



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

Title	Page
13 CSR 70-3.020 Title XIX Provider Enrollment.....	3
13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.....	5
13 CSR 70-3.040 Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments	10
13 CSR 70-3.050 Obtaining Information From Providers of Medical Services	10
13 CSR 70-3.060 Medicaid Program Payment of Claims for Medicare Part B Services (Rescinded August 11, 1988)	10
13 CSR 70-3.100 Filing of Claims, Medicaid Program	10
13 CSR 70-3.105 Timely Payment of Title XIX (Medicaid) Claims	12
13 CSR 70-3.110 Second Opinion Requirement Before Nonemergency Elective Surgical Operations	13
13 CSR 70-3.120 Limitations on Payment Out-of-State Nonemergency Medical Services	15
13 CSR 70-3.130 Computation of Provider Overpayment by Statistical Sampling.....	15
13 CSR 70-3.140 Direct Deposit of Provider of Provider Reimbursement.....	17
13 CSR 70-3.150 Authorization To Receive Payment for Medicaid Services	23
13 CSR 70-3.160 Electronic Submission of Medicaid Claims.....	23
13 CSR 70-3.170 Medicaid Managed Care Organization Reimbursement Allowance.....	24
13 CSR 70-3.180 Medical Pre-Certification Process.....	25



**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

**Division 70—Division of Medical
Services**

**Chapter 3—Conditions of Provider
Participation, Reimbursement and
Procedure of General Applicability**

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

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

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

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

(B) Applying provider—Any person who has submitted an application or request for enrollment in the Missouri Title XIX Medicaid Program;

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

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

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

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

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

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

(I) Provider—Any person having an effective, valid and current written provider agree-

ment with the Medicaid agency for the purpose of providing services to eligible recipients and obtaining reimbursement excluding, for the purposes of this rule only, all persons receiving reimbursement in their capacity as owners or operators of a licensed nursing home;

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

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

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

(2) Duties of the Single State Agency.

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

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

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

(D) In the event that an application cannot be fully investigated by the single state agency within ninety (90) days of its receipt, the Medicaid agency, upon written notice to the applying provider, may extend the time for conducting the investigation for a period not to exceed one hundred twenty (120) calendar days from the date of receipt of the applica-

tion by the Medicaid agency. The Medicaid agency must send the notice of delay to the applying provider within sixty (60) calendar days from the time the application in question was received.

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

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

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

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

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

(E) The existence of any amount due the single state agency which is the result of an overpayment under the Missouri Title XIX Medicaid Program of which the applying provider has had notice. Any amount due which is the subject of a plan of restitution shall not be considered in applying this section unless the applying provider is in default of the plan of restitution in which case enrollment may be denied or limited;

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



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

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

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

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

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

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

(M) Failure to affix a proper signature to an enrollment application. Submission of an application bearing a signature that conceals the involvement in the provider's operation of a person who would otherwise be ineligible for Medicaid participation shall be grounds for denial of enrollment by the single state agency. Otherwise, the single state agency shall give the applying provider an opportunity to provide a proper signature and, after that, consider the application as if the proper signature was originally affixed;

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

1. Endangering the welfare of a child;
2. Abusing or neglecting a resident, patient, or client;
3. Misappropriating funds or property belonging to a resident, patient, or client; or

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

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

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

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

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

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

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

(5) Denial of enrollment shall preclude any person from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, affiliate, partner or any other association to the single state agency or its fiscal agents for any services or supplies delivered under the Medicaid program whose enrollment as a Medicaid provider has been denied. Any claims submitted by a nonprovider through any clinic, group, corporation, affiliate, partner or any other association and paid shall constitute overpayments.

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

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

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

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



regardless to whom the reimbursement is paid and regardless of whom in the provider's employ or services produced or submitted the Medicaid claim.

(10) Medicaid provider numbers shall not be released to any non-governmental entity, except the enrolled provider, by the Division of Medical Services or its agents.

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

AUTHORITY: sections 208.153, 208.159, 208.164, 208.201 and 210.924, RSMo 2000. 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.*

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

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services

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

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid program shall be administered by the Department of Social Services, Division of Medical Services. 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 Medicaid provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/dms, August 1, 2006. This rule does not incorporate any subsequent amendments or additions.

