

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF COLORADO

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LIMITATIONS TO CARE AND SERVICES

I. Inpatient Hospital Services are benefits with the following limitations:

- (1) Inpatient hospital dialysis treatment is a benefit for inpatient clients only in these cases:
 - (a) hospitalization is required for an acute medical condition for which emergency dialysis treatments are required; or
 - (b) the client is admitted to the hospital for a non-related medical condition, and needs to receive the regular maintenance treatment that is usually received in an outpatient dialysis program; or
 - (c) placement or repair of the dialysis route (shunt or cannula).
- (2) Services that are defined as experimental by the U.S. Food and Drug Administration are not benefits.

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2. Outpatient Hospital Services

Routine and annual physical examinations are not provided unless determined to be medically necessary based upon a medical diagnosis, complaint or symptom.

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4.b EPSDT Program

A. Medically necessary services not otherwise provided under the State Plan but available to EPSDT participants include:

- Other necessary health care, diagnostic treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screening service will be provided when medically necessary to EPSDT participants.
- Under EPSDT, medically necessary organ transplants are provided when not experimental or investigational, and when alternative, less costly treatments have been trialed or determined ineffective.

B. Medically necessary services not otherwise provided under the State Plan but available to EPSDT participants include:

- Preventive services including fluoride varnish
- Restorative services
- Diagnostic services (radiology/diagnostic imaging/oral pathology) that are medically and dentally necessary
- Periodontics
- Endodontics
- Oral and maxillofacial surgery
- Orthodontics
- Dentures

Dental services are available for individuals age 20 and under that prevent and abate tooth decay, restore dental health and are medically necessary. Some of these services may require prior authorization. The Department authorizes additional service if:

- the proposed services are medically appropriate and
- the proposed services are more cost effective than alternative services.

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- C. Services provided by Colorado state licensed dental hygienist.
- Licensed dental hygienists may render services as defined by the scope of practice of their license issued by the Department of Regulatory Agencies (DORA).
 - Dental hygienists employed by a dentist, clinic or institution cannot receive direct reimbursement.
 - Unsupervised dental hygienists as defined by DORA may bill Medicaid for the following preventive dental services for clients age 20 and under: prophylaxis, fluoride, oral hygiene instructions, sealants and periodic evaluations.

A list of approved procedure codes and policy limitations for dental providers will be updated in conjunction with the American Dental Association's biannual publication of the Current Dental Terminology (CDT) codes on dental procedures and nomenclature and will be posted on the Department's Web site as a provider bulletin.

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4b.(I) School Health Services Program Benefits

School-based services, known as School Health Services (SHS) or Medicaid Extended Health Services (MESH) in Colorado, are delivered by the school districts, boards of cooperative educational services (BOCES) and K-12 educational institutions (herein after referred to as "providers" for this section of the State Plan). Providers deliver services to Medicaid-eligible beneficiaries under the age of 21, as included in the Medicaid statute (section 1905(a) of the Act) and as described in the Code of Colorado Regulations, 10 CCR 2505-10, Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance and Colorado Revised Statutes (C.R.S. 25.5-5-318. Health Services – Provision by School Districts). Services are delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client. Participation by Medicaid-eligible recipients is optional.

A. Qualified Providers

Services may be performed in the school, at the client's home or at another site in the community by qualified personnel or a qualified health care professional. Qualified personnel must meet State Education Agency-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice. A qualified health care professional is defined as an individual who is registered, certified or licensed by the Department of Regulatory Agencies as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional must be registered or certified by the relevant national professional health organization and must be allowed to practice if the provider is qualified per State law.

B. Medical Necessity

A medically necessary service is a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the child's needs. Medical necessity is determined as the result of a service furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, by a qualified health professional operating within the scope of his/her practice.

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Where required by Medicaid regulations, a qualified licensed practitioner of the healing arts must refer a child for services. Services are provided in accordance with the client's individual need and are not subject to any arbitrary limitations as to scope, amount or duration.

C. Free Choice of Providers

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services. School health services will be made available to all Medicaid eligible targeted recipients and shall be delivered by any participating qualified provider on a statewide basis with procedures to ensure continuity of services without duplication and in compliance with federal and state mandates and regulations related to serving the targeted population in a uniform and consistent manner.

II. School Health Services and Qualified Providers

A. Physician Services

Definition:

Physician services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary. Physician services are provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health related condition.

Physician Services include:

1. Evaluation and consultation with providers of covered services for diagnostic and prescriptive services including participation in a multi-disciplinary team assessment.
2. Record review for diagnostic and prescriptive services.

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3. Diagnostic and evaluation services to determine a beneficiary's medically related condition that results in the beneficiary's need for Medicaid services.

Physician services may be provided only in an individual setting.

Providers:

Physician services must be provided by a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) or a psychiatrist who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed physician (MD or DO);
- A currently Colorado-licensed psychiatrist.

B. Nursing Services

Definition:

Nursing services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Services considered observational or stand-by in nature are not covered. Medical policy will follow the current Colorado Nurse Practice Act scope of practice guidelines for nursing practices.

Services

Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse or Licensed Practical Nurse, provided during a face-to-face encounter and provided on a one-to-one basis. Medically necessary nursing services are health care, diagnostic services, treatments and other measures to identify, correct, reduce, cure or ameliorate the pain and suffering, or

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the physical, mental, cognitive or developmental effects of an illness, injury or disability.

