THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Claims Reimbursement for Status to Include National Correct Coding Initiative
Rule Number:	MSB 12-04-20-A
Division / Contact / Phone:	Claim Systems and Fiscal Agent Operations / Dee Cole / x2880

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 12-04-20-A, Revision to the Medical Assistance Rule Concerning Claims Reimbursement for Status to Include National Correct Coding Initiative
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) 8.041, 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*

Replace current text at §8.041 with new text provided. This change is effective 12/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Claims Reimbursement for Status to Include National Correct Coding Initiative
Rule Number:	MSB 12-04-20-A
Division / Contact / Phone:	Claim Systems and Fiscal Agent Operations / Dee Cole / x2880

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 is necessary to control and prevent improper coding which leads to improper Medicaid payments. The implementation to this rule may ultimately result in a cost savings to the Medicaid program. The basis of this rule is a set of edits, a definition of the type of claims subject to the edits, and rules regarding the application of the edits and provider appeals of denied Mediciad payments.

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. (2011);
   25.5-4-300.7 (2011)

Initial Review	**10/12/2012**	Final Adoption	**11/09/2012**
Proposed Effective Date	**12/30/2012**	Emergency Adoption	

DOCUMENT # 03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Claims Reimbursement for Status to Include National Correct Coding Initiative
Rule Number:	MSB 12-04-20-A
Division / Contact / Phone:	Claim Systems and Fiscal Agent Operations / Dee Cole / x2880

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.

   All providers shall be required to follow the methodologies defined within the rule to promote proper coding. These providers are already familiar with these methodologies as the community has been using a form of the edits both commercially and by other government agencies for a number of years; therefore, there will be no impact on these providers.

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

   No impact

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.

   There will be no effect on revenues. The Department will reduce the administrative burden on the Department and may ultimately show a cost-savings from implementation of correct coding practices.

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

   The costs associated with this rule are the amended contract with the Fiscal Agent Xerox State Healthcare for MMIS (Medicaid Management Information System) which is the Departments claims processing system. The total cost from implementation through SFY 2014-15 is $1,853,325.00.

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

   No other less costly methods for achieving this rule.

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

   The Department did not seriously consider any alternative methods for achieving this rule because there are none.

8.041 Claims Reimbursement and Status for National Correct Coding Initiative (NCCI)

8.041.1 Definitions

Current Procedural Terminology (CPT) means the common medical procedure codes used for the purpose of billing medical services as defined by the American Medical Association (AMA).

Fiscal Agent means a vendor who is contracted by the Department to process and maintain the Medicaid Management Information System (MMIS) for purpose of processing claims.

Healthcare Common Procedural Coding System (HCPCS) means an alpha numeric code set as defined by CMS used for the purpose of billing services that are not identified under CPT.

Medically Unlikely Edits (MUE) means units of service edits. This edit restricts the maximum units of services per claim line that may be billed for a procedure code.

National Correct Coding Initiative (NCCI) means a set of claim edits developed by the Centers of Medicare and Medicaid Services (CMS) to promote NCCI methodologies and control improper coding leading to improper Medicaid payments.

Procedure to Procedure edit means the prevention of certain procedure codes from being billed with other procedure codes for the same patient by the same practitioner on the same date of service.

Remittance Statement means the electronic or hard copy statement sent by the Medicaid fiscal agent to advise a provider of claims reimbursement or claims status.

8.041.2 Authority

8.041.2.A Pursuant to Colorado Revised Statute §25.5-4-300.7 the Department is authorized to implement and maintain a system for reducing medical services coding errors in Medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of Medicaid claims through the use of nationally recognized correct coding methods in MMIS.

8.041.3 NCCI Payment Methodologies

8.041.3.A All providers shall report services performed on and rendered to clients by submitting claims using the HCPCS/ CPT codes designated by the Department. The use of these codes will be limited to providers who submit claims that are reimbursed based on the CPT code. Claim forms containing these codes are submitted to the Fiscal Agent for payment. NCCI methodologies include a set of edits, a definition of the type of claims subject to the edits, and rules regarding the application of the edits and provider appeals of denied payments. Claims submitted by providers shall be edited according to the six NCCI methodologies defined within the rule:

1. NCCI procedure to procedure edits for practitioners and Ambulatory Surgical Centers (ASC) services.

2. NCCI procedure to procedure edits for out-patient hospital services reimbursed based on CPT codes.

3. NCCI procedure to procedure edits for Durable Medical Equipment (DME) claims.

4. MUE units of service edits for practitioner and ASC services.

5. MUE units of service edits for out-patient hospital services reimbursed based on CPT codes.

6. MUE units of service edits for provider claims for Durable Medical Equipment (DME).

8.041.3.B The Department shall apply the following types of NCCI edits for services performed by the same provider for the same client on the same date of service.

1. Procedure-to-procedure edits (also known as Column I/Column II define pairs of HCPCS/ CPT codes) that should not be reported together.

2. MUEs (also known as units-of-service edits) define for each HCPCS/CPT code the maximum number of units of service allowable for each (e.g., claims for excision of more than one gallbladder or more than one pancreas).

3. Providers' services shall be denied by line item for the HCPCS/CPT code that is rejected by one of the NCCI edits in the above methodology.