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

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

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

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

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

6. For those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services 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 Medicaid recipient's treatment plan;

10. The Medicaid recipient's progress toward the goals stated in the treatment plan (progress notes); and

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; and

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;

(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 Medicaid program;

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

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

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



(G) Medicaid 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 Medicaid recipients and to receive payment from the Medicaid 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 recipient 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 Medicaid recipients and payments charged or received. Medicaid 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 Missouri Medicaid dental and nurse midwife programs or a covered and allowable nonpsychiatric service under the Missouri Medicaid 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 Medicaid 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 Medicaid 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 Medicaid;

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 Medicaid 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 Medicaid agency or its authorized agents, all records relating to services provided to Medicaid recipients or records relating to Medicaid 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 Medicaid. Services billed to the Medicaid 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 Medicaid 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 Medicaid 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 Medicaid recipients, 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 Medicaid program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of recipients' personal funds or other funds;

7. Breaching of the terms of the Medicaid provider agreement of any current written and published policies and procedures of the Medicaid program (such as 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, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website www.dss.mo.gov/dms, June 15, 2005. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the Medicaid claim form;

8. Utilizing or abusing the Medicaid program as evidenced by a documented pattern of inducing, furnishing or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, 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 Medicaid patient referral; or collecting a portion of the service fee from the recipient, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

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

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

12. Violating any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri or any other state or territory, where the violation is reasonably related to the provider's qualifications, functions or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude or an act of violence;

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

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

15. Failing to accept Medicaid payment as payment in full for covered services or collecting additional payment from a recipient or responsible person, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

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 Medicaid 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 Medicaid program for services not provided prior to the date of billing (prebilling), except in the case of pre-paid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the Medicaid program;

24. Failing to reverse or credit back to the medical assistance program (Medicaid) within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the recipient; 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 Medicaid recipient's personal funds or reserve account, unless specifically authorized in writing by the recipient, relative or responsible person;

26. Submitting claims for services not personally rendered by the individually enrolled provider, except for the provisions specified in the Missouri Medicaid 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 Medicaid 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 Medicaid. 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 Medicaid provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid is also prohibited. Payment includes, without limitation, any kick-back, 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 Medicaid 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 Missouri Medicaid 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 recipient any item of durable medical equipment which has reached Medicaid-defined purchase price through Medicaid rental payments or otherwise become the property of the recipient without paying fair market value to the recipient;

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

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

37. Failure to comply with the provisions of the Missouri Department of Social Services, Division of Medical Services 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 Medicaid 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 Medicaid 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 Medicaid claim or both; and

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

(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 Medicaid program for a period of not less than sixty (60) days nor more than ten (10) years;

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

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

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

(F) Recoupment from future provider payments;

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

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

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

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

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

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF) or ICF/mentally retarded (MR) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/MRs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

(5) Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the Medicaid 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 Medicaid recipients, 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 Medicaid agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of Medicaid claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred. The Medicaid agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider's Medicaid claims. When records are examined pertaining to part of a provider's Medicaid 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 Medicaid agency. But, if the random selection process is not used, the Medicaid 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 Medicaid agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the Missouri Medicaid 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 Medicaid 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 Medicaid agency shall terminate the provider from participation in the Medicaid program.

(C) When a sanction involving the collection, recoupment or withholding of Medicaid payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. If,

in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

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

(E) Suspension or termination of any provider shall preclude the provider from participation in the Medicaid 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 Medicaid 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 Medicaid 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 Medicaid 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 Medicaid 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 Missouri Medicaid program under subsections (4)(B) and (C) may be reenrolled in the Medicaid 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 Missouri Medicaid program under subsection (4)(B) may be reenrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

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

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

(B) When a provider receives notice, established by a signed receipt of delivery, of an overpayment and the amount due is in excess of one thousand dollars (\$1,000), the provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the



case and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the provider receives notice of the overpayment, the Medicaid 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.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. 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.*

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

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

PURPOSE: This rule places a certain duty on Medicaid participating hospitals and other

vendors to assist the Division of Family Services in making Medicaid third-party liability recoveries.

