DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
Rule Number: MSB 21-08-10-D
Division / Contact / Phone: Office of Community Living / Victor Robertson / 303-866-6463

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 21-08-10-D, Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9

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)8.393.1.J.; 8.519.5.; 8.603.9, 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: 10/08/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.393.1.J with the proposed text beginning at 8.393.1.J.1 through the end of 8.393.1.J.3. Replace the current text at 8.519.5 with the proposed text beginning at 8.519.5 through the end of 8.519.5.B. Replace the current text at 8.603.9 with the proposed text beginning at 8.603.9.E through the end of 8.603.9.E. This rule is effective October 8, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
Rule Number: MSB 21-08-10-D
Division / Contact / Phone: Office of Community Living / Victor Robertson / 303-866-6463

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 rules at 8.393.1.J.; 8.519.5.; 8.603.9 outline the education and experience qualifications for case managers in the SEP, HCBS and CCB systems. Currently there is a workforce shortage impacting the system and the department is requesting changes to the qualifications to allow for more avenues to qualify as a case manager, hoping to increase the pool of candidates.

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:

   Case managers complete activities which are crucial to members' access to services and supports, including eligibility assessment and support planning as well as monitoring to assure quality services and health, safety and welfare of members. A shortage in this workforce presents potential delays in enrollment and receipt of services for our most vulnerable members, increased caseloads, impacting quality of service delivery and risks to health and safety of members.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Section 25.5-10-209.5, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Qualifications of Case Managers, Sections 8.393.1.J.; 8.519.5. and 8.603.9
Rule Number: MSB 21-08-10-D
Division / Contact / Phone: Office of Community Living / Victor Robertson / 303-866-6463

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.

   This proposed rule will affect state Medicaid providers, including Community Centered Boards, Single Entry Points and CHCBS Case Management Providers. There is no cost associated with the proposed rule. Providers and members will benefit from an improved workforce resulting from promulgation of these rules.

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

   The proposed rule will likely improve the ability for case management agencies to hire case managers. It is difficult to quantify the impact; however, the rules have incorporated input from stakeholders to remove barriers to recruiting qualified candidates.

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 anticipated costs associated with the proposed rules. The rules remove the requirement to request a waiver from the department, so there will be less administrative burden to the Case Management Agencies and the Department.

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

   There is possible cost of case managers being less qualified and the benefit of a larger candidate pool if the rule is adopted. The costs of inaction are members waiting for assessment/enrollment for services needed to assure health and safety, high caseloads resulting in poor quality of case management services, including monitoring for health and safety, support plan development, and service utilization. There are no identified benefits of inaction.

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

   No other methods have been identified.

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

   No other alternatives were considered; this is the method proposed by the stakeholders.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.J. Qualifications of Staff

1. The SEP ~~Agency's supervisor(s) and~~ case manager(s) hired on or after ~~September 10, 2021~~October 8, 2021 shall meet minimum standards for HCBS case managers required in Section~~10 CCR 2505-10~~ 8.519.5.B ~~education and/or experience~~ and shall be able to demonstrate competency in pertinent case management knowledge and skills.

   ~~a. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).~~

   ~~b. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point Agency case manager under the following conditions:~~

      ~~i. Experience as a caseworker or case manager with the LTSS population in a private or public social services Agency may substitute for the required education on a year for year basis.~~

      ~~ii. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.~~

      ~~iii. The SEP Agency shall request a written waiver from the Department in the event that the potential case manager does not meet minimum educational requirements. A copy of this waiver, if granted, shall be kept in the case manager's personnel file.~~

2.~~c~~. The case manager must demonstrate competency in each of the following areas:

   ~~i~~a. Application of a person-centered approach to planning and practice;

   ~~ii~~b. Knowledge of and experience working with populations served by the SEP Agency;

   ~~iii~~c. Interviewing and assessment skills;

   ~~iv~~d. Knowledge of the policies and procedures regarding public assistance programs;

   ~~v~~e. Ability to develop Support Plans and service agreements;

   ~~vi~~f. Knowledge of LTSS and other community resources; and

   ~~vii~~g. Negotiation, intervention and interpersonal communication skills.