Providers:

Nursing services must be provided by a qualified nurse who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed registered nurse;
- A currently Colorado-licensed practical nurse.

Nursing services may be delegated in accordance with 42 CFR § 440.130(d) and according to the delegation clause in Section 12-38-132, C.R.S. of the Colorado Nurse Practice Act to the following:

- A currently Colorado-qualified Nurse Aide or Health Technician.

The delegating nurse shall provide all training to the delegate for delegated activities and is solely responsible for determining the required degree of supervision the delegate will need.

C. Personal Care Services

Definition:

Personal care services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Services must be authorized by a physician in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State.

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Services:

Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands on assistance or cueing so that the person performs the task by him/herself.

Providers:

Personal care services must be provided by a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client.

Services may be provided by:

- A currently Colorado-licensed registered nurse;
- A currently Colorado-licensed practical nurse;
- A currently Colorado-qualified Nurse Aide;
- A qualified Health Technician
- Special Education Teacher
- Special Education Teacher's Aide
- Child Care/Group Leader
- Teaching Assistant
- Bus Aide

D. Psychological, Counseling and Social Work Services

Definition:

Psychological, Counseling and Social Work services are medically necessary services documented in the student's IEP/IFSP, which documents the planning, managing, and provision of a program of face-to-face services for Medicaid eligible beneficiaries under the age of 21, with diagnosed psychological or behavioral conditions. Medically necessary services must require the skills, knowledge and education of a physician, psychiatrist, psychologist, counselor or social worker to provide treatment.

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Services:

Medically necessary services are health care, diagnostic services, treatments and other measures to identify, correct or ameliorate any disability and/or chronic condition. Services are provided as health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical and mental health problems. These services are intended for the benefit of the Medicaid eligible beneficiary.

Psychological, Counseling and Social Work services may be provided in an individual or group setting.

Providers:

- Qualified providers who meet the requirements of, and in accordance with, 42 CFR § 440.50 and 42 CFR § 440.60(a) and other applicable state and federal law or regulation, a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50 and other applicable state and federal law or regulation, a qualified counselor who meets qualification requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation or a qualified Social Worker who meets qualification requirements of, and in accordance with 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed Psychologist (Doctoral level);
- A currently Colorado-licensed Psychiatrist;
- A currently Colorado-licensed Physician (MD or DO);
- A currently Colorado-licensed Counselor;
- A currently Colorado-licensed Marriage and Family Therapist;
- A currently Colorado-licensed Social Worker (Master's level);
- A currently Colorado-licensed Clinical Social Worker (Master's level).

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E. Orientation, Mobility and Vision Services

Definition:

Vision, orientation and mobility training services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Medically necessary health services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition.

Services:

Orientation, mobility and vision services are evaluations and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision.

Providers:

Services must be provided by a Medicaid qualified provider in accordance with 42 CFR § 440.130(d) and other applicable state or federal law. Providers include:

- An Orientation and Mobility Specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

F. Speech, Language and Hearing Services

Definition:

Speech therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Medically necessary health services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition. Services must require the skills, knowledge and education of a qualified speech language pathologist (SLP) or audiologist.

Services:

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Speech and language services require a referral from a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services are necessary to diagnose, evaluate, treat, and provide for amelioration activities for specific speech, language and hearing disorders. Services include any necessary supplies and equipment. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

An assistive technology device (ATD) is defined as "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability" (IDEA, 1997, 20, USC, Ch. 33, Sec. 1401 [25] US).

Speech and language therapy services may be provided in an individual or group setting.

Providers:

Services must be provided by a Medicaid qualified provider in accordance with 42 CFR § 440.110 and other applicable state or federal law. Providers include:

- A qualified speech language pathologist possessing a current Certificate of Clinical Competence (CCC) certification from the American Speech-Language-Hearing Association (ASHA).
- A qualified audiologist with a master's or doctoral degree in audiology and possessing a current Certificate of Clinical Competence (CCC), certification from the American Speech-Language-Hearing Association (ASHA) or licensure from the Colorado Department of Regulatory Agencies.
- An appropriately supervised speech-language pathologist and/or audiology candidate (i.e., in his/her clinical fellowship year or having completed all requirements but has not yet obtained a CCC). A speech-language pathology or audiology candidate may only deliver services under the direction of a qualified therapist in accordance with 42 CFR § 440.110(c).

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All documentation must be reviewed and signed by the appropriately credentialed supervising SLP or audiologist;

- A qualified teacher of students with speech and language impairment with current Colorado Department of Education specialty certificate of endorsement for speech and language impairments when acting under the direction of a qualified SLP in accordance with 42 CFR § 440.110(c) and other applicable state and federal law.

G. Occupational Therapy

Definition:

Occupational therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Occupational therapy services must require the skills, knowledge and education of an Occupational Therapist Registered (OTR) or Certified Occupational Therapy Assistant (COTA) to provide services.

Services:

Occupational therapy (OT) services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services include any necessary supplies and equipment. Medically necessary services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and/or chronic condition. Services are provided to improve, develop, or restore functions impaired or lost through illness, injury, or deprivation. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

Occupational therapy services may be provided in an individual or group setting.

Providers:

Occupational therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR § 440.110(b) and in accordance with applicable state and federal law or regulation. Services may be provided by:

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- An occupational therapist currently registered (OTR) in Colorado and certified by the National Board for Certification in Occupational Therapy (NBCOT);
- A certified occupational therapy assistant (COTA) under the direction of a qualified therapist in accordance with 42 CFR § 440.110 (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OTR.

