Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement, and Procedure of General Applicability

PROPOSED AMENDMENT

13 CSR 70-3.030 *[Sanctions]***Administrative Actions for Improperly Paid, False, or Fraudulent Claims for MO HealthNet Services.** This amendment changes the title of the rule and revises sections (1) through (6).

PURPOSE: This proposed amendment updates, clarifies, and simplifies language in this rule. The language changes reflect the reality that some actions taken under this rule are not due to fraud, but rather to mistakes on the part of the provider or the agency. Claims in these circumstances must still be recouped, but are not necessarily considered "sanctions." Also, the language regarding which practitioners can bill for certain services needs to be updated. Section (3) (Program Violations) has 44 distinct paragraphs/violations, some of which are not clear or are redundant, and the language updates rectify these issues.

PURPOSE: This rule establishes the basis on which certain claims for MO HealthNet services or merchandise will be determined to be ***improperly paid,*** *false****,*** *or fraudulent and lists the* ***administrative actions*** *[sanctions which]* ***that*** *may be imposed and the method of imposing those [sanctions]****actions****.*

(1) Administration.

(A) The MO HealthNet program shall be administered by the Department of Social Services, MO HealthNet Division. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the division and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website dss.mo.gov/mhd, *[October 1, 2017]* **July 20, 2022**. This rule does not incorporate any subsequent amendments or additions.

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

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

(A) "Adequate documentation" means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. "Adequate medical records" are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. *[A]* **Not a**ll documentation *[must be made available at the same site at which the service was rendered.]* **is considered a medical record. Certain services such as respite, and certain in-home services will not contain all the information that a medical record contains. All documentation must be made available at the same site at which the service was rendered, unless the services were provided in the participant's home, via a mobile unit, or other circumstance that would require the records be kept at an office location away from the delivery site.** 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**, physician assistant, nurse practitioner,** or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet. For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to MO HealthNet. Services provided by an individual under the direction or supervision are not reimbursed by MO HealthNet. Services provided by a person not enrolled with MO HealthNet are not reimbursed by MO HealthNet;

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

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

6. For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services American Medical Association Current Procedural Terminology **(CPT)** 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.) **or for Evaluation and Management (E/M) CPT procedures codes 99202-99215, the total time spent on the service** 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; **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*[; and]***.**

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

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

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

C. Name of the case manager providing the service;

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

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

F. Setting in which the service was rendered;

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

H. Progress notes;

I. Discharge summaries when applicable; and

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

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

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

(D) Contemporaneous means at the time the service was performed or within five (5) business days, of the time the service was provided;]

(B) "**Exclusion" means an individual or entity may not participate in the MO HealthNet program for misconduct ranging from fraud convictions to patient abuse.**

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

(*[F]***D**) "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]***E**) **"**MO HealthNet agency**"** or the **"**agency**"** *[means]* **or** the **"**single state agency**" means the Department of Social Services, which is the single state agency charged with** administering or supervising the administration of *[a state Medicaid plan]* **the MO HealthNet (Medicaid) program in Missouri.**;

(*[H]***F**) "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]***G**) "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]***H**) "Person" means any natural person, company, firm, partnership, unincorporated association, corporation, or other legal entity;

(*[K]***I**) "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*] **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 or its divisions for the purpose of providing services to eligible persons, and obtaining from the department or its divisions reimbursement** pursuant to [*Chapter*] 208.164, RSMo;

(*[L]***J**) "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]***K**) "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 non-psychiatric service under the MO HealthNet physician program. In order to direct the performance of such service, the provider must be in the office where the service is being provided and must be immediately available to give directions in person to the employee actually rendering the service and the adequately documented service must be cosigned by the enrolled billing provider;

(*[N]***L**) "Suspension from participation" means an exclusion from participation for a specified period of time;

(*[O]***M**) "Suspension of payments" means placement of payments due a provider in an escrow account;

(*[P]***N**) "Termination from participation" means the ending of participation in the MO HealthNet program; and

(*[Q]***O**) "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]* **Administrative Actions** 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]* **Failure to meet standards under state or federal law for participation (for example, licensure)**;

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]* **Failure to comply with the provisions of the signed Missouri Department of Social Services, MO HealthNet Division Title XIX Participation Agreement with the provider relating to health care services (The standard agreement is accessible online and 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, July 20, 2022 This rule does not incorporate any subsequent amendments or additions.)**;

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]* **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**;

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]* **Failure to accept MO HealthNet payment as payment in full for covered services or collecting additional payment from a participant or responsible person**;

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]* **Failure to reverse or credit back to MO HealthNet within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the participant; for example, prescriptions that were returned to stock because they were not picked up**;

