manual which contains a later date of incorporation than 13 CSR 70-3.030, the manual incorporated into the more specific rule shall be applied in place of the manual incorporated into 13 CSR 70-3.030.

(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 five (5) business days, 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 autho-

rized 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 inappropriate 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 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, October 1, 2017. This rule does not incorporate any subsequent amendments or additions or fail to comply with the terms of the provider certification on the MO HealthNet claim form;

8. Utilizing or abusing the MO HealthNet 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 pro-

gram 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 compli-

ance 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 report-

ed 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/individuals with intellectual disabilities (IID) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/IIDs) 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 of mailing or delivery of said notice, whichever occurs first. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date of mailing or delivery of a decision of the Department of Social Services or its designated division, whichever occurs first. 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 three (3) days after mailing of the notice to the provider or immediately upon receipt of notice by the provider, whichever occurs first.

(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 re-enrolled 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 re-enrolled 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 or delivered 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 may take appropriate action to collect the overpayment forty-five (45) days from the date of mailing or delivery of said notice, whichever occurs first. 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 of an overpayment and the amount due is in excess of one thousand dollars (\$1,000), the provider, within fourteen (14) days of the notice being mailed or delivered to the provider, whichever occurs first, 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 from the date of mailing or delivery of a decision of the notice of the overpayment to the provider, whichever occurs first, 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 fourteen (14) days of mailing 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, 208.201, and 660.017, RSMo 2016. * 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. Amended: Filed Sept. 16, 2013, effective April 30, 2014. Amended: Filed Aug. 15, 2014, effective Feb. 28, 2015. Amended: Filed Oct. 15, 2015, effective April 30, 2016. Amended: Filed Oct. 3, 2016, effective May 30, 2017. Amended: Filed Sept. 22, 2017, effective May 30, 2018.

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.040 Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments
(Rescinded November 30, 2018)

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. Rescinded: Filed April 18, 2018, effective Nov. 30, 2018.

13 CSR 70-3.050 Obtaining Information From Providers of Medical Services
(Rescinded February 28, 2022)

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. Rescinded: Filed July 16, 2021, effective Feb. 28, 2022.

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—Point-of-Service (POS), on-line claim format—National Council for Prescription Drug Programs (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 form (02-12) version or electronic claim submission;

(E) Dental Claim—American Dental Association (ADA) 2019 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. For specific claim filing instructions information, reference the appropriate—

(A) MO HealthNet provider manual, which is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jeffer-

son City, MO 65109, at its website at <http://manuals.momed.com/manuals/>, January 15, 2020. This rule does not incorporate any subsequent amendments or additions; and

(B) Forms, 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 <http://manuals.momed.com/manuals/presentation/forms.jsp>, January 15, 2020. 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 of 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 service.

(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 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, 208.201, and 660.017, RSMo 2016. 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. Amended: Filed Sept. 27, 2018, effective May 30, 2019. Amended: Filed Jan. 22, 2020, effective Aug. 30, 2020.

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma, and 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, except providers as defined in sections 198.006(14) and (23), RSMo.

(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, 208.201, and 660.017, RSMo 2016. 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. Amended: Filed Dec. 10, 2019, effective June 30, 2020.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.130 Computation of Provider Overpayment by Statistical Sampling
(Rescinded April 30, 2019)

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. Rescinded: Filed Aug. 28, 2018, effective April 30, 2019.

13 CSR 70-3.140 Direct Deposit of Provider Reimbursement

PURPOSE: This rule requires the direct deposit of MO HealthNet provider payments and describes the procedure by which those payments will be made.

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) Enrolled providers must have their MO HealthNet payments automatically deposited into an authorized bank account.

(2) Unless otherwise agreed upon by the Department of Social Services, MO HealthNet providers must complete the Electronic Funds Transfer (EFT) Authorization Agreement, which is incorporated by reference and made a part of this rule as published by the Missouri Medicaid Audit and Compliance Unit (MMAC), 205 Jefferson Street, 2nd Floor, Jefferson City, MO 65101, and available on the MMAC website at <https://mmac.mo.gov/providers/provider-enrollment/new-providers/provider-enrollment-forms/>, August 27, 2021. This rule does not incorporate any subsequent amendments or additions.

(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. 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 by the person 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 by an owner or managing employee of the entity. Signature stamps or other facsimiles will not be accepted.

(4) MMAC may 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: sections 208.201 and 660.017, RSMo 2016. Original rule filed Oct. 4, 1993, effective June 6, 1994. Amended: Filed June 1, 2010, effective Dec. 30, 2010. Amended: Filed Aug. 27, 2021, effective March 30, 2022.*

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

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 III5 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
(Rescinded November 30, 2021)

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. Rescinded: Filed May 28, 2021, effective Nov. 30, 2021.

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
(Rescinded January 30, 2019)



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. Rescinded: Filed June 8, 2018, effective Jan. 30, 2019.

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 October 1, 2013, 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 2012 gross receipts will be obtained through survey sent out by the state in 2013). Collection of the ambulance service reimbursement allowance beginning October 1, 2013, and thereafter each October 1, shall be based on gross receipts collected in the prior calendar year. (i.e. October 1, 2013 shall be based on gross receipts collected in calendar year 2012).

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 beginning October 1, 2013. The ambulance service reimbursement allowance rate beginning October 1, 2013 determined by the division, as set forth in subsection (1)(B) above, is as follows:

(A) The ambulance service reimbursement allowance rate shall be three and seventy-four hundredths percent (3.74%) of gross receipts as determined in paragraph (1)(A)5. above with an aggregate annual adjustment, by the MO HealthNet Division, not to exceed one percent (1.0%) 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. 2013. * Original rule filed March 19, 2010, effective Nov. 30, 2010. Amended: Filed Oct. 10, 2013, effective April 30, 2014.*

**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.

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) Definitions.

(A) "Provider Preventable Conditions (PPC)" is 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)" means conditions that occurred during a Medicaid inpatient hospital stay. HCACs are set forth in the most current 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)" means conditions occurring in any health care setting that include, at a



minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient pursuant to 42 CFR 447.26(b).

