THIS PAGE NOT FOR PUBLICATION

Title of Rule: Drug Class Moratorium

Rule Number: MSB 08-09-09-A

Division / Contact / Phone: Pharmacy Benefits Section / Kim Eggert / 303.866.3176

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 08-09-09-A, Drug Class Moratorium
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.885.9, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.885.9.A through §8.885.9.A.6 with the new text attached from §8.885.9.1 through §8.885.9.A.4 effective 12/30/2008.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Drug Class Moratorium

Rule Number: MSB 08-09-09-A

Division / Contact / Phone: Pharmacy Benefits Section / Kim Eggert / 303.866.3176

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The current moratorium rule will expire 12-31-2008. The proposed rule will extend the moratorium for certain drug classes until 12-31-2009 and remove immunosuppressants and anticonvulsants from the moratorium when the current rule expires on 12-31-2008.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2007);
   25.5-5-506(3)(a), C.R.S. (2007) and Executive Order No. D 004 07, Establishing a Preferred Drug List (Jan. 31, 2007).

Initial Review	**10/10/2008**	Final Adoption	**11/14/2008**
Proposed Effective Date	**12/30/2008**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Drug Class Moratorium

Rule Number: MSB 08-09-09-A

Division / Contact / Phone: Pharmacy Benefits Section / Kim Eggert / 303.866.3176

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Medicaid clients, pharmacies and medical providers are affected.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Extending the moratorium for certain classes of medications until December 31, 2009 will cause no change. Removing immunosuppressants and anticonvulsants from the moratorium could have a cost avoidance if these classes are selected for the Preferred Drug List.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Extending the moratorium will not affect costs.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   None

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   None

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department could have let the current moratorium expire but thought it was in the best interests of Medicaid client to continue the moratorium for most classes for an additional year.

8.885.9 DRUG CLASS MORATORIUM

8.885.9.A. The following Drug Classes cannot be considered for inclusion on the PDL until after December 31, ~~2008~~2009:

1. Atypical and typical antipsychotic drugs;

2. Drugs used for the treatment of HIV/AIDS;

~~3. Anticonvulsant drugs;~~

~~4. Immunosuppressants;~~

3~~5~~. Drugs used for the treatment of hemophilia; and

4~~6~~. Drugs used for the treatment of cancer.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revised Rules for Provider Audits and Reviews, Sections 8.040, 8.050, 8.076, 8.079, 8.130 and 8.300
Rule Number:	MSB 08-05-15-A
Division / Contact / Phone:	Legal / Nancy Downes / 5421

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 08-05-15-A, Revised Rules for Provider Audits and Reviews, Sections 8.040, 8.050, 8.076, 8.079, 8.130 and 8.300
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.040, 8.050, 8.076, 8.079, 8.130, 8.300.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

This rule amends various parts of text in §8.040, §8.050, §8.076, §8.079, §8.130 and §8.300. The current text in the rule should be replaced with the new text provided. Current text in these sections not included in this document is unchanged and should not be deleted or altered in any way. This rule is effective 12/30/2008.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revised Rules for Provider Audits and Reviews, Sections 8.040, 8.050, 8.076, 8.079, 8.130 and 8.300
Rule Number:	MSB 08-05-15-A
Division / Contact / Phone:	Legal / Nancy Downes / 5421

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule is to revise the procedures and requirements for provider audits and reviews to comply with HB07-1319 and to make other clarifying changes to the procedures and requirements for provider audits and reviews.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2007);
   25.5-4-301(3)(a)(IV), C.R.S. (2007); 25.5-4-301(3)(a)(IV.5), C.R.S. (2007); 25.5-4-301(3)(a)(VII), C.R.S. (2007)

Initial Review	**10/10/2008**	Final Adoption	**11/14/2008**
Proposed Effective Date	**01/01/2009**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revised Rules for Provider Audits and Reviews, Sections 8.040, 8.050, 8.076, 8.079, 8.130 and 8.300
Rule Number:	MSB 08-05-15-A
Division / Contact / Phone:	Legal / Nancy Downes / 5421

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed changes will affect providers whose records are reviewed for program integrity or quality improvement purposes. Providers will benefit from the proposed rules, as they will be given clear notice of the due dates for submitting records to the Department and will have additional time to produce those records. The new rules also clarify the requirements and procedures for submitting requests for extensions of time to produce records and give providers the opportunity to discuss preliminary audit and review findings with the Department before the final findings are mailed.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed changes increase the amount of time a provider has to produce records requested for a review from 21 days to 45 days. This change will benefit those providers who may have had difficulty producing records within 21 days. The Department does not have any data on the number of providers who could potentially benefit from this provision, as the number of providers who have not been able to produce records within 21 days is not systematically tracked.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department analyzed HB07-1319 when it was before the Legislature and determined that its passage and implementation would result in no fiscal impact.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Inaction would result in the Department not being in compliance with state statute.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rules.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rules.

8.040 RECOVERIES FROM PROVIDERS

In the event that an audit or other competent evidence (e.g. information provided by another government agency) reveals that a provider is indebted to the State for any reason, the Department shall recover this amount either through a repayment agreement with the provider; or by offsetting the amount owed against current and future claims of the provider; or through litigation; or by any other appropriate action within its legal authority.