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

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

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

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

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

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

(1) Public Law 89-97, 1965 Amendment to the Social Security Act (42 U.S.C.A. Section 301), sections 201.151 and 208.153, RSMo, and other pertinent sections of Chapter 208, RSMo require Missouri to provide certain medical services to eligible individuals and further provide that these services may be obtained from any provider who has entered

into an agreement for provision of medical services with the Missouri Division of Family Services. Therefore, to aid the Division of Family Services in determining the proper and correct payment for those services, the acceptance of these medical services and benefits by any applicant or recipient of public assistance benefits constitutes authorization for the Division of Family Services, or its duly authorized representative, to examine all records pertaining to medical services provided the applicant or recipient in order that proper payment for the services may be made to the provider of services.

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

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

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

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

(Rescinded August 11, 1988)

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

13 CSR 70-3.100 Filing of Claims, Medicaid Program

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

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 Medicaid services as appropriate to the provider of services are—

(A) Nursing Home Claim—electronic claim submission print claims from the Internet, or individualized provider software when authorized by the state’s fiscal agent;

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

(C) Outpatient Hospital Claim—UB-92 HCFA-1450;

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

(E) Dental Claim—ADA Dental Form or electronic claim submission; or

(F) Inpatient Hospital Claim—UB-92 CMS-1450 or electronic claim submission.

(2) Specific claims filing instructions are modified as necessary for efficient and effective administration of the program as required by federal or state law or regulation. Reference the appropriate Medicaid provider manual, provider bulletins, and claim filing instructions for specific claim filing instructions information, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, July 15, 2006. This rule does not incorporate any subsequent amendments or additions.

(3) Time Limit for Original Claim Filing. Claims from participating providers that request Medicaid 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 Medicaid 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.

(B) Third-Party Resources

1. Claims for recipients who have a third-party resource that is primary to Medicaid must be submitted to the third-party resource for adjudication unless otherwise specified by the Division of Medical Services. Documentation specified by the Division of Medical Services which indicates the third-party resource’s adjudication of the claim must be attached to the claim filed for Medicaid reimbursement. If the Division of Medical Services 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 Medicaid 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 Medicaid state agency. Under this set of circumstances, the provider may file a claim with the Medicaid 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 Medicaid 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 Medicaid 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 Division of Medical Services in Medicaid provider manuals which indicates the claim was originally filed timely must be attached to the resubmission or entered on the claim form (electronic or paper).

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

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

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

(7) Definitions.

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

(B) Date of payment/denial—The date of payment or denial of a claim is the date on the remittance advice at the top center of each page under the words remittance advice.

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



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

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

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

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

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

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

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

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

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

(F) 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.

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

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

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. This rule was previously filed as 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.

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

13 CSR 70-3.105 Timely Payment of Title XIX (Medicaid) Claims

PURPOSE: This rule advises Title XIX Medicaid providers of the time frames in which they can expect payment for the services(s) they provide to Title XIX Program recipients. 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 Division of Medical Services for Title XIX (Medicaid) reimbursement for a procedure, a set of procedures, or a service rendered a Medicaid recipient 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 Division of Medical Services 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 Division of Medical Services, 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 Division of Medical Services, 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 Division of Medical Services 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 Division of Medical Services 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. 1987. Original rule filed Dec. 11, 1991, effective June 25, 1992.*

**Original authority: 208.201, RSMo 1987.*

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

PURPOSE: This rule implements the requirement that a second medical opinion must be obtained before Medicaid will pay for certain nonemergency, elective surgical procedures and the related costs of these surgical procedures.

(1) Effective October 1, 1981 certain non-emergency, elective surgical procedures specified by the Division of Family Services, when performed for eligible Missouri Medicaid recipients, and for which Missouri Medicaid is to be billed, shall require a second surgical opinion by a licensed physician. Imposition of a second opinion requirement results from legislation passed by the 81st General Assembly of Missouri.

(2) The intent of the Second Surgical Opinion Program is to provide the eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. The surgical procedures of concern are those where there commonly may be a significant difference of opinion from one (1) physician to another. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient.

(3) Elective surgical operations, as specified by the Division of Family Services and all costs directly related to elective surgical operations, shall require a second surgical opinion before the surgery is performed if Missouri Medicaid is to be billed for the surgical operation and related costs.

(4) The Division of Family Services reserves the right to revise, either by deletion or expansion, those elective surgical operations specified for the purpose of the second opinion requirement at any time a revision shall be necessary.