(2) Payment to hospitals or ambulatory surgical centers 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 and would otherwise result in an increase in payment. HCAC conditions are identified in the list of Medicare Hospital Acquired Conditions, which are published by The Centers for Medicare & Medicaid Services (CMS) at their website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html, September 8, 2020. A copy of the list of Medicare Hospital Acquired Conditions from September 8, 2020, is incorporated by reference and made a part of this rule, as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Ct, Jefferson City, MO 65109, at its website at <https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action>. This rule does not incorporate any subsequent amendments or additions published by CMS after September 8, 2020.

(A) Hospitals or ambulatory surgical centers 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. The POA indicator is to be used according to the Official Coding Guidelines for Coding and Reporting and the Center for Medicare and Medicaid Services (CMS) guidelines. The POA indicator prompts review of inpatient hospital claims with a HCAC diagnosis code.

(B) All MO HealthNet enrolled hospitals or ambulatory surgical centers must report HCACs on claims submitted to MO HealthNet for consideration of payment.

(C) The MO HealthNet Division, or designee, will identify the occurrence of HCACs based on the POA indicator and calculate the payment recoupments based on the facts of each HCAC.

(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 (OPPC) will be denied or recovered by the MO HealthNet Division when the OPPC is determined to—

(A) Be within the control of the hospital or ambulatory surgical center;

(B) Have occurred during an inpatient hospital admission, outpatient hospital care, or care in an ambulatory surgical center;

(C) Have resulted in serious harm;

(D) Otherwise result in an increase in payment of the identified OPPC; and

(E) Be a wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

(4) Other Provider-Preventable Conditions (OPPC) are to be billed as follows:

(A) Medical claims using the CMS 1500 claim form, must be billed with the surgical procedure code and modifier which indicates the type of OPPC: 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 (1) of the first four (4) diagnosis codes on the claim;

(B) 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;

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

1. If there are covered services or procedures provided during the same stay as the OPPC, 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.

2. 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; and

(D) The MO HealthNet Division will identify the occurrence of OPPCs based on the type of bill, diagnoses, procedures, and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) modifiers submitted on the claim. Payment for the claims will be denied, if appropriate.

(5) 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.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Material in this rule originally filed as 13 CSR 70-15.200. Original rule filed Nov. 30, 2011, effective June 30, 2012. Amended: Filed Aug. 28, 2018, effective April 30, 2019. Amended: Filed Nov. 14, 2019, effective May 30, 2020. Amended: Filed Nov. 13, 2020, effective May 30, 2021.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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) 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).

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

(E) NCQA—National Committee for Quality Assurance, an 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.

(F) 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.

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

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

(I) Chronic Pain—Pain that lasts past the time of normal healing and that can lead to other medical conditions such as substance use disorder, becoming overweight/obese, anxiety, and depression. For the purpose of participant eligibility for Primary Care Health Home, chronic pain must be a pre-existing condition for at least twelve (12) consecutive months.

(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 have a physician champion to provide physician leadership and encourage practice transformation to the Health Home model. Health Home practice sites 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 behavioral health consultant, and a nurse clinical care manager. The team will be supported as needed by the care coordinator, Health Home Director, and the practice administrator or office manager. 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 webinars, care team forums, and other training opportunities. A Health Home will participate in topical work groups as requested by MHD.

(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 for Quality Assurance (NCQA) an application for Health Home status and has obtained NCQA recognition of Health Home status of at least Level 1 under the most recent NCQA standard; or

2. Applied to a nationally recognized accrediting organization for certification as a Primary Care Medical Home.

(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; and

3. 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. Changes in the employment or contracting of Health Home team members, or changes in the percentage of full-time equivalent work time devoted to the Health Home by any Health Home team member; or

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 processes with area hospitals to share information on Health Home participants admitted to inpatient departments or seen in the emergency department.

(L) In order to provide Health Home services to a participant with substance use disorder and who is eligible for Health Home services in accordance with subparagraph (4)(A)2.A., a Primary Care Health Home practice must have at least one (1) performing provider who qualifies and applies for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) to provide medication-assisted treatment.

(M) In order to provide Health Home services to enrolled participants with chronic pain, clinicians in a Primary Care Health Home must participate in monthly interactive video conferences on chronic pain that will be scheduled by accredited academic institutions. The video conferences will include pain management specialists who will provide guidance on the care of participants with a chronic pain diagnosis. Health Homes will directly collaborate with a pain management specialist on the management of these individuals. A pain management specialist is defined as a licensed physician (MD or DO) who is board certified in anesthesiology or pain management.

(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 conditions:

- (I) Asthma;
- (II) Diabetes;
- (III) Cardiovascular disease;
- (IV) A developmental disability;
- (V) Be overweight, as evidenced by having a body mass index (BMI) of at least twenty-five (25) for adults, or being at or above the eighty-fifth (85th) percentile on the standard pediatric growth chart for children;
- (VI) Depression;
- (VII) Anxiety;
- (VIII) Substance use disorder; or
- (IX) Chronic pain; 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; or

C. One (1) of the following stand-alone chronic conditions:

- (I) Uncontrolled pediatric asthma as defined by MO HealthNet;
- (II) Obesity, as evidenced by having a BMI over thirty (30) for adults, or being above the ninety-fifth (95th) percentile on the standard pediatric growth chart for children; or
- (III) Chronic pain.

(B) A list of participants eligible for Health Home services and identified by MHD as existing users of services at Health Home practices will be provided monthly to each Health Home based on qualifying chronic health conditions. Health Home organizations will determine enrollees from the lists provided by MHD as well as practice patients identified through the Health Homes' EMR systems.

(C) After being enrolled in Health Homes, participants will be granted the option at any time to change their Health Homes if desired. Participants will be given the opportunity to opt out of receiving services from their Health Home providers.

(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 beginning 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. A Health Home will receive PMPM payments only for MHD or MHD managed care participants who meet the payment requirements in paragraph (7)(B)2. and who have the required qualifying health home conditions specified in section (4).