Providers shall have the right to appeal pursuant to the provisions of 8.050. ~~guidelines for administrative review-provider appeal mechanism in the Medical Assistance Manual.~~

8.040.1 ENROLLMENT OF PROVIDERS

Before claims can be accepted for payment for goods and services provided to eligible ~~Medicaid~~clients ~~recipients~~, the provider of goods and services shall be enrolled in the ~~Colorado~~ Medical Assistance program and assigned a provider number.

8.040.2 SUBMISSION OF CLAIMS

Effective July 1, 1994, all Medical Assistance program ~~Medicaid services~~ providers shall be required to transmit in an approved electronic format to the ~~Medicaid~~ fiscal agent for the Department ~~Deparmtent of Social Services~~ all claims for goods and services which are benefits of the ~~Colorado~~ Medical Assistance ~~P~~program provided to eligible ~~Medicaid~~clients ~~recipients~~. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the ~~State~~ Department.

A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the ~~Medicaid services~~ provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required client ~~recipient~~ information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the ~~State~~ Department, and the Medicaid Fraud Control Unit and their authorized agents.

A. Hard Copy Claims

Hard copy (i.e., paper) claim forms shall be submitted only by authorization of the ~~State~~ Department. The state approved certification statements contained on the claim form become effective and serve as a contractual basis for payment when the provider signs the form.

B. Automated Medical Payments System/Electronic Transfer of Claims

All ~~Medicaid services~~ providers shall be required to transmit claims for goods and services in the approved electronic format to the ~~Medicaid~~ fiscal agent for the ~~State~~ Department. Only those electronic formats which have been approved by the fiscal agent will be accepted for Automated Medical Payments System.

Before a provider can submit claims electronically, either directly to the fiscal agent or through a vendor or billing service, state approved provider certification agreements which contain all state approved certification statements and conditions shall be signed and accepted by both the provider and the ~~State~~ Department. The state approved certification statements become effective and serve as a contractual basis for payment once the provider signs the form. A billing service shall also have a state approved billing service agreement signed and accepted by the Department before any claims will be accepted. The content of the agreements shall be determined by the Department.

If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the ~~State~~ Department, and the Medicaid Fraud Control Unit and their authorized agents.

A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number. However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

If a provider utilizes a billing service to transmit claims, the provider shall provide source documents and any ~~or~~ other data transfer materials ~~methods~~ necessary to create the electronic claim ~~shall become the source document~~. The billing service shall retain the source documents and data transfer materials for a six year period except when these items ~~documents~~ are maintained by the provider. Original source documents and data transfer materials shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the ~~State~~ Department, and the Medicaid Fraud Control Unit and their authorized agents. If the provider furnishes the information to the billing service on a computer disc or some other method of electronic transmission, then the source docu~~uc~~ments used to create the disc or transmission shall be retained by the provider for six years and made readily available and produced upon request.

If the billing service goes out of business, then u~~U~~pon cessation of business, the billing service shall immediately return all documents to each individual provider.

Upon receipt of the electronic transmission, the fiscal agent will process the claims to the M.M.I.S. If the transmission is rejected, the fiscal agent shall send an electronic acknowledgement of rejection to the sender. Claims denied through the M.M.I.S. shall be described on the Medicaid remittance statement.

Electronic transmission of claims shall be required of any provider or billing service. ~~The Department may cancel any agreement for any violation of its contents.~~ The Department also reserves the right to reject any electronic claims transmission methods.

Failure of the provider or billing service to maintain and certify appropriate records as required by the state approved provider agreements constitutes breach of the state approved provider agreement, and entitles the Department to recover any payments for goods and services made to the provider and to terminate any state approved provider agreement. Thirty day written notice by registered mail shall be used by either party to terminate a state approved provider agreement unless the Department determines that good cause as defined in 8.076.1.7.~~051.01~~ exists in which immediate termination is necessary. Recovery may be accomplished by withholding the amount from future payments or requiring the provider to make payments directly to the Department ~~state~~ as described in 8.040.

Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years.

8.050 PROVIDER APPEALS

8.050.1 DEFINITIONS

1. Adverse Action means:

~~1~~a. An adverse action means a ~~A~~ finding of fact or interpretation of rules that ~~does not involve a determination of medical necessity but that~~ results in a determination that goods or services ~~or items~~ were not medically necessary; results in identification of overpayments~~;~~ or results in a reduction in, or denial of, other specific payments under the Medical Assistance program; or

~~2~~b. The denial, non-renewal or termination of a Provider agreement; or

~~3~~c. Denial of the application or request for additional information regarding an application pursuant to 10 C.C.R. 2505-10, Section 8.430.

2. Mailed means caused to be directed, transmitted, or made available and includes, but shall not be limited to:

a. The use of the United States Postal Service;

b. The use of electronic mail (e-mail) when agreed to by the provider;

c. Making a notice available for retrieval through the Internet or an internet application when agreed to by the provider;

d. The use of private courier or delivery services; and

e. The use of facsimile (fax) machines.

3. Medical assistance shall have the meaning defined in 25.5-1-103(5), C.R.S.

4. Provider means any person, public or private institution, agency, or business concern that:

a. ~~p~~Providesing medical or remedial care, services or goods authorized under the Medical Assistance program;~~Medicaid and~~

b. ~~h~~Holdsing, where applicable, a current valid license or certificate to provide such services or to dispense such goods~~;~~ and

c. Is enrolled in ~~under~~ the ~~State~~ Medical Assistance ~~P~~program. ~~For purposes of these regulations, Provider does not include any person, public or private institution, agency, or business concern with which the Department does business pursuant to a capitated reimbursement contract.~~

8.050.2 NOTICE OF ADVERSE ACTION

8.050.2.A. A notice of Adverse Action shall be in writing and shall be mailed to the Provider.