H. Physical Therapy

Definition:

Physical therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Physical therapy services must require the skills, knowledge and education of a currently Colorado-licensed Physical Therapist (LPT) or appropriately supervised Certified Physical Therapy Assistant (CPTA) to provide therapy.

Services:

Physical therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services include any necessary supplies and equipment.

Medically necessary services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition. Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD) or orthotic/prosthetic devices.

Physical therapy services may be provided in an individual or group setting.

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Providers:

Physical therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation. Services may be provided by:

- A currently Colorado-licensed physical therapist (LPT);
- A Colorado certified physical therapy assistant (CPTA) when the assistant is acting under the direction of a currently Colorado-licensed LPT in accordance with 42 CFR § 440.110. All documentation must be reviewed and signed by the appropriately licensed supervising LPT.

I. Specialized Transportation

Definition:

Specialized transportation services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the transportation services are medically necessary and documented in an IEP/IFSP.

Services:

Services must be provided on the same date of service that a Medicaid covered service, required by the student's IEP/IFSP, is received. Transportation must be on a specially adapted school bus to and/or from the location where the Medicaid service is received. Transportation services are not covered on a regular school bus unless an Aide for the transported student(s) is present and is required by the student's IEP/IFSP.

All specialized transportation services provided must be documented in a transportation log.

Providers:

Transportation services include direct services personnel, e.g. bus drivers, aides etc. employed or contracted by the school district.

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J. Targeted Case Management Services

Definition:

Targeted Case Management (TCM) services are activities, which will assist Title XIX eligible individuals, ages 0-21, who have a disability or who are medically at risk, in gaining access to services pursuant to an IEP/IFSP. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. Medically at risk refers to individuals who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social or physical development.

Activities:

Targeted Case Management (TCM) activities are a component of the IEP/IFSP treatment plan. TCM identifies special health problems and addresses needs that affect the student's ability to learn, assist the child to gain and coordinate access to a broad range of medically necessary services covered under the Medicaid program, and ensures that the student receives effective and timely services appropriate to their needs. TCM activities shall not restrict or be used as a condition to a client's access to other services under the state plan.

Recipients of TCM activities are eligible for the entire span of activities described as school health services in the Colorado Medicaid State Plan. A unit of service is defined as each completed 15-minute increment that meets the description of a case management activity with or on behalf of the individual, his or her parent(s) or legal guardian.

TCM activities include the following activities:

- Comprehensive Needs Assessment and Reassessment;
- Development and Revision of Care Plan;
- Referral and Related Activities;
- Monitoring and Follow-Up Activities;
- Case Record Documentation.

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1. Comprehensive Needs Assessment and Reassessment

Reviewing the individual's current and potential strengths, resources, deficits and identifying the need for medical, social, educational and other services that are related to Medicaid-covered services. If necessary to form a complete assessment of the client, information shall be gathered from other sources, such as family members, medical providers, social workers, and educators. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and/or guardian, and the case manager to determine whether services are needed and, if so, to develop a specific care plan. At minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.

2. Development and Revision of Care Plan

Developing a specific written care plan based on the assessment of the individual's strengths and needs. The written care plan shall be a distinct component of the IEP or IFSP and shall identify the health-related activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parent(s) or legal guardian, and the case manager. The care plan shall describe the amount, duration and scope of TCM activities. Service planning may include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Referral and Related Activities

Facilitating the individual's access to the care, services and resources needed through linkage, coordination, referral, and consultation. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services that are related to Medicaid-covered services; facilitating communication

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between the individual, his or her parent(s) or legal guardian and the case manager or other service providers; or, arranging for translation or another mode of communication. It may include advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual.

4. Monitoring and Follow-Up Activities

As necessary, but at least annually, the case manager shall conduct monitoring and follow-up activities with the client or the client's legal representative. Monitoring and follow-up activities are necessary to insure the care plan is effectively implemented and adequately addresses the needs of the client. The review of the care plan may result in revision or continuation of the plan, or termination of case management services if they are no longer appropriate. Monitoring may involve either face-to-face or telephone contacts with the individual and other involved parties. Results of the monitoring and follow-up shall be documented in the care plan.

5. Case Record Documentation

Case record documentation of the above service components is included as a case management activity. Providers shall maintain case records that document for all individuals receiving TCM, the dates of service; the nature, content and units of TCM services received; status of goals specified in care plan; whether client declined services in care plan; the need for and coordination with other case managers; a timeline for obtaining needed services and a timeline for reevaluation of the care plan.

SHS Program Targeted Case Management activities do not include:

- Activities related to the development, implementation, annual review and triennial review of IEP documents, that are the inherent responsibility of the Colorado Department of Education;

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- Activities related to IDEA functions such as scheduling IFSP team meetings, and providing prior written notice;
- Activities or interventions specifically designed to only meet the student's educational goals;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an IEP or IFSP;
- Program activities of the agency itself that do not meet the definition of targeted case management;
- Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to targeted case management;
- Treatment or instructional services, including academic testing;
- Services that are an integral part of another service already reimbursed by Medicaid; and
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

Providers:

The targeted case management provider must meet state or national licensure, registration, or certification requirements of the profession in which they practice and must act within the profession's scope of practice. Targeted case managers who also provide direct services will not self-refer for the provision of direct services. Additionally, only those TCM providers who bill TCM throughout the school year will be included on the cost reporting forms to ensure the appropriate cost allocation for reimbursement purposes.