8.041.4 PROVIDER APPEALS

8.041.4.A Providers may submit an appeal for denied line items due to NCCI edits in accordance with 10 CCR 2505-10 Sections 8.049 and 8.050.

8.041.5 REMITTANCE STATEMENTS

8.041.5.A A system of electronic remittance statements shall be used by the Department's Fiscal Agent to advise all Medicaid providers of claims reimbursement or claims status unless hard copy remittance statements are specifically authorized by the Department.

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 12-07-03-A, Revision to the Medical Assistance Rule Concerning Medicaid Income Limits for Children and Pregnant Women, Sections 8.100.4.F and 8.100.4.G
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) 8.100.4.F, and 8.100.4.G, 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: 1/1/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Various text throughout §8.100.4.F and §8.100.4.G has been revised, amended and/or added or deleted. Other text has been provided for clarification only. The text for clarification only that should not be revised, amended, and/or added or deleted is indicated in the filing in blue. All text in black is revised, amended and/or added or deleted. This rule change is effective 01/01/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Income Limits for Children and Pregnant Women, Sections 8.100.4.F and 8.100.4.G
Rule Number:	MSB 12-07-03-A
Division / Contact / Phone:	Eligibility / Kathleen Seese / 303-866-5941

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).

   SB 11-008 and SB 11-250 were passed to allow for an increase in the income limits for our childrens and pregnacy categories. The income limit for our Ribicoff category will increase from 100% FPL to 133% FPL and the income limit for our pregnancy categories will increase from 133% FPL to 185% FPL

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:

   Sections 1902(l)(1)(D) and 1905(n)(1) of the Social Security Act and 42 CFR 435.116 and 42 CFR 435.229

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-5-205

Initial Review	**10/12/2012**	Final Adoption	**11/09/2012**
Proposed Effective Date	**01/01/2013**	Emergency Adoption	

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Income Limits for Children and Pregnant Women, Sections 8.100.4.F and 8.100.4.G
Rule Number:	MSB 12-07-03-A
Division / Contact / Phone:	Eligibility / Kathleen Seese / 303-866-5941

REGULATORY ANALYSIS

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

   The proposed rule extends the income limit for two Family Medicaid categories. Children aged 6 through 18 with family income between 101% and 133% FPL and pregnant women with income between 134% and 185% FPL will become eligible for Family Medicaid. These changes will increase Medicaid enrollment while decreasing CHP+ enrollment.

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

   The proposed rule will increase the income limit for two Family Medicaid categories, making some children and pregnant women eligible for Medicaid rather than CHP+. The affected children and pregnant women are eligible for CHP+ under current eligibility standards, and will be able to access additional benefits and services in Family Medicaid.

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 legislation increasing the eligibility for children age 6 through 18 with family income between 101% and 133% FPL is SB 11-008, which projects that approximately 20,000 children will transition from CHP+ to Medicaid coverage, with state savings of $3,459,040 in FY 2013-14. The legislation increasing the eligibility for pregnant women with income between 134% and 185% FPL is SB 11-250, which projects that approximately 1,300 pregnant women will transition from CHP+ to Medicaid coverage, with state savings of $1,572,187 in FY 2013-14.

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

   The proposed rules are anticipated to result in state savings of approximately $5 million. The Department must implement these rules to comply with SB 11-008 and SB 11-250.

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

   N/A

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

8.100.4.F. Family and Children's Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of nineteen may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

    a. an applicant shall have a verified pregnancy, declare that her household's income shall not exceed ~~133~~ 185% of federal poverty level and declare that she is a United States citizen or a documented immigrant.

    b. a child under the age of 19 shall have a declared household income that does not exceed ~~100~~ 133% of federal poverty level ~~for a child age 6-18 or 133% of federal poverty level for a child under the age of 6~~ and declare that the child is a United States citizen or a documented immigrant of at least five years.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

4. The presumptive eligibility sites shall attempt to obtain all necessary documentation to complete the application within fourteen calendar days of application.

5. The presumptive eligibility site shall forward the application to the county within five business days of being completed. If the application is not completed within fourteen calendar days, on the fifteenth calendar day following application, the presumptive eligibility sites shall forward the application to the appropriate county.

6. The presumptive eligibility period shall be no less than 45 days. The presumptive eligibility period ends on the last day of the month following the completion of the 45 day Presumptive Eligibility period. The county department shall make a Medical Assistance eligibility determination within 45 days from receipt of the application. The effective date of Medical Assistance eligibility shall be the date of application.

7. A Presumptive eligible client may not appeal the end of a presumptive eligibility period.

8. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. Family and Children's Covered Groups

1. For Family and Children's Medical Assistance, any person who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.

2. Families whose total income does not exceed 100% of the federal poverty level Parents or caretaker relatives eligible for this category shall have a dependent child in the household receiving Medical Assistance. This population is referenced as 1931 Medical Assistance.

3. Medical assistance shall be furnished to any person who is residing in a participating Medicaid facility and who would be eligible for section 1931 Medical assistance if that person resided outside a facility.

4. Persons who would be eligible for 1931 Medical Assistance except for the inclusion in the assistance unit of a relative not included as financially responsible whose income makes the unit ineligible. This procedure is referenced as the 113 rule.