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.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed Dec. 15, 2011, effective July 30, 2012. Amended: Filed Sept. 29, 2016, effective June 30, 2017. Amended: Filed Nov. 27, 2019, effective June 30, 2020.*

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

13 CSR 70-3.250 Payment Policy for Early Elective Delivery

PURPOSE: This rule establishes the MO HealthNet payment policy for early elective delivery provided in any setting. The goal of this payment policy is to improve health outcomes for both the mother and child.

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) The following definition(s) will be used in administering this rule:

(A) Early Elective Delivery—a delivery by induction of labor without medical necessity followed by vaginal or Caesarean section delivery or a delivery by Cesarean section before thirty-nine (39) weeks gestation without medical necessity.

(2) Early elective deliveries, or deliveries before thirty-nine (39) weeks gestation without a medical indication, shall not be reimbursed by the MO HealthNet Division (MHD). Those delivery-related services shall be denied or recouped by MHD. Non-payment includes services billed by the delivering physicians/provider and the delivering institution.

(3) Services determined to be caused by Early Elective Delivery—

(A) All services provided during the delivery-related stay at the delivering institution for maternal care related to an early elective delivery shall not be reimbursed by MHD. Non-payment or recoupment includes obstetric and institutional or facility charges; and

(B) Non-routine newborn services provided for newborns during the initial delivery-related stay at the delivering institution for conditions resulting from an early elective delivery and that are identified within seventy-two (72) hours of delivery may be subject to review and recoupment. Non-payment or recoupment includes facility or institutional charges.

(4) Payment for delivery prior to thirty-nine (39) weeks shall only be made if delivery is medically indicated.

(A) Services must be consistent with accepted health care practice standards and guidelines. MHD, through consultants, including expertise in obstetrics and pediatrics/neonatology, shall audit deliveries prior to thirty-nine (39) weeks gestational age that are billed to MHD for medical necessity and review those that would potentially be denied due to questions regarding medical necessity and non-routine services provided for newborns during the initial delivery related stay. Documentation must adequately demonstrate sufficient evidence of medical necessity to justify delivery prior to thirty-nine (39) weeks. Evidence shall include information of substantial nature about the pregnancy-complicating condition which is

directly associated with the need for delivery prior to thirty-nine (39) weeks. Delivery will be considered medically necessary if without delivery, the mother or child would be adversely affected (significant and immediate impact on the normal function of the body, illness, infection, mortality).

(B) Delivery must be demonstrated to be—
1. Of clear clinical benefit and required for reasons other than convenience of the patient, family, or medical provider;

2. Appropriate for the pregnancy-complicating condition in question; and

3. Conform to the standards of generally accepted obstetrics practice as supported by applicable medical and scientific literature and as included in the MO HealthNet provider manuals and bulletins, which are incorporated by reference and made 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, dated April 15, 2013.

(C) The determination of services caused by Early Elective Delivery shall be a final decision of the MO HealthNet Division.

(5) If a newborn or mother or both are transferred to another hospital for higher level care following standard medical practice, the receiving hospital shall not be subject to this early elective delivery policy. The hospital receiving the transfer shall be reimbursed following MHD reimbursement rules.

AUTHORITY: section 208.201, RSMo Supp. 2013. Original rule filed March 12, 2014, effective Sept. 30, 2014.*

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

13 CSR 70-3.260 Payment Policy for Asthma Education and In-Home Environmental Assessments

(Moved to 13 CSR 70-25.150)

13 CSR 70-3.280 Home and Community-Based Services Waiver Definitions

PURPOSE: This rule defines terms used in 13 CSR 70-3.290, which implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 42 CFR 441.301(c)(4). These requirements must be met for settings in which home and community-based services are provided under a 1915(c) HCBS Waiver Program.

(1) “Enroll/Enrollment” is the process that Missouri Medicaid Audit and Compliance (MMAC) uses to establish eligibility to receive a Medicaid billing number and/or Medicaid billing privileges. The process includes—

(A) Identification of a provider;

(B) Validation of the provider’s eligibility to provide items or services to Medicaid beneficiaries;

(C) Identification and confirmation of the provider’s practice location(s) and owner(s); and

(D) Granting the provider Medicaid billing privileges and/or a Medicaid billing number.

(2) “Heightened Scrutiny” is a process whereby a provider submits information to Department of Social Services (DSS), or its designee, to overcome the presumption that the setting has the qualities of an institution. If DSS or its designee, based on the information presented by the provider, determines that the setting does have the qualities of a home and community-based setting, the evidence will be sent to the Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services will review evidence submitted by the state and make a final determination as to whether the evidence is sufficient to overcome the presumption that the setting has the qualities of an institution. These settings include those in a publicly or privately-owned facility that provide inpatient treatment; are on the grounds of, or are immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded Home and Community-Based Services (HCBS) from the broader community of individuals not receiving Medicaid-funded HCBS.

(3) “Home and Community-Based Services” are MO HealthNet Division covered services provided to individuals in their own home or community rather than in a hospital, nursing home, or intermediate care facility for individuals with intellectual disabilities.

(4) “Home and Community-Based Services Waiver” is a program approved by the Centers for Medicare and Medicaid Services under the authority of Section 1915(c) of the Social Security Act that provides home and community based services.

(5) “Hospital” is a facility licensed by the Missouri Department of Health and Senior Services, or by the appropriate state agency for facilities located in another state, as an acute care, psychiatric or rehabilitation hospital.



(6) “Institution for Mental Diseases (IMD)” is a hospital, nursing facility, or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.

(7) “Intermediate Care Facilities for individuals with Intellectual disability (ICF/IID)” is a facility as defined at 19 CSR 30-83.010(24).

