



Rules of
Department of Social Services
Division 65—Missouri Medicaid Audit and Compliance
Chapter 2—Medicaid

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**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

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

Chapter 2—Medicaid

13 CSR 65-2.010 Definitions

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 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, defining the terms used in the rules of the Missouri Medicaid Audit and Compliance Unit.

- (1) Application shall include:
- (A) Enrollment application to become a MO HealthNet Program provider;
 - (B) Revalidation application to remain a MO HealthNet Program provider;
 - (C) New practice location application;
 - (D) Provider direct deposit application;
 - (E) Change of ownership application;
 - (F) Hardship waiver request; or
 - (G) Other information MMAC needs, under applicable federal or state laws and regulations as they pertain to the Medicaid program, in order to enroll a MO HealthNet Program provider.
- (2) Application fee means a fee required to be paid by a MO HealthNet Program institutional provider at the time of—
- (A) Initial application;
 - (B) Revalidation application;
 - (C) Change of ownership application; or
 - (D) New practice location application.
- (3) Applying provider means any person submitting an application to become a MO HealthNet Program provider, submitting a renewal or revalidation application to continue to be a MO HealthNet Program provider and/or submitting an application to establish a new practice location.
- (4) Approve/Approval as to a billing provider means the billing provider has been determined to be eligible under Medicaid rules and regulations to receive a Medicaid billing number and be granted Medicaid billing privileges.
- (5) Approve/Approval as to a performing provider means the performing provider has been determined to be eligible under Medicaid rules and regulations to receive a Medicaid billing number.
- (6) Best interests of the MO HealthNet Program shall include consideration of the following factors:
- (A) Ensuring reasonable access to MO HealthNet Program services;
 - (B) Promoting health, safety, and welfare of participants;
 - (C) The provider's history of compliance with applicable rules and regulations related to the MO HealthNet Program; and
 - (D) Any other factors related to MO HealthNet Program integrity.
- (7) Billing provider means a provider or supplier who is authorized to bill the MO HealthNet Program for items or services provided to Medicaid participants. Billing provider includes providers who are authorized to bill Medicaid for items or services provided by performing providers.
- (8) Closed-end provider agreement means an agreement which is for a specific period of time not to exceed twelve (12) months and which must be renewed in order for the provider to continue to participate as a Missouri Medicaid Title XIX, SCHIP Title XXI, or Waiver program provider.
- (9) Deactivate means that the provider's billing privileges were stopped, but such provider's billing number was not terminated.
- (10) Deny/Denial means the applying provider has been determined to be ineligible under Medicaid rules and regulations to receive a Medicaid billing number and/or Medicaid billing privileges.
- (11) Department means the Department of Social Services or its designated divisions or units.
- (12) Enroll/Enrollment means the process that 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.
- (13) Enrollment application means a MMAC-approved paper enrollment application or an electronic MMAC-approved enrollment process.
- (14) Federal health care program means a program as defined in section 1128B(f), of the Social Security Act.
- (15) Fiscal agent means an organization under contract to the state of Missouri for providing services related to the administration of the MO HealthNet Program.
- (16) Hardship means a financial condition in which paying the application fee would impose a significant financial burden on the provider, and the provider is otherwise eligible to be a MO HealthNet Program provider. Other factors which may indicate that a hardship exists include:
- (A) Considerable bad debt expenses incurred by the provider;
 - (B) Considerable amount of charity care/financial assistance furnished to patients;
 - (C) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
 - (D) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments; or
 - (E) Whether the provider is enrolling in a geographic area that is a presidentially-declared disaster area under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).
- (17) Hardship waiver request means a request submitted to MMAC (defined below) along with the provider application requesting that the application fee be waived due to hardship, detailing the hardship, and providing any documentation in support of the hardship waiver request.
- (18) Institutional provider is a non-corporeal provider. Individual physicians, individual dentists, and individual non-physician practitioners are not institutional providers. Institutional provider includes, but is not limited to:
- (A) Ambulance service suppliers (ambulance);
 - (B) Ambulatory surgical centers;
 - (C) Community mental health centers;
 - (D) Comprehensive outpatient rehabilitation centers (comprehensive rehabilitation centers);
 - (E) End stage renal disease facilities (dialysis clinic);
 - (F) Federally qualified health centers;
 - (G) Health clinics;
 - (H) Histocompatibility laboratories;
 - (I) Home health agencies;



