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Title of Rule: Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B
Rule Number: MSB 20-03-17-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 20-03-17-A, Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B

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) 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B, 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: 3/20/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.520.4.B.1 with the proposed text beginning at 8.520.4.B.1.g through the end of 8.520.4.B.1.g. Replace the current text at 8.700.1.B with the proposed text beginning at 8.700.1.B through the end of 8.700.1.B.2. Replace the current text at 8.730.3.B with the proposed text beginning at 8.730.3.B.12 through the end of 8.730.3.B.12. Replace the current text at 8.740.1 with the proposed text beginning at 8.740.1 through the end of 8.740.1. Replace the current text at 8.750.3.B with the proposed text beginning at 8.750.3.B through the end of 8.750.3.B.3. This rule is effective March 20, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B
Rule Number: MSB 20-03-17-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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).

   This rule revision permits telemedicine for select home health, Federally-Qualified Health Center, Family Planning, Rural Health Clinic, and Community Mental Health Centers/Clinic services using interactive audio, interactive video, or interactive data communication in lieu of face-to-face visits between clients and health professionals. The purpose of the rule revision is to limit face-to-face visits between clients and providers, where appropriate, to help contain the spread of the 2019 Novel Coronavirus Disease (COVID-19). Telemedicine also increases efficiency for providers with a high volume of clients.

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:

   Permitting the utilization of telemedicine through interactive audio, interactive video, or interactive data communication, where appropriate, to limit face-to-face visits between clients and health professionals and to help contain the spread of COVID-19 is imperatively necessary for preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR 410.78 (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-5-320, C.R.S. (2019)

Initial Review
Proposed Effective Date **03/20/2020**
Final Adoption
Emergency Adoption **03/20/2020**

DOCUMENT #01

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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 receiving services for telemedicine-eligible home health, Federally-Qualified Health Center, family planning, Rural Health Clinic, and Community Mental Health Center/Clinic services, and the providers that render such services, will be benefit from the proposed rule. Providers of such services will bear the cost of maintaining any technology resources required to provide telemedicine services to 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.

   Affected clients and providers will benefit from reduced face-to-face visits, and the associated in-person visits to medical facilities, where exposure to COVID-19 may occur. Providers will also benefit from the efficiencies of telemedicine at a time when the volume of clients seeking care is high.

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 to the Department or to any other agency to implement and enforce the proposed rule.

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

   The probable cost of the proposed rule to a provider is setting up and maintaining the technology resources necessary to implement telemedicine, if such technology is not already utilized by a provider. The benefits of the proposed rule are limiting face-to-face visits between clients and providers to help contain the spread of COVID-19, where appropriate, and increased efficiency for providers rendering care to a high volume of 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 or less intrusive methods for achieving the purpose of the proposed rule.

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

   There are no alternative methods for achieving the purpose for the proposed rule.

8.520 HOME HEALTH SERVICES

8.520.4. Covered Services

8.520.4.B. Place of Service

1. Services shall be provided in the client's place of residence or one of the following places of service:

   a. Assisted Living Facilities (ALFs);

   b. Alternative Care Facilities (ACFs);

   c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;

   d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer clients reside Services shall not duplicate those that are the contracted responsibility of the IRSS; or

   e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.

   f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

   g. Services may be provided using interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) instead of in-person contact. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

A. Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later

amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

B. Visit means a one-on-one, face-to-face, interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

1. A visit includes a one-on-one, face-to-face, interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

2. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care.