(8) “Missouri Medicaid Audit and Compliance Unit (MMAC)” is the unit within the Department of Social Services that is responsible for the oversight and auditing of compliance for the Medicaid Title XIX, CHIP Title XXI, and Waiver Program in Missouri, which includes the oversight and auditing of compliance of MO HealthNet providers and Medicaid participants through the lock-in program. MMAC is charged with the responsibility of detecting, investigating, and preventing fraud, waste, and abuse of the Missouri Medicaid Title XIX, CHIP Title XXI, and Waiver Programs.

(9) “MO HealthNet” is the division within the Department of Social Services, pursuant to sections 208.001 and 208.201, RSMo, that administers the Medicaid Title XIX, CHIP Title XXI, and waiver programs, approves claims from MO HealthNet providers for services or merchandise provided to eligible Medicaid participants, and authorizes and disburses payment for those services or merchandise accordingly.

(10) “MO HealthNet Program” is a program operated pursuant to Title XIX of the Social Security Act, Title XXI of the Social Security Act and/or waiver programs authorized by the United States Department of Health and Human Services.

(11) “Licensed Nursing Home” is a skilled nursing facility as defined at 19 CSR 30-83.010(49).

(12) “Person-Centered Service Plan” is a document that is the result of a planning process which identifies the strengths, capacities, preferences, needs, goals, and desired personal outcomes of the individual.

(13) “Provider” is a person or entity who enters into a contract or provider agreement with MMAC for the purpose of providing items or services to Missouri Medicaid participants. Provider includes ordering and referring physicians, dentists, and non-physician practitioners.

(14) “Provider Owned or Controlled Residential Setting” is a physical place where an individual resides and is owned, co-owned, and/or operated by a provider of HCBS. A setting is considered provider owned or controlled if the HCBS provider leases from a third party or owns the property. If the HCBS provider does not lease or own the property but has a direct or indirect financial relationship with the property owner, the setting is considered provider controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants.

(15) “Residential Setting” is a physical place to live where an individual has services and supports, ranging from twenty-four- (24-) hour supervision to on-call assistance, to live as independently as possible.

(16) “Revalidation” is a requirement that all existing MO HealthNet Program providers must go through in accordance with 13 CSR 65-2 to continue to be a MO HealthNet Program provider.

(17) “Setting” is the place where a home and community-based service or support is provided.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed Dec. 21, 2018, effective July 30, 2019.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.290 Home and Community-Based Services Waiver Setting Requirements

PURPOSE: This rule implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 42 CFR 441.301(c)(4) establishing the requirements that must be met for settings in which home and community-based services are provided under a 1915(c) HCBS Waiver Program. 1915(c) Home and Community-Based Services (HCBS) Waiver Programs are programs that provide home and community based services to individuals who, in the absence of those services, require the level of care provided in a hospital, a nursing facility, or an ICF/IID. To offer a 1915(c) HCBS Waiver Program the state must submit a waiver application for

approval to the Centers for Medicare and Medicaid Services, who, on behalf of the Secretary of Health and Human Services, determines if the waiver meets the statutory and regulatory requirements found in 42 CFR 441.301–441.310.

(1) Home and Community-Based Setting Requirements. Home and community-based settings must have all of the following qualities based on the needs of individuals as indicated in their person-centered service plans:

(A) The setting is integrated in and supports full access of individuals receiving Medicaid Home and Community-Based Services (HCBS) to the greater community, including providing opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;

(B) The setting is selected by the individual from setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;

(C) The setting ensures the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint;

(D) The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact;

(E) The setting facilitates individual choice regarding services and supports, and who provides them; and

(F) In a provider-owned or controlled residential setting, in addition to the qualities at 13 CSR 70-3.290 (1)(A) through (E), the following additional conditions must be met:

1. The unit or dwelling is a physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State of Missouri, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, a lease, residency agreement, or other form of written agreement must be in place for each HCBS participant, and that document must provide protections that address eviction processes and appeals comparable to those provided



under the jurisdiction's landlord tenant law;

2. Individuals have privacy in their sleeping or living unit including:

A. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

B. Individuals sharing units have a choice of roommates in that setting;

C. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;

3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

4. Individuals are able to have visitors of their choosing at any time;

5. The setting is physically accessible to the individual; and

6. Any modification of the additional conditions, under (1)(F)1. through 4. of this rule, must be supported by a specific assessed need and justified in the person-centered service plan. If any modifications are made, the following requirements must be documented in the person-centered service plan:

A. A specific and individualized assessed need;

B. Positive interventions and supports used prior to any modifications to the person-centered service plan;

C. Less intrusive methods of meeting the need that have been tried but did not work;

D. A clear description of the condition that is directly proportionate to the specific assessed need;

E. Regular collection and review of data to measure the ongoing effectiveness of the modification;

F. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

G. The informed consent of the individual; and

H. An assurance that interventions and supports will cause no harm to the individual.

(2) Settings that are not Home and Community-Based. Home and community-based settings do not include the following:

(A) A nursing facility;

(B) An institution for mental diseases;

(C) An intermediate care facility for individuals with intellectual disabilities;

(D) A hospital; or

(E) Any other locations that have qualities of an institutional setting, as determined by the Department of Social Services (DSS) or its designee.

(3) Heightened Scrutiny process. Any setting

that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS, will be presumed to be a setting that has the qualities of an institution and is not a home and community based setting. The provider may submit information to DSS or its designee as evidence that the setting does have the qualities of a home and community-based setting. If DSS or its designee, based on the information presented by the provider, determines that the setting does have the qualities of a home and community-based setting, the evidence will be sent to the Centers for Medicare and Medicaid Services to make the final determination as to whether the evidence is sufficient to overcome the presumption that the setting has the qualities of an institution.

(4) Provider Enrollment.

(A) Prior to enrolling with MO HealthNet, HCBS providers will need to certify in writing on forms provided by the Missouri Medicaid Audit and Compliance Unit (MMAC) that they understand and will comply with the requirements of this rule. Providers will certify by the signature of an authorized agent of the business as part of their MO HealthNet application documentation. Providers that refuse to certify shall be denied enrollment with MO HealthNet.