5. A child born to a woman receiving Medical Assistance at the time of the child's birth is continuously eligible for one year as long as the child remains a member of the mother's household. This provision also applies in instances when the woman received Medical Assistance to cover the child's birth through retroactive Medical Assistance. To receive Medical Assistance under this category, the family need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.

6. Children up to age six whose income does not exceed their proportionate share of 133% of the federal poverty level or whose total family income does not exceed 133% of the federal poverty level. This population is referenced as Expanded Child.

7. Children up to age 19 whose income does not exceed their proportionate share of ~~100~~ 133% of the federal poverty level or whose total family income does not exceed ~~100~~ 133% of the federal poverty level. This population is referenced as Ribicoff.

8. Medical assistance shall be provided to a woman:

   a. whose pregnancy is medically verified in writing by a medical professional (a certified medical assistant or higher level position supervised by a registered nurse or doctor) confirming the pregnancy and the estimated date of delivery, if pregnancy is not observable ; and

   b. whose income does not exceed her proportionate share of ~~133~~ 185% of the federal poverty level or whose total family income does not exceed ~~133~~185% of federal poverty level.

   c. For a period beginning with the date of application for medical assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances. This population is referenced as Expanded Pregnant.

9. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for medical care if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.9. This population is referenced as Legal Immigrant Prenatal.

10. If an individual is found ineligible because their income exceeds their proportionate share of the federal poverty level, a recalculation shall be performed to look at the Medical Assistance required household as a whole. The household's total income, after the allowable Medical Assistance deductions, shall be compared to the maximum federal poverty level. If the individual

is then eligible under this process, they shall be eligible under the same category for which they originally were determined ineligible. This procedure is referenced as the Boatwright rule.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Medicare Part D Coverage, Section 8,800.4
Rule Number:	MSB 12-08-31-A
Division / Contact / Phone:	Pharmacy / Cathy Traugott / x6338

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 12-08-31-A, Revision to the Medical Assistance Pharmacy Section Rule Concerning Medicare Part D Coverage, Section 8,800.4
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) 8.800.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Text revised in this rule filing is at §8.800.4.G and is indicated in black. All other text provided is for clarification only and is provided in blue. This rule change is effective 01/01/2013

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Medicare Part D Coverage, Section 8,800.4
Rule Number:	MSB 12-08-31-A
Division / Contact / Phone:	Pharmacy / Cathy Traugott / x6338

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 is in accordance with a statutory change that was a part of the Patient Protection and Affordable Care Act. Effective January 1, 2013, benzodiazepines and barbiturates that are used for certain indications will become covered Part D drugs under Medicare. Under Part D, once a drug is a covered Part D benefit, Medicaid programs can no longer pay for that drug. Medicaid's pharmacy rule needs to be changed to reflect this change in policy.

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:

   42 U.S.C. § 1395w-102(e)(2)(A), 42 U.S.C. § 1396u-5(d)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);

Initial Review	**10/12/2012**	Final Adoption	**11/09/2012**
Proposed Effective Date	**12/30/2012**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Medicare Part D Coverage, Section 8,800.4
Rule Number:	MSB 12-08-31-A
Division / Contact / Phone:	Pharmacy / Cathy Traugott / x6338

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.

   All dual eligible clients who take these medications will be affected; they will need to obtain these medications from their Medicare Part D plan instead of Medicaid.

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

   There should be minimal impact on the clients as they will receive these medications from their Medicare Part D plan instead of Colorado Medicaid. The only adverse impact will be if the client's Part D plan does not cover his/her medication. The client will need to change to a covered medication or pay for the medication out of pocket. These generally are not expensive medications so any out-of-pocket cost should not be significant.

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.

   There should be no significant costs associated with the system changes or the notices associated with this change. The State will save money because the State will no longer pay for these medications for dual eligible clients.

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

   The State will be in violation of Federal law if it continues to pay for these medications after January 1, 2013.

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

   There are no less costly or less intrusive methods to comply with this change in Federal 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.

   There are no other methods to comply.

8.800.4 DRUG BENEFITS

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed if the Department has made a determination that the availability of the drug is essential, such drug has been given an "A" rating by the U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. The following drug categories may be excluded from being a drug benefit or may be subject to restrictions:

1. Agents when used for anorexia, weight loss or weight gain;
2. Agents when used to promote fertility;
3. Agents when used for cosmetic purposes or hair growth;
4. Agents when used for symptomatic relief of cough and colds;
5. Agents when used to promote smoking cessation;
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
7. Non-prescription Drugs;
8. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;
9. Barbiturates;
10. Benzodiazepines; and
11. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

8.800.4.C. The following are not pharmacy benefits of the Medical Assistance Program:

1. Spirituous liquors of any kind;
2. Dietary needs or food supplements;
3. Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;

4. Medical supplies;

5. Drugs classified by the FDA as "investigational" or "experimental" ;

6. Less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program; and

7. Medicare Part D Drugs for Part D Eligible Individuals.

8.800.4.D. Aspirin, OTC insulin and medications that are available OTC and that have been designated as Preferred Drugs on the PDL, in compliance with the provisions of Section 8.800.16, are the only OTC drugs that are regular benefits without restrictions.