1. The notice shall include a statement of what action the Department intends to take.

2. The notice shall include the reasons for the intended action.

8.050.2.B. A notice of Adverse Action regarding a nursing facility's rate determination shall include a description of the method of rate calculation, the recommended or proposed audit adjustments with an explanation of adjustments and the final rate established.

8.050.2.C. A notice of Adverse Action regarding a determination of overpayment(s) following a review or an audit of a provider shall include the offer of an informal reconsideration of the review or audit

findings and notice that no recovery of the overpayment will be implemented until such informal reconsideration, if requested, has been completed.

8.050.3 PROVIDER APPEALS

8.050.3.A. A Provider, other than a nursing facility whose notice of Adverse Action is regarding a rate determination, may appeal a notice of Adverse Action by filing a written appeal within thirty (30) calendar days from the date on the Notice of Adverse Action. The appeal shall be filed with the Office of Administrative Courts, Department of Personnel and Administration, 633 Seventeenth Street, Suite 1300, Denver, Colorado 80202.

8.050.3.B. The appeal shall specify the basis upon which the Provider appeals the Adverse Action.

8.050.3.C. The date of filing the appeal shall be the date the Office of Administrative Courts receives the appeal. Failure to file a timely appeal shall result in dismissal of the appeal.

8.050.3.D. No recovery of an overpayment shall be implemented until the appeal process has been completed.

8.050.4 NURSING FACILITY RATE DETERMINATION APPEALS

8.050.4.A. Mandatory Informal Reconsiderations

1. A nursing facility, whose notice of Adverse Action results from its rate determination, may file a written request for informal reconsideration with the Department within 30 days of the date the rate determination letter is mailed. The request shall state, with specificity, the adjustments to the cost report the nursing facility wants reconsidered and the nursing facility's position as to each adjustment.

2. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

3. When the first rate letter that incorporates a nursing facility's new appraised value is issued, the nursing facility may file a written request with the Department for informal reconsideration of the appraisal within thirty (30) days of the date on the rate letter. Failure to file an informal reconsideration as set forth in this section shall cause any subsequent reconsideration or appeal of the appraisal at issue to be untimely and the reconsideration or appeal shall be dismissed.

4. Failure to file a written request for reconsideration as set forth in this section shall result in a waiver of the right to appeal the Adverse Action. Any issue not presented for informal reconsideration shall not be considered ~~timely filed~~ and shall not be appealable to the Office of Administrative Courts.

5. At informal reconsideration, the Provider shall not be allowed to present any information that was not submitted during the audit process prior to the issuance of the rate determination.

8.050.4.B. The nursing facility may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.

8.050.4.C. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the nursing facility may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.

8.050.4.D. Notwithstanding the position of the parties, their conduct or statements made during the Informal Reconsideration process, any subsequent appeal initiated by the nursing facility shall be a de novo proceeding, and neither the Department nor the nursing facility shall be bound by their

positions, conduct or statements. The evidence submitted by the nursing facility and considered at the *de novo* proceeding , shall be limited to that which was submitted during the audit process prior to the issuance of the rate determination being appealed. No new nursing facility information or documentary evidence shall be admissible at the *de novo* proceeding.

8.050.4.E. The administrative law judge (ALJ) shall not under any circumstances alter the appraisal methodology which is described in the most recent Request for Proposal (RFP). This limitation means the RFP defines how the appraisal is to be conducted and the ALJ may not change the RFP's described method. In particular, where the RFP describes which variables or components from the Boeckh program are to be specifically calculated through Boeckh's built-in data, those requirements from the RFP cannot be altered by the ALJ. This limitation on the ALJ's scope of review also means that where the RFP requires physical depreciation to be calculated through the use of the tables published in the Boeckh manual, the ALJ has no authority to consider appeals from providers requesting the use of alternative tables or any other method of calculating depreciation.

8.050.4.F. The ALJ may alter the findings of fact, judgments and opinions contained in the appraisal report (e.g. measurements, decisions regarding the depreciation components of effective age and building condition).

8.050.5 EXEMPTIONS FROM MANDATORY INFORMAL RECONSIDERATION IN NURSING FACILITY RATE DETERMINATION APPEALS

8.050.5.A. The following nursing facility rate issues are exempt from mandatory informal reconsideration.

1. In the case of Class I and Class II nursing facilities or private for-profit or non-profit nursing facility Class IV Providers, the nursing facility's right to appeal shall commence on the mailing date of the rate letter setting a rate based on the maximum reasonable cost calculation or on the date the facility array and other data used by the Department in its determination of the maximum reasonable rate is made available to Providers. This appeal period shall then expire thirty (30) days after the commencement date.

2. In the case of state-administered Class IV intermediate nursing care facilities for the mentally retarded which are not subject to maximum reasonable cost calculations, the nursing facility's right to appeal shall commence on the mailing date of the nursing facility's rate letter setting the final rate based on the facility's actual allowable audited costs as reported on the form MED-13. Such appeal period shall then expire thirty (30) days after the commencement date. The Office of Administrative Courts shall not conduct the appeal hearing. The appeal process shall be resolved by both agencies presenting their position to the Governor's office. The Governor's decision shall be binding on both agencies.

