THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number:	MSB 14-04-21-A
Division / Contact / Phone:	Pharmacy Section / Eskedar Makonnen / 4079

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 14-04-21-A, Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
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) 8.590.7.I., 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 §8.590.7.I.2 and §8.590.7.I.3 with the new text provided. All text indicated in blue is for clarification only and should not be changed. This revision is effective 08/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number:	MSB 14-04-21-A
Division / Contact / Phone:	Pharmacy Section / Eskedar Makonnen / 4079

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 proposed rule will increase the DME reimbursement rate by 2% to account for General Assembly funding appropriation

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:

   A state plan amendment (SPA) will be submitted to CMS with a requested effective date of July 1, 2014. The reimbursement rate for DME will be made under the current rate until the SPA is approved. Once approval is received, any such reimbursements made after July 1, 2014 will be adjusted to reflect the new rate contained in the rule.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review — Final Adoption **07/11/2014**

Proposed Effective Date **08/30/2014** — Emergency Adoption

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number:	MSB 14-04-21-A
Division / Contact / Phone:	Pharmacy Section / Eskedar Makonnen / 4079

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.

   DME providers will receive increased reimbursement for equipment and supplies provided.

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

   Reimbursement to DME providers is estimated to be increased by $3,084,913 For FY 2014-15

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.

   No costs beyond the estimated expenditures due to the rate increase are anticipated.

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

   The rate increase will give providers the ability to continue supplying DME items to clients at their incremental threshold margin. Inaction can result in decreased client services and access to benefits.

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

   There is not a less costly method for achieving the purpose of the proposed rule which is to comply with HB14-1336 Long Appropriation Bill.

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.

   An alternative method for achieving a rate increase for the proposed rule was not considered.

8.590.7 REIMBURSEMENT

8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.B. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.D. Clients and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a client because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.E. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department.

8.590.7.F. Reimbursement for allowable modifications, service, and repairs on durable medical equipment is as follows:

1. Labor for modifications, service, and repairs on durable medical equipment shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.I.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.G. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the client accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the client to make the item useful and functional.

3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home.

4. Training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the client or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.

2. Manually priced items that do not have an assigned Fee Schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less ~~21.43~~ 19.86 percent.

3. Manually priced items that do not have an MSRP or Fee Schedule rate shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus ~~14.96~~ 17.26 percent.

8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Medicaid Bulletin.

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

   a. A copy of the Explanation of Medicare Benefits' shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

   b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 14-04-21-B
Division / Contact / Phone:	Rates / Luisa Sanchez de Tagle / 6277

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 14-04-21-B, Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
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) 8.300.6.A, 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*

Add new text at the seventh unnumbered paragraph in §8.300.6.A.1 (immediately before §8.300.6.A.2.) All text indicated in blue is for clarification only and should not be changed. This revision is effective 08/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 14-04-21-B
Division / Contact / Phone:	Rates / Luisa Sanchez de Tagle / 6277

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).

   On April 30, 2014, Governor Hickenlooper signed House Bill 14-1336, which set the Colorado state budget for FY 2014-15. After much debate by the General Assembly, the signed budget includes reimbursement increases for Medicaid providers, including hospitals. As a result, Medicaid hospitals are receiving a 2% increase in their reimbursement rate for outpatient services. This outpatient reimbursement rate change requires a new rule since the rate history is included in the regulation for cost settlement purposes. Currently, hospitals are reimbursed at 70.2% of cost for outpatient services (excluding those services reimbursed based upon the fee schedule such as lab, physical therapy, and occupational therapy). Effective July 1, 2014, the proposed rule will change the reimbursement to 71.6% of cost, which represents a payment increase of 2.0% as required by House Bill 14-1336.

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. 1396a(a)(30)(A);
   42 C.F.R. 447.321

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   24-4-103(6), C.R.S., (2013), 25.5-4-402.3(4)(B)(I) C.R.S (2013); 10 CCR 2505-10 8.300.6; HB 14-1336

Initial Review		Final Adoption	**07/11/2014**
Proposed Effective Date	**08/30/2014**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 14-04-21-B
Division / Contact / Phone:	Rates / Luisa Sanchez de Tagle / 6277

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.