- (J) Hospices;
- (K) Hospitals;
- (L) Inpatient psychiatric facilities;
- (M) Inpatient rehabilitation facilities;
- (N) Independent clinical laboratories;
- (O) Independent diagnostic testing facilities;
- (P) Mammography centers;
- (Q) Mass immunizers (roster billers);
- (R) Mental health hospitals or inpatient facilities;
- (S) Organ procurement organizations;
- (T) Outpatient physical therapy facilities;
- (U) Outpatient occupational therapy facilities;
- (V) Outpatient rehabilitation centers;
- (W) Outpatient speech pathology services;
- (X) Pharmacies;
- (Y) Portable x-ray suppliers (independent x-ray supplier);
- (Z) Public health department clinics;
- (AA) Skilled nursing facilities (nursing home);
- (BB) Radiation therapy centers;
- (CC) Religious nonmedical healthcare institutions;
- (DD) Rural health clinics;
- (EE) Other institutional entities that bill the MO HealthNet Program on a fee-for-service basis, such as personal care agencies, non-emergency transportation providers, residential care facilities, adult day care facilities, assisted living facilities, residential treatment centers, providers billing under the Consumer Directed Services Program or entities established under sections 205.968-205.973, RSMo;
- (FF) Durable medical equipment, prosthetics, orthotics, and supplies suppliers whether owned by physicians or otherwise;
- (GG) Institutional non-profit and public providers;
- (HH) Institutional providers establishing a new practice location in a different enrollment jurisdiction or as a new provider type;
- (II) Local education agencies, which are institutional providers consistent with the state plan; or
- (JJ) Any other types of non-corporeal MO HealthNet Program providers consistent with the state plan, the Waiver Program, and CHIP Title XXI.
- (19) Limited provider agreement means an agreement with an applying provider which has been accepted as a MO HealthNet Program provider by MMAC (defined below) conditional upon the applying provider performing services, delivering supplies, or otherwise participating in the program only in adherence to, or subject to, specially set out conditions agreed to by the applying provider prior to enrollment.
- (20) Managed care entity has the same meaning as set forth in 42 CFR Section 455.101 (2011).
- (21) Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider.
- (22) Missouri Medicaid Audit and Compliance Unit (MMAC) means 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 Program.
- (23) Medical assistance benefits means those benefits authorized to be provided by Chapter 208, RSMo.
- (24) MO HealthNet Program means programs 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.
- (25) MO HealthNet Program provider means applying provider, billing provider, and/or performing provider.
- (26) MO HealthNet means the division within the department, pursuant to 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.
- (27) Non-physician practitioner means any person other than a physician or dentist that provides medical, dental, or professional items or services such as, but not limited to, nurses, therapists, counselors, social workers, pharmacists, pharmacies, and dental hygienists. This does not include persons that provide nonmedical support services such as clerical staff, carpenters, janitorial staff, food service workers, home health aides, personal care aides, Adult Day Health Care employees and Adult Day Care waiver employees, community support workers and case managers, peer specialists, family support workers, family assistance workers, psychosocial rehabilitation workers, detox technicians/aides, residential technicians/aides, personal assistants, non-professional direct care staff and other secondary support services, but does include the organizations that bill for services provided by these persons.
- (28) Owner means any individual or entity that has any partnership interest in, or that has five percent (5%) or more direct or indirect ownership of, the provider as defined in sections 1124 and 1124A(a) of the Social Security Act.
- (29) Ownership or control interest means a person has a direct or indirect ownership of five percent (5%) or more, or is a managing employee, of a provider.
- (30) Participant means a person who is eligible to receive benefits allocated through the department as part of the MO HealthNet Program.
- (31) Performing provider means a provider or supplier who provides items or services to Medicaid participants but who does not directly bill the MO HealthNet Program for such items or services or does not directly receive payment from the MO HealthNet Program for such items or services. Performing provider also includes referring and/or ordering physicians, dentists, and non-physician practitioners.
- (32) Person means any corporeal person or individual; or any legal or commercial entity, including but not limited to, any partnership, corporation, not-for-profit, professional corporation, business trust, estate, trust, limited liability company, association, joint venture, governmental agency, or public corporation.
- (33) Provider means billing and performing providers and includes any person that 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.