8.800.4.E. Restrictions may be placed on drugs in accordance with 42 U.S.C. Section 1396r-8(d) (2007), which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Without limiting the foregoing, restrictions may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.

8.800.4.F. Medicare Part D Drugs shall not be covered by the Medical Assistance Program for Part D Eligible Individuals.

8.800.4.G. To the extent the drug categories ~~The excluded drugs~~ listed in Section 8.800.4.B are not Medicare Part D Drugs, they shall be covered for Part D Eligible Individuals in the same manner as they are covered for all other eligible Medical Assistance Program clients.

8.800.4.H. Generic drugs shall be dispensed to clients in fee-for-service programs unless:

1. Only a brand name drug is manufactured.

2. A generic drug is not therapeutically equivalent to the brand name drug.

3. The final cost of the brand name drug is less expensive to the Department.

4. The drug is in one of the following exempted classes for the treatment of:

   a. Biologically based mental illness as defined in C.R.S. 10-16-104 (5.5) (2008). Without limiting the foregoing, restrictions may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, overutilization, other

inappropriate utilization or the availability of more cost-effective comparable alternatives.;

b. Treatment of cancer;

c. Treatment of epilepsy; or

d. Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

5. The Department shall grant an exception to this requirement if:

a. The client has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive; or

b. The client is started on a generic drug but is unable to continue treatment on the generic drug.

Such exceptions shall be granted in accordance with procedures established by the Department.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Physician Services, Section 8.200
Rule Number:	MSB 11-03-16-A
Division / Contact / Phone:	Medicaid Program Division / Richard Delaney / 3436

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 11-03-16-A, Revision to the Medical Assistance Rule Concerning Physician Services, Section 8.200
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) 8.200, 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*

Current text from §8.200 through the end of §8.200.8.E.2 is deleted and replaced with text provided from §8.200 though § 8.200.5.F. Various text in §8.482.33. and §8.565 and §8.565.11 has been revised, amended and/or added or deleted. Other text has been provided for clarification only. The text for clarification only that should not be revised, amended, and/or added or deleted is indicated in the filing in blue. All text in black is revised, amended and/or added or deleted. Any text currently published in these sections of the rule that are not included in this filing should not be changed. This change is effective 01/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Physician Services, Section 8.200
Rule Number:	MSB 11-03-16-A
Division / Contact / Phone:	Medicaid Program Division / Richard Delaney / 3436

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 covers basic requirements for physician services in the Colorado Medicaid program, including reimbursement. The existing rule requires physicians to order all care delivered by nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. The state law and practice is for these providers to order care within their scope of practice. Therefore, the suggested rule change eliminates the supervisory requirements of certain non-physician providers consistent with state law and practice.

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:

   42 CFR 440.60

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   12-29-101 through 12-43.7-118 C.R.S.

Initial Review	**10/12/2012**	Final Adoption	**11/09/2012**
Proposed Effective Date	**01/30/2013**	Emergency Adoption	

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Physician Services, Section 8.200
Rule Number:	MSB 11-03-16-A
Division / Contact / Phone:	Medicaid Program Division / Richard Delaney / 3436

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.

   Persons affected directly by the rule are Colorado Medicaid enrolled providers. The rule change aligns Medicaid requirements for supervision and ordering of services with state law and practice for health professions. There are no costs associated with this rule amendment. Clients will not be affected.

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

   There is no impact of the rule. The changes reflect current practice and align Colorado Medicaid rules with the practice of health care and medicine in the state.

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.

   There are no costs associated with the amendments.

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

   Without the proposed changes, Medicaid will not be able to continue to allow certain non-physician providers, and organizations that use these providers, to practice without supervision. This would have a negative impact on health care access for clients.

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

   There are no less costly methods.

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.

   Changing the rule is the only option that is seriously considered, to align the rules with state health practice laws.

8.200 Physician services

8.200.1 Definitions

An Advanced Practice Nurse is a provider that meets the requirements to practice advanced practice nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced Practice Nurse may have prescriptive authority.

A Licensed Psychologist is a provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.

Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.

Medical Necessity is defined in 10 C.C.R. 2505-10, Section 8.076.1.8.

8.200.2 Providers

8.200.2.A A doctor of medicine or a doctor of osteopathy may order and provide all medical care goods and services within the scope of their license to provide such goods and services that are covered benefits of the Colorado Medical Assistance Program.

1. A provider of covered dental care surgery can be either enrolled as a dentist or oral surgeon, but not both. A dentist may order and provide covered dental care.

8.200.2.B Physician services that may be provided without a physician order by non-physician providers.

1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.

2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.

    a. Services ordered by a Licensed Psychologist but rendered by another provider shall be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.

3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado Revised Statutes without a physician order.

4. Podiatrists may provide covered foot care services within their scope of practice as described by the Colorado Revised Statutes without a physician order.

5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in accordance with the scope of practice for dental hygienists as described in the Colorado Revised Statutes without a physician order.

    a. Unsupervised dental hygiene services are limited to those clients and procedures as defined by the Department of Health Care Policy and Financing.

8.200.2.C Physician services that may be provided by a non-physician provider when ordered by a provider acting under authority described in Sections 8.200.2.A and 8.200.2.B.