3~~d.~~. The SEP Agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

8.519 Case Management

8.519.5. Qualifications of Case Managers

8.519.5.A. All Home and Community-Based (HCBS) case managers must be employed by a certified Case Management Agency.

1. CMAs must maintain verification that employed case managers meet the qualifications set forth in these regulations.

8.519.5.B.~~8.519.5.B.~~ minimum qualifications for HCBS Case Managers hired on or after ~~September 10~~October 8th, 2021 are~~is~~:

1. A bachelor's degree; or
2. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:

a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,

b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.

~~1. A bachelor's degree from an accredited college or university in human services, nursing, psychology, sociology, behavior science, social work, special education, gerontology, public health or non-profit administration; or~~
~~2. A bachelor's degree and a minimum of one (1) year of relevant work experience; or~~
~~3. Four (4) years of combined relevant work experience and education in human services, nursing, psychology, sociology, behavior science, social work, special education, gerontology, public health or non-profit administration, where 30 semester and 45 quarter credits equals one year; or,~~
~~4. Five (5) years of relevant work experience.~~
~~5. Relevant work experience is defined as:~~

~~a. Paid work experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,~~

~~b. Completed coursework and/or paid work experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant work experience.~~

~~The minimum requirement for HCBS Case Managers is a bachelor's degree in a human behavioral science or related field of study. If an individual does not meet the minimum requirement, the Case Management Agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:~~

~~1. Experience working with long-term services and supports (LTSS) population, in a private or public agency, which can substitute for the required education on a year for year basis; or~~

~~2. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.~~

~~3. A copy of the waiver request and Department approval shall be kept in the case manager's personnel file.~~

8.519.5.C. Case Managers may not:

1. Be related by blood or marriage to the Client.

2. Be related by blood or marriage to any paid caregiver of the Client.

3. Be financially responsible for the Client.

4. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a power of attorney.

5. Be a provider for the Client, have an interest in, or be employed by a provider for the same Client. Case Managers employed by a Case Management Agency that is operating under an exception approved by the Centers for Medicare and Medicaid Services (CMS) in the approved waiver application are exempt from this requirement.

8.519.5.D. Case Managers must complete the Department prescribed attestation form.

8.519.5.E. Case Managers must complete and document the following trainings within 120 days from the date of hire and prior to providing case management services independently:

1. Department prescribed assessment tool;

2. Service plan development and revision;

3. Referral for services, to include Medicaid and non-Medicaid;

4. Monitoring;

5. Case documentation;

6. Level of Care determination process;

7. Notices and appeals;

8. Incident and critical incident reporting;

9. Waiver requirements and services;

10. Person-centered approaches to planning and practice;

11. Interviewing and assessment skills; and

12. Regulations and state statutes for the LTSS program.

13. Department IMS Documentation

14. Mandatory Reporting

15. Participant Directed Training

16. Disability and Cultural Competency

17. Any Case Management training required by contract

8.519.5.F. Case Managers must demonstrate and document competency in the following areas:

1. Knowledge and experience working with populations served by the Case Management Agency;

2. Knowledge of the statutes, regulations, policies and procedures regarding public assistance programs and the American with Disabilities Act;

3. Knowledge of LTSS and other community resources;

4. Negotiation, conflict resolution, intervention, cultural and linguistic training, disability cultural competency, and interpersonal communication skills; and

5. Knowledge of consumer direction philosophy and programs.

8.519.5.G. Case Managers shall attend any mandatory training required by the Department.

8.519.5.H. Case Manager supervisors shall meet the minimum requirements for education and/or experience for Case Managers and shall have one year of competency in pertinent case management knowledge and skills.

8.519.5.I. Background checks.

1. Prior to employment, all case management staff must have the following minimal background checks and screenings:

a. Criminal;

b. Medicaid or other federal health programs exclusion list;

c. Sex offender registry; and

d. Adult protective services data system.

2. Background checks must be repeated at minimum every five (5) years with the exception of the adult protective services data system.

