Missouri Department of
SOCIAL SERVICES
*Your Potential. Our Support.*

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

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MISSOURI MEDICAID AUDIT & COMPLAINCE
PO BOX 6500 JEFFERSON CITY, MO • 65102
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October 3, 2016

Cindy Kadlec, Director
Joint Committee on Administrative Rules
Capitol Building, Room 8-B
Jefferson City, MO 65101

***RE: Proposed rulemaking - 13 CSR 70-3.030 – Sanctions for False or Fraudulent Claims for MO HealthNet Services***

Dear Ms. Kadlec:

Attached is an accurate and complete copy proposed rulemaking pertaining to the Missouri Medicaid Audit Compliance Unit, Department of Social Services. It is anticipated that this proposed rulemaking will be filed with the Secretary of State on or after October 3, 2016.

Statutory Authority: sections 208.201 and 208.153, RSMo 2008

Sincerely,

Jessica Dresner, M. Ed., Director
Missouri Medicaid Audit & Compliance Unit

Attachments

**Jason Kander**
**Secretary of State**
**Administrative Rules Division**

**RULE TRANSMITTAL**

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COPY

Rule Number 13 CSR 70-3.030

Use a "SEPARATE" rule transmittal sheet for EACH individual rulemaking.

Name of person to call with questions about this rule:
Content Sarah Madden Phone 522-8368 FAX 522-6092
Email address Sarah.Madden@dss.mo.gov

Data Entry Debbie Lindquist Phone 526-0414 FAX 522-6092
Email address Deborah.Lindquist@dss.mo.gov

Interagency mailing address 221 W High, Broadway Bldg., Jefferson City, Mo 65109

TYPE OF RULEMAKING ACTION TO BE TAKEN
☐ Emergency rulemaking, include effective date
☒ Proposed Rulemaking
☐ Withdrawal ☐ Rule Action Notice ☐ In Addition ☐ Rule Under Consideration
☐ Request for Non-Substantive Change
☐ Statement of Actual Cost
☐ Order of Rulemaking
Effective Date for the Order _____
☐ Statutory 30 days OR Specific date _____
Does the Order of Rulemaking contain changes to the rule text? ☐ NO
☐ YES—LIST THE SECTIONS WITH CHANGES, including any deleted rule text:

Small Business Regulatory Fairness Board (DED) Stamp

JCAR Stamp

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Missouri Department of
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MISSOURI MEDICAID AUDIT & COMPLIANCE UNIT
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October 3, 2016

Jason Kander
Secretary of State
Administrative Rules Division
600 West Main Street
Jefferson City, Missouri 65101

***Re: 13 CSR* 70-3.030 – Sanctions for False or Fraudulent Claims for MO HealthNet Services**

Dear Secretary Kander,

CERTIFICATION OF ADMINISTRATIVE RULE

I do hereby certify that the attached is an accurate and complete copy of the proposed rulemaking lawfully submitted by Missouri Medicaid Audit Compliance Unit, Department of Social Services.

The Missouri Medicaid Audit Compliance Unit, Department of Social Services has determined and hereby certifies that this proposed rulemaking will not have an economic impact on small businesses. The Missouri Medicaid Audit Compliance further certifies that it has conducted an analysis of whether or not there has been a taking of real property pursuant to section 536.017, RSMo 2000, that the proposed rulemaking does not constitute a taking of real property under relevant state and federal law, and the proposed rulemaking conforms to the requirements of 1.310, RSMo Supp. 2009, regarding user fees.

The Missouri Medicaid Audit Compliance, Department of Social Services has determined and hereby also certifies that this proposed rulemaking complies with the small business requirements of 1.310, RSMo, in that it does not have an adverse impact on small businesses consisting of fewer than fifty full or part-time employees or it is necessary to protect the life, health, or safety of the public, or that this rulemaking complies with 1.310, RSMo, by exempting any small business consisting of fewer than fifty full or part-time employees from its coverage, by implementing a federal mandate, or by implementing a federal program administered by the state or an act of the general assembly.

Statutory Authority: Statutory Authority: sections 208.201 and 208.153, RSMo 2008

If there are any questions regarding the content of this proposed rulemaking, please contact:

Sarah G. Madden
221 West High Street, Room 230
Jefferson City, MO 65102
572-526-0414
Sarah.Madden@dss.mo.gov

Sincerely,

Jessica Dresner, M. Ed.
Director, Missouri Medicaid Audit & Compliance

**AFFIDAVIT**

**PUBLIC COST**

**State of MISSOURI** )
) **ss.**
**County of COLE** )

I, Jessica Dresner, Director of the Missouri Medicaid Audit Compliance Unit, Department of Social Services, first being duly sworn, on my oath, state that it is my opinion that the cost of the proposed rule, 13 CSR 70-3.030 is less than five hundred dollars ($500) in the aggregate to this agency, any other agency of state government or any political subdivision thereof.

Jessica Dresner, Director
Missouri Medicaid Audit Compliance

Subscribed and sworn to before me this 29th day of September 2016. I am commissioned as a Notary Public within the County of Callaway, State of Missouri, and my commission expires March 19, 2019.