(5) Surgical operations and any costs related directly to those surgical operations which are not normally covered by Missouri Medicaid shall not be allowed for reimbursement under the Second Surgical Opinion Program.

(6) A second opinion shall be required for those elective surgical operations specified by the Division of Family Services, regardless of

the setting in which the surgery is performed, unless an emergency situation exists.

(7) For the purpose of the second opinion requirement, nonemergency, elective surgical operations shall be defined as those where the patient's life will not be threatened or the patient's health will not be permanently impaired by any delay in performing the surgery.

(8) When the eligible Medicaid patient has obtained a proper second surgical opinion, regardless of whether or not it confirms the primary recommendation for the specific surgery, the final decision to undergo or forego the surgery shall remain with the patient.

(9) A third surgical opinion, provided by a third physician, shall be allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is medical need for the specific surgical operation and if the eligible Medicaid patient desires the third opinion.

(10) If a third surgical opinion is obtained, whether it confirms either the primary or secondary opinion, the final decision to undergo or forego the specific surgery shall remain with the eligible Medicaid patient. Medicaid will not cover a further opinion.

(11) A second opinion must be obtained within thirty (30) days after the primary recommendation. A third opinion must be obtained within thirty (30) days after the second opinion. The specific surgical operation under consideration must be performed within one hundred twenty (120) days after the primary recommendation.

(12) Each physician who provides a surgical opinion, the physician who performs the specific surgery and the hospital or other facility which provides directly related services must be enrolled in the Missouri Medicaid program if that provider desires to file a claim for Medicaid payment.

(13) Provider enrollment in the Missouri Medicaid program shall be as defined by the Division of Family Services and as permitted by enacted legislation. The division stipulates that reimbursement shall not be made for the services of staff-in-residence (for example, interns and residents).

(14) A physician providing a surgical opinion is not required to be either board-eligible or board-certified. However, the Medicaid patient shall be encouraged to seek a surgical opinion from a specialist in the appropriate medical field, wherever possible.

(15) The second (or third) opinion may be provided by a physician associated with the

same medical practice as the primary physician, although the Medicaid patient shall be encouraged to seek the second (or third) opinion from a physician not associated with the same practice.

(16) When a second (or third) opinion has been obtained by the Medicaid patient, any one (1) of the Medicaid-participating physicians involved in the case may perform the specific surgical operation; or the case shall be closed at the end of the one hundred twenty (120)-day limit for that case.

(17) The physicians involved in the case may know each other's identity(ies). No attempt shall be made by Missouri Medicaid to suppress this knowledge. Cooperation between the physicians is encouraged for the benefit of the Medicaid patient.

(18) The use of existing laboratory data, X rays, by the second (or third) opinion physician is necessary in every case where it is possible to form an intelligent surgical opinion based upon the existing diagnostic materials.

(19) To receive Medicaid reimbursement, the physician performing one (1) of the specified surgeries and the hospital or other facility providing direct patient care for the surgery shall attach a Missouri Medicaid second opinion form to the claim. The second opinion form must be properly completed by the attending physician, the physician(s) providing the second (and third) opinion(s) and the surgeon. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

(20) Anesthesiologists, assistant surgeons, independent laboratories, independent X-ray services, shall be exempted from attaching a second opinion form to their Medicaid claims relating to the specified surgical operations.

(21) The claims shall be denied if a Missouri Medicaid second opinion form is not attached, if the second opinion form attached is incomplete, illegible or not properly signed.

(22) All other rules and policies which are in effect for the Missouri Title XIX Medicaid Program shall apply to services provided under this rule.

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.*

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



MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM

PLEASE PRINT OR TYPE

MO-8807

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN

Form for Section I containing fields for Recipient's Name, Surgical Procedure, Physician's Name, Office Address, and Signature.

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

Form for Section II containing fields for Need for Surgery, State Remarks, Surgical Procedure, Second Opinion Physician's Name, Office Address, and Signature.

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

Form for Section III containing fields for Need for Surgery, State Remarks, Surgical Procedure, Third Opinion Physician's Name, Office Address, and Signature.

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THE FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

Form for Section IV containing fields for Surgical Procedure, ICD-9-CM DX. Code, Date of Surgery, Surgeon's Name, Office Address, and Signature.