(34) Provider agreement means an agreement, no greater than five (5) years in duration, and no less than twelve (12) months in duration, requiring revalidation prior to expiration of the agreement, with MMAC which provides a provider with the authority to provide items or services to eligible Missouri Medicaid participants.

(35) Provider application means the MMAC-approved application and supplemental forms required to be submitted for the purpose of becoming a MO HealthNet Program provider, containing all information and documentation requested by MMAC.

(36) Provider direct deposit means a signed writing utilizing forms specified by MMAC containing all information requested by MMAC and submitted by a provider of Medicaid Title XIX, CHIP Title XXI, or Waiver Program services for the purpose of having Missouri Medicaid checks automatically deposited to an authorized bank account.

(37) Reject/Rejected means that the provider's enrollment application was not processed due to incomplete information, failure to submit application fee, or hardship waiver request, or that additional information or corrected information was not received from the provider in a timely manner.

(38) Revalidation means the requirement that all existing MO HealthNet Program providers must go through a revalidation application process in accordance with this rule to continue to be a MO HealthNet Program provider.

(39) Revalidation application means an approved MMAC revalidation application and supplemental forms which are required to be submitted by all existing MO HealthNet Program providers containing all information and documentation requested by MMAC under applicable federal or state laws and regulations and submitted at the time revalidation is required pursuant to this rule.

(40) Site visit may include any or all of the following:

(A) Physical visit to, and inspection of, the premises of the provider or a beneficiary's home if the provider has no central operational facility;

(B) Obtaining photographs of the provider or the provider's business for inclusion in the provider's enrollment file;

(C) Full documentation of observations made at the provider's premises including such facts as:

1. The facility was vacant and free of all furniture;

2. A notice of eviction or similar documentation is posted at the facility; and

3. The premises are not occupied by the provider, but by another person;

(D) A written report of the findings regarding each site visit;

(E) Verification that the facility is operational, open for business, and staff is present;

(F) Verification that customers are present at the facility where appropriate for the provider type;

(G) Acceptance of attestation with documentation when deemed appropriate by MMAC and consistent with applicable federal or state laws and regulations; or

(H) Acceptance of proof of a recent site visit under the Medicare program or other state Medicaid program when deemed appropriate by MMAC and consistent with applicable federal or state laws and regulations.

(41) State plan means a document completed by the state of Missouri to tell the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) how the state will administer the MO HealthNet Program according to federal laws and regulations.

(42) Suspension from participation means an exclusion from being a provider for a specified or indefinite period of time.

(43) Suspension of payments means withholding of payments otherwise due to a provider for a specified or indefinite period of time.

(44) Termination means the department's non-temporary discontinuation of a provider's billing privileges and/or elimination of the provider's number.

(45) Voluntary termination means that a provider submits written confirmation to MMAC of its decision to discontinue enrollment in the MO HealthNet Program.

(46) Waiver program means programs authorized in section 1915 of the Social Security Act (or other waiver programs authorized by federal law). These programs permit states to furnish an array of services that complement and/or supplement the services that are available to participants through the state plan.

(47) Written notice means a notice to the address of the provider as listed in MMAC's system, in writing, transmitted via the US mail, other public or private service for the delivery of correspondence, packages or other

things, facsimile, e-mail, or any other method/mode of transmittal that is deemed by MMAC to be an efficient, cost-effective, verifiable and reliable method/mode of communication with the provider or applying provider.

(48) Except to the extent inconsistent with this rule, the requirements of 13 CSR 70-3.020 and 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

AUTHORITY: sections 208.159 and 660.017, RSMo 2000. Original rule filed Dec. 12, 2013, effective July 30, 2014.*

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

13 CSR 65-2.020 Provider Enrollment and Application

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 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, establishing the basis on which providers under the MO HealthNet Program may be approved or denied as a new provider and/or as a revalidating provider, establishing the basis on which a new practice location may be approved or denied, establishing a revalidation requirement for all providers and establishing application and periodic screening requirements.

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) Enrollment.

