THIS PAGE NOT FOR PUBLICATION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 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / 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 13-04-09-C, Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
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) 8.300.6.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)? Yes
   If yes, state effective date: 7/1/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new unnumbered paragraph (6) immediately following the fifth unnumbered paragraph at §8.300.6.A.1 and immediately before current text at §8.300.6.A.2. All text indicated in blue is for clarification purposes and should not be revised. This change is effective 07/01/2013.

*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THIS PAGE NOT FOR PUBLICATION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 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / 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).

   This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandates an increase of two percent for reimbursement for hospitals providing outpatient services effective July 1, 2013. Thus, the proposed rule will change the reimbursement for outpatient hospital services to 70.2% of cost which represents a payment increase of 2.0% as required by Senate Bill 13-230.

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:

   Senate Bill 13-230 Long Appropriations Bill includes a mandatory increase of 2% for outpatient hospital services effective July 1, 2013. A state plan amendment (SPA) will be submitted to CMS with a requested effective date of July 1, 2013. Reimbursement for outpetient hospital services will be made under the current rate until the SPA is approved. Once approval is received any such reimbursements made after July 1 will be adjusted to reflect the new rate contained in the rule.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   24-4-103(6), C.R.S. (2012); 25-4-402, C.R.S. (2012); Senate Bill 13-230

Initial Review — Final Adoption

Proposed Effective Date **07/01/2013** — Emergency Adoption **06/14/2013**

DOCUMENT #01

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 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / 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 hospital services provided to Medicaid clients. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230.

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 $5,210,189 for FY 2013-14 as a result of the 2.0% rate increase. The increase contained in this rule will allow participating hospitals to recuperate an additional portion of their costs of providing services to Medicaid clients. As a consequence, the availability of additional funding will affect Medicaid clients by increasing the provision of services.

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 $5,210,189 in FY 2013-14 for the increased reimbursement to hospitals. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230. 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 Senate Bill 13-320. 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. If this rule is not adopted by 7/1/2013, the effective date of the rate increase will need to be delayed and it will not be possible to apply the increase retroactively back to 7/1/2013.

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

Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. 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.

   Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no alternative methods for achieving the purpose of the proposed rule.

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%).

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.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and 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 13-04-22-A, Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
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) 8.700.7, 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: 7/1/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text in the unnumbered paragraph immediately following §8.700.7.B with the new text provided. Please replace current text at §8.700.7.B.2 and at §8.700.7.B.3 with the new text provided. All text indicated in blue is for clarification only and should not be revised. This change is effective 07/01/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and 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).

   This rule is being changed to comply with Senate Bill 13-230 Long Appropriations Bill, which mandated an increase of 2% for Federally Qualified Health Centers (FQHCs) effective July 1, 2013. The rate increase is not, however, allowed to exceed the higher of the Alternative Payment Methodology (APM) rate or the PPS rate.

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:

   Senate Bill 13-230 Long Appropriations Bill includes a mandatory increase of 2% for FQHCs effective July 1, 2013.

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
24-4-103(6), C.R.S. (2012); Senate Bill 13-230

Initial Review — Final Adoption

Proposed Effective Date **07/01/2013** — Emergency Adoption **06/14/2013**

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and 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 $2,124,383 for FY 2013-14 as a result of the 2% rate increase. 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 7/1/2013, 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 $2,124,383 in FY 2013-14 for the increased reimbursement to FQHCs. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230. 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 Senate Bill 13-320, the proposed rule will allow the Department to increase the reimbursement rate received by FQHCs for services provided to Medicaid clients. Specifically, FQHCs will receive a 2% rate increase, 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.

Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. 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.

   Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no alternative methods for achieving the purpose of the proposed rule.

8.700.7 REIMBURSEMENT

8.700.7.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits.

8.700.7.B 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.

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. 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.

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. 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 Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
Rule Number:	MSB 13-04-23-A
Division / Contact / Phone:	Office of Clinical Services, Pharmacy Unit / Andrea Skubal / 303-866-2113

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 13-04-23-A, Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, 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)? Yes
   If yes, state effective date: 7/1/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.590.7.I.1 with new text provided. Please delete current text at §8.590.7.I.2 and §8.590.7.I.3. Please insert new text provided at §8.590.7.I.2 and §8.590.7.I.3. All text indicated in blue is for clarification purposes only and should not be revised. This change is effective 07/01/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
Rule Number:	MSB 13-04-23-A
Division / Contact / Phone:	Office of Clinical Services, Pharmacy Unit / Andrea Skubal / 303-866-2113

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 encounter 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:

   This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandated an increase of 2% for the Durable Medical Equipment encounter rate, effective July 1, 2013.

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, 2013. Reimbursement for the Durable Medical Equipment encounter rate will be made under the current rate until the SPA is approved. Once approval is received, any such reimbursements made after July 1, 2013 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. (2012);
   25.5-4-401, 25.5-4-416, C.R.S. (2012); and
   Senate Bill 13-230.

Initial Review — Final Adoption

Proposed Effective Date **07/01/2013** — Emergency Adoption **06/14/2013**

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
Rule Number:	MSB 13-04-23-A
Division / Contact / Phone:	Office of Clinical Services, Pharmacy Unit / Andrea Skubal / 303-866-2113

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 $2,100,089 for FY 2013-14.

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.

   Although the rate change is expected to increase expenditures, the proposed rule revision is in response to recent years' reductions and is highly anticipated by providers. Although inaction would result in cost savings, the cost would likely be realized through decreased client services and access to benefits. Providers have expressed concern over their ability to continue supplying items that are at their incremental threshold margin.

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

   The proposed changes to increase the provider reimbursement rates were specifically targeted to those provider rates that had been the subject of rate reductions in recent years. There is not a less costly method for achieving the purpose of the proposed rule, which is to reinstate previous rates.

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 is targeting the 2% rate increase for services that were impacted by rate reductions in recent years. 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 ~~d~~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 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 percent.

~~2. Manually priced items that have no maximum allowable reimbursement rate assigned, but have a Manufacture Suggested Retail Price (MSRP) shall be reimbursed the MSRP less 22.97 percent.~~

~~3. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a MSRP shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus 12.71 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.