3. Proof of checks and screenings must be maintained and made available.

8.603 PROGRAM APPROVAL BY THE DEPARTMENT

8.603.9 PERSONNEL AND CONTRACTOR ADMINISTRATION

A. Community centered boards and program approved service agencies shall establish qualifications for employees and contractors (Host Home and other providers) and maintain records documenting the qualifications and training of employees and contractors who provide services pursuant to these rules and regulations.

B. The community centered board or service agency may, in accordance with section 27-90-110, C.R.S., conduct background checks and reference checks prior to employing staff providing supports and services and contracting with Host Home and other providers.

C. The community centered board in its role as support coordinating agency, as defined in section 8.609.1, shall have screening procedures for individual providers who are not agency employees and for other entities providing services and supports.

D. The community centered board and program approved service agency shall have an organized program of orientation and training of sufficient scope for employees and contractors to carry out their duties and responsibilities efficiently, effectively and competently. The program shall, at a minimum, provide for:

1. Extent and type of training to be provided prior to employees or contractors providing supports and services having unsupervised contact with persons receiving services;

2. Training related to health, safety and services and supports to be provided within the first ninety (90) days for employees and contractors; and,

3. Training specific to the individual(s) for whom the employees or contractors will be providing services and supports.

E. Community centered boards shall ensure that individuals who are hired to fulfill the duties of case management services on or after ~~September 10~~October 8, 2021 meet the requirements in Section ~~10 CCR 2505 10~~ 8.519.5.B. ~~have at least a bachelor's level degree of education, five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.~~

F. All employees and contractors, not otherwise authorized by law to administer medication, who assist and/or monitor persons receiving services in the administration of medications or the filling of medication reminder systems shall have passed a competency evaluation offered by an approved training entity, as defined in 6 CCR 1011-1, Chapter 24, *et seq*.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
Rule Number: MSB 21-09-15-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 21-09-15-A, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements

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) 8.520.8, 8.540.2 and 8.540.7, 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: 10/8/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.520 with the proposed text beginning at 8.520.8.C through the end of 8.520.8.C. Replace the current text at 8.540 with the proposed text beginning at 8.540.2.A through the end of 8.540.2.A. Replace the current text at 8.540.7 with the proposed text beginning at 8.540.7 through the end of 8.540.7. This rule is effective October 8, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
Rule Number: MSB 21-09-15-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).

   Update the long-term home health and private duty nursing rules to resume prior authorization on a tiered schedule over the course of ten months.

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:

   These revisions are required to bring Department regulations in line with the Colorado State Plan. The Department otherwise risks deferral or disallowance from CMS for being out of compliance. A deferral or disallowance would impact the Department's ability to provide adequate services to members.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7
Rule Number: MSB 21-09-15-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Members receiving pediatric long-term home health and private duty nursing, and the providers rendering such services, will be affected by the proposed rule. Providers will bear the cost of submitting prior authorization requests for these services.

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

   Providers of pediatric long-term home health and private duty nursing will be required to submit prior authorization requests to continue, or initiate new, services. Prior authorization review will determine whether such services will be covered under Health First Colorado (Colorado Medicaid) moving forward.

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.

   Implementing and enforcing this rule change could result in a reduction in Medicaid spending on pediatric long-term home health and private duty nursing over time if services authorized through the prior authorization requests are lower than current utilization. The Department anticipates that expenditure will remain in line with historical utilization trends as the suspension of the prior authorization requirements was temporary.

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

   The probable costs of the proposed rule are implementing prior authorization requirements for pediatric long-term home health and private duty nursing. The probable benefit of the proposed rule is bringing Department practice in line with the Colorado State Plan. The probable cost of inaction is misalignment between

Department rule and the Colorado State Plan. There are no probable benefits to inaction.

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 intrusive methods to align Department rule with the Colorado State Plan.

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 of the proposed rule.

8.520 HOME HEALTH SERVICES

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.

    a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health clients.

2. If a client receiving long-term Home Health Services experiences an acute care event that necessitates moving the client to an acute home health episode, the agency shall notify the Department or its Designee that the client is moving from long-term home health to acute Home Health Services.