1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.

    a. Services shall be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Revised Statutes.

8.200.2.D Physician services that may be provided when supervised by an enrolled provider.

1. With the exception of the non-physician providers described in Sections 8.200.2.A through 8.200.2.C, a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Revised Statutes. If the Colorado Revised Statutes do not designate who has the authority to supervise, the non-physician provider shall provide services under the Direct Supervision of an enrolled physician.

    a. Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.

8.200.2.E Licensure and required certification for all physician service providers shall be in accordance with their specific specialty practice act and with current state licensure statutes and regulations.

8.200.3. Benefits

8.200.3.A Physician services are reimbursable when the services are a benefit of Medicaid and meet the criteria of Medical Necessity as defined in 10 C.C.R. 2505-10, Section 8.076.1.8 and are provided by the appropriate provider specialty.

1. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fraction of the jaw or facial bones. Service includes dental splints or other devices.

2. Outpatient mental health services are provided as described in 10 CCR 2505-10, Section 8.212.

3. Physical examinations are a benefit when they meet the following criteria:

    a. Physical examinations are a benefit for preventive service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment for clients under the age of 21 as described in 10 C.C.R. 2505-10, Section 8.280.

    b. Physical examination as a preventive service for adults is a benefit limited to one per state fiscal year.

4. Physician services for the provision of immunizations are a benefit. Vaccines provided to enrolled children that are eligible for the Vaccines for Children program shall be obtained through the Colorado Department of Public Health and Environment.

5. Physician services for laboratory testing described in 10 C.C.R. 2505-10, Section 8.660, are a benefit.

6. Occupational and physical therapy services are benefits.

7. Family planning services described in 10 C.C.R. 2505-10, Section 8.730 are benefits.

8.200.3.B Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.

1. Physician services may be provided as telemedicine.

2. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

8.200.3.C Services and goods generally excluded from coverage are identified in 10 C.C.R. 2505-10, Section 8.011.11.

8.200.4 Certified Family Planning Clinics

8.200.4.A Laboratories at Certified Family Planning Clinics providing services must meet all Clinical Laboratory Improvement Amendment requirements.

8.200.4.B Services at a Certified Family Planning Clinic shall be rendered under the General Supervision of a physician. General Supervision means the procedure is furnished under the

physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

8.200.4.C The Certified Family Planning Clinic shall contact the client's Primary Care Provider or Primary Care Medical Provider or managed care organization, if applicable, prior to rendering services that require a referral.

8.200.5 Reimbursement

8.200.5.A The amount of reimbursement for physician services is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.B Reimbursement for services may be made directly to Advanced Practice Nurses, registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed psychologists unless the non-physician practitioner is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.

8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.

a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the employer's provider identification number.

8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid directly to the clinic and is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural Health Center, clinic, home health agency, school, or physician.

8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a student in a graduate education program and the facility where the provider delivers services receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.

~~8.200 PHYSICIAN SERVICES~~

~~8.200.1 DEFINITIONS~~

~~Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.~~

~~General Supervision means the procedure is furnished under the physician's overall direction and control but the physician's presence is not required during the performance of the procedure.~~

~~Medically Necessary means a covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.~~

~~8.200.2 COVERED PHYSICIAN SERVICES~~

~~8.200.2.A. Physician services are authorized when the service is Medically Necessary, a benefit of Medicaid and provided by the appropriate physician specialty.~~

~~8.200.2.B. Physician services in regard to family planning are considered in the same manner as any other medical visit.~~

~~8.200.2.C. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones. Service includes dental splints or other devices. A provider of dental care surgery can either be enrolled as a dentist or oral surgeon, not both.~~

~~8.200.2.D. Physician services in regard to foot care are a benefit when provided by a physician or licensed podiatrist.~~

~~8.200.2.E. Physician services in regard to vision care are a benefit.~~

~~8.200.2.F. Physician services in regard to laboratory testing are a benefit in accordance with 10 C.C.R. 2505-10, Section 8.660.~~

~~8.200.2.G. Physician services in regard to the provision of immunizations are a benefit. Vaccines provided to enrolled children shall be obtained through the Colorado Department of Public Health and Environment.~~

~~8.200.2.H. Physician services in regard to mental health are a benefit. Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.~~

~~8.200.3 QUALIFIED NON-PHYSICIAN PRACTITIONERS ELIGIBILE TO PROVIDE PHYSICIAN'S SERVICES~~

~~8.200.3.A. A doctor of medicine or osteopathy shall order all medical care services or goods that are benefits of Section 8.200 except for dental, podiatry, optometric and mental health services.~~

~~8.200.3.B. The following requirements apply to non-physician practitioners rendering Medicaid services:~~

~~Certified registered nurse anesthetists, certified nurse practitioners, certified occupational therapists, licensed physical therapists, certified audiologists, certified speech pathologists, licensed/certified respiratory therapists and licensed physician assistants may provide services under the following conditions:~~

~~1. Services shall be rendered under the General Supervision of a physician.~~

~~2. There is appropriate consultation between the non-physician personnel who administers the service. Continuing consultation is the responsibility of the physician. Periodic review of the client's plan of care is required and shall be documented in the client's record. Periodic review shall be at the level required by the medical necessity of the patient, no less than once every two months.~~