3. An appeal from the imposition of a civil money penalty or the denial of a Medicaid payment for a Medicaid-only certified nursing facility's failure to meet federal requirements for participation in Medicaid, shall follow the formal appeal process set forth in 10 C.C.R. 2505-10, Section 8.050.3. The penalty shall not be enforced or collected until the Department sends a certified letter to the Provider explaining the penalty or the denial of payment. In cases where the Provider appeals the penalty, collection of the penalty shall be suspended until the administrative law judge adjudicates the appeal.

8.050.6 INFORMAL RECONSIDERATIONS ~~IN~~ AND APPEALS OF OVERPAYMENTS RESULTING FROM REVIEW OR AUDIT FINDINGS

8.050.6.A. A Provider whose notice of Adverse Action results from a determination of overpayment(s), may file a written request for informal reconsideration with the Department within thirty (30) calendar days of the date of the notice of Adverse Action.

1. Requests made by telephone shall not be accepted.

2. The written request shall include the following: ~~state~~

a. ŧThe specific overpayments the Provider wants reconsidered; and

b. ŧThe Provider's position as to each overpayment.; and

c. Documentation that has not already been provided to the Department that substantiates the Provider's position as to each overpayment.

3. If a Provider files a written request for informal reconsideration of an Adverse Action and an appeal of the same Adverse Action before a decision has been rendered on the informal reconsideration, the appeal shall control, and the request for an informal reconsideration shall not be acted upon.

8.050.6.B. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

8.050.6.C. The Department shall issue a written decision on the informal reconsideration within forty-five (45) calendar days of the date on which the Department received the request for informal reconsideration. The provider may file a written appeal of the informal reconsideration decision no later than 30 calendar days from the date of the informal reconsideration decision pursuant to 8.050.3. A provider may appeal the written decision on the informal reconsideration pursuant to 8.050.3.

8.050.6.D. If the Department is unable to issue a written decision on the informal reconsideration decision within the time period described at 8.050.6.C., then the Department shall notify the Provider of its inability to complete the decision. The Provider may file a written appeal no later than 30 calendar days from the date of the notice stating that the Department is unable to render an informal reconsideration decision pursuant to 8.050.3.

8.050.6.C. The Provider may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.

8.050.6.D. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the Provider may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.

8.050.6.E. Notwithstanding the position of the parties, their conduct or statements made during the Informal Reconsideration process, any subsequent appeal initiated by the Provider shall be a de novo proceeding, and neither the Department nor the Provider shall be bound by their positions, conduct or statements.

8.050.6.F. No recovery of an overpayment shall be implemented until the informal reconsideration process has been completed.

8.050.7 STAY

If an appeal is timely filedfiled, upon motion of the Provider, the administrative law judge may stay the effective date of the adverse action until final agency action.

8.076 PROGRAM INTEGRITY

8.076.1 DEFINITIONS

1. Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result~~s~~ in an unnecessary cost to the ~~Medicaid~~ Medical Assistance program, an overpayment by ~~to~~ the Medical Assistance program, or in reimbursement for goods or services that are not medically necessary, as defined at 8.076.1.8., or that fail to meet professionally recognized standards for health care. These practices may include, but are not limited to:

   ~~1~~a. Billing for goods or services ~~and/or supplies~~ without valid documentation to support the claims submitted for reimbursement.

   ~~2~~b. Unbundling charges on claims for goods or services ~~medical services and supplies~~ by separating components of a group of procedures that are required to be billed together (or bundled), and billing each component separately.

   ~~3~~c. Submitting a fee-for-service claim or claims for goods or services before they have been provided.

   ~~4~~d. Signing prior authorizations or physician's orders for goods or services ~~or supplies~~ that are inappropriate or not medically necessary for the client.

   e. Presenting or causing to be presented for payment any false or fraudulent claim for goods or services.

   f. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

   g. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

   h. Failing to retain or disclose or make available to the Department or its authorized agent(s) records of goods or services provided to eligible clients and related records of payments when requested.

   i. Engaging in a course of conduct or performing an act deemed improper or continuing such conduct following notification that said conduct should cease.

   j. Visiting a facility, such as a nursing home, and billing for individual visits without rendering any specific service to individual clients.

   k. Overutilizing by inducing, furnishing, or otherwise causing a client to receive goods or services not otherwise required or requested by the client or prescribing provider.

   l. Violating any applicable regulation listed at 10 C.C.R. 2505-10, Section 8.000, et. seq.

   m. Submitting a false or fraudulent application for provider status.

   n. Violating any laws~~,~~ or regulations pertaining to federal or state health care programs or failing to meet professionally recognized standards for health care.~~, or codes of ethics governing the conduct of occupations or professions of regulated industries.~~

   o. Conviction of a criminal offense relating to:

      i) Performance of the Provider Agreement with the State;

      ii) Negligent practice resulting in the death or injury to patients;

iii) Patient abuse;

iv) Fraudulent billing practices; or

v) Misuse or misapplication of program funds.

p. Failure to meet standards required by state or federal law for participation such as licensure or certification requirements.

q. Failure to correct deficiencies in provider operations in accordance with an accepted plan of correction after receiving written notice of these deficiencies from the Department, its designees, or other state agencies.

r. Formal reprimand or censure by an association of the provider's peers or the appropriate state or federal regulatory or licensing body for unethical, illegal, or improper practices.

s. Suspension, exclusion, or termination from participation in another governmental medical program for fraudulent or abusive practices.

t. Failure to repay or make arrangements to repay overpayments or payments made in error.

u. Use of another provider's provider identification number for the purpose of obtaining reimbursement.

v. Use of client identification numbers to submit claims for reimbursement for goods or services that were not rendered or delivered.

w. Alteration of any source documentation performed to support claims billed or creation of new source documentation to support claims billed when the alteration or creation occurs after a request for documentation is received by the provider from the Department or its agent. Alteration does not include a late entry that is signed and dated when documented or transcriptions made to facilitate a Department review.