Targeted case management activities may be provided by any willing qualified provider pursuant to 1902(a)23 of the Social Security Act. Additionally, a provider that meets the qualifications established by the State's licensure act for educators as special service providers who develop and implement Individualized Plans for services under the Individuals with Disabilities Education Act (IDEA) may also provide targeted case management activities. State Education Agency (SEA) providers must hold a Colorado Department of Education Professional, Provisional or Alternative Teacher License with an appropriate endorsement in

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special education. Individuals providing special education services through Temporary Teacher Eligibility (TTE) under 3.04(2) of the Rules for the Administration of the Exceptional Children's Education Act (ECEA) are considered qualified to provide Medicaid Targeted Case Management activities.

TCM activities may be provided by:

- A currently Colorado-licensed Physician (MD or DO);
- A currently Colorado-licensed Psychiatrist;
- A currently Colorado-licensed Registered Nurse;
- A currently Colorado-licensed Practical Nurse;
- A currently Colorado-qualified Nurse Aide;
- A qualified Health Technician;
- A qualified Special Education teacher with current Colorado Department of Education Professional, Provisional or Alternative Teacher License;
- A Special Education Teacher's Aide;
- A Child Care/Group Leader;
- A Teaching Assistant;
- A Bus Aide;
- A currently Colorado-licensed Psychologist (Doctoral level);
- A currently Colorado-licensed Counselor;
- A currently Colorado-licensed Marriage and Family Therapist;
- A currently Colorado-licensed Social Worker (Master's level);
- A currently Colorado-licensed Clinical Social Worker (Master's level);
- A Teacher of students with speech and language impairment possessing a Colorado Department of Education Specialty Certificate;
- An ACVREP-certified Orientation and Mobility Specialist;
- A qualified Speech Language Pathologist possessing a current Certificate of Clinical Competence (CCC) certification from the American Speech-Language-Hearing Association (ASHA);
- A qualified Audiologist with a Master's or Doctoral degree in audiology and possessing a current Certificate of Clinical Competence (CCC), certification from the American Speech-Language-Hearing Association (ASHA) or licensure from the Colorado Department of Regulatory Agencies;
- A supervised Speech Language Pathologist Candidate;

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SCHOOL HEALTH SERVICES PROGRAM
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SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

- A supervised Audiologist Candidate;
- An Occupational Therapist currently registered (OTR) in Colorado and certified by the National Board for Certification in Occupational Therapy (NBCOT);
- A supervised NBCOT-Certified Occupational Therapy Assistant;
- A currently Colorado-licensed Physical Therapist (LPT); and
- A supervised Certified Physical Therapy Assistant.

Choice of Providers:

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services.

TCM activities shall be delivered by any participating qualified provider on a statewide basis with procedures to ensure continuity of services without duplication and in compliance with federal and state mandates and regulations related to serving the targeted population in a uniform and consistent manner.

Non-Duplication of Services:

To the extent that any of the services required by the client are a Title XIX benefit of a managed care organization of which the client is a member, the School Health Service provider will ensure that timely referrals are made and that coordination of care occurs.

TCM will not be billed for activities that are components of direct services. Additionally, targeted case management activities will not be duplicative of activities that are components of the administration of the Individuals with Disabilities Education Act (IDEA). The State assures that it will not seek federal matching for case management activities that are duplicative.

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Supplement to Attachment 3 IA

4 d Tobacco Cessation Counseling Services for Pregnant Women

1. Allowable Providers

Face-to-face tobacco cessation counseling services for pregnant women are provided

(i) By or under supervision of a physician,

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations

*describe any limits on who can provide these counseling services:

All providers are required to complete a tobacco cessation counseling training course in order to deliver tobacco cessation counseling to pregnant women. This training course requirement applies to both the practitioner who is furnishing the service directly, and the provider who is supervising others who are furnishing the service

2. Service Limitations

- **Intermediate Counseling:** A maximum of five units per year of tobacco use cessation counseling in an individual setting. Each unit is greater than three minutes and up to ten minutes long
- **Intensive Counseling:** A maximum of three units per year of tobacco use cessation counseling in an individual or group setting. Each unit is greater than ten minutes long

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LIMITATIONS TO CARE AND SERVICES

- 5.a. Physician's services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Adult clients are limited to one routine annual physical examination per state fiscal year.

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LIMITATIONS TO CARE AND SERVICES

5b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act.)

Medical services are a benefit when determined to be medically necessary as based upon a medical diagnosis.

Surgical services including dental splints or other devices are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones.

Emergency treatment can be provided to an adult client who:

- Presents with an acute condition of the oral cavity that requires hospitalization and or immediate surgical care.
- Presents with a condition of the oral cavity that would result in acute hospital medical care and or subsequent hospitalization if no immediate treatment is rendered.

Emergency treatment provided to an adult client includes, but is not limited to:

- Immediate treatment or surgery to repair trauma to the jaw.
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity.
- Repair of traumatic oral cavity wounds.
- Anesthesia services ancillary to the provision of emergency treatment.

Additional non-emergent procedures are available for adult clients with a documented concurrent medical condition. Allowable concurrent medical conditions include:

- neoplastic disease requiring chemotherapy and/or radiation
- pre organ transplant
- post organ transplant
- pregnancy
- chronic medical condition in which there is documentation that the medical condition is exacerbated by a condition of the oral cavity.