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

(10/81)



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 Medicaid-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. 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) All nonemergency, Medicaid-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 Missouri Medicaid recipients and for which Missouri Medicaid is to be billed, must be prior authorized in accordance with policies and procedures established by the Division of Medical Services before the services are provided.

(2) Nonemergency services, for the purpose of the prior authorization requirement, are those services which do not meet the definition of emergency. Emergency services are defined as those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in a) placing the patient's health in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

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

icaid participation basis as providers of services located within Missouri for purposes of administration of this rule.

(4) The out-of-state provider of services must meet the requirements for participation in the Missouri Medicaid 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 Medicaid program.

(B) All prior authorization requests must be submitted in accordance with policies and procedures established by the Division of Medical Services as stated in the respective Medicaid Provider Manual.

(C) Prior authorization by the state Medicaid agency shall approve the medical necessity of the covered services to be performed only. It shall not guarantee payment as the recipient 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 Recipient Services Unit of the Division of Medical Services. The physician who is referring the patient for the nonemergency services, must call or write the Division of Medical Services for authorization.

(F) Telephone prior authorizations may be granted.

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

(A) All services provided individuals having both Medicare and Medicaid coverage for which Medicare does provide coverage and is the primary payer (cross-overclaims);

(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 Medicaid 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 Missouri Medicaid program will be in effect for services provided by out-of-state providers.

*AUTHORITY: sections 207.020 and 208.201, RSMo 1994. * 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.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993 and 208.201, RSMo 1987.*

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

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

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

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

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

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

(D) Medicaid agency or the agency means the single state agency administering or



supervising the administration of the state Medicaid plan;

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

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

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

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

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

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

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

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

(2) When the Medicaid agency determines that claims for payment submitted by a

provider shall be reviewed, the following actions will be taken:

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

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

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

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

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

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

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

4. The state agency has the sole discretion both to request a waiver and whether to offer in this request an election to the provider to use a sample selected by statistical sampling formula. If a waiver is requested, the provider has the sole discretion whether to have the full twenty-five percent

(25%) statistical sample reviewed or to waive examination of a portion of claims in a statistical sample. If the provider elects the waiver, only claims paid above a fixed amount will be reviewed or, if a statistical sampling formula option has been offered by the state agency, the provider has the sole discretion to elect the statistical sampling formula.

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

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

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

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

3. Determination that services or merchandise were delivered by the provider in compliance with the requirements of 13 CSR 70-3.030(2)(A)1.-35. The reimbursement received by the provider for services or merchandise delivered in violation of any provision of 13 CSR 70-3.030(2)(A)1.-35. shall constitute an overpayment;

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

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

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

7. Determination that information submitted by the provider accompanying the



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

(3) When a review of a provider's claims by statistical sampling has been completed, a total overpayment shall be computed by totaling all overpayments for the statistical sample and subtracting all underpayments found in the sample to obtain a total overpayment. This total is then divided by the number of claims contained in the statistical sample to obtain an average overpayment for the sample. The total overpayment for the review will then be determined by multiplying the average sample overpayment by the number of claims in the review group. If there exists a net underpayment for the sample, then the average underpayment shall be computed in the same manner and the provider notified of the results.

(4) When a total overpayment has been computed by statistical sampling, the Medicaid agency may proceed to recover the full amount of the overpayment from the provider as an amount due. Recovery of the overpayment shall be accomplished according to the provisions of 13 CSR 70-3.030(5)(A)-(D), except that in cases where the amount due was computed by statistical sample, the notice informing the provider of the amount due required by 13 CSR 70-3.030(5)(A) and (B) shall also contain the following information:

- (A) The dates encompassed by the review group;
- (B) The number of claims in the review group and, if applicable, what particular service or item or merchandise pertained to the review group;
- (C) The number of claims in the statistical sample; and
- (D) A generally summarized description of the reasons for the overpayment determinations with all claims in the statistical sample identified as to which overpayment description applies to each.

AUTHORITY: sections 207.020, RSMo Supp. 1993, 208.165, RSMo 1986 and 208.153, RSMo Supp. 1991. 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.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.165, RSMo 1982.*

13 CSR 70-3.140 Direct Deposit of Provider Reimbursement

PURPOSE: This rule describes the procedures for the direct deposit of Medicaid (Title XIX) provider payments. This option will decrease the amount of time required to receive funds through the mail and eliminate lost checks.