(A) All persons are required to enroll with MMAC as a billing or performing provider in the MO HealthNet Program if the services or items they provide will be billed to the MO HealthNet Program.

(B) For any person to receive payment from the MO HealthNet Program for items or services other than out-of-state emergency



services, the billing providers and the performing providers of such items or services must be enrolled providers in the MO HealthNet Program on the date the items or services are provided unless applicable rules or manuals permit enrollment as of an earlier date, up to a maximum of three hundred sixty-five (365) days prior to the actual enrollment date.

(C) As required by 42 CFR Section 455.440, all claims for payment for items and services that were ordered or referred must contain the National Provider Identifier (NPI) of the provider who ordered or referred such items or services.

(D) All persons enrolled as MO HealthNet providers shall abide by the policies and procedures set forth in the MO HealthNet provider manual(s) applicable to the provider's provider type(s). The MO HealthNet provider manuals 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 the website dss.mo.gov/mhd, January 15, 2014. This rule does not incorporate any subsequent amendments or additions. A MO HealthNet provider's breach of any MO HealthNet provider manual may result in imposition of sanctions, including but not limited to, termination.

(2) Application.

(A) All applying providers shall have a valid e-mail address and shall submit an MMAC-approved application and any supplemental forms, information and documentation required by MMAC for the appropriate provider type for which the person is applying.

(B) All information and documentation requested in the application and supplemental forms must be provided to MMAC prior to the application being considered and screening being conducted pursuant to this rule.

(C) Specific application instructions are modified as necessary for efficient and effective administration of the MO HealthNet Program as required by federal or state laws and regulations. Providers applying on or after the promulgation of this rule should refer to the appropriate MMAC provider bulletins and application filing instructions for specific application filing instructions and information, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, 205 Jefferson Street, Second Floor, Jefferson City, MO 65109, at its website mmac.mo.gov, January 15, 2014. This rule does not incorporate any subsequent amend-

ments or additions.

(D) The application shall include all information required in the mandatory disclosures pursuant to section (3). Upon submission of any application(s), supplemental form(s), information and documentation requested in the application(s) and supplemental form(s), MMAC may, at its discretion, request additional or supplemental information and documentation from the applying provider prior to considering the application and/or conducting screening pursuant to this rule in order to clarify any information previously submitted and to verify that the provider meets all applicable requirements of state or federal laws and regulations.

(3) All providers, fiscal agents, and managed care entities are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of any person with an ownership or control interest in the applying provider. The address for corporate entities must include as applicable primary business address, every business location, and PO Box address;

2. Date of birth and Social Security number (in the case of a corporeal person);

3. Other tax identification number of any person with an ownership or control interest in the applying provider or in any subcontractor in which the applying provider has a five percent (5%) or more interest;

4. Whether any person with an ownership or control interest in the applying provider is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

5. Whether any person with an ownership or control interest in any subcontractor in which the applying provider has a five percent (5%) or more interest is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

6. The name of any other provider or applying provider in which an owner of the applying provider has an ownership or control interest; and

7. The name, address, date of birth, and Social Security number of any managing employee of the applying provider;

(B) Disclosures from any provider or applying provider are due at the following times, and must be updated within thirty-five (35) days of any changes in information required to be disclosed:

1. Upon the provider or applying provider submitting an application; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting the proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of the contract; and

4. Within thirty-five (35) days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting the proposal;

2. Upon request of MMAC; and

3. Ninety (90) days prior to renewal or extension of the contract;

(E) Disclosures from Primary Care Case Management Programs (PCCM). PCCMs will comply with disclosure requirements under subsection (B) of this section;

(F) All Disclosures Must be Provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) Consequences for Failure to Provide Required Disclosures.

1. Any person's failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination. If the failure is inadvertent or merely technical, MMAC may choose not to impose consequences if, after notice, the person promptly corrects the failure.

(4) Provider Revalidation.

(A) All enrolled MO HealthNet Program providers as of the effective date of this rule who are not on a closed-end provider agreement shall revalidate their enrollment as a MO HealthNet Program provider, on or before March 24, 2019, according to schedule as determined by MMAC, by submitting an MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with any required application fee, hardship waiver request, or documentation showing that the provider has revalidated with Medicare or another state's Medicaid Program or CHIP within the previous twelve (12) months, if applicable.

