**THIS PAGE NOT FOR PUBLICATION**

**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 11-06-10-A, Revision to the Medical Assistance Rule Concerning the Colorado Indigent Care Program, Sections 8.901 and 8.903
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) 8.901 and 8.903, 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 §8.901 DEFINITIONS from §8.901.C through §8.901.E unnumbered paragraph 1. All other text in this section is provided for clarification only.**
**Please replace current text at §8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS from §8.903.A.1 through§8.903.3.a. All other text in this section is provided for clarification purposes only.**
**This change is effective 09/30/2011.**

*to be completed by MSB Board Coordinator

**THIS PAGE NOT FOR PUBLICATION**

Rule Number: MSB 11-06-10-A

Division / Contact / Phone: Financial & Administrative Services Office / Nancy Dolson / 303-866-3698

**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).

   This rule change will align the definition of health care providers qualified to participate in the Colorado Indigent Care Program (CICP) with state statute. Legislation passed in the 2011 session and signed into law by Governor Hickenlooper changed the definition of "general provider" to include Federally Qualified Health Centers and Rural Health Centers. This rule change adds those two provider types to the list of qualified CICP providers.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law 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. (2010);
   25.5-3-104, C.R.S. (2011)

Initial Review — Final Adoption **08/12/2011**

Proposed Effective Date **09/30/2011** — Emergency Adoption

**DOCUMENT #05**

**THIS PAGE NOT FOR PUBLICATION**

| | |
|---|---|
| Title of Rule: | Revision to the Medical Assistance Rule Concerning the Colorado Indigent Care Program, Sections 8.901 and 8.903 |
| Rule Number: | MSB 11-06-10-A |
| Division / Contact / Phone: | Financial & Administrative Services Office / Nancy Dolson / 303-866-3698 |

**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.

   Prior to the passage of HBs 11-1101 and 11-1323, facilities licensed as general hospitals, birth centers, or community health clinics by the Colorado Department of Public Health and Environment qualified to participate in the Colorado Indigent Care Program (CICP). These legislative actions expanded the definition of qualified CICP providers to include Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as defined under federal law. This rule change allows FQHCs and RHCs to participate in CICP without completing the community health clinic licensure process with the state.

   All 15 FQHCs in Colorado currently participate in the CICP, so this rule change does not affect the FQHCs. Currently one of 21 federally-licensed RHCs participates in the CICP, so this rule change will allow 20 RHCs to participate in CICP, if they so choose, with no additional licensure requirements.

   The CICP provides funding to participating providers to partially offset the uncompensated care costs for low-income Coloradans who do not qualify for Medicaid or the Child Health Plan Plus (CHP+). By removing an administrative barrier to provider participation in CICP, this rule change may reduce uncompensated care costs for RHCs who choose to participate and may increase access to discounted health care for low-income Coloradans.

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

   Available funding for all CICP clinic providers is limited by the available appropriation. If more providers choose to participate due to the decreased administrative requirements, the funding available for current CICP clinic providers could be reduced. However, no new RHCs have applied to participate in the CICP to date since the legislation was passed.

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.

   None. Available funding for CICP clinics is limited by the available appropriation. There are no additional costs to the Department to allow more providers to participate in the CICP.

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

   This proposed rule aligns the definition of qualified CICP provider with state law. Inaction would mean that the program's rules would be inconsistent with statute.

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

   None. This proposed rule aligns the definition of qualified CICP provider with state law.

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.

   None. This proposed rule aligns the definition of qualified CICP provider with state law.

**8.901 DEFINITIONS**

A. "Applicant" means an individual who has applied at a qualified health care provider to receive discounted health care services.

B. "Client" means an individual whose application to receive discounted health care services has been approved by a qualified health care provider.

C. "Emergency care" is treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section ~~26-15-103~~25.5-3-103, C.R.S.

D. "Urgent care" is treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.

E. "General provider" means ~~any~~ a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. 1395x (aa)(4), a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2), a~~any~~ health maintenance organization issued a certificate authority pursuant to section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to section 25.5-3-108 ~~26-15-106~~(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider" includes associated physicians.

42 U.S.C. 1395x is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203. Additionally, any incorporated material in these rules may be examined at any State publications depository library.

F. "Qualified health care provider" means any general provider who is contracted with the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

G. "Hospital provider" means any "qualified health care provider" that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to C.R.S. §25-1.5-103 and which operates inpatient facilities.

H. "State-owned hospital provider" is any "hospital provider" that is either owned or operated by the State.

I. "Local-owned hospital provider" is any "hospital provider" that is either owned or operated by a government entity other than the State.

J. "Private-owned hospital provider" is any "hospital provider" that is privately owned and operated.

## 8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by ~~26-15-106~~25.5-3-108 (5)(a)(I), C.R.S.

2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by 25.5-3-108 (5)(a)(II), C.R.S.

3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:

   a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment, or ~~,~~ certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

   b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.

   c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

   d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).