(1) Effective November 1, 1993, the Missouri Medicaid program will offer enrolled providers the option of having their Medicaid (Title XIX) checks automatically deposited to an authorized bank account.

(2) Medicaid providers electing to participate in the direct deposit option must complete the Application for Provider Direct Deposit Form MO 886-3089, unless otherwise agreed upon by the Department of Social Services.

(A) The completed application authorizes the Office of Administration to deposit Medicaid 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;
2. The successful processing of a test transaction through the banking system; and
3. Authorization to make payment using the direct deposit option by the Division of Medical Services.

(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 provider enrolled in the Medicaid program when that provider is an individual. Signature stamps will not be accepted. Applications on behalf of groups or businesses (except those described in this rule) must be signed by the individual (officer) with fiscal responsibility for the group or business. Applications for nursing homes, hospitals, independent laboratories and home health agencies must be signed by an individ-

ual listed on the disclosure of ownership form (HCFA-1513) in section III(a) or in the Remarks section of the form.

(4) The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions, including, but not limited to, ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

(5) Effective February 1, 1994, the Division of Medical Services will no longer allow providers or their representatives to accept delivery of the Medicaid checks in person. All checks will be direct deposited or mailed.

AUTHORITY: section 208.201, RSMo Supp. 1987. Original rule filed Oct. 4, 1993, effective June 6, 1994.*

**Original authority: 208.201, RSMo 1987.*



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES, PROVIDER ENROLLMENT UNIT
APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT LEGIBLY USING A BALL POINT PEN. SEE INSTRUCTIONS ON REVERSE SIDE.

SECTION A

1. TYPE OF ACTION

NEW OR RE-ENROLLMENT CANCEL CHANGE

2. PROVIDER NAME (AS SHOWN ON THE CURRENT PROVIDER LABEL)

3. PROVIDER NUMBER

SECTION B
TO BE COMPLETED BY PROVIDER IF NEW OR RE-ENROLLMENT OR CHANGE BOX IN SECTION A IS CHECKED. A VOIDED CHECK OR DEPOSIT TICKET MUST BE ATTACHED.

1. ROUTING NUMBER 2. DEPOSITOR ACCOUNT NUMBER

3. TYPE OF ACCOUNT - CHECK ONLY ONE BOX

C (CHECKING) S (SAVINGS)

4. FINANCIAL INSTITUTION NAME

5. BRANCH NUMBER OR NAME (IF APPLICABLE)

6. FINANCIAL INSTITUTION ADDRESS

CITY STATE ZIP CODE TELEPHONE NUMBER

SECTION C

1. CHECK APPROPRIATE BOX

I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account designated above.

I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.

I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.

I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I hereby cancel my Direct Deposit authorization.

2. SIGNATURE OF PROVIDER DATE TELEPHONE NUMBER

(see requirements on reverse side of this form)

MO 886-3089 (9-93)



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No 0938-0086

**INSTRUCTIONS FOR COMPLETING DISCLOSURE OF
OWNERSHIP AND CONTROL INTEREST STATEMENT (HCFA-1513)**

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

- Title V - 42CFR 51a.144
- Title XVIII - 42CFR 420.200-206
- Title XIX - 42CFR 455.100-106
- Title XX - 45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I (a)** Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
- (b) For Regional Office Use Only.** If the yes box is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.



Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a) Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) (To be completed by HCFA Regional Office) Chain Affiliate No. LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

LB5

(b) Type of Entity: Sole Proprietorship Partnership Corporation Unincorporated Associations Other (Specify)

LB6

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes No LB7

Name	Address	Provider Number



Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No 0938-0086

IV (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ Yes No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ Yes No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? Yes No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name _____ EIN # _____ Yes No LB13

Address _____

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name _____ EIN # _____ Yes No LB18

Address _____

LB19

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
If yes, give year of change _____ Yes No LB15

Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES. A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks



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 Medicaid Claims

PURPOSE: This rule implements the requirement that claims for reimbursement by the Missouri Medical Assistance Program (Medicaid) be submitted electronically.