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Dental procedures for adults with a concurrent medical condition may include:

- clinical oral evaluations
- radiographs
- test and laboratory examinations,
- periodontal and non-periodontal surgical procedures
- extractions
- biopsy
- removal of lesions, tumors, cysts and neoplasms
- treatment of fractures
- management of temporomandibular joint dysfunction
- repair procedures
- anesthesia and professional consultation

Both the dental and medical provider must provide documentation that the concurrent medical condition is exacerbated by the condition of the oral cavity.

The following services/treatments are not a benefit for adult clients under any circumstances:

- preventive services to include prophylaxis
- fluoride treatment and oral hygiene instruction
- treatment for dental caries, gingivitis and tooth fractures
- restorative and cosmetic procedures including but not limited to inlay and onlay restorations, crowns, treatment of the oral cavity in preparation for partial or full mouth dentures and assessment for the delivery of dentures or subsequent adjustments to dentures and bridges.

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LIMITATIONS TO CARE AND SERVICES

6.b. Ophthalmologist or Optometrist Services

- A. These are services for clients ages 21 and over. These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.
- 1) Diagnostic eye examinations, when medically necessary to diagnose, manage, or treat a client with signs or symptoms of injury or disease of the eye.
 - 2) Determination of the refractive state (an exam to test for visual acuity and the need for corrective lenses), only in these situations:
 - a.) As part of the diagnostic eye exam described in (1).
 - b.) After eye surgery.
- B. These are the services for clients ages 20 and younger (EPSDT program). These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.
- 1) Routine vision screening and diagnostic eye exams.
 - 2) Orthoptic vision treatment services, with prior authorization.

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LIMITATIONS TO CARE AND SERVICES

6.d. Other practitioners' services.

The following services are provided:

1. Services provided by State licensed psychologists.
2. Services provided by Certified Registered Nurse Anesthetists.
3. Services provided by Clinical Nurse Specialists.
4. Services provided by Physician Assistants.

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Services

Limitations

6.d Medication Therapy Counseling

1. The Department will contract with qualified pharmacists to perform a medication therapy counseling session with eligible Medical Assistance Program clients.
2. The medication therapy counseling sessions are intended to
 - i) Achieve drug therapy treatment goals;
 - ii) Minimize undesirable medication effects;
 - iii) Improve client medication adherence;
 - iv) Enhance medication safety; and
 - v) Reduce health expenditures.
3. The counseling session must be conducted face-to-face unless the client is unable or refuses to meet in person or lives outside of a reasonable travel distance from the consulting pharmacist, then the counseling session may be conducted by telephone.
4. The Department shall distribute the pharmacist's report documenting the counseling session to the client and client's providers.

Client Eligibility and Selection

1. The medication therapy counseling sessions are available to fee-for-service Medical Assistance Program clients. participation is voluntary
2. Clients must have paid claims for at least five medications in three consecutive months.
3. Clients may receive only one counseling session per year.
4. Eligible clients are identified through a data query performed by the Department or
5. Complex clients may be referred to the Department for inclusion in the program by a licensed, practicing physician, advanced practice nurse or physician's assistant.
6. The Department refers eligible clients who meet medical necessity criteria to participating pharmacists.
7. The Department shall send a letter to selected clients that states the service, indicates participation is voluntary and names the pharmacist who will be contacting them to schedule the counseling session.

Pharmacist Duties

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Limitations

1. Review the client's profile provided by the Department.
2. Contact the client to schedule a mutually agreeable location and time for the counseling session.
3. During the course of the counseling session, the pharmacist shall.
 - i) Review the client's profile with the client for accuracy and inquire as to any additional medications, providers or disease states;
 - ii) Perform a medication review to identify, resolve and prevent medication related problems; and
 - iii) Provide education and training designed to enhance the client's understanding and appropriate use of the client's medications and compliance with their therapeutic regimen.
4. Draft and submit a report to the Department which documents the counseling session and includes recommended changes to the client's medication therapy and any other information providers may find relevant to the appropriate treatment of the client's health.

Pharmacist Qualifications

1. Participating pharmacists must have and maintain an unrestricted license in good standing to practice pharmacy in Colorado; and
2. Maintain liability insurance; and
3. Meet one of the following qualifications:
 - i). Proof of completion of a pharmacy practice residency accredited by the American Society of Health Systems Pharmacists or the American Pharmaceutical Association in the specialty being practiced; or
 - ii) Completion of a certificate program accredited by the Accreditation Council for Pharmacy Education in each area of practice, and 40 hours of onsite supervised clinical practice and training in each area in which the pharmacist is choosing to practice; or
 - iii) Completion of at least 40 hours of ACPE approved continuing education regarding clinical practice and 40 hours of onsite supervised clinical practice and training in the area in which the pharmacist is choosing to practice; or
 - iv) Current Board specialty certification from the Board of Pharmaceutical Specialties, current certification from the

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- National Institute for Standards in Pharmacist Credentialing, or current certification from the Commission for Certification in Geriatric Pharmacy. Such credentials must be in the area of pharmacy practice undertaken in the drug therapy management; or
- v) All of the following criteria shall be met in order to practice drug therapy management:
- (1) Forty (40) hours of onsite supervised clinical practice and training in the area(s) in which the pharmacist is choosing to practice;
 - (2) Documented competency of each area of practice in which the pharmacist is choosing to practice.