**THIS PAGE NOT FOR PUBLICATION**

Title of Rule: 8.520 Home Health Services

Rule Number: MSB 10-08-6-A

Division / Contact / Phone: Medicaid/Benefit Management / Guinevere Blodgett / 5927

**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 10-08-6-A, 8.520 Home Health Services
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Insert Section(s) affected, 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 insert new text provided at §8.523.11.G.1 immediately following current text at §8.523.11.G and prior to current text at §8.523.11.H.**
**Please insert new text provided at 8.524.12 immediately following current text at §8.524.11 and renumber subsequent paragraphs 12, 13 and 14 to 13, 14 and 15.**
**Please insert new text provided at §8.525.10.C immediately following § 8.525.10.B and prior to §8.525.11.**
**Please insert new text provided at §8.525.15 through §8.525.15.G immediately following current text at §8.525.14.E and prior to §8.526.**
**Please insert new text provided at §8.527.13 through §8.527.13.C.4 immediately following current text at §8.527.12 and renumber subsequent paragraph 13 to 14.**
**Please insert new text at §8.528.E immediately following current text at §8.528.D.3 and prior to §8.528.12.**
**Please insert new text "uncomplicated" into current text in paragraph at §8.528.13.A, par 3.**
**Please replace current text at §8.528.14.B.1, §8.528.14.B.2 and §8.528.14.C with new text provided.**
**All other text provided is for clarification purposes only.**
**This change is effective 09/30/2011.**

*to be completed by MSB Board Coordinator

**THIS PAGE NOT FOR PUBLICATION**

Title of Rule: 8.520 Home Health Services

Rule Number: MSB 10-08-6-A

Division / Contact / Phone: Medicaid/Benefit Management / Guinevere Blodgett / 5927

**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 implement SB 07-196, updated by HB 10-1005, to allow telehealth as a covered service for Colorado Medicaid Home Health recipients. Home health telehealth is the monitoring of health care data through information processing technologies. It includes the collection of clinical data in a clients home, and the transmission of that data to a home health agency for a clinical assessment and review, and action as needed. The rule is necessary to initiate the service and comply with CRS 25.5-5-321. Several items within the rule have been updated to decrease ambiguity and clarify intent of the current rules.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

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

   Explain:

3. Federal authority for the Rule, if any:

   1905(a)(7) of the Social Security Act (P.L. 74-271)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   CRS 25.5-5-321

| | | | |
|---|---|---|---|
| Initial Review | **July 8, 2011** | Final Adoption | **08/12/2011** |
| Proposed Effective Date | **10/01/2011** | Emergency Adoption | |

**DOCUMENT #06**

**THIS PAGE NOT FOR PUBLICATION**

Title of Rule: 8.520 Home Health Services

Rule Number: MSB 10-08-6-A

Division / Contact / Phone: Medicaid/Benefit Management / Guinevere Blodgett / 5927

## 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 persons who will benefit from this rule are Colorado Medicaid clients who access Home Health benefits and who have the qualifying diagnoses identified in the rule. Clients will benefit from the increased monitoring and treatment intervention, which will enhance effective home health disease management. Recipients may also see the benefit that comes from reduced hospitalizations and emergency room visits due to better management of their disease process. Home health and home and community based service agencies and clients may also benefit, as cost reductions and efficiencies are realized when inpatient and emergency room utilization is decreased.

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 qualitative impact will be the effective management and monitoring of clients whose medical needs can be appropriately met at home through home health telehealth intervention, resulting in better disease management and health outcomes. This service will allow for early identification of exacerbation of disease symptoms which will decrease the likelihood of emergency room or inpatient interventions. An economic impact is not anticipated for clients, although the Colorado Medicaid program may realize some savings.

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 costs to the Department are $91,963 appropriated annually for vendor services to do rate evaluations, policy evaluations, claims audits, and clinical review. Current staff in the Benefits Management and Rates sections will absorb the program management activities. Initially the program will be funded by gifts, grants and donations and are anticipated to cost $312,576 in FY 2011-12. Should the Department determine the program to be cost effective and beneficial to clients, the Department could extend the program through the use of General Fund beginning in FY 2012-13.

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

   HB 10-1005 mandates the implementation of this benefit.

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

   None known

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.

   No alternatives considered, as this new service was mandated by CRS 25.5-5-321

## 8.520 HOME HEALTH SERVICES

### 8.521 LEGAL BASIS

The Medicaid Home Health Program in Colorado is authorized under 1905(a)(7) of the Social Security Act (P.L. 74-271); and by state law at 26-4-202(1) f, C.R.S. (1994 Supp.) and 26-4-302(l) m, C.R.S. (1994 Supp.).

### 8.522 COVERED SERVICES

Home Health services reimbursed by Medicaid shall be limited to skilled nursing services, home health aide services, occupational therapy services, physical therapy services, and speech/language pathology services, as defined at Section 8.525, SERVICES REQUIREMENTS.

### 8.523 ELIGIBILITY

.10 Home Health services are a benefit available to all Medicaid clients and to all Modified Medical Program clients when all program and services requirements are met. To be eligible for Long Term Home Health services, as set forth at Section 8.523.11.K, Medicaid clients 18 and over shall meet the Level of Care Screening Guidelines for Long Term Care Services at Section 8.401. Medicaid clients under the age of twenty-one may be eligible for special Home Health benefits according to rules at 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES.