(B) HCBS providers shall be subject to a pre-enrollment site visit per 13 CSR 65-2.020(9)(B)(2)(B). Enrolling HCBS providers who are non-compliant with sections (1)-(3) of this rule shall be denied enrollment with MO HealthNet.

1. Providers who request in writing an extension to their application process in order to become compliant with sections (1)-(3) of this rule shall be granted thirty (30) calendar days to become compliant, without paying an additional application fee per 13 CSR 65-2.020(5). This thirty- (30-) day time period is in accordance with the provisions of 13 CSR 70-3.020(2)(D) and MMAC shall notify the provider in writing of the thirty- (30-) day extension accordingly. If, at the end of the thirty- (30-) day extension, the provider is still non-compliant, the provider shall be denied enrollment.

(5) Provider Revalidation. All MO HealthNet providers must revalidate in accordance with 13 CSR 65-2.020(4). HCBS providers must be compliant with sections (1)-(3) of this rule

upon revalidation or they shall not be entitled to continued MO HealthNet participation. If an enrolled HCBS provider is found to be out of compliance during its revalidation process, the provider shall be granted thirty (30) days to come into compliance or shall be denied continued enrollment in the MO HealthNet program.

(6) Providers enrolled with MO HealthNet on or after March 17, 2014, must be in compliance and maintain continued compliance with all the requirements of this regulation upon publication of the regulation.

(7) Providers enrolled with MO HealthNet prior to March 17, 2014, that do not meet the requirements of this regulation, must come into compliance within ninety (90) days of the publication of this regulation or submit and have approved a remediation plan to come into compliance with the requirements of this regulation. The remediation plan must be submitted and approved by DSS or its designee. All providers must be in compliance with the requirements of this regulation no later than March 17, 2022.

(8) Sanctions. Enrolled providers that are non-compliant with sections (1)-(7) of this rule, during their participation with MO HealthNet, are subject to sanctions per 13 CSR 70-3.030.

(A) DSS or its designee shall inform enrolled providers of non-compliance in writing by e-mail or U.S. Mail.

(B) Enrolled providers shall submit a plan to remediate areas of non-compliance ("transition plan") to DSS or its designee within forty-five (45) calendar days of the notice of non-compliance.

(C) Remediation must be complete within one hundred twenty (120) days of the notice of non-compliance or the provider shall be subject to sanctions per 13 CSR 70-3.030 (5)(A).

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed Dec. 21, 2018, effective July 30, 2019.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.300 Complementary Health and Alternative Therapies for Chronic Pain Management

PURPOSE: This rule establishes the MO HealthNet payment policy for the complementary health and alternative therapies for chronic pain management for adult Medicaid



participants. The goal of this policy is to improve health outcomes and decrease opioid use by adult participants to manage chronic pain.

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 governs the practice of complementary health and alternative therapy for adult participants as a covered MO HealthNet benefit. The intent of this regulation is to provide complementary health and alternative therapy, coordinated by the prescribing physician, in an effort to provide alternatives to opioid use for the treatment of chronic pain, reduce opioid misuse, improve MO HealthNet participants' chronic pain management skills, reduce avoidable costs, and improve health outcomes.

(B) Complementary health and alternative therapy for chronic pain management 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 Physician Provider Manual, which is 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 <http://www.dss.mo.gov/mhd> on August 15, 2018. This rule does not incorporate any subsequent amendments or additions.

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

1. "Adult participant" means a person who is at least twenty-one (21) years of age or older and who is enrolled as a MO HealthNet participant;

2. "Complementary health and alternative therapy for chronic pain" combines the use of physical therapy, cognitive-behavioral therapy, chiropractic therapy, and/or acupuncture to promote chronic pain relief for adult participants;

3. "Physical therapy treatment for

chronic pain" includes, but is not limited to, participant education and counseling, manual techniques, therapeutic exercises, electrotherapy, and massage;

4. "Cognitive-behavioral therapy for chronic pain" or "CBT" combines treatment of emotional thinking and behavioral health for participants with chronic pain, trains in behavioral techniques, and helps patients modify situational factors and cognitive processes that exacerbate pain;

5. "Chiropractic therapy for the treatment of chronic pain" may include, but is not limited to, spinal manipulation or spinal adjustment, and as further defined by section 331.010.1, RSMo;

6. "Acupuncture" involves the use of needles inserted into the body by piercing of the skin and other modalities as defined by sections 331.030.8 and 324.475(1), RSMo;

7. "Prescribing physician" means a physician licensed under Chapter 334, RSMo, who specializes in family medicine or internal medicine and is authorized to prescribe medication or other therapy within the scope of such person's practice;

8. "Complementary health and alternative therapy provider" means a complementary health and alternative therapy care provider licensed by the state of Missouri and authorized to provide health care services within the scope of such person's practice;

9. "First-line non-opioid medication therapy" includes, but is not limited to, analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, cyclooxygenase 2 (COX-2) inhibitors, SAM-E herbal therapy, topical analgesics, selected antidepressants, selected anticonvulsants, and/or muscle relaxer medication;

10. "Opioid medication therapy" includes any prescription drug, natural or synthetic, that binds to the brain's opioid receptors having an addiction-forming or addiction-sustaining ability, or being capable of conversion into a drug having such addiction-forming or addiction-sustaining ability;

11. "Chronic pain" means a non-cancer, non-end-of-life pain lasting more than three (3) months, or longer than the duration of normal tissue healing;

12. "Acute pain" means pain, whether resulting from disease, accidental or intentional trauma, or other cause that the practitioner reasonably expects to last only a short period of time. Acute pain does not include chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care; and

13. "High dose opioid therapy" is to be considered as any therapy greater than ninety

(>90) MME (morphine milligram equivalents) per day.

(2) Covered Services and Limitations of Complementary Health and Alternative Therapy for Chronic Pain Management.

(A) Participant eligibility.