8.730 FAMILY PLANNING SERVICES

8.730.3 Provider Eligibility

8.730.3.A. The following Medicaid enrolled providers may offer family planning services:

1. Physician

2. Osteopath

3. Nurse Practitioner

4. Certified Nurse-Midwife

5. Physician Assistant

6. Clinical Nurse Specialist

7. Certified Registered Nurse Anesthetist

8. Family Planning Clinic

9. Public Health Agency

10. Non-physician Practitioner Group

8.730.3.B. Eligible places of service include:

1. Office

2. Clinic

3. Family Planning Clinic

4. Public Health Agency

5. Home

6. School

7. School-based Health Center

8. Federally Qualified Health Center

9. Rural Health Center

10. Hospital

11. Ambulatory Surgery Center

12. Telemedicine, including interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission)

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face, interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter between a clinic client and any health professional providing the services set forth in 8.740.4. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

8.750 COMMUNITY MENTAL HEALTH CENTERS/CLINICS

8.750.3 COVERED SERVICES

8.750.3.A. Services shall include but are not limited to prevention, diagnosis and treatment of emotional or mental disorders. Such services shall be rendered primarily on an outpatient and consultative basis for clients residing in a particular community in or near the facility so situated.

8.750.3.B. Community Mental Health Centers/Clinics shall provide medically necessary rehabilitation services in an outpatient setting. Covered services shall include:

1. Case management services, including but not limited to:

   a. Service planning and program linkage.

   b. Referral recommendations.

   c. Monitoring and follow up.

   d. Client advocacy.

   e. Crisis management.

2. Group psychotherapy services shall be face-to-face, interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall

assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

3. Individual psychotherapy services shall be face-to-face, interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. Individual psychotherapy services are limited to thirty-five visits per State fiscal year. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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 20-03-16-A, Revision to the Medical Assistance Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1

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) 8.800.11.E.1, 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: 3/20/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.11.E.1.c with the proposed text beginning at 8.800.11.E.1.c through the end of 8.800.11.E.1.c. This rule is effective March 20, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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).

   Due to the COVID19 pandemic, the Department must ensure that member's access to critical medication is not thwarted. Therefore, the Department is waiving the prescription signature requirements in Sections 8.800.11.E.1.a and 8.800.11.E.1.b only when a public health emergency is declared by the Governor. This will serve as a safety precaution by eliminating the need to touch pens and electronic screens; in addition to eliminating a potential barrier for a member to receive medication when they can not physically come into the pharmacy to obtain it if they have contracted COVID19.

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:

   COVID19 Pandemic

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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.

   Waiving the signature requirements poses an auditing concern as it is more difficult to confirm delivery of medications. However, amid this pandemic an auditing concern is less worrisome than members potentially spreading the virus to other people and/or not being able to obtain their medications in the event that they cannot physically come into the pharmacy to sign for their medications if they have contracted COVID19 and are placed in quarantine.

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 quantitative impact is the potential for pharmacies to bill Medicaid for medications that have not been dispensed to members; i.e. it is more difficult for the Department to audit pharmacies on whether or not a member actually received their medications without the signature requirement in place. However, qualitatively this potential rule change can assist in mitigating the spread of COVID19 which is far more cost effective quantitatively and qualitatively than preventing potential billing mistakes by pharmacies given the declaration of a public health emergency by the Governor.

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 probable cost to the Department is that while the governor has declared a state of public health emergency, pharmacies can bill the Department for claims without the signature requirement meaning that some pharmacies could bill the Department for claims that were never actually given to a member.

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

   The probable cost of the proposed rule is that the Department will not be able to effectively audit pharmacy claims for this period of time. The probable benefit is

mitigating the spread of COVID19 and ensuring patients can access the medications they need if they have contracted COVID19 without having to physically come into the pharmacy and sign for their medication. The probable cost of inaction is spreading COVID19 through pharmacy touchpads and pens. The probable benefit of inaction is that the Department will still be able to more effectively audit pharmacy claims.

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.

   N/A

8.800 PHARMACEUTICALS

8.800.11 PRESCRIPTION RECORD REQUIREMENTS

8.800.11.A. The original prescription shall be a hard copy written, faxed or electronically mailed or otherwise transmitted by the prescriber or reduced to writing by pharmacy staff when received by telephone. All information required by the Colorado State Board of Pharmacy shall appear on each prescription including any information required if a substitution for a drug is made. All refill information shall be recorded in accordance with the Colorado State Board of Pharmacy requirements.