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]* **For providers of Consumer Directed Services (CDS), failure to submit to MO Medicaid Audit and Compliance (MMAC) a required CDS quarterly Financial and Services report, annual service report, or an annual financial statement audit or financial statement review**;

7. *[Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, October 1, 2017. This rule does not incorporate any subsequent amendments or additions or fail to comply with the terms of the provider certification on the MO HealthNet claim form]* **Failure to utilize an Electronic Visit Verification (EVV) system that complies with the requirements of 13 CSR 70-3.320 to document delivery of personal care services requiring EVV usage**;

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

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]***Failure to advise MMAC, 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**;

10. *[Violating any provision of the State Medical Assistance Act or any corresponding rule]* **Refusing to execute a new provider agreement when requested to do so by MMAC in order to preserve the single state agency's compliance with federal and state requirements; or failure to execute an agreement within thirty (30) days for compliance purposes**;

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]***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**;

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]***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**;

13. *[Failing to meet standards required by state or federal law for participation (for example, licensure)]* **Submitting claims for services not personally rendered by the individually-enrolled provider, except for the provisions specified in the MO HealthNet 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 (Such policies and procedures are contained in 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,** *[November 16, 2015]* **July 20, 2022. This rule does not incorporate any subsequent amendments or additions.)**;

14. *[Exclusion from the Medicare program or any other federal health care program]* **Failure to provide and maintain quality, necessary, and appropriate services, including adequate staffing for 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. The medical review may be conducted by qualified peers employed by the single state agency**;

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]* **Breaching of the terms of the MO HealthNet provider agreement or of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in 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,** *[November 16, 2015]* **July 20, 2022. 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**;

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]***Failure to meet any of the documentation requirements under this paragraph. All records must be kept a minimum of six (6) years from the date of service unless a more specific provider regulation applies. The minimum six- (6-) 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 single state agency or its authorized agents, regardless of the media in which they are kept:**

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

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

C. Failure 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;

D. Failure to make these records available on a timely basis;

E. Failure to provide copies as requested;

F. Failure to keep and make available adequate records which adequately document the services and payments;

G. Failure to send records, which have been requested via mail, fax, or email, to the address or number on record with the agency, within the specified time frame;

H. For providers other than long-term care facilities, failure to retain in legible form for at least six (6) 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; or

I. 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.

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]***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**;

*[19]***18**. *[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]***Failure 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**;

*[20]***19**. *[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]***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 non-licensed or MO HealthNet non-certified bed**;

*[21]***20**. *[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]***Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in their employment or service produced or submitted the MO HealthNet claim**;

*[22]***21**. *[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]* **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 their employment or service produced or submitted the MO HealthNet claim or both**;

*[23]***22**. *[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] **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**;

*[24]***23**. *[Failing to reverse or credit back to the medical assistance program (MO HealthNet) within thirty (30) days any pharmacy claims submitted to the agency that represent products or services not received by the participant; for example, prescriptions that were returned to stock because they were not picked up]* **Failure to repay or make arrangements for the repayment of identified overpayments or otherwise improper payments prior to the allowed forty-five (45) days which the provider has to refund the requested amount**;

*[25]***24**. *[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]* **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 by an agent or employee of the provider**;

*[26]***25**. *[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]***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**;

*[27]***26**. *[Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a MO HealthNet provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet is also prohibited. Payment includes, without limitation, any kickback, bribe, or rebate made, either directly or indirectly, in cash or in-kind]***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**;

*[28]***27**. *[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]***Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program or failing to correct deficiencies in provider operations within ten (10) days or a 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. This will include inappropriate or improper actions relating to the management of participants' personal funds or other funds**;

*[29]***28**. *[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;]***Billing violations as follows:**

A. Billing for services through an agent, which were upgraded from those actually ordered and performed;

B. 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;

C. Billing a higher level of service than is documented in the patient/client record; or

D. Unbundling procedure codes;

*[30]***29**. *[Having sanctions or any other adverse action invoked by another state Medicaid program]* **Utilizing or abusing the MO HealthNet program as evidenced by a documented pattern of inducing, furnishing, or otherwise causing a participant to receive services or merchandise not otherwise required or requested by the participant, attending physician, or appropriate utilization review team; or as evidenced by 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**;

*[31]***30**.*[Failing]***Failure** 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]***31**. *[Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider]***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**;

*[33]***32**. *[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]***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**;

*[34]***33**. *[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]***Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful, or unprofessional conduct; or 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**;

*[35]***34**. *[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]***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**;

*[36]***35**. *[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]***Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a MO HealthNet provider for the delivery of any goods or services for which payment may be made in whole or in part under MO HealthNet is also prohibited. "Payment" includes, without limitation, any kickback, bribe, or rebate made, either directly or indirectly, in cash or in-kind**;