.11 Home Health services are eligible for reimbursement under Medicaid only when the services meet all of the following requirements:

A. Services are provided for the treatment of an illness, injury, or disability which may include mental disorders.

B. Services are medically necessary.

C. Services are reasonable in amount, duration, and frequency.

D. Services are provided under a plan of care as defined at Section 8.524 DEFINITIONS.

E. Services are provided on an intermittent basis, as defined at Section 8.524, DEFINITIONS.

F. The only alternative to Home Health services is hospitalization or the emergency room; or the client's medical records accurately justify a medical reason that the services should be provided in the client's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

1. The client, due to the client's illness, injury or disability, is not able to go to a physician's office, clinic or other out-patient setting for the needed service, for example, a client with quadriplegia who needs aide services to get in and out of bed.

2. If, because of the client's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the client. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the client's medical records. Examples of medical hardship would include: a client who would require ambulance transportation, a client in severe pain, or a client who is just out of the

hospital after major surgery. Some examples of conditions that would not by themselves be considered creation of a medical hardship would include: a client who is on oxygen, a client who walks with a limp, or a client who uses a cane.

3. Going to a physician's office, clinic, or other out-patient setting for the needed service is contra-indicated by the client's documented medical condition, for example, a client who must be protected from exposure to infections.

4. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service. Examples include a young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located; clients living in regions where traveling to out-patient therapy would require hours of travel; a client who needs a service repeated at frequencies that would be extremely difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as IV care three times per day, or daily insulin injections; a client who needs regular and prn catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dis-lodgement or blockage; a client who, because of the client's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered adverse health consequences as a result, including use of emergency room and hospital admissions.

5. The client's medical condition requires teaching which is most effectively accomplished in the client's home on a short-term basis.

G. Services are provided in the client's place of residence. The client's place of residence is where the client lives, except that home health services shall not be reimbursed if the client's place of residence is a nursing facility or hospital. Assisted living faculties of any kind are places of residence. If a client is visiting relatives or staying in a hotel during a trip, or similar temporary accommodations, the place where the client is staying will be considered the temporary place of residence for purposes of this rule. Services shall not be reimbursed if provided at the workplace, school, child day care, adult day care, or any other place that is not the client's place of residence, except when the services are prior authorized according to 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES, or Section 8.531 through 8.539, HOME HEALTH AIDE PILOT PROGRAM.

1. Monitoring of health care status may be provided remotely through Home Health Telehealth services.

H. Services are provided by a Medicaid-certified Home Health agency.

I. The Client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver able and willing to perform the tasks.

J. When the client has Medicare or other third-party insurance, Medicaid Home Health shall be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

K. The Client's care falls under one of the following three categories:

1. Acute Home Health , which means Medicaid-reimbursed Home Health services that are:

a. Provided for 60 calendar days; and

b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.

5) Exacerbation or severe instability of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

2. Long Term Home Health , which means Medicaid-reimbursed Home Health services that are:

a. Provided for 61 calendar days or longer; or

b. Provided for less than 61 calendar days when services are provided solely for the care of chronic conditions.

3. Long Term with Acute Episode Home Health , which means Medicaid-reimbursed Home Health services that are:

a. Provided for care of long-term chronic conditions; and

b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, decubitus.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization.

5) Exacerbation of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

**8.524 DEFINITIONS**

.10 HOME HEALTH AIDE ASSIGNMENT FORM

Home health aide assignment form means the form which the home health agency uses to list the duties to be performed by the home health aide at each visit.

.11 HOME HEALTH SERVICES

Home Health Services means those services listed at Section 8.522, COVERED SERVICES, and described at Section 8.525, SERVICES REQUIREMENTS.

.12 HOME HEALTH TELEHEALTH

Home Health Telehealth means the remote monitoring of clinical data through electronic information processing technologies.

.132 INTERMITTENT

Intermittent is defined as no more than the combined number of all visits and/or other units of service which will cause the reimbursement per calendar day to equal the maximum reimbursement limits as set forth in the Reimbursement section of these rules. Visits and/or units or combinations thereof may directly follow each other without any break and still be considered intermittent, as long as the maximum reimbursement limit per day is not exceeded.

.143 PLAN OF CARE

A plan of care means a coordinated plan developed by the Home Health agency as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

.154 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

**8.525 SERVICES REQUIREMENTS**

.10 NURSING SERVICES

A. Nursing services include those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards.

B. Nursing services also includes skilled nursing services which are provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.

C. Nursing services include the remote monitoring of health status through Home Health Telehealth.

.11 HOME HEALTH AIDE SERVICES

A. Home health aide services may be provided when a nurse or therapist determines that an eligible client requires the services of a qualified home health aide, as such services are defined in this section.

B. Home health aide services must be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 84.36 (d). No later amendments to or editions of 42 CFR 484.36 (d) are included. Copies of 42 CFR 484.36 (d) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

1. If the client receiving home health aide services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist must make on-site supervisory visits to the client's home no less frequently than every two weeks.

2. If the client receiving home health aide services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse must make on-site supervisory visits to the client's home no less frequently than every 62 days. Each supervisory visit must occur while the home health aide is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the home health aide services, and shall not be billed to Medicaid as nursing visits.