~~3. A physician may prescribe occupational or physical therapy for clients when Medically Necessary. Clients are allowed a set number of units of occupational and physical therapy without prior authorization as established by the Department. If a client requires additional therapy, the provider shall obtain prior authorization before rendering services. Services not properly prior authorized shall not be reimbursed.~~

~~8.200.3.C. Reimbursement for certified registered nurse anesthetists, certified pediatric nurse practitioners, certified occupational therapists, licensed physical therapists, certified family nurse practitioners, certified audiologists, certified speech pathologists and certified/licensed respiratory therapists shall be as follows:~~

~~1. Services rendered shall be reimbursed by the methodology described in Section 8.200.8.C.~~

~~2. Services shall be reimbursed directly to the non-physician provider unless the non-physician provider is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.~~

~~8.200.3.D. Services provided by licensed physician assistants shall be billed through an enrolled physician.~~

~~8.200.3.E. All other non-physician practitioners shall provide services under the Direct Supervision of a physician. Direct Supervision means the physician shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.~~

~~1. Reimbursement for other non-physician practitioners shall be made as described in Section 8.200.8.A and billed to Medicaid by the enrolled physician.~~

2. Reimbursement shall not be made if the practitioner is acting within the scope of their graduate education training program or as contract agents or employees of a nursing home, hospital, FQHC, clinic, home heath agency, school or physician.

8.200.3.F. Supervision shall meet the specific requirements of the state laws governing each medical specialty when those supervision requirements are more stringent than the requirements contained in Section 8.200 et seq.

8.200.3.G. Licensure and required certification for non-physician providers shall be in accordance with their specific specialty practice act and with current state licensure statutes and regulations.

8.200.3.H. Certified nurse midwives shall work in coordination with a physician as described in their practice act. Reimbursements shall be made as described in Section 8.200.8.A.

8.200.3.I. Licensed dental hygienists shall be directly reimbursed for unsupervised dental hygiene services. Hygienists who serve enrolled children shall provide the child with the name of a licensed dentist. Hygienists employed by a dentist, clinic or institution shall submit claims under the employer's provider number. Reimbursements shall be made as described in Section 8.200.8.E.

8.200.4 TELEMEDICINE

8.200.4.A. Telemedicine means the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.

8.200.4.B. No enrolled managed care organization may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if the client resides in a county with a population of 150,000 or fewer residents and the county has the technology necessary for the provision of telemedicine. The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance.

8.200.4.C. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

8.200.5 MENTAL HEALTH

8.200.5.A. Services of licensed psychologists are a benefit. Services are not required to be under the direct supervision of a physician.

8.200.5.B. Psychology services shall be reimbursed under the same methodology as physician services described in Section 8.200.8.A.

~~8.200.5.C. Services ordered by a psychologist, but rendered by another provider shall be billed under the psychologist. The psychologist shall order the service and provide supervision as outlined under the Psychology Practice Act.~~

~~8.200.6 PHYSICAL EXAMINATIONS~~

~~8.200.6.A. Physical examinations are a benefit for annual preventative service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment as described in 10 C.C.R. 2505-10, Section 8.282. For the purpose of the adult annual preventive service benefit, annual shall mean state fiscal year.~~

~~8.200.7 CERTIFIED FAMILY PLANNING CLINICS~~

~~8.200.7.A. Laboratory services provided by Certified Family Planning Clinics shall be reimbursed if the laboratory has met all Clinical Laboratory Improvement Amendment requirements.~~

~~8.200.7.B. Services shall be rendered under the General Supervision of a physician.~~

~~8.200.7.C. The Certified Family Planning Clinic shall contact the client's PCP or managed care organization if applicable prior to rendering services that require a referral.~~

~~8.200.7.D. Clinic services shall be reimbursed under the same methodology as physician services described in section 8.200.8.A and paid directly to the clinic.~~

~~8.200.8 REIMBURSEMENT~~

~~8.200.8.A. Physician services shall be reimbursed at the lower of the following:~~

~~1. Submitted charges; or~~

~~2. Fee schedule as determined by the Department.~~

~~8.200.8.B. Physician surgery shall be reimbursed at the lower of the following:~~

~~1. Submitted charges; or~~

~~2. Fee schedule as determined by the Department.~~

~~8.200.8.C. Non-physician practitioners consisting of certified nurse midwives, certified registered nurse anesthetists, certified nurse practitioners, certified audiologists, certified speech pathologists, licensed/certified respiratory therapists, and licensed physician assistants, services shall be reimbursed at the lower of the following:~~

~~1. Submitted charges; or~~

~~2. Fee schedule as determined by the Department.~~

~~8.200.8.D. Out patient clinical diagnostic laboratory tests preformed by a physician or independent lab shall be reimbursed at the lower of the following:~~

~~1. Submitted charges; or~~

~~2. Fee schedule as determined by the Department.~~

~~8.200.8.E. Dental services shall be reimbursed at the lower of:~~

~~1. Submitted charges; or~~

~~2. Fee schedule as determined by the Department.~~

8.482.33 POST ELIGIBILITY TREATMENT OF INCOME

C. The allowable expenses for special medical services (dental care, hearing corrective lenses) are subject to the following criteria:

1. General Instructions (applies to all special medical services).

a. All PETI expenses exceeding $400 per calendar year for equipment, supplies, or services must be authorized by the Department or its designee to be considered an allowable cost.

b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.

c. All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not these costs meet the requirements for prior authorization. Lack of documentation shall cause the patient payment deduction to be disallowed, causing the provider to be overpaid by the Medicaid program.

d. All allowable costs must be for ith~~h~~ems that are medically necessary as described in 8.011, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

e. The resident or legally-appointed guardian must agree to the purchase of the service/equipment and related charge, with signed authorization in the residents record.

f. Nursing facilities are not permitted to assess surcharge or handling fee to the residents income.

g. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

h. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

i. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.

j. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

k. If the client does not make a patient payment; then no PETI will be allowed.

l. PETI payments may not exceed the patient payment Payments made over a period of time shall only be allowed if the provider agrees to accept installment payments.

2. Dental Care Instructions

a. Prescription of dentures (partial or full plate, fixed or removable) must be made by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).

b. The prescription (as defined in Section 8.482.33.2.a.) must be part of a comprehensive evaluation to determine the medical necessity and suitability for wearing dentures.

c. Oral and maxillofacial surgery that is required to render soft-tissue and bony structures suitable for wearing dentures must be prior authorized by the Department as defined in Section~~s~~ 8.200~~.10 and 8.200.30.~~ et seq.

8.565 REIMBURSEMENT

Reimbursement shall be made according to the following:

A. Payment for benefit services shall be in accord with the physician reimbursement policies as cited in Section 8.200~~.20.~~ et seq.

8.765.11 ELIGIBILITY FOR PROVIDERS DELIVERING SERVICES IN AN RCCF

8.765.11.A Individual, group and family therapy provided in an RCCF shall be provided by a Licensed Mental Health ~~Professionial~~ Professional or a provisionally-licensed Mental Health Professional supervised by a Licensed Mental Health Professional, employed by or contracted with an RCCF that is licensed by the Colorado Department of Human Services~~.~~.

8.765.11.B. Licensed Mental Health Professionals providing mental health services to clients in an TRCCF are exempt from the direct physician supervision requirement in 10 C.C.R. 2505-10, Section 8.200.2.A through ~~3.~~E.

8.765.11.C. Licensed Mental Health Professionals providing mental health services to clients in the RCCF enroll as Medicaid rendering providers.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home Health Covered Standards and Prior Authorization, Sections 8.522 and 8.527
Rule Number:	MSB 12-04-27-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 12-04-27-A, Home Health Services
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) 8.522 Covered Services and 8.527 Prior Authorization, 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*

Replace current text at §8.522 with the text provided in this filing. Replace current text from §8.527 through the end of §8.527.14.E with the text provided in this filing. Any text currently published in either of these sections not provided in this filing should not be altered. This change is effective 12/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home Health Covered Standards and Prior Authorization, Sections 8.522 and 8.527
Rule Number:	MSB 12-04-27-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 revision is to incorporate the Home Health Benefit Coverage Standard, developed through the Benefits Collaborative, into the Home Health rule. The second purpose for this rule is to remove the specifically named prior authorization reviewing agencies and replace them with the term "the Department or its designated review entities." The current form of the rule only includes two of the four entities authorized and contracted by the Department to review Home Health prior authorization requests. At this time the designated review entities include the ColoradoPAR Program, Single Entry Point Case Management Agencies, and Community Centered Board Case Management Agencies. The rule only names ACS and the single entry point case management agencies. By using the term "the Department or its designated review entities," the rule will remain current despite contract changes. The revision also streamlines the Prior Authorization section and removes redundant or outdated information.

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:

   42 CFR 440.70
   42 CFR 456.3

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-5-102 C.R.S.

Initial Review	**07/13/2012**	Final Adoption	**11/09/2012**
Proposed Effective Date	**12/30/2012**	Emergency Adoption	

DOCUMENT # 09

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Title of Rule:	Revision to the Medical Assistance Rule Concerning Home Health Covered Standards and Prior Authorization, Sections 8.522 and 8.527
Rule Number:	MSB 12-04-27-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.

   In Fiscal year 2010-11, a total of 8,302 clients received long-term home health services with a total $146,517,871.81 claims paid. All clients who receive Medicaid Home Health benefits for long term services will be affected by these rule revisions. The Medicaid enrolled Home Health Agency Providers will also be affected because the Benefit Coverage Standard includes provider responsibilities.

   Changes to the entities that are authorized to review prior authorization requests will experience little change despite updates to the sections that pertain to the prior authorization request reviewers, to reflect current practice.

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 purpose of this benefit coverage standard is to achieve the goal of ensuring appropriate utilization as well as statewide equity and consistency in the delivery of services. Any changes experienced by clients as a result of this rule are a result of clearer coverage standards. Clearly defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria, guidance for service providers, and assurance to the Department that public funds are responsibly allocated. Clarity of available benefits based on individual need using evidence based criteria will ensure that people know what services are appropriate for their needs, simplify access to authorized supports, and will also ensure that that providers are paid for appropriate services. Well defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Additionally, clearly defined benefits will simplify the appeal process for all participants.

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.