2. Conviction or Convicted means that:

a. ~~a~~ A judgment of conviction has been entered against an individual or an entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending;

b. A federal, state, or local court has made a finding of guilt against an individual or entity;

c. A federal, state, or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or

d. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

3. ~~Exclusion~~ Excluded means a Provider that has been barred from participating in any health care program pursuant to 42 USC §1320a-7(a) or (b). 42 USC §1320a-7(a) and 42 USC §1320a-7(b) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been

incorporated by reference in this rule may be examined at any state publications repository library. ~~that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.~~

4. False representation means an inaccurate statement that is relevant to a claim for reimbursement and is made by a Provider who has actual knowledge of the truth or false nature of the statement or by a Provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A Provider acts with deliberate ignorance of or with reckless disregard for the truth if the Provider fails to maintain records required by the Department or if the Provider fails to become familiar with rules, manuals, and bulletins issued by the Department, board or the Department's fiscal agent.

5. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

6. Furnished refers to goods ~~items~~ and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a Provider, or other supplier of goods or services.

7. Good cause, for the purpose of withholding payments to a provider or denying, terminating, or not renewing a Provider agreement means:

~~1~~a. The Provider has failed to comply substantially with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent. ~~Provider agreements, Provider billing manuals and/or Provider bulletins.~~

~~2~~b. The Provider has not complied with applicable federal and state statutes and regulations.

~~3~~c. The Provider, either by omission or commission, is endangering or has endangered the health, safety, or well-being of a program services beneficiary or beneficiaries.

d. The owner, operator, partner, or other participating employee of the Provider has previously owned, operated, or otherwise participated in and received direct or indirect payment from the Medical Assistance Program and has a documented pattern of program abuse, substandard care, endangerment of the health or well-being of clients, or non-compliance with program requirements.

~~4~~e. The Provider's license or certification has expired, been revoked or suspended, or surrendered while a formal disciplinary proceeding was pending before a state licensing authority, or for any other reason is invalid at the time goods are provided or services are rendered for which claims are submitted for reimbursement. ~~are rendered.~~

~~5~~f. The Provider has been excluded or suspended from the Medical Assistance ~~Medicaid~~ program or has been excluded or suspended from reimbursement under the Medicare program unless a waiver is granted by the Department of Health and Human Services Office of Inspector General.

~~6~~g. The Provider has failed to fully and accurately make any disclosures required by federal and state statutes or regulations.

~~7~~h. Any person with an ownership or controlling interest in the Provider, or who is a Provider's agent or managing employee, who has been convicted of a criminal offense related to that person's involvement in any program established under Medicare or Medicaid.

~~8~~i. The Provider has demonstrated a pattern of abuse.

~~9~~j. The Provider has engaged in false representation and/or fraud in submitting Medical Assistance program claims ~~to Medicaid~~.

k. The Provider has solicited or accepted from an eligible client, his or her family, friend, estate, or other representative an amount over and above the Medical Assistance program reimbursement amount for covered goods or services, excluding any required copayment, coinsurance, or other client cost-sharing amounts.

l. The Provider has failed to return money paid by clients for covered goods or services rendered during any period of client eligibility. This includes failing to pay back clients for goods or services for which they were charged when their eligibility was determined retroactively and there is evidence of notification of retroactive eligibility for the client, regardless of whether payment for the covered goods or services were received.

8. Medical necessity means a Medical Assistance program good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. ~~and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.~~ It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be:

i) Provided in accordance with generally accepted standards of medical practice in the United States;

ii) Clinically appropriate in terms of type, frequency, extent, site, and duration; ~~and~~

iii) Not primarily for the economic benefit of the provider or for the convenience of the client, caretaker, or provider; and~~.~~

iv) Performed in a cost effective and most appropriate setting required by the client's condition.

~~that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:~~

~~1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and~~

~~2. Meets at least one of the following criteria:~~

~~a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.~~

~~b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.~~

~~c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.~~

~~d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.~~

~~Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.~~

98. Overpayment means the amount paid ~~by a Medicaid agency~~ to a Provider which is in excess of the amount that is allowable for goods or services furnished under Section 1902 of the Social Security Act and which is required to be refunded under Section 1903 of the Act.

109. Provider means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under the Medical Assistance program ~~Medicaid~~ and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods, and enrolled in ~~under~~ the ~~State~~ Medical Assistance ~~P~~program~~. For purposes of these regulations, Provider does not include any person, public or private institution, agency, or business concern with which the Department does business pursuant to a capitated reimbursement contract.~~

110. Suspension means that goods ~~items~~ or services furnished by a specific Provider who has been convicted of a program-related offense in a federal, state or local court will not be reimbursed under the Medical Assistance program. ~~Medicaid.~~

8.076.2 COMPLIANCE MONITORING

8.076.2.A. All Providers shall comply with the efforts of the Department~~'s~~, its designees, any investigative entity, or the Medicaid Fraud Control Unit ~~efforts~~ to monitor Provider compliance with federal and state ~~Medicaid~~ Medical Assistance program statutes and regulations in order to detect and correct noncompliance and prevent fraud and abuse.