3. Registered nurses and physical, occupational and speech therapists supervising home health aides must comply with applicable State laws governing their respective professions. In addition, the Nurse Aide Practice Act at § 12-38.1-102(5) C.R.S. (1998), which requires supervision of the practice of nurse aide services, must be followed. No later amendments to or editions of § 12-38.2-102(5) C.R.S. (1998) are included. Copies of § 12-38.1-102(5) C.R.S. (1998) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street. Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

C. Before providing any services, all home, health aides shall be trained and certified according to Federal Medicare regulations at 42 CFR 484.36 and all applicable. State and Federal laws and regulations governing nurse, aide certification, as amended, except that later amendments to or editions of 42 CFR 484.36 shall not be included in this rule. Copies, of 42 CFR 484.36 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator, at the. Colorado. Department of Health Care Policy and Financing, 1575 Shaman Street, Denver, Colorado 80203-1714; or may be examined at any state, publications depository library.

D. Home, health aide services include, skilled personal care, unskilled personal care, and homemaking as defined below:

1. Skilled personal care includes nurse aide tasks performed by a certified. nurse aide pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as unskilled personal care, in HCBS personal care regulations at Section 8.489, PERSONAL CARE.

2. Unskilled personal care means those tasks which are allowed as unskilled personal care at Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD,

PERSONAL CARE. Unskilled care shall be provided only as secondary to required skilled personal care, provided within contiguous units of service.

3. Homemaking includes those tasks that are allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES. Homemaking services shall be provided only as secondary to required skilled personal care provided within contiguous units of service.

4. Home health aide services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

.12 PHYSICAL THERAPY SERVICES

A. Physical therapy includes any evaluations and treatments allowed under state law at 12-41-101 through 130, C.R.S. (1991, as amended), which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training or the use of the equipment.

C. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation under Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the physical therapist may open be case and establish the Medicaid plan of care.

E. Effective September 1, 2002, physical therapy services are available for Acute Home Health clients when medically necessary and clients under 18 years of age when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.13 OCCUPATIONAL THERAPY SERVICES

A. Occupational therapy includes any evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training on the use of the equipment.

C. Treatment must be provided by or under the supervision of a certified occupational therapist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or ml be provided at cost upon request by the Home Health Program Administrator at the

Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care or physical or speech therapy, the occupational therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002, occupational therapy services are available for Acute Home Health clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.14 SPEECH/LANGUAGE PATHOLOGY SERVICES

A. Speech/language pathology services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

C. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002; speech/language pathology services are available for Acute Home Health, clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201A.

.15 HOME HEALTH TELEHEALTH SERVICES

A. The home health telehealth service is the remote monitoring of clinical data through electronic information processing equipment.

B. The information and data collected remotely will be transmitted through electronic information processing equipment from the client to the home health provider. The transmission of the data shall meet HIPAA compliance standards.

C. The home health agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the client and manage the client's care, and shall include all of the following elements:

1. All data collected must be reviewed by a registered nurse, or licensed practical nurse consistent with state law, within 24 hours of receipt of the ordered transmission,

2. Any planned interventions must be overseen by the client's designated nurse.

3. Collection of clinical data;

4. Transmission of the clinical data from the client to the home health provider;

5. Clinical review and assessment of the clinical data by a registered nurse.

6. Client specific parameters and protocols defined by the agency staff and the client's authorizing physician or podiatrist; and

7. Documentation of the clinical data in the client's chart and a summary of response activities, if needed.

a. Documentation shall be signed and dated by the nurse who assessed the clinical data,

b. Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

D. Monitoring equipment shall have the capability to measure any changes in the monitored diagnoses, and meet all of the following requirements:

1. Monitoring equipment shall be FDA certified or UL listed, and used according to the manufacturer's instructions;

2. Monitoring equipment shall be maintained in good repair and free from safety hazards; and

3. Monitoring equipment shall be sanitized before it is installed in a client's home.

E. Home health telehealth services are available to clients receiving home health services, when all of the following requirements are met:

1. Client is receiving services from a home health provider for at least one of the following diagnoses:

a. Congestive Heart Failure;

b. Chronic obstructive pulmonary disease;

c. Asthma; or

d. Diabetes.

2. Client requires ongoing and frequent, minimum of 5 times weekly, monitoring to manage their qualifying diagnosis, as defined and ordered by a physician or podiatrist;

3. Client has demonstrated a need for ongoing monitoring as evidenced by having been hospitalized two or more times in the last twelve months for conditions related to the qualifying diagnosis; or, if the client has received home health services for

less than six months, the client was hospitalized at least once in the last three months, an acute exacerbation of a qualifying diagnosis that requires telehealth monitoring, or new onset of a qualifying disease that requires ongoing monitoring to manage the client in their residence;

4. Client or caregiver misses no more than 5 transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and

5. Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.

F. The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.

G. The Home Health Agency shall develop agency-specific criteria for assessment of the need for home health telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. These assessment forms must be completed prior to the submission of the Enrollment Application and on file at the agency

**8.526 PROVIDER AGENCY REQUIREMENTS**

.10 A Home Health agency must be a public agency or private organization or part of such an agency or organization which:

A. Is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act; and

B. Has a valid agreement with the State, according to Section 8.130, PROVIDER AGREEMENTS, of this manual, to provide Medicaid Home Health services, as defined above. The Medicaid agreement will cover only those services which are covered by the agency's Medicare certification; and

C. Maintains liability insurance for the minimum amount set annually by the Colorado Department of Health Care Policy and Financing.