   Hospitals will receive increased reimbursement for outpatient services provided to Medicaid clients. These costs have already been accounted for in the state budget for FY 2014-15 through House Bill 14-1336.

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

   Reimbursement to hospitals for outpatient services is estimated to increase by $9,200,000 for FY 2014-15 as a result of the 2.0% rate increase. The increase contained in this rule will allow hospitals who underwent several years of rate cuts to recuperate more of their costs of providing services to Medicaid clients and potentially provide improved services to more recipients.

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.

   This would cost the Department approximately $9,200,000 in FY 2014-15 for the increased reimbursement to hospitals. These costs have already been accounted for in the state budget for FY 2014-15 through House Bill 14-1336. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   The proposed rule will allow the Department to increase reimbursement to hospitals for outpatient services provided to Medicaid clients as required in House Bill 14-1336. Hospitals will receive a 2% rate increase, which will be funded by both state and federal dollars. Inaction would leave the Department out of compliance with state legislation, and Hospitals would continue to receive reimbursement at current levels.

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

House Bill 14-1336 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2014. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

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.

House Bill 14-1336 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2014. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective

adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6
Rule Number:	MSB 14-04-21-C
Division / Contact / Phone:	Rates & Analysis / Greg Linster / 303-866-4370

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 14-04-21-C, Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6
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) 8.700.6, 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*

Remove current text at the unnumbered paragraph immediately following §8.700.6.C and replace with new text provided.
Remove current text at §8.700.6.C.3 and renumber paragraphs 4., 5., and 6. All text indicated in blue is for clarification purposes only and should not be changed. This revision is effective 08/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6
Rule Number:	MSB 14-04-21-C
Division / Contact / Phone:	Rates & Analysis / Greg Linster / 303-866-4370

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 preserve the public health, safety, and welfare. Since 2009, FQHC providers have been receiving rate cuts during the budget shortfall. This rule will eliminate the midpoint reduction for services provided by Federally Qualified Health Centers participating in Medicaid. After multiple years of rate cuts, the increase contained in this rule may allow these facilities to provide improved services to more recipients

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:

Social Security Act, Section 1902(a)(30)(A)
(42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. 405.2462

4. State Authority for the Rule:

   § 24-4-103(6), C.R.S. (2013); §§ 25.5-1-301-303, C.R.S. (2013); § 25.5-5-408(1)(d), C.R.S. (2013); 10 CCR 2505-10 8.700.6; HB 14-1336

Initial Review — Final Adoption **07/11/2014**

Proposed Effective Date **08/30/2014** — Emergency Adoption

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6
Rule Number:	MSB 14-04-21-C
Division / Contact / Phone:	Rates & Analysis / Greg Linster / 303-866-4370

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.

   Federally Qualified Health Centers (FQHCs) will receive increased reimbursements for services provided to Medicaid clients.

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

   Reimbursements to FQHCs are estimated to increase by $7,192,722 for FY 2013-14 as a result of the APM restoration. The rate increase contained in this rule will reduce the necessary reimbursement cuts applied in 9/1/2009. As a consequence, more funding is available to providers which will affect Medicaid clients by increasing the provision of services. If this rule is not adopted by 7/1/2014, the Department will be out of compliance with state law.

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.

   This proposed rule would cost the Department approximately $7,192,722 in FY 2014-15 for the increased reimbursement to FQHCs. These costs have already been accounted for in the state budget for FY 2014-15 through House Bill 14-1336. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   As is required by House Bill 14-1336, the proposed rule will allow the Department to increase the reimbursement rate received by FQHCs for services provided to Medicaid clients. Specifically, FQHCs will have their rates restored to the APM, which will be funded by both state and federal dollars. There would be no benefit to inaction, as it would result in the Department operating out of compliance with state legislation, and FQHCs would continue to receive reimbursement at the current rate levels.