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LIMITATIONS TO CARE AND SERVICES

7 Home Health Services

A Service Limitations

- 1 Acute Home Health shall be assessed for medical necessity and is provided during a 60 calendar day episode
- 2 Long Term Home Health is provided for 61 calendar days or longer for chronic conditions. Medicaid clients receiving Long Term Home Health shall be assessed for medical necessity and services shall be prior authorized by the State designated agency
- 3 All services provided by a home care agency must be medically necessary and under a physician's order as part of a written plan of care, reviewed every 60 days, indicating the amount, duration and scope of the home care services the client can receive
- 4 Sample post-pay review applies to all Home Health services
- 5 Effective January 1, 2000, maximum daily reimbursement limits are set for long term home health and for acute home health. These maximum reimbursement limits are based upon type and cost of long term home health services (primarily aide visits) and acute home health services (primarily nursing visits). These maximums will be adjusted in accordance with rate changes.

B Services

a Skilled nursing services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
b Home health aide services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
c Physical therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home Health
d Occupational therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home

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EFFECTIVE DATE October 1, 2011

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7 Home Health Services

e Speech/language pathology services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home
f Home health telehealth services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
g Medical supplies, equipment and appliances suitable for use in the home	Provided to Medicaid clients for use in the home

C Provider Qualifications

- I Physical therapists and Speech therapists are licensed by the State of Colorado
 - i Physical therapists must meet the provider qualifications for Medicaid found at 42 CFR 440 110
 - ii Speech therapists must meet the provider qualifications for Medicaid found at 42 CFR 440 110
- 2 Occupational therapists are not licensed in Colorado but must be registered at the Colorado Department of Regulatory Agencies (DORA)
 - i Occupational therapists must meet the provider qualifications for Medicaid found at 42 CFR 440 110

D All Home Care agencies are required to meet the conditions of participation in Medicare found at 42 CFR 484

E Provider Choice

- I Clients are free to choose from any qualified Colorado Medicaid provider

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42 CFR 440.80

State of Colorado

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LIMITATIONS TO CARE AND SERVICES

8. Private Duty Nursing Services

Private Duty Nursing is face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the Home Health benefit or routinely provided in a hospital or nursing facility. Private Duty Nursing is provided in the home, or outside of the home when normal life activities take the client away from the home. Private Duty Nursing shall not be reimbursed in a hospital or nursing facility. Private Duty Nursing services provided to eligible clients shall be provided through Medicaid licensed Home Health agencies.

To be eligible for Private Duty Nursing, a Medicaid client must meet medical necessity criteria.

Private Duty Nursing services are provided by a registered nurse or a licensed practical nurse; under the direction of the recipient's physician.

Private Duty Nursing services may be provided by one nurse to more than one client at the same time, in the same setting, at a reduced rate.

The amount of Medicaid-reimbursed Private Duty Nursing per day may not exceed the hours that are determined necessary under the medical criteria up to sixteen hours per day.

For EPSDT clients, Private Duty Nursing will be provided up to the amount of medical need.

All Private Duty Nursing services must be prior authorized.

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LIMITATIONS TO CARF AND SERVICES

9. CLINIC SERVICES

Provided in a licensed community mental health center or clinic.

Provided by a certified public health agency. "Certified health agency" means a county/district or regional health department or local board of health established under state law that is certified by the Colorado Department of Public Health and Environment. Services provided must be medically necessary and include obstetric services and/or EPSDT medical screening services. Services must be provided by or under the direction of a physician.

Provided in an ambulatory surgery center that has an agreement with the Centers for Medicare and Medicaid Services under Medicare to participate as an ambulatory surgery center and meets the conditions set forth in the Act. Covered surgical procedures are those groupings of surgical procedures approved by the Centers for Medicare and Medicaid Services. Additional surgical procedures may be included as approved by the Department of Health Care Policy and Financing.

Drug and alcohol treatment provided to a pregnant woman with a substance use disorder who is at risk of a poor birth outcome. Approved services must be provided in a facility which is not part of a hospital but is organized and operated as a free-standing alcohol or drug treatment program approved and certified by the Division of Behavioral Health of the Colorado Department of Human Services or in a facility which is not a part of a hospital but is organized and operated as a school-based clinic. Allowable services include risk assessment, case management, drug/alcohol individual and group therapy, and health maintenance group.

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LIMITATIONS TO CARE AND SERVICES

10 Dental Services

Dental services for adults age 21 and over are limited to the following categories of service and may require prior authorization:

- a. Routine diagnostic and preventive services:
 - 1. Prophylaxis
 - i. Adult cleaning, two per twelve months
 - 2. Examinations
 - 3. Radiographs
 - i. Bitewings, one set (2-4 films) per twelve months.
 - ii. Intra-oral; complete series, one per sixty months.
 - iii. Panoramic image; with or without bitewings, one per sixty months.
- b. Restorative services
- c. Endodontic services
- d. Periodontal services

For clients under 21 years of age, dental services are provided in accordance with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) service category. See Supplement to Attachment 3.1-A, section 4b.

Dental services for adults 21 years of age and older, except for services for the immediate relief of severe pain, alleviation of acute infection, or necessary because of trauma, are limited to a total of \$1,000 per adult Medicaid recipient per state fiscal year.