.11 Home Health agencies which perform procedures in the client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.

.12 Home Health agencies must have written policies regarding nurse delegation.

.13 For all clients who are expected to need home health aide services for at least a year, the supervising nurse must, during supervisory visits:

A. Obtain the client's, or the-client's designated representative's, input into the home health aide assignment form, including all home health aide tasks to be performed during each scheduled time period. Details such as, but not limited to, housekeeping duties and standby assistance, must be negotiated and included on the home health aide assignment form so that all obligations and expectations are clear. The home health aide assignment form shall contain information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information that is pertinent to the care that will be given by the aide. The client or the client's designated representative must sign the form, and must be given a copy, at the

beginning of services, and at least once per year thereafter. For purposes of complying with this rule, once per year shall be defined as sometime within the certification period which includes the anniversary date of the last signature on a home health aide assignment form.

B. Give each client, and/or the client's designated representative, a new copy of the Patient's Rights form, and explain those rights whenever the home health aide assignment form is renegotiated and rewritten.

.14 Home Health agencies shall obtain the official Medicaid rules, 10 CCR 2505-10 also known as Volume 8, and shall subscribe annually to the official updates. These rules shall be made available to all staff.

.15 Home Health agencies shall have written policies regarding maintenance of clients durable medical equipment, and shall make full disclosure of these policies to all clients with durable medical equipment in the home. The policies shall provide such disclosure to the client at the time of intake.

.16 Home Health agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum, how agencies will inform case managers that services are being provided or are being changed; and procedures for sending copies of plans of care if requested by case managers. These policies shall be developed with input from case managers.

.17 Any Home Health Agency applying to become a Medicaid participating Home Health Agency shall submit an acceptable compliance plan as a condition of eligibility for entering into a Medicaid provider agreement in Colorado. The plan must demonstrate how the agency will assure compliance with Colorado Medicaid rules, and must demonstrate that the applicant agency knows and understands the rules.

18. A home health provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

19. A Home Health Agency may be denied or terminated from participation in Colorado Medicaid <u>independently of participation in Medicare</u> , according to procedures found at Section 8.050 through Section 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a Home Health Agency shall include, but not be limited to, the following:

A. <u>Medicare Conditions Out of Compliance</u> . For purposes of this section, the applicable Medicare Conditions of Participation are found in 42 CFR 484, at 484.10,484.12,484.14, 484.16,484.18,484.30, 484.32,484.36,484.48, and 484.52. No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on the first re-certification survey after initial certification, or on a complaint investigation prior to the first re-certification survey.

2. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on two consecutive surveys and/or complaint investigations.

3. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on three non-consecutive surveys and/or complaint investigations.

B. Medicare Standards Out of Compliance . For purposes of this section, the applicable Medicare Standards are the Standards under each of the above-referenced Medicare Conditions of Participation, with special emphasis on standards found at 484.10 (b)(4), (b)(5),and (c); 484.12 (a) and (c); 484.14 (c)(d) and (g); 484.18 (b) and (c); 484.30 (a); 484.36 (c); and 484.52 (b). No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that receives repeated deficiency citations on the same standard, or standards, more man twice, or less often if the scope and severity is high.

2. Number of, as well as severity and scope of deficiency citations against standards shall be considered as factors in decisions to deny or terminate provider agreements.

C. Improper Billing Practices : Any Home Health Agency that is found by .the State or its agent(s) to have engaged in the following practices may he denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.

2. Billing for unnecessary visits, or visits that are unreasonable in amount, frequency and duration; especially nursing visits solely for the purpose of assessment and teaching.

3. Billing for home health aide visits on which no skilled tasks were performed and documented, or the skilled tasks performed were not medically necessary.

4. Billing for home health services provided at locations other than the client's, place of residence. This rule shall not apply for out-of-home Services provided with prior authorization as EPSDT extra-ordinary Home Health.

5. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any Home Health Agency that is also certified as a personal care/homemaker provider, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total tune spent on the visit does not equal at least 2 ½ hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 ½ hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

g. If any of the above practices occur, the Home Health Agency shall not be absolved from liability by failure or refusal to include personal care and/or homemaking needs on the Home Health plan of care.

1. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 5 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

2. Billing for excessive units of home health aide services for all time periods during which regulations are in effect defining the unit for home health aide as hour and/or half hour increments.

8. Billing for any services that are found to be out of compliance with any of the rules in this section, including but not limited to, those found in post-payment review rules at 8.529.

D. Prior Termination From Medicaid Participation , A Home Health Agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a Home Health Agency or any other type of service provider.

E. Abrupt Prior Closure . A Home Health Agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

20. Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for 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 State, the Medical Services Board, or the State's fiscal agent.

21. When a Home Health Agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

**8.527 PRIOR AUTHORIZATION**

.10 ACUTE HOME HEALTH

Acute Home Health services, as defined at Section 8.523, ELIGIBILITY, do not require prior authorization. This includes episodes of Acute Home Health for Long Term Home Health clients.