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

   House Bill 14-1336 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2014. There are no methods for achieving the purpose of the proposed rule that are less costly or intrusive.

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.

   House Bill 14-1336 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2014. There are no alternative methods for achieving the purpose of the proposed rule.

8.700.6.C Encounter rate calculation

~~Effective September 1, 2009, the encounter rate shall be the average of the Prospective Payment System (PPS) rate and the alternative payment rate. Effective July 1, 2013, encounter rates will be raised by 2% with the encounter rate not to exceed the higher of the alternative payment rate or the PPS rate.~~ Effective July 1, 2014, the encounter rate shall be the higher of the Prospective Payment System (PPS) rate or the alternative payment rate.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. BIPA 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, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

   a) Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

   b) The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

~~3. If the PPS rate is higher than the alternative payment rate, the FQHC encounter rate shall be the PPS rate.~~

~~4~~3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.

New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4.~~5~~. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end.

The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate.

All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.332.

~~6~~5. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201
Rule Number:	MSB 14-06-02-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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 14-06-02-A, Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201
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) 8.201, 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)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.201 DENTAL SERVICES through the end of §8.201.6.2**.** with the new text provided. This change is effective 08/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201
Rule Number:	MSB 14-06-02-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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 Joint Budget Committee authorized funding for complete dentures during the 2014 legislative session. The appropriation included approximately $26.8 million total funds from the Adult Dental Fund and the Hospital Provider Fee Cash Fund.

The purpose of this rule change is to add dentures to our existing rules regarding Dental Services. The specific unit limits were developed through the Benefits Collaborative Process and with the input/advice from our consultants and other key stakeholders such as the Colorado Dental Association. This benefit will be subject to prior authorization and will not be subject to the $1,000 annual maximum for Dental Services.

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. (2013);
   §§ 25.5-1-301-303, C.R.S. (2013); § 25.5-5-201(1)(w), C.R.S. (2013).

Initial Review — Final Adoption **07/11/2014**

Proposed Effective Date **08/30/2014** — Emergency Adoption

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Title of Rule:	Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201
Rule Number:	MSB 14-06-02-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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.

Clients who meet the criteria for medical necessity for dentures will now be able to access Dentures Services where previously this service was unavailable. Furthermore, providers who previously were not able to be reimbursed for Dentures will now be able to offer these services to their clients.

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

Clients will be positively impacted by this rule. Where they were previously unable to access these services, they will now be able to obtain dentures so long as they meet the medical necessity criteria.

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

The Department was appropriated approximately $26.8 million total funds for this benefit, including approximately $5.9 million from the Adult Dental Fund and $87,874 from the Hospital Provider Fee Cash Fund for the purpose of adding coverage for complete dentures (prosthetics) with prior authorization as part of the limited adult dental benefit.
4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

See items #2 and #3.

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

This rule is legislatively mandated and the state share is fully funded by monies collected as part of the Adult Dental Fund.

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 were no alternative methods for achieving the purpose of this proposed rule as it was legislatively mandated.

8.201 DENTAL SERVICES

8.201.1 DEFINITIONS

Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.

Cleaning is the removal of dental plaque and calculus for teeth, in order to prevent dental caries, gingivitis and periodontis.

Comprehensive Oral Evaluation means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Endodontic services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues.

Emergency Services means the need for immediate intervention by a physician, osteopath or dental professional to stabilize an oral cavity condition. Immediate Intervention or Treatment means services rendered within twelve (12) hours.

Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions, as defined by the CDT (2014).

Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

Limited Oral Evaluation means an evaluation limited to a specific oral health problem or complaint.

Palliative Treatment for Dental Pain means emergency treatment to relieve the client of pain; not a mechanism for addressing chronic pain.

Preventive services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries, as defined by the CDT (2014).

Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the CDT (2014).

Year begins on the date of service.