8.076.2.B. Compliance monitoring includes, but is not limited to:

1. Conducting prospective, concurrent, and/or post-payment ~~and/or concurrent~~ reviews of claims.

2. Verifying Provider adherence to professional licensing and certification requirements.

3. Reviewing goods provided and services rendered for fraud and abuse.

4. Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.

5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT) and Current Dental Terminology (CDT).

6. Reviewing adherence to the terms of the Provider Participation Agreement.

8.076.2.C. Compliance monitoring activities may include, but are not limited to:

1. Site reviews.

2. Desk audits.

3. Medical records reviews.

4. Claims reviews.

5. Data mining.

8.076.2.D. The US Department of Health and Human Services, the Department, the Medicaid Fraud Control Unit, or their designees has the right to audit and confirm any information submitted by the Provider to the Medical Assistance program. The Provider shall furnish information about submitted claims, claim documentation records, and original source documentation including, but

not limited to, provider and patient signatures; medical, accounting, or financial records; or any other relevant information upon request.

8.076.2.E. The Department or its designees shall provide a written request to the Provider to review records. This request shall include clearly defined due dates for submitting requested records, the procedures for requesting an extension of time to submit the requested records, and the procedures for requesting an informal reconsideration or an appeal. This request shall include the option of providing paper copies of records, electronic copies of records in a format that is compatible with the Department's or its designee's systems, or an inspection or reproduction of the records by the Department or its designees at the Provider's site. Medical records requested for review shall be provided to the Department at the expense of the Provider. The Provider shall submit or produce the requested materials within forty-five (45) calendar days unless:

1. The review is based on quality of care concerns, in which case the materials shall be submitted within fourteen (14) calendar days of the request; or

2. The request is made during the course of a civil or criminal investigation, in which case the records shall be submitted immediately upon request.

8.076.2.F. Records received by the Department after the forty-five (45) calendar day deadline shall not be considered in the review, unless the Department has granted a written extension. The written request for an extension to submit records must be received by the Department within fifteen ~~ten~~ (15~~0~~) calendar days from the date of the Department's request. Telephone requests shall not be accepted. The request shall specify the additional time requested and the ~~extraordinary~~ circumstances present that require an extension of time.

8.076.2.G. Any claims submitted for which documentation is not received within the time limits specified in this section shall be considered an overpayment subject to recovery regardless of whether goods or services have been provided.

8.076.2.H. A Provider subject to a review or audit may request an interview in person or by telephone with the Department or its designees before the final written post-review correspondence is released. During this interview, the Provider may discuss the preliminary findings of the review or audit, what documentation the Provider may use to refute the findings, and the next steps in the review or audit process.

8.076.2.I. The Department's post-review formal correspondence shall indicate areas of strength, suggestions for improvement and required actions, unless the review is conducted for the purpose of post-payment review. For all post payment reviews, the Provider shall receive a letter identifying the overpayment demand or notice of no repayments. This notice shall include the procedures for requesting an informal reconsideration or an appeal.

8.076.2.J. Duplication of Records – The Department staff, its designees, or the Medicaid Fraud Control Unit may photocopy or otherwise duplicate any paper or electronic document, chart, policy, or other record relating to medical care or services provided, charges to or payments made by clients, or goods or services provided for which a claim is submitted. The Department or its designees and the Medicaid Fraud Control Unit shall be allowed to use duplicating equipment on the Provider's premises to the extent that such use results in minimal disruption of the Provider's business. If such use of duplicating equipment shall cause more than minimal disruption of business, the Provider shall notify the Department in writing or by telephone, and the Department shall attempt to resolve the issue with the Provider or make other arrangements.

8.076.2.K. Providers who maintain records to substantiate their claims for reimbursement in another entity's records including, but not limited to, a nursing facility, adult day care center, or hospital, shall be subject to the requirements ~~outlined~~set forth at 8.076.2.E.

8.076.2.L. The Department may delegate compliance monitoring activities.

8.076.2.M. Nothing in section 8.076 shall be construed as limiting the right of the Department to conduct quality improvement activities in accordance with the provisions of section 8.079.

8.076.2.N. Nothing in section 8.076 shall be construed as limiting the right of the Department to conduct emergency site visits when the Department has concerns about client safety, quality of care, fraud, abuse, or Provider financial failure.

8.076.3 RECOVERY OF OVERPAYMENTS

8.076.3.A. Any identified overpayment to a Provider shall be recoverable following exhaustion of any informal reconsideration or appeal pursuant to 8.050.6 and 8.050.3.

1. Overpayments and/or other indebtedness to the state are recoverable through a repayment agreement with the Provider,; by offsetting the amount owed against current and future claims of the Provider, through litigation,; or by any other appropriate action within the Department's legal authority.

2. The offset rate shall be 100% of the total amount owed to be withheld from subsequent payments until the entire amount owed is recovered. The overpayment offset rate may be reduced if the Provider shows good cause that withholding payment at the established rate will result in undue hardship.