1. To qualify for complementary health and alternative therapy for chronic pain, a MO HealthNet participant must be an adult participant with—

A. Chronic, non-cancer neck and/or back pain; or

B. Chronic pain post traumatic injury, such as traumatic injury resulting from a motor vehicle collision; or

C. Other chronic pain conditions as medically necessary.

2. A prescribing physician's referral to a complementary and alternative therapy provider is necessary for the adult participant to be eligible for complementary health and alternative therapy for chronic pain. The prescribing physician must prescribe the complementary health and alternative therapy in the adult participant's plan of care during a regular in-office visit.

(B) Provider qualifications.

1. To refer or provide complementary health and alternative therapy, the prescribing physician and the complementary health and alternative therapy provider must be currently enrolled as a MO HealthNet provider and currently licensed in Missouri or a bordering state to provide therapy.

2. Both the prescribing physician and the complementary health and alternative therapy provider must meet the provider qualifications outlined in this regulation to deliver and bill for the service.

(C) Medical Services for Complementary Health and Alternative Therapy for Chronic Pain Management.

1. Adult participants may be referred by the prescribing physician for complementary health and alternative therapy to treat and manage chronic back pain, chronic neck pain, chronic pain resulting from a post-traumatic injury, or other chronic pain conditions as medically necessary.

2. The prescribing physician must seek prior authorization from the MO HealthNet Division prior to the adult participant starting complementary health and alternative therapy.

3. A prescribing physician's referral to a complementary and alternative therapy provider is necessary for the adult participant to be eligible for complementary health and alternative therapy.

4. The prescribing physician will perform an initial assessment and provide the



adult participant evidence-based education regarding pain management during the adult participant's regular in-office visit.

5. The prescribing physician shall evaluate adult participants in the initial assessment for any potentially serious condition and refer the adult participant for further evaluation and/or diagnostic testing as medically necessary.

6. The prescribing physician shall document the injury, all tried and failed treatments, and shall submit any supporting documentation establishing that chronic pain treatment, or whether further chronic pain treatment, is medically necessary.

7. The prescribing physician will work in conjunction with the complementary health and alternative therapy provider(s) to make recommendations regarding medically necessary services based on clinical criteria and the adult participant's risk.

8. Covered Services and Limitations.

A. Complementary health and alternative therapy services for qualified adult participants requires a determination by the prescribing physician of a combination of physical therapy, chiropractic therapy, acupuncture, and non-opioid medication therapy, as clinically appropriate.

B. Complementary health and alternative therapy services shall be structured according to the prescribing physician's preference, but with an allowable maximum of thirty (30) total visits or one hundred twenty (120) units per year, and with one (1) unit equaling fifteen (15) minutes in combination of therapy defined by the prescribing physician. The prescribing physician shall reassess evidence of the adult participant's improvement and the risks of complementary health and alternative therapy when considering discontinuing or requesting further coverage of complementary health and alternative therapies for chronic pain.

C. An annual maximum of cognitive-behavioral health visits are to be determined based upon best practice and evidence-based guidelines and are listed in the MO HealthNet Physician Provider's Manual.

9. Non-opioid and opioid therapy for chronic pain shall include initiating the first-line of non-opioid treatment, use of alternative pain therapy, establishing treatment goals, the use of opioids as supported by clinical guidelines, and the implementation of a tapering plan and schedule as clinically appropriate based upon the adult participant's clinical presentation. The prescribing physician shall document in the patient's medical record the method of tapering, progress, and challenges that may require intervention for participants currently receiving long-term

opioid medications and/or high dose opioids on a clinically appropriate tapering plan.

10. Cognitive behavioral therapy for each adult participant must be re-assessed by a cognitive-behavioral therapy provider every ninety (90) days for continuation of care, including assessment of any impacts on the participant's ability to work and function, increased self-efficacy, or other clinically significant improvement.

11. The prescribing physician and the complementary health and alternative therapy provider shall reassess and evaluate the risks and benefits to the adult participant of any complementary and alternative therapies and whether the therapies continue to be medically necessary to continuing treatment, requesting further treatment, and/or discontinuing treatment as medically necessary.

A. Provider(s) of complementary health and alternative therapy will make recommendations for a treatment plan, continuation of services, and the final determination of care.

B. The complementary health and alternative therapy must be deemed medically necessary.

(3) Reimbursement Methodology.

(A) Effective for dates of service beginning February 18, 2019, complementary health and alternative therapy for chronic pain management services will be paid at the Medicaid fee schedule and will be published at <https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm> under "Fee Schedules & Rate Lists," which is incorporated by reference and made part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109 as of November 13, 2018. This rule does not incorporate any subsequent amendments or additions. This fee schedule is calculated based on 62.5% of the Medicare physician fee schedule rates for physical therapy, acupuncture, and chiropractic services using MO Locality 01 as updated August 28, 2018.

(B) Reimbursement shall only be made for services authorized by the MO HealthNet Division or its designee.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2018. Original rule filed Aug. 15, 2018, effective March 30, 2019.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.310 Chiropractic Services

PURPOSE: The purpose of this rule is to establish the Department of Social Services' MO HealthNet Division guidelines regarding coverage and reimbursement for chiropractic services as mandated in House Bill 1516, 99th General Assembly, section 208.152 RSMo.

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 Chiropractic Program shall be administered by the MO HealthNet Division, Department of Social Services. The chiropractic 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 MO HealthNet Division and shall be included in the MO HealthNet *Physician Provider Manual*, which is incorporated by reference and made 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, <http://manuals.momed.com/manuals/>, May 15, 2019. This rule does not incorporate any subsequent amendments or additions. Chiropractic services covered by the MO HealthNet program shall include only those which are clearly shown to be medically necessary. The MO HealthNet Division considers medically necessary when all of the following criteria are met: The member has a neuromusculoskeletal disorder; and the medical necessity for treatment is clearly documented; and improvement is documented within the initial two (2) weeks of chiropractic care. If no improvement is documented within the initial two (2) weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified. If no improvement is documented within thirty (30) days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary. The division reserves the right to effect changes in services, limitations, and fees with proper



notification to MO HealthNet chiropractic providers.