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LIMITATIONS TO CARE AND SERVICES

11 PHYSICAL THERAPY AND RELATED SERVICES

11a Physical therapy

- Services shall be provided by a licensed physical therapist who is an approved Medicaid provider, or a physical therapist assistant under the general supervision of a licensed physical therapist
- A medical prescription for services is required and the service/procedure must be a covered benefit of the Medicaid program.
- Clients ages 21 and over are limited to 48 units of any combination of physical and occupational therapy per 12-month period For clients ages 20 and under, prior authorization is required after 48 units of any combination of physical and occupational therapy per 12-month period A unit is defined by the current procedural terminology (CPT) code
- A prior authorization request shall be effective for a length of time that is determined medically necessary, not to exceed a maximum of 12 months
- Services shall be provided in accordance with 42 CFR 440 110.

11b Occupational therapy

- Services shall be provided by a registered occupational therapist who is an approved Medicaid provider or an occupational therapy assistant under the general supervision of a registered occupational therapist.
- A medical prescription for services is required and the service/procedure must be covered benefit of the Medicaid program.
- Clients ages 21 and over are limited to 48 units of any combination of physical and occupational therapy per 12-month period For clients ages 20 and under, prior authorization is required after 48 units of any combination of occupational and physical therapy per 12-month period A unit is defined by the current procedural terminology (CPT) code.
- A prior authorization request shall be effective for a length of time that is determined medically necessary, not to exceed a maximum of 12 months
- Services shall be provided in accordance with 42 CFR 440 110

11c Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech-language pathologist or audiologist)

- Audiology services shall be provided by a licensed audiologist or an audiologist's aide An audiologist's aide is a person who, after appropriate training and demonstrated

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competency, performs tests that are prescribed, directed, and supervised by a licensed audiologist as recommended by the American Academy of Audiology

11 c Services for individuals with speech, hearing, and language disorders (continued)

- Speech-language pathology services may be provided by any of the following
 - A certified speech-language pathologist with a current certification by the American Speech-Language-Hearing Association,
 - A clinical fellow under the general supervision of an ASHA-certified speech-language pathologist,
 - A speech-language pathology assistant A speech-language pathology assistant is a person who has an associate's degree from a technical training program in speech-language pathology assistants' scope of work as recommended in ASHA guidelines
- A medical prescription for services is required and the service/procedure must be a covered benefit of the Medicaid program
- Speech-language pathology services are limited to five units per date of service A unit is defined by the current procedural terminology (CPT) code
- Diagnostic procedures provided by an audiologist for the purpose of determining general hearing levels or for the distribution of a hearing device are not a covered benefit, except for the EPSDT population.
- Speech-language pathology services provided for simple articulation or academic difficulties that are not medical in origin are not a covered benefit

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12.a. Prescribed Drugs

1. Only those drugs designated by companies participating in the federally approved Medicaid drug rebate program and not otherwise excluded according to the Department's rules are regular drug benefits, with the following exceptions:
 - a. Brand name drugs not covered by rebate agreements are a covered benefit if the Department has made a determination that the availability of the drug is essential, such drug has been given an "A" rating by the Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are a regular drug benefit may be restricted as set forth in the Department's rules.
 - b. Only those investigational drugs that are specifically named in the state plan are a covered benefit.
2. Restrictions, including prior authorizations, may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, over-utilization, other inappropriate utilization or the availability of more cost-effective alternatives. The prior authorization process provides for a turn-around response by telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication.
3. Erectile dysfunction drugs will only be covered for FDA approved indications other than erectile or sexual dysfunction
4. Generic drugs shall be prescribed to clients in the fee-for-service program unless
 - a. Only a brand name drug is manufactured.
 - b. A generic drug is not therapeutically equivalent to the brand name drug.
 - c. The final cost of the brand name drug is less expensive to the Department
 - d. The drug is used for the treatment of
 - 1) Biologically based mental illness as defined in C.R.S. 10-16-104 (5.5).
 - 2) Treatment of cancer;
 - 3) Treatment of epilepsy, or
 - 4) Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
 - e. The client has been stabilized on a brand name medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive

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- f. The client has taken a generic drug but is unable to continue treatment on the generic drug
 - g. A client requests a brand name drug for a prescription and none of the above-listed exceptions apply. In that case, the client may pay the allowed ingredient cost difference between the generic drug and the brand name drug.
 - h. Any exceptions to the generic drug requirement shall be granted in accordance with procedures established by the Department.
- 5 The following are not pharmacy benefits of the Medical Assistance Program
- a. Spirituous liquors of any kind,
 - b. Dietary needs or food supplements unless prior authorized within Department guidelines;
 - c. Personal care items such as mouthwash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc ,
 - d. Medical supplies;
 - e. Drugs classified by the FDA as "investigational" or "experimental," except for the following:
 - 1. Stiripentol and clobazam (prior to availability of Onfi in the US) may qualify for coverage (generic coverage, if available, brand coverage if no generic is available) for clients up through age 20, if the coverage has been ordered by the child's physician, has been determined medically necessary by the Colorado Medical Assistance Program Medical Director (or clinical appointee of the Executive Director), and has been authorized for the specific child's use by the U.S. Food & Drug Administration
 - f. Less-than-effective drugs (LTE) identified by the Drug Efficacy Study Implementation (DESI) program.
-
- 6 Injectable drugs, allergen extracts, infusion drugs and immunizations administered in a physician's office are considered part of the physician's services and not a pharmacy benefit. However, a licensed physician who prepares, dispenses and instructs patients to self-administer medications and whose offices are located more than twenty-five miles from the nearest participating pharmacy may be reimbursed for drugs that are dispensed from the offices for self-administration by the patient