(B) All MO HealthNet Program providers shall revalidate their enrollment as MO HealthNet providers every five (5) calendar years from the effective date of the provider's most recently executed provider agreement,



in order to remain a MO HealthNet provider. For example, a provider whose initial or revalidated provider agreement is effective on March 1, 2014, is required to revalidate his/her/its enrollment no later than March 1, 2019.

(C) The MMAC approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with the application fee and/or hardship waiver request, if applicable, shall be submitted no later than one-hundred twenty (120) days prior to the expiration of the effective provider agreement.

(D) Revalidating providers must comply with the requirements of this rule and will be subject to the screening process noted in this rule upon revalidation in order to have their applications for revalidation approved.

(E) MMAC may request that the provider revalidate on an off-cycle revalidation period as a result of information obtained by MMAC indicating documented patterns of local health care fraud, national initiatives, complaints, or other reasons that cause MMAC to question the compliance of the provider with MO HealthNet Program.

(F) All MO HealthNet provider agreements with effective dates on or before the effective date of this rule shall be terminated by MMAC pursuant to the terms of the provider agreement, effective March 25, 2016, if the provider has not revalidated or begun the process of revalidation.

(5) Application Fee.

(A) An application fee, hardship waiver request, and/or an exemption reason must accompany every institutional provider's application.

(B) The application fee must be in the form of a cashier's check, money order, or an electronic payment acceptable to MMAC and for the correct application fee amount in effect as of the date of receipt by MMAC.

(C) Failure to submit the application fee in the form of a cashier's check, money order, or electronic payment acceptable to MMAC for the correct amount will result in the return of the fee to the provider and rejection of the application.

(D) Applying providers and MO HealthNet providers that are revalidating with the Missouri Medicaid Audit and Compliance Unit (MMAC) must submit an application fee subject to the requirements of 13 CSR 65-2.020. The application fee is determined as follows:

1. As of the effective date of this rule for calendar year 2015, five hundred fifty-three dollars (\$553); and

2. For calendar year 2016 and subsequent years—

A. The amount of the application fee shall be the amount for the preceding year adjusted by the percentage change in the consumer price index for all urban consumers for the twelve- (12-) month period ending with June of the previous year as published by the Bureau of Labor Statistics of the United States Department of Labor. If the adjustment sets the fee at an uneven dollar amount, MMAC will round the fee to the nearest whole dollar amount; and

B. The application fee will be effective from January 1 to December 31 of a calendar year.

(E) An institutional provider shall submit an application and application fee for each provider type for which the institutional provider is applying. If an application is denied and the institutional provider submits another application, an additional application fee shall be included with each, all, and every subsequent application.

(F) If a person as defined herein is considered to be an institutional provider as defined herein, that person is required to pay the fee.

(G) Exemptions from Application Fee. Providers who are enrolled in, and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee. Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.

(6) Hardship Waiver Request.

(A) Institutional providers may submit application fee hardship waiver requests when submitting their initial enrollment applications, their revalidation applications, and their applications to establish new practice locations.

(B) A hardship waiver request may be granted if any of the following exists:

1. The provider demonstrates, via authenticated financial and legal records, hardship and MMAC, at its discretion, determines that imposition of the application fee would result in a hardship for the provider subject to the following requirements:

A. All records submitted in support of a hardship waiver must be authenticated by an affidavit signed under oath by the applying provider's or provider's owner(s) and chief financial officer or chief executive officer. Records not meeting this requirement shall not be considered as evidence of hardship;

B. Providers applying for hardship waivers must permit, upon request, MMAC to

inspect the provider's financial records and other records MMAC deems relevant to MMAC's determination of whether hardship exists, including, but not limited to, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, and tax returns. Any provider who does not permit MMAC to inspect such records upon MMAC's request shall be denied a hardship waiver. Any provider who is denied a hardship waiver request based upon the provider's failure to permit MMAC to inspect the provider's financial records and any other records MMAC deems relevant to MMAC's determination of whether a hardship exists, shall not be eligible for a waiver under paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its hardship waiver request was denied due to the provider's failure to permit MMAC to inspect the provider's records; and

C. A provider who is granted a hardship waiver pursuant to paragraph (6)(B)1. shall not be granted a second waiver based upon paragraph (6)(B)1. for a period of five (5) years from the date of MMAC's letter notifying the provider that its most recent paragraph (6)(B)1. waiver request was granted;

2. MMAC, in consultation with other state of Missouri departments, divisions and units, determines that imposition of the application fee would impede Missouri Medicaid participants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.