3 In cases where multiple overpayments to the same Provider have been found, the recovery may be determined through scientific statistical analysis and extrapolation of data from a statistically valid selected sample of the claims.

4. A provider shall have the right to request an informal reconsideration or an appeal of an identified overpayment. The regulations for reconsiderations are set forth at 8.050.6.A. The regulations for appeals are set forth at 8.050.3.A.

8.076.4 WITHHOLDING OF PAYMENTD DURING INVESTIGATION FOR FRAUD AND/OR WILLFUL MISREPRESENTATION

8.076.4.A. Medicaid pPayments to a provider may be withheld, in whole or in part, upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medical Assistance Medicaid program. Payments may be withheld without first notifying the Provider of the intention to withhold such payments. A Provider shall be granted appeal rights upon request.

8.076.4.B. Notice of withholding shall be sent to the Provider within five (5) calendar days of taking such action. The notice shall:

1. State that payments are being withheld in accordance with this provision;

2. State that the withholding is for a temporary period, as stated in 8.076.4.C and cite the circumstances under which withholding will be terminated;

3. Specify, when appropriate, to which type or types of Medicaid claims withholding is effective; and

4. Inform the Provider of the right to submit written evidence for consideration by the Department.

8.076.4.C. All withholding of payment actions under 8.076.4 shall becease if the Department or prosecuting authorities determine that there is insufficient evidence of fraud or false representation by the Provider. temporary and shall not continue after:

1. The Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the Provider; or

2. Legal proceedings related to the Provider's alleged fraud or willful misrepresentation are completed.

8.076.5 DENIAL, TERMINATION AND/OR NONRENEWAL OF PROVIDER AGREEMENTS

8.076.5.A. The Department may deny an application for a Provider agreement, terminate or not renew a Provider agreement for ~~G~~good ~~C~~cause, as defined at 8.076.1.7.

8.076.5.B. A potential Provider shall be notified of the Department's decision to deny an application for a Provider agreement by a notice of Adverse Action.

8.076.5.C. A Provider shall be notified of the Department's decision to terminate or not renew a Provider agreement by a notice of Adverse Action. Termination and/or nonrenewal shall not be effective sooner than thirty (30) calendar ~~fifteen~~ days ~~(15)~~ from the date of the notice except as provided at 8.076.5.D. ~~for an emergency termination.~~

8.076.5.D. Provider agreements may be terminated without prior notice if:

1. ~~t~~The Provider has been found guilty of fraud; ~~or~~

2. The Provider has been found to have made a false representation; or

3. ~~t~~The termination is imperatively necessary for the preservation of the public health, safety, or welfare and observance of the requirements of notice would be contrary to the public interest. Within five (5) business days of the emergency termination, the provider shall receive a notice of Adverse Action.

8.079 QUALITY IMPROVEMENT

8.079.1 DEFINITIONS

Managed Care Entity means, for purposes of Section 8.079, any person, public or private institution, agency or business concern with which the Department does business pursuant to a capitated reimbursement contract.

Provider means a Provider, as defined in 8.050.1.4. ~~means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under Medicaid and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods, and enrolled under the State Medical Assistance Program. Provider does not include a Managed Care Entity.~~

8.079.2 EXTERNAL QUALITY REVIEW (EQR)

Providers and Managed Care Entities shall comply with annual EQR activities. EQR may include, but is not limited to the following activities:

1. Performance improvement projects.
2. Performance improvement project validation.
3. Performance improvement measurement.
4. Performance improvement measurement validation.
5. Consumer satisfaction survey.
6. Medical record review.
7. Review of individual cases.
8. PCPP credentialing and recredentialing.

8.079.3 MONITORING AND REVIEW

8.079.3.A. All Providers and Managed Care Entities shall comply with the efforts of the Department, its designees, any investigative entity, or the Medicaid Fraud Control Unit ~~efforts~~ to monitor performance through site visits, reviews, desk audits, emergency site visits, profiling, compliance reporting requirements and other quality and program integrity review activities. Monitoring activities shall be conducted for the purpose of determining compliance with state and federal requirements, contracts or Provider agreements, Medicaid service provision and billing procedures, and/or Medicaid Bulletins and Provider Manuals.

1. Managed Care Entities - The Managed Care Entity shall be subject to annual site visits to determine compliance with established standards. The annual site visit process shall consist of a desk audit component and an onsite visit. The Managed Care Entities and/or its subcontractors shall, upon request, provide and make available staff to assist in the audit or inspection efforts and provide adequate space on the premises to reasonably accommodate review personnel.

2. Providers – ~~the Department may conduct site reviews, desk audits, medical records review and/or claims review for Providers as it deems appropriate.~~Providers shall be subject to the compliance monitoring provisions of 8.076.2.