.11 LONG TERM HOME HEALTH

Long Term Home Health services, as defined at Section 8.523, ELIGIBILITY, shall be prior authorized according to the requirements below.

A. PRIOR AUTHORIZATION PROCESS

Long Term Home Health services provided to clients 18 and over shall be prior authorized by the Single Entry Point Agencies. Long Term Home Health services provided to clients under 18 shall be prior authorized by the Medicaid fiscal agent.

1. Upon admission of a client 18 and over to Long Term Home Health services, the Home Health Agency shall contact the Single Entry Point Agency to inform the case manager of the client's need for Home Health services.

2. The Home Health Agency shall submit the formal written prior authorization request to the Single Entry Point Agency for clients 18 and over and to the Medicaid fiscal agent for clients under 18, within 10 working days of the "from" date on the Home Health plan of care. Physician signature on the plan of care is not needed for prior authorization purposes. The SEP shall not send the prior authorization to the fiscal agent until the Home Health Agency submits the formal, complete, written prior authorization request (PAR).

3. The complete formal written PAR shall include:

   a. A completed State-prescribed Prior Authorization Request Form;

   b. A Home Health plan of care which shall include nursing and/or therapy assessments for clients under 18 and nursing assessments for clients over 18, and current clinical summaries or updates of the client. The plan of care shall be on the HCFA-485 form, or a form that is identical in

format to the HCFA-485, and all sections of the form shall be completed. For clients under 18, all therapy services requested shall be included in the plan of care or addendum, which shall list the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.528.11.B and C, are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided.

c. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a home health aide visit;

d. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, the record shall document that the client's pharmacy was contacted and advised/the Home Health Agency that the pharmacy will not provide medication set-ups.

e. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, the record shall provide documentation supporting the current need for two person transfers and the reason adaptive equipment cannot be used instead.

4. Authorization time frames:

a. Prior authorization requests shall be submitted and may be approved for up to a one year period. For clients 18 and over, the Single Entry Point Agencies shall communicate this date to the Home Health Agencies. For clients under 18, the Medicaid fiscal agent shall communicate this date to the Home Health Agencies.

b. Home Health Agencies shall not be required to change dates on the Home Health plans of care to match the SEP program certification dates.

c. For clients 18 and over, Home Health Agencies shall send Single Entry Point Agencies new plans of care every two (2) months, and other documentation as requested by the SEP agency. For clients under 18, the information referred to in this section shall be sent to the Medicaid fiscal agent.

d. Single Entry Point Agencies, for clients 18 and over, and the Medicaid fiscal agent, for clients under 18, may initiate PAR revisions if the plans of care indicate significantly decreased services.

e. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the HCFA-485.

5. The prior authorization request shall be reviewed by the Single Entry Point Agency or the Medicaid fiscal agent, as applicable, to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485.

6. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall approve or deny according to the following guidelines for safeguarding clients:

    a. PAR Approval: If services requested are in compliance with Medicaid rules, and are medically necessary and appropriate for the diagnosis and treatment plan, the services shall be approved retroactively to the start date on the PAR form.

    b. PAR Denial:

        1. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify Home Health Agencies of denials based on non-compliance with Medicaid rules on the appropriate PAR form. Denials based on medical necessity, (the PAR is not consistent with the client's documented medical needs and functional capacity), shall be determined and signed by a registered nurse or physician. The Utilization Review Contractor shall notify the client of a determination of denial for level of care.

        2. SEPs, through the Medicaid fiscal agent, shall notify clients of LTHH denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.059.16, APPEALS RELATED TO REQUESTS FOR PRIOR AUTHORIZATIONS.

        3. If any services have already been provided, but are subsequently denied on the prior authorization request, the Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify the Home Health Agency. Services already provided shall be approved for payment, retroactive to the start date on the PAR form, or 30 working days whichever is shorter. (This 30 working days includes a 10 day period for the HHA to submit the PAR, a 10 day period for the Utilization Review Contractor to determine level of care for adult clients, and a 10 day period for the sep to complete an assessment or the Medicaid fiscal agent, as applicable, to approve, deny, or request further information.) If denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client, so that the client's right to advance notice is preserved. An informal case conference may be arranged to discuss disagreements. If the disagreement is not satisfactorily resolved, the Home Health Agency may file a provider appeal in accordance with Section 8.050, PROVIDER APPEALS.

7. Neither the presence nor the absence of a preliminary authorization or a formal written PAR approval from the authorizing agent shall exempt a Home Health Agency at any time from:

    a. Following all applicable Medicaid rules;

    b. Providing only services that are medically necessary to the needs of the client; or

    c. Ensuring the accuracy of preliminary and formal written PAR information provided to the SEP.