(C) Application fee hardship waiver requests shall be considered by MMAC on a case-by-case basis.

(D) Application fee hardship waiver requests are subject to approval by CMS.

(7) MMAC shall use the application fee to offset the costs associated with the provider screening program in its entirety. This includes, but is not limited to, the following:

(A) Implementation and augmentation of MMAC's provider enrollment system; and

(B) Any other administrative costs related to the provider screening program, which include costs associated with processing fingerprints and conducting criminal background checks. The application fee does not cover the cost associated with capturing fingerprints and a provider may be charged additional costs for this purpose in addition to the application fee.



(8) Refund of the Application Fee.

(A) If an institutional provider is granted a hardship exception pursuant to this rule or if the application is rejected because it was not properly signed or is missing other information required to be provided on the application itself, and an application fee was included with the application and the hardship waiver request, the application fee shall be returned to the applying provider.

(B) Once the screening process has begun, regardless whether the application goes through part or all of the screening process, the application fee is non-refundable.

(9) Screening.

(A) The screening requirements contained in this section apply to all applying providers and to all persons disclosed, or required to be disclosed, in the application.

(B) MMAC shall conduct pre-enrollment screening and post-enrollment monthly screenings. Screenings shall include the following:

1. Screening pursuant to 42 CFR sections 455.410(a), (b); 42 CFR 455.412; 42 CFR 455.432; 42 CFR 455.436; and 42 CFR 455.452;

2. Screening to ensure that the providers meet all enrollment criteria for their provider type;

3. Unannounced pre- and post-approval site visits; and

4. For screening purposes, utilization of databases and other sources of information to prevent enrollment of non-existent providers, to ensure that spurious applications are not processed, and to prevent fraud, waste, and abuse in the MO HealthNet Program.

(C) The screening procedures and requirements in this rule shall be implemented as of the effective date of this rule.

(D) The new screening procedures and requirements will be applicable to all enrolled MO HealthNet Program providers and applying providers as of the effective date of this rule. All enrolled MO HealthNet providers are required to revalidate according to the schedule of revalidation. After being screened pursuant to this rule, MO HealthNet Program providers will be required to revalidate every five (5) years from the date of their most recent revalidation.

(E) Upon the effective date of this rule, no provider shall be allowed to enroll or revalidate in the MO HealthNet Program without being screened pursuant to this rule. On or before March 25, 2016, all providers in, and applying providers to, the MO HealthNet Program shall be screened pursuant to this section. By operation of law, any provider who has not been screened pursuant to this

section on or before March 25, 2016, shall have his/her/its provider number deactivated at 5:00 p.m. on March 25, 2016. Such deactivation shall remain in effect until the provider or applying provider has been screened pursuant to this rule.

(F) The following screening categories are established for MO HealthNet providers, as required by federal law and regulation for Medicare and Medicaid providers under 42 CFR section 424.518 and section 1902(kk) (1) of the Social Security Act. There are three (3) levels of screening: limited, moderate, and high. Each provider type is assigned to one (1) of these screening levels. If a provider could fit within more than one (1) screening level described in this section, the highest risk category of screening is applicable.

1. Limited Risk Category.

A. The following providers pose a limited risk of fraud, waste, and abuse to the MO HealthNet Program and are subjected to limited category screening:

(I) Physicians, dentists, or non-physician practitioners (except as otherwise listed in another risk category) and medical groups or clinics with the exception of physical therapists and physical therapy(ist) groups;

(II) Ambulatory surgical centers (ASCs);

(III) Competitive acquisition program/Part B vendors;

(IV) End-stage renal disease (ESRD) facilities;

(V) Federally qualified health centers (FQHCs);

(VI) Histocompatibility laboratories;

(VII) Hospitals, including critical access hospitals (CAHs);

(VIII) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act (IHS);

(IX) Mammography screening centers;

(X) Mass immunization roster billers;

(XI) Organ procurement organizations (OPOs);

(XII) Pharmacies;

(XIII) Religious nonmedical health care institutions (RNHCIs);

(XIV) Rural health clinics (RHCs);

(XV) Radiation therapy centers;

(XVI) Skilled nursing facilities (SNFs);

(XVII) Occupational therapists;

(XVIII) Speech language pathologists;

(XIX) Rehabilitation agencies; and

(XX) Community mental health centers (CMHCs).