*[37]***36**. *[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]***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**;

*[38]***37**. *[Failure to maintain documentation which is to be made contemporaneously to the date of service]***Having an adverse action invoked against the provider by another state Medicaid program**;

*[39]***38**. *[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]***Committing civil or criminal fraud against the MO HealthNet program or any other state Medicaid program, or any criminal fraud related to the conduct of the provider's profession or business**;

*[40]***39**. *[Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim]***Being excluded, suspended, or terminated from participation, or having payments suspended by the Medicare program or any other federal health care program. Voluntarily terminating from the Medicare program or other federal health care program is not a violation.**

[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]***administrative actions** 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%) r]***R**eview of **some or all of** the provider's claims prior to payment;
(K) Referral to the state licensing board for investigation;
(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;
(M) Retroactive denial of payments; and
(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF), or ICF/individuals with intellectual disabilities (IID) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/IIDs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this *[sanction]***administrative action** must be in accordance with all applicable federal statutes and regulations.

(5) Imposition of *[a Sanction]***an Administrative Action**.
(A) The decision as to the *[sanction]***administrative action** to be imposed shall be at the discretion of the MO HealthNet agency. The following factors shall be considered in determining the *[sanction]***administrative action**(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]***administrative actions** 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]***administrative actions**. If the history includes a prior imposition of *[sanction]***administrative action(s)**, the agency should not apply a lesser *[sanction]***action** in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of *[sanctions]***administrative actions**—The MO HealthNet agency shall consider more severe *[sanctions]***administrative action** in cases where a provider has been subject to *[sanctions]***actions** 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]***action** should be considered as a prior imposition of a *[sanction]***actions** for the purpose of this subsection;

5. Prior provision of provider education—In cases where *[sanctions]***administrative actions** are being considered for billing deficiencies only, the MO HealthNet agency may mitigate its *[sanction]***action** if it determines that prior provider education was not provided. In cases where *[sanctions]***actions** 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]***actions**; 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]***had** previous*[ly sanctioned]***actions invoked** 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]***an administrative action** involving the collection, recoupment, or withholding of MO HealthNet payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date of mailing or delivery of said notice, whichever occurs first. When any other *[sanction]***action** is imposed on a provider it shall become effective thirty (30) days from the date of mailing or delivery of a decision of the Department of Social Services or its designated division, whichever occurs first. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of *[a sanction]***an administrative action**, any *[sanction]***action** 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]***administrative action** 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]***that** 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]***an administrative action imposed**, 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]***action(s)** 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]***an administrative action imposed** may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

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

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

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

(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]***administrative action** by the single state agency upon the provider.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo [2016]. This rule was previously filed as 13 CSR 40-81.160. Original rule filed Sept. 22, 1979, effective Feb. 11, 1980. Amended: Filed Nov. 25, 1981, effective March 11, 1982. Emergency amendment filed April 14, 1982, effective April 24, 1982, expired July 10, 1982. Amended: Filed April 14, 1982, effective July 11, 1982. Amended: Filed April 16, 1985, effective Sept. 1, 1985. Emergency amendment filed Dec. 5, 1986, effective Dec. 15, 1986, expired April 13, 1987. Amended: Filed Dec. 16, 1986, effective April 11, 1987. Amended: Filed Jan. 7, 1987, effective April 26, 1987. Emergency amendment filed April 15, 1988, effective April 25, 1988, expired Aug. 22, 1988. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Aug. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency amendment filed April 15, 1994, effective April 30, 1994, expired Aug. 13, 1994. Amended: Filed Feb. 16, 1994, effective Aug. 28, 1994. Amended: Filed May 16, 2005, effective Nov. 30, 2005. Amended: Filed July 3, 2006, effective Dec. 30, 2006. Amended: Filed Nov. 15, 2006, effective May 30, 2007. Amended: Filed March 30, 2007, effective Sept. 30, 2007. Amended: Filed Aug. 31, 2007, effective March 30, 2008. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010. Amended: Filed Sept. 16, 2013, effective April 30, 2014. Amended: Filed Aug. 15, 2014, effective Feb. 28, 2015. Amended: Filed Oct. 15, 2015, effective April 30, 2016. Amended: Filed Oct. 3, 2016, effective May 30, 2017. Amended: Filed Sept. 22, 2017, effective May 30, 2018.*

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

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 proposed amendment with Department of Social Services, MO HealthNet Division, PO Box 6500, Jefferson City, MO 65102-6500 or online at https://dssruletracker.mo.gov/dss-proposed-rules/welcome.action. 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.