8. EXPEDITED AUTHORIZATION PROCESS

If requested by a Home Health Agency, for extreme emergencies or complicated cases, following the initial assessment by the Home Health Agency, and after receipt of HCFA-485 or care notes in writing, the SEP or the Medicaid fiscal agent, as applicable, may use the information provided by the Home Health Agency to take one of the following actions:

a. Provide preliminary authorization of the services, including a Case Manager (CM) signed, department approved, preliminary authorization form, in writing, until the formal written PAR procedure delineated at 8.527.11,A, 1-8 above is completed. If an expedited authorization was provided by the SEP or the Medicaid fiscal agent, as applicable, the date of service effective under the expedited authorization (never dated back prior to "from" date on HCFA-485) shall be indicated on the prior authorization form that is forwarded to the fiscal agent.

b. Provide preliminary authorization of the services, including a CM signed, department approved, preliminary authorization form, in writing, for a lesser amount of time than a) above, based on the needs of the client or the need for additional information;

c. Postpone/deny preliminary authorization until such time as the Home Health Agency provides full documentation as delineated at 8.527.11,A, 3 above. The Home Health Agency shall submit a formal written PAR in order for due process to occur as delineated at 8.527.11,A,6.

9. If the client has an acute episode, the Home Health Agency shall bill for Acute Home Health, in accordance with billing manual instructions, without obtaining prior authorization from the applicable agency. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within ten (10) working days of the beginning and within ten (10) working days of the end of the acute care episode.

10. Transition

a. SEP CLIENTS

For clients already receiving Long Term Home Health services prior to July 1,2001, the Home Health Agency shall contact the SEP Agency prior to the beginning of the next Home Health certification period, and submit prior authorization requests to the SEP for services beginning with the next Home Health certification period as delineated in 8.527.11.A.3.a-e.

Note: The Section numbered 8.527.11 B was deleted effective July 1,2002.

.12 EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES

Extra-ordinary Home Health services may be provided when identified as medically necessary through an Early Periodic Screening Diagnosis and Treatment (EPSDT) screen, and prior authorized according to the requirements below.

A. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.103 shall include:

1. Any combination of necessary Home Health services that exceed the maximum allowable limit per day;

2. Any Home Health services that must, for medical reasons, be provided at locations other than the child's place of residence;

3. Home Health aide services for the purpose of providing only unskilled personal care.

B. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.10,B shall not include services that are available under other Colorado Medicaid benefits, and for which the client is eligible, including but not limited to, Private Duty Nursing, Section 8.540; HCBS personal care, Section 8.489; School Health and Related Services, Section 8290, or out-patient therapies, Section 8.330. Exceptions may be made if extra-ordinary Home Health services will be more cost-effective, provided that client safety is assured. Such exceptions shall in no way be construed as mandating the delegation of nursing tasks.

C. Prior authorization requests for EPSDT extra-ordinary Home Health shall be submitted and processed as follows:

1. The complete prior authorization request shall include a State-prescribed Prior Authorization Request Form; a plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the' results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care shall be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form shall be completed. All therapy services requested shall be included in the plan of care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency. The prior authorization request shall include detailed information on each planned Home Health visit, including the approximate times in and out, all tasks to be performed on each visit, and the place of service for each visit All Home Health services to be provided, both ordinary Home Health and extra-ordinary Home Health, shall be included in the prior authorization request Physician signature on the plan of care is not needed for prior authorization purposes.

2. The prior authorization request shall be sent to the State or its agent.

3. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as incomplete or referred for Private Duty Nursing review, within 10 working days of receipt.

4. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.

5. The State or its agent shall notify' clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of me prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

.13 HOME HEALTH TELEHEALTH SERVICES

A. Home Health Telehealth services are available to clients only after the Home Health Agency has received prior authorization.

B. The Home Health Agency shall request prior authorization every 60 days that continuing telehealth services are needed.

C. The PAR shall include all of the following:

1. A completed Home Health Telehealth PAR form;

2. An order for Telehealth monitoring signed and dated by the ordering physician or podiatrist;

3. A home health plan of care, which shall include nursing and/or therapy assessments for clients. Telehealth monitoring shall be included on the HCFA-485 form, or a form that contains similar information to the HCFA-485, and all applicable forms shall be completed; and

4. For on-going telehealth, the agency shall include documentation on how Telehealth data has been used to manage the client's care, if the client has been using Telehealth services.

.14~~3~~ Prior authorization requests shall be submitted and processed as follows:

A. The complete prior authorization request must include a State-prescribed Prior Authorization Request Form; a physician-signed plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care must be on the HCFA-485 form or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services requested must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. The prior authorization request must be sent to the State or its agent.

C. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as "unable to approve or deny due to insufficient information", or referred for physician review, within 10 working days of receipt

D. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.

E. The State or its agent shall notify clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of the prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

**8.528 REIMBURSEMENT**

.10 CLAIMS

Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

.11 UNIT OF REIMBURSEMENT

A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit of time that is less than fifteen minutes shall not be reimbursable as a basic unit.

C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.]

D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:

1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

E. The unit of reimbursement for home health telehealth is one calendar day.

1. The Home Health Agency may bill one initial visit per client each time the monitoring equipment is installed in the home.

2. The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client's care.

.12 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.

C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $270, effective July 1, 2002, for Acute Home Health Services or Long Term with Acute Episode Home Health Services; and shall not exceed $211, effective My 1, 2002, for Long Term Home Health Services.

Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed S291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed $227 for Long Term Home Health Services.

Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other, persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.

F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.