   There is no anticipated cost to the Department or State Agency for these rule revisions. There is the potential for savings to be realized as a result of the incorporation of the Benefit Coverage Standards and enforcement of the Home Health Services rule, due to appropriate utilization of the benefit. Clearly defined coverage standards will help the Department to

ensure proper payment for appropriate services. Additionally, clear coverage standards could reduce administrative overhead for defending Department decisions in appeal processes.

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

   If Colorado Medicaid does not clearly define our covered services in accordance with federal regulation, and Colorado Medicaid inadvertently reimburses for care that is not contained within our definition of a covered service or considered to be medically necessary, Colorado Medicaid risks losing FFP for those services provided that were considered non-covered and not medically necessary.

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

   This is deemed by the Department to be the least costly and least intrusive method for ensuring that the Home Health services rule is correct and enforced.

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.

8.522 COVERED SERVICES

All Home Health providers enrolled in the Medicaid program shall be in compliance with the Colorado Medicaid Home Health Services Benefit Coverage Standard, effective January 1, 2013, incorporated by reference. The incorporation of the Home Health Benefit Policy Statement excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Standards." Pursuant to 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided, at cost, upon request. Any material that has been incorporated by reference may be examined in any Colorado State Publications Depository Library.

~~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.~~

8.527 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 Medicaid clients ~~18 and over~~ shall be prior authorized by the Department or its designated review entity.~~Single Entry Point Agencies. Long Term Home Health services provided to clients under 18 shall be prior authorized by the Medicaid fiscal agent.~~

1. When an agency accepts ~~Upon admission of~~ an HCBS waiver client 18 years of age and older~~ver~~ to Long Term Home Health services, the Home Health Agency shall contact the ~~Single Entry Point Agency~~client's case management 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~~Department or its designated review entity ~~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 or within 10 working days of the end of the client's Acute Home Health period or current Long Term Home Health PAR. Physician signature on the plan of care is not needed for prior authorization purposes. The Department or its designated review entity~~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~~Department-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~~all ~~pertinent~~ clinical assessments 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 content~~format~~ to the

HCFA-485, and all sections of the form shall be completed. For clients ~~under 18~~20 years of age or younger, 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. If there are no nursing needs, the plan of care and assessments may be completed by a therapist if the client is 20 years ~~old~~of age or younger and is receiving home health therapy services.

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 client's waiver~~SEP~~ program certification dates, if a client is in an HCBS waiver program.

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 Department or its designated review entity.~~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~~The Department or its designated review entity ~~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~~Department or its designated review entity ~~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 Department or its designated review entity ~~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. ~~If the PAR form is submitted by the Home Health Agency greater than 10 working days after the PAR start date, s~~Services ~~shall only~~may be approved retroactively for no more than 10 days ~~from~~prior to the PAR submission date.

b. PAR Denial:

1. The Department or its designated review entity~~Single Entry Point Agency or the Medicaid fiscal agent, as applicable,~~ shall notify Home Health Agencies in writing of denials ~~based on~~that result from non-compliance with Medicaid rules ~~on the appropriate PAR form.~~ or ~~D~~denials ~~based on~~failure to establish medical necessity~~,~~ (the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity~~,~~ 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. The Department or its designated review entity~~SEPs~~, through the Medicaid fiscal agent, shall notify clients of Long Term Home Health denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.~~059~~057~~.16~~, RECIPIENT 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 Department or its designated review entity~~Single Entry Point Agency or the Medicaid fiscal agent, as applicable,~~ shall notify the Home Health Agency of the denial. Services already provided ~~shall~~ may be approved for payment, retroactive to the start date on the PAR form, or up to 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 Department or its designated review entity~~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 Department or its designated

review entity~~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, for up to a maximum of 15 calendar days. If an expedited authorization was provided by the Department or its designated review entity ~~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~~b. 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 approval from the Department or its designated review entity.~~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.

Note: The Section numbered 8.527.10 A was deleted effective August 30, 2012.

~~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 for pediatric clients 20 years of age or younger 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 be reviewed for medical necessity under the EPSDT Federal requirement.~~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 8.290, or out-patient therapies, Section 8.330. Exceptions may be made if ~~extra-ordinary~~EPSDT 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 reviewed as outlined in SECTION 8.527.11 A.~~processed as follows:~~

1. The complete prior authorization request shall include all documentation outlined in SECTION 8.527.11.3 ~~State-prescribed Prior Authorization Request Form; a plan of care which~~ and 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~~ EPSDT Home Health services. The plan of care shall include the place of service for each Home Health visit.~~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 enrollment~~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 ~~Prior authorization requests shall be submitted and processed as follows~~The complete prior authorization request must include:

A. ~~The complete prior authorization request must include a~~A State-prescribed Prior Authorization Request Form;

B. ~~a~~A physician-signed plan of care on the HCFA-485 or a form that is identical in content to the HCFA-485, which shall include nursing and~~/or~~ therapy assessments, ~~or~~ current clinical summaries ~~or~~ and updates of the client, and ~~A~~all therapy services requested ~~must be included in the plan of care, which must list~~ including the specific procedures and modalities to be used and the amount, duration and frequency~~.~~;

C. ~~w~~Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and

D. ~~a~~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.~~