3. If the client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the client, or submit a PAR for long-term Home Health Services if the client is eligible.

    a. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the client's care under the current acute home health Plan of Care.

    b. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the client returns to the Home Health Agency.

    c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C. Long-Term Home Health

1. Beginning November 1, 2021, ~~L~~providers must submit a prior authorization request (PAR) for all new long-term pediatric Home Health Services ~~do not require prior authorization~~ under Section 8.017.E. For members currently receiving long-term pediatric Home Health Services initiated prior to November 1, 2021, providers must submit a PAR in accordance with the following schedule:

   1. Ten percent (10%) of PARs must be submitted by November 30, 2021;

   2. An additional 10% of PARs must be submitted by December 31, 2021;

   3. An additional 10% of PARs must be submitted by January 31, 2022;

   4. An additional 10% of PARs must be submitted by February 28, 2022;

   5. An additional 10% of PARs must be submitted by March 31, 2022;

   6. An additional 10% of PARs must be submitted by April 30, 2022;

   7. An additional 10% of PARs must be submitted by May 31, 2022;

   8. An additional 10% of PARs must be submitted by June 30, 2022;

   9. An additional 10% of PARs must be submitted by July 31, 2022;

   ~~1.~~10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

   a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

   b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

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

d. Any other medical information which will document the medical necessity for the Home Health Services;

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

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

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

h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

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

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied or reduced, services shall be approved for ~~15~~ 60 additional days after the date on which the notice of denial is mailed to the client.

through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

8.520.8.D. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for clients ages 0 through 20, shall be reviewed for medical necessity under the EPSDT requirement, as defined at Section 8.280.1.

2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to medical necessity, cannot include services that are available under other Colorado Medicaid benefits for which the client is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; HCBS Personal Care, Section 8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that client safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.

3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the medical necessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

8.520.8.E. Home Health Telehealth Services

1. Home Health Telehealth services require prior authorization.

2. The Home Health Telehealth PAR shall include all of the following:

   a. A completed enrollment form;

   b. An order for telehealth monitoring signed and dated by the Ordering Practitioner or podiatrist;

   c. A Plan of Care, which includes nursing and therapy assessments for clients. Telehealth monitoring shall be included on the CMS-485 form, or a form that contains identical information to the CMS-485, and all applicable forms shall be complete; and

   d. For ongoing telehealth, the agency shall include documentation on how telehealth data has been used to manage the client's care, if the client has been using Home Health Telehealth services.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.2 BENEFITS

8.540.2.A. Beginning November 1, 2021, providers must submit a prior authorization request for all new PDN services ~~do not require prior authorization~~. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.

2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.

3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day.

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.

8.540.7 PRIOR AUTHORIZATION PROCEDURES

8.540.7.A. The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.

8.540.7.B. The PAR shall be approved for up to six months for a new client and up to one year for ongoing care depending upon prognosis for improvement or recovery, according to the medical criteria.

8.540.7.C. The PAR information shall:

1. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.

2. Be submitted with the plan of care that:

    a. Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed.

    b. Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.

    c. Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.

    d. Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

3. Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.

4. Cover a period of up to one year depending upon medical necessity determination.

5. Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it.

6. Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.

7. Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall

notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency.

8. Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.

8.540.7.D. The URC shall review PARs according to the following procedures:

1. Review information provided and apply the medical criteria as described herein.

2. Return an incomplete PAR to the Home Health Agency for correction within ~~seven~~ ten working days of receipt.

3. Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR.

4. Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.

5. Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.

6. Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.

7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.

8. Notify the submitting party of all PAR approvals.

9. Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.

8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.

8.540.7.G. ~~Claims for O~~For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client.

1. Ten percent (10%) of PARs must be submitted by November 30, 2021;

2. An additional 10% of PARs must be submitted by December 31, 2021;

3. An additional 10% of PARs must be submitted by January 31, 2022;

4. An additional 10% of PARs must be submitted by February 28, 2022;

5. An additional 10% of PARs must be submitted by March 31, 2022;

6. An additional 10% of PARs must be submitted by April 30, 2022;

7. An additional 10% of PARs must be submitted by May 31, 2022;

8. An additional 10% of PARs must be submitted by June 30, 2022;

9. An additional 10% of PARs must be submitted by July 31, 2022;

~~1.~~10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.