8.201.2 BENEFITS

8.201.2.A Covered Services

1. Covered Evaluation Procedures:

   a. Periodic Oral Evaluation, two (2) per ~~fiscal~~ years.

   b. Limited Oral Evaluations are available to clients presenting with a specific oral health condition or problem.

i. If rendered by the same dental provider or the same dental practice, shall be deemed as one of two (2) periodic oral evaluations allowed per ~~fiscal~~ year.

ii. Dental hygienists may only provide limited oral evaluations for a client of record.

c. Comprehensive Oral Evaluation, new clients only, one (1) every three (3) ~~fiscal~~ years.

d. Comprehensive Periodontal Oral Evaluation, one (1) every three (3) ~~fiscal~~ years.

2. Covered Diagnostic Imaging Procedures:

a. Intra-oral; complete series, one per five (5) ~~fiscal~~ years; minimum of ten (10) (periapical or bitewing) films. Counts as one set of bitewings per ~~fiscal~~ year.

b. Intra-oral first periapical x-ray, six (6) per five (5) ~~fiscal~~ years. Providers may not bill the same day as full mouth series.

c. Each additional periapical x-ray. Providers may not bill the same day as a full mouth series. Working and final treatment films for endodontics are not covered.

d. Bitewing; single image, one set per ~~fiscal~~ year; one set is equal to two (2) to four (4) films.

e. Bitewing; two images, one set per ~~fiscal~~ year; one set is equal to two (2) to four (4) films.

f. Bitewing; three images, one set per ~~fiscal~~ year; one set is equal to two (2) to four (4) films.

g. Bitewing; four images, one set per ~~fiscal~~ year; one set is equal to two (2) to four (4) films.

h. Vertical bitewings; seven (7) to eight (8) images, as one (1) every five (5) ~~fiscal~~ years. Counts as a full mouth series.

i. Panoramic image; with or without bitewing, one (1) per five (5) ~~fiscal~~ years. Counts as full mouth series

3. Covered Preventive Services

Clients determined to fit into a high-risk category, as described below, are eligible for any combination of the following periodontal maintenance and cleanings, but are limited to a maximum of four (4) per ~~fiscal~~ year:

a. ~~Adult~~ Cleaning, two (2) per ~~fiscal~~ year; unless client falls into a high risk category.

i. Clients at high risk for periodontal disease or for caries may receive up to four (4) cleanings per ~~fiscal~~ year. High risk is indicated by:

1. active and untreated caries (decay) at the time of examination;

2. history of periodontal scaling and root 5lanning;

3. history of periodontal surgery;

4. diabetic diagnosis; or

5. pregnancy.

b. Fluoride varnish, two (2) per ~~fiscal~~ year for clients with:

i. dry mouth; and/or

ii. history of head or neck radiation; or

iii. high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the ~~fiscal~~ year they no longer have active decay, they are no longer considered high risk.

c. Topical fluoride, two (2) per ~~fiscal~~ year for clients with:

i. dry mouth; and/or

ii. history of head or neck radiation; or

iii. high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the ~~fiscal~~ year they no longer have active decay, they are no longer considered high risk.

4. Minor Restorative Services.

a. The occlusal surface is exempt from the three (3) ~~fiscal~~ year frequency limitations listed below when a multi-surface restoration is required or following endodontic therapy.

b. Amalgam and composite fillings shall be limited to one (1) time per surface per tooth, every three (3) years. The limitation shall begin on the date of service and multi-surface fillings are allowable.

~~a. One surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.~~

~~b. Two (2) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.~~

~~c. Three (3) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.~~

~~d. Four (4) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.~~

~~e. One (1) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

~~f. Two (2) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

g. ~~Three (3) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

h. ~~Four (4) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

i. ~~Resin based composite crown (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

j. ~~One (1) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

k. ~~Two (2) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

l. ~~Three (3) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

m. ~~Four (4) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.~~

5. Major Restorative Services

a. The following crowns are covered:

i. Single crowns, one (1) per tooth every seven (7) ~~fiscal~~ years~~.~~

ii. Core build-up; building, one per tooth every seven (7) ~~fiscal~~ years.

iii. Pre-fabricated post and core, one per tooth every seven (7) ~~fiscal~~ years.