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

(2) Electronic submission of Medicaid claims for services rendered under the Medicaid program is required. A Missouri Medicaid 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 Missouri Medicaid Internet Access Account link.

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

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

(E) The enrolled Medicaid 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 Medicaid 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 Medicaid 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 recipient of service furnished by the Medicaid enrolled provider or, when applicable, the signature of a responsible person made on behalf of the recipient. Clinical laboratories, radiologists, and pathologists are exempt from the requirement that a Medicaid enrolled provider establish and maintain a record containing the signature of each recipient 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 Medicaid service for which they request reimbursement.

(A) The failure of the enrolled Medicaid 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 Medicaid 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 recipients under the Missouri Medical Assistance (Medicaid) Plan and to furnish information regarding any payment of claims for providing such services as the Division of Medical Services, or its designee, may request. The enrolled Medicaid 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 Medicaid 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 Medicaid 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 Medicaid provider must identify and bill third party insurance and Medicare coverage prior to billing Medicaid.

(7) Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient 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



Medicaid program and shall be responsible for modifications necessary to meet electronic billing standards.

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

(10) The submission of an electronic media claim is a claim for Medicaid 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.

*AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Original rule filed April 29, 2005, effective Nov. 30, 2005.**

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

13 CSR 70-3.170 Medicaid Managed Care Organization Reimbursement Allowance

PURPOSE: This rule establishes the formula for determining the Medicaid Managed Care Organizations' Reimbursement Allowance each Medicaid Managed Care Organization is required to pay for the privilege of engaging in the business of providing health benefit services in this state as required by Senate Bill 189, 93rd General Assembly.

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

(A) Definitions.

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

2. Department. Department of Social Services.

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

4. Division. Division of Medical Services.

5. Health annual statement. The National Association of Insurance Commissioners (NAIC) annual financial statement filed with the Missouri Department of Insurance.

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

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

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

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

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

A. Exceptions.

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

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

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

A. Exceptions.

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

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

1. Effective Jul 1, 2005, the schedule shall include:

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

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

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

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

(D) Payment of the Medicaid MCORA.

1. Offset. Each Medicaid MCO may request that their Medicaid MCORA be offset against any Missouri Medicaid payment due to that MCO. A statement authorizing the offset must be on file with the division before any offset may be made relative to the Medicaid MCORA by the MCO. Assessments shall be allocated and deducted over



the applicable service period. Any balance due after the offset shall be remitted by the Medicaid MCO to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the Medicaid MCORA Fund. If the remittance is not received before the next Medicaid payment cycle, the division shall offset the balance due from that check.

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

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

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

final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a Medicaid MCO's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo and 621.055, RSMo.

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

(A) The Medicaid MCORA will be five and ninety-nine hundredths percent (5.99%) of the Total Revenues reported by each Medicaid MCO on the calendar year 2004 NAIC Health Annual Statement Analysis of Operations by Lines of Business, for the six (6)-month period of July 2005 through December 2005, and five percent (5.00%) of the Total Revenues reported by each Medicaid MCO on the calendar year 2004 NAIC Health Annual Statement Analysis of Operations by Lines of Business for the six (6)-month period of January 2006 through June 2006. The Medicaid MCORA will be collected over twelve (12) months (July 2005 through June 2006). No Medicaid MCORA shall be collected by the Department of Social Services if the federal Center for Medicare and Medicaid Services (CMS) determines that such reimbursement allowance is not authorized under Title XIX of the Social Security Act. If CMS approval of the reimbursement allowance occurs after July 2005, the total Medicaid MCORA for SFY 2006 will be collected over the number of months remaining in the fiscal year.

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

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

AUTHORITY: sections 208.201, RSMo 2000 and 208.431 and 208.435, RSMo Supp. 2005. 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.

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

13 CSR 70-3.180 Medical Pre-Certification Process

PURPOSE: This rule establishes the medical pre-certification process of the Missouri Medical Assistance 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 Missouri medical assistance recipients.

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, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, August 1, 2006. 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 on 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 Division of Medical Services. A covered service for which pre-certification is requested must meet medical criteria established by the Division of Medical Services' 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 recipient 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 recipient will receive a letter which outlines the reason for the denial and the procedure for appeal. The medical assistance recipient must contact the Recipient 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 2000. Original rule filed July 3, 2006, effective Feb. 28, 2007.*

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