B. The providers in the limited category are subject to the following screening requirements:

(I) Verification that the applying provider, and all persons disclosed or required to be disclosed, meet all applicable federal regulations and MO HealthNet Program requirements for the provider type;

(II) Verification that the applying provider, and all persons disclosed, have a valid license, operating certificate, or certification if required for the provider type, and that there are no current limitations on such licensure, operating certificate, or certification which would preclude enrollment;

(III) Verification that the applying provider's, and that of all persons disclosed, license(s) held in any other state has/have not expired and that there is/are no current limitations on such license(s) which would preclude enrollment;

(IV) Confirmation of the identity of the applying provider and determination of the exclusion status of the applying provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of the following federal databases:

(a) Social Security Administration's Death Master File;

(b) National Plan and Provider Enumeration System;

(c) List of Excluded Individuals/Entities;

(d) The Excluded Parties List System;

(e) Medicare Exclusion Database;

(f) Department of the Treasury's Debt Check Database; and

(g) Department of Housing and Urban Development's (DHUD) Credit Alert System or Credit Interactive Voice Response System;

(V) Database checks of the Missouri Department of Revenue;

(VI) Database check of the National Sex Offender Public Website;

(VII) The information from these databases shall be used to determine eligibility of the MO HealthNet provider and for verification of: the identity of the applying person; the Social Security number; the National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB) licensure; any exclusion by the Department of Health and Human Services, Office of Inspector General;



the taxpayer identification number; any Missouri tax delinquencies and death of the applying provider and all other persons disclosed in the applications and supplemental forms; and

(VIII) MMAC may conduct pre-approval site visits prior to acceptance of an applying provider's application.

2. Moderate Risk Category:

A. The following providers pose a moderate risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to moderate screening requirements:

(I) Comprehensive outpatient rehabilitation facilities (CORFs);

(II) Hospice organizations;

(III) Independent diagnostic testing facilities (IDTFs);

(IV) Independent clinical laboratories;

(V) Ambulance service suppliers;

(VI) Physical therapists including physical therapy groups;

(VII) Portable x-ray suppliers;

(VIII) Revalidating home health agencies;

(IX) Revalidating durable medical equipment providers;

(X) Adult day care waiver providers;

(XI) Personal care providers, including providers billing under the Consumer Directed Services program;

(XII) Entities established under sections 205.968-205.973, RSMo;

(XIII) Prosthetics, orthotics, and supplies suppliers (DMEPOS) (this includes an existing pharmacy durable medical equipment supplier that seeks to add a new DMEPOS supplier store, new practice locations, and those that are owned by occupational or physical therapists); or

(XIV) Non-emergency transportation providers; and

B. In addition to the screening requirements for the limited risk category in paragraph (9)(F)1., the providers in the moderate risk category shall be subject to pre-approval site visits prior to acceptance of an applying provider's application and are additionally subject to unannounced pre- and post-enrollment site visits—

(I) To determine and ensure that the provider is operational at the practice location found on the enrollment application. For these purposes, "operational" means the provider has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicaid claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider specialty, or the services or items

being rendered), to furnish these items or services; and

(II) To verify established provider standards or performance standards other than conditions of participation subject to survey and certification by MMAC, where applicable, to ensure that the provider remains in compliance with program requirements.