b. Crowns are covered services only when:

i. The tooth is in occlusion; and

ii. The cause of the problem is either decay or fracture; and

iii. The tooth is not ~~a second or~~ a third molar; and

iv. The tooth is not a second molar, unless crowning the second molar is necessary to support a partial denture or to maintain eight (8) artificial or natural posterior teeth in occlusion; and

1. ~~The second molar is covered if it meets all of the above criteria and it is necessary to support a partial denture or to maintain eight (8) posterior teeth (artificial or natural) in occlusion; and~~

v. The client's record reflects evidence of good and consistent oral hygiene; and

vi. E~~e~~ither one of the following is also true:

1. The tooth in question requires a multi-surface restoration and it cannot be restored with other restorative materials; or

2. A crown is requested for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.

c. Crown materials are limited to porcelain and noble metal on anterior teeth and premolars.

6. Endodontic Services

a. The following endodontic procedures are covered:

i. Root canal; anterior tooth, one (1) per tooth per lifetime.

ii. Root canal; premolar, one (1) per tooth per lifetime.

iii. Root canal; molar, one (1) per tooth per lifetime.

iv. Pulpal debridement, one (1) per tooth per lifetime:

1. Covered in emergency situations only;

2. Is exempt from prior authorization process but may be subject to post-treatment and pre-payment review.

v. Retreatment of previous root canal therapy; anterior tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

vi. Retreatment of previous root canal therapy; premolar tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

vii. Retreatment of previous root canal therapy; molar tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

b. Endodontic procedures are covered services when:

i. The tooth is not a second or third molar. Root canals for third molars are not covered; root canals for second molars are covered only when the second molar is essential to keep eight posterior teeth or more in occlusions or when it is necessary to support a partial denture; ~~and/or~~

ii. The tooth is in occlusion; ~~and/or~~

iii. A root canal is requested for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided; ~~and~~

iv. The client's record reflects evidence of good and consistent oral hygiene; and

v. the cause of the problem is either decay or fracture.

c. In all instances in which the client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. In these instances, there may not be time for prior authorization. Such emergency procedures may be subject to post-treatment and pre-payment review.

d. Working films (including the final treatment film) for endodontic procedures are considered ~~a~~ part of the procedure and will not be paid for separately.

7. Periodontal Treatment

a. Periodontal scaling and root planning; four (4) or more teeth per quadrant, once per quadrant every three (3) ~~fiscal~~ years.

i. Prophylaxis ~~is not paid~~shall not be billed on the same day.

ii. No more than two (2) quadrants per day.

b. Periodontal scaling and root planning/ one (1) to three (3) teeth per quadrant, once per quadrant every three (3) ~~fiscal~~ years.

i. Prophylaxis ~~is not paid~~ shall not be billed ~~-~~ on the same day.

ii. No more than two (2) quadrants per day.

c. Periodontal maintenance, two (2) times per ~~fiscal~~ year; counts as a cleaning.

i. Can only be approved when history of periodontal disease as evidenced by a history of scaling and root planning and/or osseous surgery.

ii. Clients with diabetes and pregnant women with histories of periodontal disease are entitled to four (4) per ~~fiscal~~ year.

d. Clients who are determined to fit into the high risk category, are eligible for any combination of periodontal maintenance and cleanings, up to four (4) per ~~fiscal~~ year.

8. Removable Prosthetics

Removable prosthetics are not covered if eight posterior teeth (natural or artificial) are in occlusion. Anterior teeth are covered, irrespective of the number of teeth in occlusion. Removable prosthetics covered include:

a. Removable partial upper denture; resin based, one (1) time every seven (7) ~~fiscal~~ years.

b. Removable partial lower denture; resin based, one (1) time every seven (7) ~~fiscal~~ years.

c. Removable partial upper denture; cast metal framework, one (1) time seven (7) ~~fiscal~~ years.

d. Removable partial lower denture; cast metal framework, one (1) time every seven (7) ~~fiscal~~ years.

e. Removable partial upper denture; flexible base, one (1) time every seven (7) ~~fiscal~~ years.

f. Removable partial lower denture; flexible base, one (1) time every seven (7) ~~fiscal~~ years ~~.~~

g. Complete Upper Dentures; one (1) time every seven (7) years. Includes initial six (6) months of relines

h. Complete Lower Dentures; one (1) time every seven (7) years. Includes initial six (6) months of relines.