8.800.11.B. All records for new prescriptions and refills for which payment from the Medical Assistance Program is requested shall be maintained in accordance with Colorado State Board of Pharmacy requirements except that such records must be retained for the length of time set forth in 10 C.C.R. 2505-10, Section 8.040.2.

8.800.11.C. The pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record, and maintain the following member information from the member or his/her apparent agent for each new prescription:

1. Name, address, telephone number, date of birth or age, and gender;

2. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive, chronological list of medications and prescribed relevant devices; and

3. Additional comments relevant to the member's pharmaceutical care as described in the Prospective Drug Review and Member Counseling sections set forth in 10 C.C.R. 2505-10, Section 8.800.9.

8.800.11.D. TAMPER-RESISTANT PRESCRIPTION DRUG PADS OR PAPER

1. The use of tamper-resistant prescription drug pads or paper is required for all written or electronically printed prescriptions for all Medical Assistance Program members when:

   a. Prescriptions are issued for outpatient drugs, including controlled and uncontrolled substances, or OTC drugs that are reimbursable through the Medical Assistance Program and dispensed by a pharmacy; and

   b. The Medical Assistance Program is the primary or secondary payer of the prescription being filled.

2. To be considered tamper-resistant, the pad/paper used for a written or electronically printed prescription shall integrate three distinct characteristics. The three characteristics and the specific features required are as follows:

   a. Characteristic #1: One or more industry-recognized features designed to prevent unauthorized copying of completed or blank prescription form. A prescription shall contain at least one of the following features:

i) Void/Illegal/Copy Pantograph with or with the Reverse Rx feature. The word “Void”, “Illegal”, or “Copy” appears when the prescription is photocopied. If the paper has the Reverse Rx feature, the Rx symbol must disappear when photocopied at light setting. The Reverse Rx feature is not allowed as a feature by itself.

ii) Micro-fine printed security message generated by a computer, electronic medical records system or other electronic means. The message may serve as a signature line or border. This must be printed in 0.5 font or smaller and readable when viewed at 5x magnification or greater and illegible when copied.

iii) Coin-reactive ink or security mark. The pad or paper identifies an area on the pad/paper where the ink changes color or reveals wording or a picture when that area is rubbed by a coin. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

iv) Security print watermark. Specific wording is printed on the front or back of the prescription paper and can only be seen when viewed at an angle.

v) Paper with a watermark. This is paper that contains a watermark that can be seen when backlit.

b. Characteristic #2: One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. A prescription shall contain at least one of the following features:

i) An erasure-revealing background. This is a background that consists of a non-white solid color or consistent pattern that has been printed onto the paper. If an erasure or modification is attempted, the background will show marks or the color of the underlying paper where the alterations were made.

ii) Toner fusing technology for laser-printed prescriptions. This is a treatment that is added to the surface of the paper to create a strong bond between the laser-printed text and the paper. The computer-printed information cannot be lifted from the surface of the paper without damaging the paper.

iii) Chemical-reactive paper. This is paper that contains features that show discoloration or reveals a hidden message if solvents are used to attempt to wash the ink from its surface.

iv) Plain bond paper combined with inkjet-printing. The inkjet printing is absorbed into the high grade paper stock. Erasures and modifications cannot be made without damaging the paper.

v) Pre-printed quantity check-off boxes indicated in ranges of no more than 25 per range combined with a written quantity. The range box corresponding to the quantity prescribed must be checked by the prescriber for the prescription to be valid.

vi) Pre-printed refill indicator where the number of refills allowed is marked or no refills or “NR” is marked when no refills are authorized. Refill

information must be completed by the prescriber for the prescription to be valid.

vii) Characters surrounding the authorized dispensing quantity and the number of refills. Special characters such as a series of asterisks must be repeated on both sides of the numbers indicating the quantity and the number of refills authorized (e.g., Quantity ***50*** Refill ***3***). This is acceptable only for prescriptions that are generated by a computer, electronic medical records system or other electronic means.