(2) **Provider Participation.** To be eligible for participation in the MO HealthNet Chiropractic Program, a provider must be licensed to practice chiropractic by complying with the provisions of Chapter 331, RSMo and shall have signed a participation agreement to provide chiropractic services under the MO HealthNet program.

(3) **Participant Eligibility.** Any person who is eligible for Title XIX benefits from the Family Support Division and who is found to be in need of chiropractic services in accordance with the procedures described in this rule shall be deemed eligible to receive these services.

(4) **Chiropractic Services.** Up to twenty (20) visits per year are covered for services limited to examinations, diagnoses, adjustments, manipulations and treatments of malpositioned articulations, and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice.

(5) **Records Retention.** Providers who provide chiropractic services must follow section 13 CSR 70-3.030.

AUTHORITY: section 208.152, RSMo Supp 2019, and section 660.017, RSMo 2016. Original rule filed May 15, 2019, effective Nov. 30, 2019.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-3.320 Electronic Visit Verification (EVV)

PURPOSE: This rule sets forth requirements for use of electronic verification of services that the MO HealthNet Division may identify and provide to a MO HealthNet participant with a prior authorization or an approved care plan. This rule also defines terms used by MO HealthNet in establishing procedures for the Electronic Visit Verification (EVV) requirements for Medicaid funded in-home services. These definitions apply solely to the information in this chapter. This rule further establishes the minimum necessary criteria required of Medicaid funded Home and Community Based Services provider agencies in relation to implementation of an EVV system. This rule establishes the minimum necessary

criteria of the EVV system required to document delivery of Medicaid funded Home and Community Based Services provided in the home of the MO HealthNet participant. Failure to comply with requirements in this section may result in claim denial or termination of contract to deliver services through the MO HealthNet program.

(1) **Definitions.**

(A) “Agency Model Services” shall mean a service delivery option in which a contracted agency directs service delivery.

(B) “Aggregator Solution” shall mean the electronic system that supports the collection of electronic visit verification vendor data and stores the data for purposes of analysis and monitoring.

(C) “Direct Care Worker” shall mean the individual providing the Medicaid funded services to the MO HealthNet participant, either through an agency based or self-directed model.

(D) “Electronic Visit Verification (EVV)” shall mean electronic technology used for the purpose of recording the date, location, begin time, end time, type of service, and any related tasks. EVV also verifies the identity of the MO HealthNet participant and direct care worker in relation to Medicaid funded services authorized by the Department of Health and Senior Services (DHSS) or the Department of Mental Health (DMH).

(E) “Exception” shall mean any manual adjustment or update to an EVV record, indicated within the EVV system and passed to the aggregator solution.

(F) “MO HealthNet Participant” shall mean an individual who the Family Support Division has determined eligible for MO HealthNet benefits who is receiving Medicaid funded services authorized by the Department of Health and Senior Services or the Department of Mental Health.

(G) “Fiscal Agent” shall mean a Person or Entity that provides financial management services to a self-directed employer.

(H) “Manual Visit Entry” shall mean the entry of a paper record, used in exigent circumstances for a provider visit to a participant, into the EVV solution. The paper record shall be maintained by the provider agency and made available upon request from state agency.

(I) “Provider Agency” shall mean an agency authorized to deliver Medicaid funded services or other Medicaid funded services as defined in this rule, or a fiscal agent, as authorized by the Department of Health and Senior Services or the Department of Mental Health.

(J) “Reason Codes” shall mean codes

established by electronic visit verification vendors and utilized by personal care service providers to explain a manual visit entry/exit or an acknowledgement of exception; passed along to aggregator solution.

(K) “Self-Directed Services” shall mean a service delivery option in which a MO HealthNet participant employs a direct care worker and directs delivery of service themselves.

(L) “Services” shall mean all Medicaid funded services or other service required by the state to use EVV including:

1. Advanced Personal Care;
2. Chore Services;
3. Consumer-Directed/Self-Directed Personal Care;
4. Homemaker Services;
5. In-Home Respite authorized by the Department of Health and Senior Services;
6. Personal Care;
7. Any of the above services reimbursed by a managed care organization; and
8. Any services where federal or state statute or rule requires EVV, but not specifically listed above.

(M) “Task” shall mean, as applicable, description of a service or services including, but not limited to, tasks authorized on the care plan.

(2) **Provider Agency Responsibilities regarding Electronic Visit Verification.**

(A) Provider agencies must communicate with MO HealthNet Participants regarding the requirement to utilize EVV to document receipt of services as a condition of participation in services. Provider agencies delivering services shall contract with an EVV vendor who meets all criteria established in this rule.

(B) Provider agencies and self-directed fiscal agents who deliver or administer services through Medicaid funding shall utilize EVV for all visits. EVV requirements are applicable to services authorized through the Department of Health and Senior Services and the Department of Mental Health.

(C) EVV requirements do not apply to the following services:

1. Authorized Nurse Visits;
2. Private Duty Nursing;
3. Provider Reassessments;
4. Assisting individuals with their necessary daily needs during delivery of other DMH Home and Community Based Services (HCBS) waiver services; or
5. Services provided in a residential/group setting.

(D) Except as provided in subsection (2)(C) of this rule, all MO HealthNet Participants who receive services must utilize EVV. MO HealthNet participants who refuse to utilize



an electronic system shall no longer be eligible to receive Medicaid funded services as defined in this rule.

(E) Provider agencies must work with MO HealthNet participants to identify the provider's chosen EVV solution that best accommodates the participant's individual needs. Documentation of any concern or barrier regarding a specific form of EVV shall be reported to DHSS and/or DMH as the authorizing agency.

(F) Manual visit entry shall be utilized only when the EVV system is unavailable or when exigent circumstances, documented by the provider agency, make usage of the system impossible or impractical. Justification documentation must support any instance of human error and such errors must be readily identifiable. Repeated instances of human error are subject to audit. The provider agency shall enter justification documentation into the EVV system, which may include an editor program. Information shall include the date and time of the manual entry, the reason for the entry, and the identification of the person making the entry. The provider agency must pass a manual entry indicator and reason for manual entry to the aggregator solution within documentation timeframes established by the MO Medicaid Audit and Compliance Unit.