Notary Public

ROBERT VETH
Notary Public - Notary Seal
State of Missouri
Commissioned for Callaway County
My Commission Expires: March 19, 2019
Commission Number: 15711430

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**Title 13 – DEPARTMENT OF SOCIAL SERVICES**
**Division 70 – MO Healthnet Division**
**Chapter 3 – Participant and Provider Procedure**

**PROPOSED AMENDEDMENT**

COPY

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

***PURPOSE:*** *This amendments to sections (5)(C), (6)(A) and (6)(B) clarify that the effective date of agency actions is the day the notice is mailed to the provider and not the day the notice is received.*

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

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

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

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

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

2. An accurate, complete, and legible description of each service(s) provided;

3. Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical record must

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contain signed and dated physician orders for services billed to MO Health-Net. Services provided by an individual under the direction or supervision are not reimbursed by MO HealthNet. Services provided by a person not enrolled with MO HealthNet are not reimbursed by MO Health-Net;

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

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

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

7. The setting in which the service was rendered;

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

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

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

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

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

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

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

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

C. Name of the case manager providing the service;

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

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

F. Setting in which the service was rendered;

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

H. Progress notes;

I. Discharge summaries when applicable; and

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

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

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

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

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

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

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

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

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

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

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

(L) Record means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays, and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to MO HealthNet participants and payments charged or received. MO HealthNet claim for payment information, appointment books, financial ledgers, financial journals, or any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;

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

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

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

(P) Termination from participation means the ending of participation in the MO Health-Net program; and

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

(3) Program Violations.

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

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

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

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

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

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

6. Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of participants' personal funds or other funds;

7. Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet

Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the MO HealthNet claim form;

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

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

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

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

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

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

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

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

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

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

18. Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful, or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender, or other disqualification

of all or part of any license, permit, certificate, or registration related to the provider's business or profession in Missouri or any other state or territory of the United States;

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

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

21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments prior to the allowed forty-five (45) days which the provider has to refund the requested amount;

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

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

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

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

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

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

28. Billing for services through an agent, which were upgraded from those actually ordered, performed; or billing or coding services, either directly or through an agent, in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in MO HealthNet policy for payment in a total payment less than the

aggregate of the improperly separated services; or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;

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

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

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

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

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

34. Removing or coercing from the possession or control of a participant any item of durable medical equipment which has reached MO HealthNet-defined purchase price through MO HealthNet rental payments or otherwise become the property of the participant without paying fair market value to the participant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Recoupment from future provider payments;

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

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

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

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

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

(M) Retroactive denial of payments; and

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

(5) Imposition of a Sanction.

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

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

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

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

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

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

6. Actions taken or recommended by peer review groups, licensing boards, or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records,

negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

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

(C) When a sanction involving the collection, recoupment, or withholding of MO HealthNet payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date *[the provider receives]***of mailing or delivery of said** notice*[established by a signed receipt of delivery of the imposition of the sanction]*, **whichever occurs first.** 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]***of mailing or delivery of a decision of the department of social services or its designated division, whichever occurs first.** If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective **three (3) days after mailing of the notice to the provider or** immediately upon receipt of notice by the provider, **whichever occurs first.**

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

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

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

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

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

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

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

1. Telephone and written instructions;

2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction on the use and format of provider manuals;
5. Instruction on the use of procedure codes;
6. Key provisions of the MO HealthNet program;
7. Instruction on reimbursement rates; and
8. Instruction on how to inquire about coding or billing problems.

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

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

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

(B) When a provider receives notice*[, established by a signed receipt of delivery, or receipt of undelivered mail from the United States Post Office using the address on the provider's enrollment record,]* of an overpayment and the amount due is in excess of one thousand dollars ($1,000), the provider, within *[ten]***fourteen** (*[10]***14**) days of the notice **being mailed or delivered to the provider, whichever occurs first**, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept, or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days *[after the provider receives]* **from the date of mailing or delivery of a decision of the** notice of the overpayment **to the provider, whichever occurs first**, the MO HealthNet agency may take appropriate action to collect the balance of the amount due.

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

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

(E) The single state agency may collect provider overpayments from any other enrolled provider when the other enrolled provider has received payment on behalf of the provider who incurred the overpayment (such as when a provider has directed payment to another enrolled provider). The single state agency may also collect provider overpayments from any enrolled provider with the same federal employer identification number (EIN) as the provider who incurred the overpayment. The state agency shall notify the other enrolled provider(s) forty-five (45) days prior to initiating the overpayment action. The notice shall be mailed to the address on the provider's(s') enrollment record. If the amount due is in excess of one thousand dollars ($1,000), the other enrolled provider, within *[ten]***fourteen** *([10])***14** days of **mailing of the** the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plan will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from the other enrolled provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept, or offer to accept a modified version of the other enrolled provider's plan for repayment. The single state agency shall notify the other enrolled provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the other enrolled provider receives notice of the overpayment, the Medicaid agency may take appropriate action to collect the balance of the amount due.

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

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

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this rule with the Department of Social Services, Jessica Dresner, Director, Missouri Medicaid Audit and Compliance Unit, P.O. Box 6500, 205 Jefferson St., 2nd Floor, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*