c. Characteristic #3: One or more industry recognized features designed to prevent the use of counterfeit forms. A prescription must contain at least one of the following features:

i) Security features listed visibly in a box, band or border on the prescription. This must be a complete listing of all of the security features incorporated into the prescription pad/paper in order to minimize tampering.

ii) Security threads. Metal, fluorescent or plastic security threads are embedded into the prescription pad/paper.

iii) Thermochromic ink. All or some of the pad or paper is pre-printed with ink that changes color when exposed to heat and then changes back to its original color when cooled. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

3. The use of tamper-resistant prescription pads or paper is not required when:

a. Prescriptions are transmitted by telephone, fax or E-prescription directly to the pharmacy by the prescriber or prescriber's staff that is authorized to act on the prescriber's behalf; or

b. A prescriber administers or provides the drug directly to the member; or

c. A prescriber in an institutional setting writes the order into the medical record and then the order is given by medical staff directly to the pharmacy; or

d. A Medical Assistance Program managed care entity pays for or dispenses the prescription; or

e. A prescription is written for any medical item, service or equipment that is not considered an outpatient drug; or

f. A drug that is provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made as part of payment for the following and not as direct reimbursement for the drug):

i) Inpatient hospital services;

ii) Hospice services;

iii) Dental services (except when a State Plan authorizes direct reimbursement to the dispensing dentist);

iv) Physician services;

v) Outpatient hospital services;

vi) Nursing facilities and intermediate care facilities for the mentally retarded;

vii) Other laboratory and x-ray services; or

viii) Renal dialysis.

4. The pharmacy may dispense up to a 72-hour supply of a covered outpatient prescription drug in an emergency situation, provided that the pharmacy obtains a compliant prescription in writing, or by telephone, facsimile, or E-prescription, within 72 hours of filling the prescription.

5. When a Medical Assistance Program member is determined retroactively eligible after a pharmacy has filled the recipient's prescription, the prescription shall be deemed to comply with the tamper-resistant pad/paper requirements. This presumption applies only to prescriptions that were filled before the member was determined eligible. Prescriptions that are filled or refilled after the member is determined eligible require a new, tamper-resistant prescription or the pharmacy may obtain verbal confirmation of the prescription from the prescriber or may obtain the prescription from the prescriber by facsimile or E-prescription.

8.800.11.E. Prescription tracking and claim reversals

1. The pharmacy shall keep:

a. A chronological log that contains the member's name, his or her signature or agent's signature and date of the receipt of the prescription; or

b. An electronic prescription tracking system that records the status of prescriptions through the fill process including the date and time that the prescription was transferred to a person whom pharmacy personnel verified was the member or agent of the member.

c. The requirements in subsections (a) and (b) are waived for the duration of a public health emergency as declared by the Governor.

2. Pharmacies using a chronological log shall review all Medical Assistance Program prescriptions in shall-call status (filled but not released to the member or the member's agent) at least weekly and enter a reversal of prescriptions not picked up within 14 days of billing. In no case shall prescriptions be kept in shall-call status for more than 21 days. The pharmacy shall maintain a record of each reversal for audit purposes.

3. Pharmacies using an electronic prescription tracking system shall review all Medical Assistance Program prescriptions in shall-call status on a daily basis and enter a reversal of prescriptions not picked up within 10 days of billing. In no case shall prescriptions be kept in shall-call status for more than 14 days. The pharmacy shall maintain a record of each reversal for audit purposes.

4. Upon receipt of a written request from the Department or the Medicaid Fraud Unit for a record of Medical Assistance Program claims and reversals, the pharmacy has up to 72

hours or three working days to provide the requested information or to enter into an agreement with the Department or Unit stating the specific time within which the data shall be produced.

8.800.11.F. Any information, documents or records required to be retained under 10 C.C.R. 2505-10, Section 8.800.11 shall be made available for inspection to authorized personnel of the Department, U.S. Department of Health and Human Services or the Medicaid Fraud Control Unit.