~~The Department shall provide a written request to the Provider to review records. This request shall include the option of providing either a reproduction of records or an inspection of the records by the Department at the Provider's site. The Provider shall submit or produce requested materials within twenty-one (21) calendar days, unless the review is~~

based on quality of care concerns, in which case the materials shall be submitted within fourteen (14) calendar days of the request. Medical records requested for review shall be provided to the Department at the expense of the Provider.

a. Records received by the Department after the twenty-one (21) calendar day deadline shall not be considered in the review, unless the Department has granted a written extension. The request for an extension must be received by the Department within ten (10) calendar days from the date of the Department's request., must specify the additional time requested, and reasons for requesting the extension.

b. Any claims submitted for which documentation is not received within the time limits specified in this section shall be an overpayment subject to recovery regardless of whether or not services have been provided.

c. The Department's post-review formal correspondence shall indicate areas of strength, suggestions for improvement and required actions, unless the review is conducted for the purpose of post-payment review. For all post payment reviews, the Provider shall receive a letter identifying the overpayment demand, or notice of no repayments.

d. Duplication of Records - The Department staff, its designated representatives, or the Medicaid Fraud Control Unit may photocopy or otherwise duplicate any document, chart, policy, or other record relating to medical care or services provided, or goods dispensed for which a claim is submitted. The Department or its designee and the Medicaid Fraud Control Unit shall be allowed to use duplicating equipment on the Provider's premises to the extent that such use results in minimal disruption of the Provider's business. If such use of duplicating equipment will cause more than minimal disruption of business, the Provider will notify the Department, which will attempt to resolve the issue with the Provider or make other arrangements.

3. The Department reserves the right to deem other State agencies or private accreditation organizations approved reviews to constitute compliance with specific contractual obligations or regulatory requirements.

4. The Department may delegate monitoring activities.

5. The Department may shall conduct unannounced or emergency site visits when the Department has concerns about in instances where patient safety, quality of medical care, potential fraud, abuse, or Provider financial failure is imminent.

8.130 PROVIDER PARTICIPATION

8.130.1 DEFINITION

Requesting Agency means the United States Department of Health and Human Services, the Department or its designees, Department of Human Services, or the Medicaid Fraud Control Unit, acting through their representatives who have written or de facto~~r~~ designation as such.

8.130.2 MAINTENANCE OF RECORDS

8.130.2.A. Each provider shall:

1. Maintain legible records necessary to disclose the nature and extent of goods and services provided to clients ~~recipients~~ including but not limited to:

   a. Billings.

   b. ~~Treatment p~~Prior authorization requests.

   c. All medical records, service reports, and orders prescribing treatment plans.

   d. Records of ~~items~~ goods~~, including drugs,~~ prescribed, ordered for, or furnished to clients~~ recipients,~~ and unaltered copies of original invoices for such items.

   e. Records of all payments received from the Medical Assistance ~~Medicaid P~~program.

2. Maintain legible records, which fully substantiate or verify claims submitted for payment.

   a. The records shall be created at the time the goods or services are provided.

~~3. Furnish the records listed in 8.130.2.A.1 on request to the requesting agency.~~

8.130.2.B. Records of ~~institutional~~ providers shall include employment records, including but not limited to shift schedules, payroll records and time cards of employees.

8.130.2.C. Providers who issue prescriptions shall keep in the patient's record, the date of~~l~~ each prescription and the name, strength and quantity of the item prescribed.

8.130.2.D. Records must be maintained for six years unless an additional retention period is required elsewhere in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in the provider agreement.

8.130.2.E. Each provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles and auditing standards.

8.130.2.F. Each entry in a medical record must be signed and dated by the individual providing the medical service. Stamped signatures are not acceptable.

8.130.2.G. Providers utilizing electronic record-keeping may apply computerized signatures and dates to the medical record if their record-keeping systems guarantee the following security measures:

1. Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.

2. Prevent alterations to authenticated (signed and dated) reports. If the provider ~~of service~~ chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The provider must not be allowed to change the initial entry.

3. Printed or displayed electronic records must note that signatures and dates have been applied electronically.

8.130.2.H. At the discretion of the requesting agency, record verification may include but not be limited to interviews with providers, employees of providers, billing services that bill on behalf of providers, and any member of a corporate structure that includes the provider as a member.

8.130.2.I. Nothing in Section 8.130 shall negate or modify any specific record keeping requirements contained in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in individual provider agreements.

8.130.3 ADVANCE DIRECTIVES

8.130.3.A. Advanced Directive means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.

8.130.3.B. Providers shall provide adult Medical Assistance program ~~Medicaid~~clients ~~recipients~~ with written information about the individual's rights under state law to accept or refuse medical treatment, the right to formulate advance directives and the providers' policies regarding the implementation of such rights as follows:

1. Hospitals, at the time of the individual's admission as an inpatient.

2. Nursing facilities, at the time of the individual's admission as a resident.

3. Providers of home health care or personal care services, in advance of the individual coming under the care of the provider.

4. Hospice programs, at the time of initial receipt of hospice care by the individual from the program.

5. Health maintenance organizations, at the time of enrollment of the individual with the organization.

8.130.3.C. The provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the provider organization which shall include:

1. Documentation in the individual's medical records indicating whether the individual has executed an advance directive.

2. Documentation that the individual will not be discriminated against, nor will the provision of care be conditioned on whether he/she has executed an advance directive.

3. Documentation ensuring compliance with requirements of state law respecting advanced directives.

4. Documentation in the individual's medical record substantiating the provider's reason(s) for non-compliance with an advance directive based on conscience or professional ethics.

8.130.3.D. Providers shall provide education for staff and the patient/client community on issues concerning advance directives.

8.300.4 PRIOR AUTHORIZATION, POST-PAYMENT REVIEW AND CONTINUING STAY REVIEW

1. All participating Hospitals shall participate in a prior authorization and retrospective post-payment review program administered by a Quality Improvement Organization (QIO); and may be subject to additional reviews including, but not limited to, those conducted by the Department or its representatives pursuant to 10 C.C.R. 2505-10, Sections 8.076 and 8.079.