(G) Any adjustment or exception requires the provider agency to enter justification documentation into the EVV system, which may include an editor program, within documentation timeframe requirements established by 13 CSR 70-3.030(3)(A)38. Information must include the date and time of the entry and/or update, the reason for the entry and/or update, and the identification of the person making the entry and/or update.

(H) Provider agencies shall report any suspected falsification of EVV data to the Missouri Medicaid Audit and Compliance Unit via the standard reporting process as defined by the Missouri Medicaid Audit and Compliance Unit within two (2) business days of discovery.

(I) All provider agencies must interface EVV data with an aggregator solution designated by the Department of Social Services (DSS) in a format and at a frequency specified by DSS.

(3) Electronic Visit Verification Vendor Responsibilities Upon Implementation of an Aggregator Solution.

(A) Pursuant to this rule, the DSS or its designee must approve the EVV system utilized by a provider agency. In order to be approved, the EVV system must have a primary, secure method for collecting visit data

through use of one (1) or more of the following:

1. Location technologies, including but not limited to Global Positioning System (GPS);

2. Telephony (if utilized, the telephone number from which the call is placed is used in lieu of GPS coordinates and must be a telephone number from an established landline in the participant's place of residence);

3. Fixed devices placed in the home of the MO HealthNet participant which generate a one- (1-) time password or code;

4. Biometric recognition; or

5. Alternative technology that meets the requirements of this rule.

(B) The EVV vendor must register with the Missouri Medicaid Audit and Compliance unit and be approved by the Department of Social Services or its designee pursuant to this rule.

(C) The aggregator solution vendor must certify the EVV vendor has successfully interfaced and has the ability to securely exchange required data with the aggregator solution before DSS can grant approval for registration.

(D) Any cost related to development, modification, or testing of EVV systems shall be the responsibility of the EVV vendor.

(E) In the event of modifications of the state's requirements or policies affecting the electronic collection of visit data, EVV vendors must update systems as necessary and, in a timeframe determined by the state.

(F) The DSS may require re-approval of any qualifying EVV system in circumstances including, but not limited to, a change in data requirements that must be transmitted to the aggregator component or failure to maintain compliance with the department's requirements. Any cost related to re-testing or re-approval shall be the responsibility of the EVV vendor.

(G) EVV vendors must provide the training necessary for provider agency staff to fully utilize the capabilities of the EVV system. Additionally, the EVV vendor must provide support for the system during standard business hours (8:00 am to 5:00 pm Central Time Zone) at a minimum.

(H) EVV vendors shall successfully complete all training required by the aggregator system before being registered as a qualifying EVV vendor.

(I) EVV systems shall have a minimum of two (2) forms of recording visit data, one (1) of which must be manual visit entry. Manual visit entry shall not be considered the primary means of recording visit data and shall only be used in the event of human error, natural disaster, system failure, or when all other

forms of entry have been exhausted or are unavailable.

(J) When employing any form of EVV aside from the use of a designated landline telephone or a fixed object in the MO HealthNet participant's home, the EVV system must use location technologies to record the location of the direct care worker at the start and stop of service delivery.

(K) For situations in which the provider agency's EVV system does not provide adequate network capacity, the EVV system shall have the ability to enter visit information in an offline mode and upload upon accessing network connectivity.

(L) At a minimum, the EVV system shall meet the following requirements:

1. Record the type of service performed, including individual tasks as authorized or progress notes dependent on requirements of the authorizing program;

2. Document and verify the MO HealthNet participant's identity, either by a unique number assigned to the MO HealthNet participant, biometric recognition, or through alternative technology;

3. Document and verify the direct care worker by the assignment of a personal identification number unique to the direct care worker or through alternative technology;

4. Document the date of services delivered;

5. Document the time services begin to the minute;

6. Document the time services end to the minute; and

7. Document the location in which the services began and ended.

(M) In addition, the EVV system must demonstrate the following requirements are met:

1. Accept and update the plan of care as entered or modified by DHSS or DMH;

2. Allow for an unlimited number of service codes and tasks to be available for selection as approved by DHSS or DMH;

3. Allow for direct care workers to access the same MO HealthNet participant record for verification of service delivery more than once in a twenty-four- (24-) hour period;

4. Allow for multiple service delivery locations for each MO HealthNet participant, including multiple locations in a single visit;

5. Accommodate more than one (1) MO HealthNet participant and/or direct care worker in the same home or at the same phone number;

6. Document the delivery of multiple types of services during a single visit;

7. Maintain a reliable backup and recovery process to ensure that the EVV system



preserves all data in the event of a system malfunction or disaster;

8. Be capable of retrieving current and archived data to produce reports of services and tasks delivered, MO HealthNet participant identity, Direct Care Worker identity, begin and end time of services, begin and end location of service delivery, and dates of service in summary fashion that constitutes adequate documentation of services delivered;

9. Allow for manual entry with required justification including a reason for the manual entry with the reason code and manual entry indicator passed to the aggregator solution;

10. Be capable of creating an exception when the direct care worker accesses the system from a location other than the authorized service location; and

11. Retain all data regarding the delivery of services as required by law, but at a minimum of six (6) years from the date of service. Fiscal and medical records shall coincide with and fully document services billed to the MO HealthNet agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal, or retain adequate documentation for services billed to the MO HealthNet program, as specified above, is a violation of this regulation.

(N) Nothing in this rule shall limit the provider agency's ability to accrue partial units pursuant to 13 CSR 70-91.010.

(O) EVV systems shall be capable of producing reimbursement requests for participant approval that ensure accuracy and compliance with program expectations of both the participant and the provider agency.

(P) Reports from the EVV system are subject to review and audit by the Departments of Social Services, Health and Senior Services, Mental Health, or any federal agency, or their designee.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed July 9, 2020, effective Jan. 30, 2021.*

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