9. Oral surgery, palliative treatment and anesthesia

a. The following surgical and palliative treatments are covered:

i. Simple extraction, one (1) time per tooth.

ii. Surgical extraction, one (1) time per tooth.

iii. Incision and drainage, as needed

iv. Minor surgical procedures to prepare the mouth for removable prostheses, one (1) time per lifetime per quadrant.

v. Palliative treatment of dental pain.

1. Not payable on the same visit as any definitive treatment codes; except for covered service necessary for diagnosis.

vi. Deep sedation; general anesthesia.

1. Only covered when there is sufficient evidence to support medical necessity.

2. General anesthesia and/or deep sedation is not covered when it is for the preference of the client or the provider and there are no other medical considerations.

b. In all instances in which the client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. In these instances, there may not be time for prior authorization. Such emergency procedures may be subject to post-treatment and pre-payment review.

c. Biopsies are covered only in instances where there is a suspicious lesion.

d. Removal of third molars is only covered in instances of acute pain and overt symptomatology.

8.201.2.B. Exclusions.

1. The following services/treatments are not a benefit for Adult Clients under any circumstances:

a. Cosmetic Procedures.

b. Inlay and onlay restorations.

c. Crowns in the following categories:

i. Cosmetic Crowns;

ii. Multiple units of crown and bridge;

iii. To restore vertical dimension;

iv. When client has active and advanced periodontal disease;

v. When the tooth is not in occlusion; or

vi. When there is evidence of periapical pathology

~~d. Treatment of the Oral Cavity in preparation for full mouth dentures.~~

~~e. Assessment for delivery of dentures or subsequent adjustments to dentures and bridges.~~

~~f~~d. Implants.

~~g~~e. Screening and assessment.

~~h~~f. Periodontal surgery.

~~i~~g. Protective restorations.

~~j~~h. Full mouth debridement.

~~k~~i. Graft procedures.

~~l~~j. Endodontic surgery.

~~m~~k. Treatment for temporomandibular joint disorders.

~~n~~l. General Biopsies.

~~o~~m. Orthodontic treatment.

~~p~~n. Tobacco cessation counseling.

~~q~~o. Oral hygiene instruction.

~~r. Dentures~~

~~s~~p. Any service that is not listed as covered.

8.201.3 PRIOR AUTHORIZATION REQUEST

1. Emergency Services do not require a prior authorization before services can be rendered.
2. The following services require prior authorization:

a. Single crowns; core build-ups; post and cores

b. Complete and Partial dentures

c. Scaling and root planing

d. Root canals; prior authorization is not required for pulpal debridement in instances of acute pain

e Non-emergency surgical extractions

f. inor surgical procedures

g. General anesthesia and deep sedation except in instances of acute pain or medical necessity.

8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.201.4.A. Dental services shall only be provided by a licensed dentist or dental hygienist who is enrolled with Colorado Medicaid. Providers shall only provide covered services that are within the scope of their practice.

8.201.5 Eligible Clients

Dental services described in 8.201.2 shall be available to Adult Clients age 21 years and older.

8.201.6 Annual Limits

1. Dental services for adults 21 years of age and older are limited to a total of $1,000 per adult Medicaid recipient per state fiscal year. A client may make personal expenditures for services beyond the $1,000 annual limit and shall be charged the lower of the Medicaid Fee Schedule or submitted charges.

2. The complete and partial dentures benefit will be subject to prior authorization and will not be subject to the $1,000 annual maximum for dDental sServices for adults age 21 and over. Although the complete and partial dentures benefit is not subject to the $1,000 annual maximum for the adult dDental sServices, it they will be subject to a set Medicaid allowable rate.