G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;

2. The therapy assists in overcoming developmental problems;

3. Therapy visits are necessary to prevent deterioration;

4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or

5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

J. Nursing visits provided <u>solely</u> for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

2. If a nursing visit involves the nurse <u>performing a nursing task</u> for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being <u>solely</u> for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is <u>solely</u> for the purpose of assessing and teaching.

3. Nursing visits <u>solely</u> for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic

condition under Long Term Home Health, as defined in Section 3.523, ELIGIBILITY.

4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment

6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit.

Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet.

Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit The clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for footcare to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

1. absent (not palpable) posterior tibial pulse;

2. absent (not palpable) dorsalis pedis pulse;

3. three of the advanced trophic changes such as:

    a. hair growth (decrease or absence),

    b. nail changes (thickening),

    c. pigmentary changes (discoloration),

    d. skin texture (thin, shiny),

    e. skin color (rubor or redness);

4. claudication (limping, lameness);

4. temperature changes (cold feet);

5. edema;

6. parasthesia;

7. burning.

L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015. No later amendments to or editions of 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of 25-1-107 (ee) (L5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and

2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non- compliance with taking medications if they are not pre-poured; and

3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and

4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through Section 8.530.10, B, HOME HEALTH SERVICES, are met.

.13 RATES OF REIMBURSEMENT

A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement.

For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges.

Prior authorized charges for stable clients requiring uncomplicated daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

B. Maximum interim payment unit rates are:

Effective July 1, 2002:

1. Nursing visits: $67.85
2. Acute Home Health Aide Basic unit: $22.37
3. Long Term Home Health Aide Basic unit: $30.08
4. Home Health Aide Extended unit: $8.99
5. Physical Therapy visits: $58.36
6. Occupational Therapy visits: $61.98
7. Speech Therapy visits: $63.60

Effective September 1, 2002:

1. Nursing visits: $71.42
2. Any Home Health Aide Basic unit $31.66
3. Home Health Aide Extended unit: $9.46
4. Physical Therapy visits: $61.43
5. Occupational Therapy visits: $65.24
6. Speech Therapy visits: $66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed $73,571,787. If total expenditures for the Home Health budget do exceed $73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies

the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

D. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

a) Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt.

b) Agencies that had total Medicaid Home Health payments of less than $125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

a) Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans.

b) Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge, from the nursing facility; and if they do not return to nursing facility placement after an interim period of Home Health care.

E. The FT 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed $198,862,688. If total expenditures for the community long term care budget do exceed $198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.

F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.

1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.

2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and

speech therapy as Long Term Home Health. For Long Term Home Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201. A.

3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.

4. For all nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.

G. Maximum unit rates may be adjusted by the State as funding becomes available.

.14 SPECIAL REIMBURSEMENT CONDITIONS

A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an ~~Intensive Adult Residential Service group home~~Intermediate Care Facility for the Mentally Retarded (ICF/MR), or ~~a personal care host home, or personal care alternatives home~~Individual Residential Services & Supports (IRSS) Host Homes and Settings; or

2. By the group home provider, if the client resides in ~~a Moderate Supervision Group Home, or Specialized Group Home~~Group Residential Services & Supports (GRSS), because the ~~group home~~provider has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the ~~Single Entry Point~~designated review entity ~~agency, if the client is 18 years old: or more; or to the Medicaid fiscal agent if the client is less than 18 years old~~.

D. All Medicare requirements shall be met and exhausted prior to any dual eligible client's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except in the specific cases listed at 8.528.14.D.1 and 8.525.14.D.2.

1. A Home Health Agency may bill Medicaid without billing Medicare if the services below are the only services on the claim:

a. Pre-pouring of medications;

b. Certified Home Health Aide services;

c. Occupational Therapy services when provided as the sole skilled service; or

d. Routine Laboratory Draw services.

2. A Home Health Agency may bill Medicaid at the time of services, if the conditions below apply. The claim must also be submitted to Medicare so that the denial, when received, is part of the client's file.

a. The client is stable;

b. The client is not experiencing an acute episode; and

c. The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

3. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without billing Medicare.

4. A Home Health Advance Beneficiary Notice (HHABN) shall be filled out as prescribed by Medicare.

E. A dual eligible Long Term Home Health Care client who has an Acute Episode shall be switched from Medicaid to Medicare reimbursement. Medicaid resumes as the payer of record when Medicare denies payment as a non-covered benefit and the service is a Medicaid benefit, or when the service consists of those listed in 8.528.14.D.2.

F. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement shall be considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

1. Upon receiving a duplicate payment, Home Health agencies shall return the payment to Medicaid within sixty (60) calendar days of final Medicare payment.

2. Failure to return the Medicaid payment to the Department shall be deemed a false claim and subject to the provisions set forth in 25.5-4-303.5, C.R.S., et seq. and referred to the Medicaid Fraud Control Unit in the Colorado Department of Law for criminal investigation.

**8.529 POST-PAYMENT REVIEW**

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

A. Are found to be out of compliance with all applicable regulations;

B. Are not consistent with the client's documented medical needs and functional capacity,

C. Are not reasonable in amount, frequency, and duration;

D. Are duplicative of any other services that the client received or that the client received funds to purchase;

E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);

F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.