3. High Risk Category.

A. The following providers pose a high risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to high screening requirements:

(I) Prospective (newly enrolling) home health agencies; and

(II) Prospective (newly enrolling) DMEPOS suppliers; and

B. In addition to the screening requirements for the limited risk category in paragraph (9)(F)1. of this rule, and for the moderate risk category in paragraph (9)(F)2. of this rule, the providers in the high risk category must submit to, or subject individuals with ownership or control interests to, a fingerprint-based criminal history report check of the Federal Bureau of Investigations (FBI) Integrated Automated Fingerprint Identification System—

(I) A revalidating provider who has already submitted fingerprints once will not be required to submit fingerprints a second time unless required by FBI protocols;

(II) Pursuant to 42 CFR section 455.434(b), the provider is responsible for the cost of taking the fingerprints and supplying the fingerprints, and the state and federal government will share the cost of the processing of the fingerprints and the background check; and

(III) This fingerprint-based criminal history report check applies to all persons in this risk category applying to be a provider (whether as a billing or performing provider), or an individual with a five percent (5%) or greater direct or indirect ownership interest in such provider, or a managing employee;

(G) MMAC must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

1. MMAC imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse by the provider; the provider has an existing Medicaid overpayment; or the provider has been excluded by the Department of Health and Human Services, Office of Inspector General or another state's Medicaid program within the previous ten (10) years. The upward adjustment of the provider's categorical risk level for a payment suspension or overpayment shall continue only so long as the payment suspension or overpayment continues; or

2. MMAC or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.

(H) If a person has been screened by Medicare or by another state Medicaid agency and paid Medicare or another state Medicaid agency's application fee, within two (2) years of the date of the application to MMAC, such person will not be subject to the screening requirements or application fee provided for by this rule except those screening requirements and application fee imposed pursuant to subsection (G) of this section.

(I) Any MO HealthNet Program provider not categorized by this regulation as within the limited, moderate or high risk category shall be a considered moderate risk and screened as a moderate risk.

(J) MMAC may request and consider additional information or documentation related to the eligibility criteria, if at any time during the application process it appears that: the enrollment application or supporting documentation is inaccurate, incomplete, or misleading; or it appears the applying person may be ineligible to become a MO HealthNet provider.

(10) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

(11) Except to the extent inconsistent with this rule, the requirements of 13 CSR 70-3.020 and 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

AUTHORITY: sections 208.159 and 660.017, RSMo 2000. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed May 26, 2015, effective Nov. 30, 2015. ***

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

***Pursuant to Executive Orders 20-04, 20-10, and 20-12, 13 CSR 65-2.020, section (5) and subsections (9)(B) and (9)(F) was suspended from March 19, 2020 through December 30, 2020.*

13 CSR 65-2.030 Denial or Limitations of Applying Provider

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 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, establishing the bases on which enrollment, revalidation, and establishment of a new practice location may be approved, limited, or denied.

(1) Missouri Medicaid Audit Compliance (MMAC) shall terminate the provider's enrollment or deny enrollment—

(A) Where the provider or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider did not submit timely and accurate information or did not cooperate with screening methods required under applicable statutes and regulations unless the provider or person cures the failure to comply with this subsection within thirty (30) days of MMAC's notice that it intends to terminate the provider or deny enrollment;

(B) Where the provider or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years, unless MMAC determines that denial or termination of enrollment is not in the best interests of the MO HealthNet Program and MMAC documents that determination in writing;

(C) Of any provider that is terminated on or after January 1, 2011, under Title XVIII of the Social Security Act or under the Medicaid Program or Children's Health Insurance Program (CHIP) of any other state unless MMAC determines that the termination was not for cause, which may include, but is not limited to, fraud, integrity, or quality. Termination or denial of enrollment will not be required if MMAC determines it would not be in the best interests of the MO HealthNet Program and MMAC receives a waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services pursuant to 42 USC 1320a-7;

(D) If the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing;

(E) If the provider, or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider, fails to

submit sets of fingerprints in a form and manner to be determined by MMAC within thirty (30) days of a request by CMS or MMAC, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing; and

(F) If the provider fails to permit access to provider locations for any site visits under 13 CSR 65-2.020, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing.

(2) MMAC may terminate the provider's enrollment or deny enrollment if CMS or MMAC—

(A) Determines that the provider has falsified any information provided on the application; or

(B) Cannot verify the identity of any provider applicant.

(3) Except to the extent inconsistent with this rule, the requirements of 13 CSR 70-3.020 and 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

(4) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

AUTHORITY: sections 208.159 and 660.017, RSMo 2000. Original rule filed Dec. 12, 2013, effective July 30, 2014.*

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