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Limitations

12.a Prescribed Drugs

6. Pursuant to 42 U.S.C. Section 1396r-8, the Department is establishing a Preferred Drug List which indicates the Preferred and Non-preferred Drugs in selected therapeutic drug classes. Those products within a selected therapeutic drug class that are designated Non-preferred will require prior authorization. All drugs covered by the National Drug Rebate Agreements remain available to Medical Assistance Program clients, though some drugs may require prior authorization. The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927(d)(5) of the Social Security Act. The Department will appoint a Pharmacy and Therapeutics Committee and utilize the Drug Utilization Review Board in accordance with Federal Law.
7. CMS has authorized the state of Colorado to enter into the Colorado Medicaid Supplemental Drug Rebate Agreement for drugs provided to the Medical Assistance Program. This supplemental drug rebate agreement was submitted to CMS on November 2, 2007 and has been authorized by CMS. Any additional versions of the rebate agreements negotiated between the state and manufacturer(s) after November 2, 2007 will be submitted to CMS for authorization. The Department may collect supplemental rebates from drug manufacturers for Preferred Drugs. Supplemental rebates received by the Department in excess of those required under the National Drug Rebate Program will be shared with the Federal government on the same percentage basis as applied under the National Drug Rebate Agreement. All drugs covered by the Medical Assistance Program, irrespective of a supplemental rebate agreement, will comply with the provisions of the National Drug Rebate Agreement. The unit rebate amount is confidential and cannot be disclosed except in accordance with Section 1927(b)(3)(D) of the Social Security Act.

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LIMITATIONS TO CARE AND SERVICES

Citation	Provision
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	<p>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit- Part D.</p> <p><input checked="" type="checkbox"/> The following excluded drugs are covered</p> <p><i>("All" drugs categories covered under the drug class)</i> <input type="checkbox"/></p> <p><i>("Some" drugs categories covered under the drug class -List the covered-common drug categories not individual drug products directly under the drug class)</i> <input checked="" type="checkbox"/></p> <p><i>("None" of the drugs under this class are covered)</i> <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> (a) agents when used for anorexia, weight loss or weight gain. Only Xenical. Prior authorization is required</p> <p><input type="checkbox"/> (b) agents when used to promote fertility</p> <p><input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth</p> <p><input checked="" type="checkbox"/> (d) agents when used for the symptomatic relief cough and colds. Products must include a cough suppressant. No other cough and cold products are covered. Prior authorization is required for clients 21 and older.</p>

TN No. 14-008
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- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride. Prior authorization required for all, except vitamin D products, which are covered without prior authorizations.
- (f) Nonprescription drugs, except insulin. Aspirin is covered without prior authorization. All other nonprescription drugs require prior authorization.
- (g) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

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12.b. Dentures

1. Complete and Partial Removable Prosthetics are a benefit for recipients age 21 and older based on medical necessity. Services consist of fabrication of complete or partial dentures and are subject to Prior Authorization Requests.
 - a. Complete Dentures are limited to one set every 7 years, includes initial 6 months of relines
 - b. Partial Dentures are limited to one set every 7 years

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12.c. Prosthetic Devices

May be prior authorized as
medically necessary for adult
clients and for clients of the
EPSDT Program.

TN 98-010

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Supercedes
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12.d. Eyeglasses and Contact Lenses

- A. These are services for clients ages 21 and over. These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider:
- 1) Standard eyeglasses (one or two single or multifocal clear lenses with one standard frame) following eye surgery only. When a client chooses eyeglass options with additional costs, the provider is permitted to charge the client for the remaining amount not paid by Medicaid.
 - 2) Eyeglasses with tint, anti-reflective coating, U-V coating, occluder, progressive lenses, and oversized lenses, following eye surgery only, with prior authorization.
 - 3) Contact lenses following eye surgery only, with prior authorization.
- B. These are the services for clients ages 20 and younger (EPSDT program). These services must be provided by a certified ophthalmologist or licensed optometrist who is an approved Medicaid provider.
- 1) Standard eyeglasses (one or two single or multifocal clear lenses with one standard frame). When a client chooses options with additional costs, the provider is permitted to charge the recipient for the remaining amount not paid by Medicaid.
 - 2) Replacement or repair of standard eyeglass frames or lenses. Repairs are not to exceed the cost of replacement.
 - 3) Contact lenses, with prior authorization. No prior authorization is required if the contact lenses are for vision correction after surgery.
 - 4) Ocular prosthetics, with prior authorization.

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Item 13.b Screening Services

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The purpose of SBIRT services is to screen clients for potential risky substance use behaviors. These services are not designed for treatment of clients already diagnosed with a substance abuse disorder or those already receiving substance abuse treatment services.

a. Covered Services

- i. Full Screening, using an evidence-based screening tool approved by the Department. The full screening is indicated for clients with positive pre-screens and for clients with signs, symptoms, and medical conditions that suggest risky substance use. There is a limit of 2 full screens per client per state fiscal year. Providers are required to use an evidence-based screening tool for the full screen.
- ii. Brief Intervention and Referral to Treatment. A brief intervention may be a single session or multiple sessions of motivational discussion focused on raising a client's awareness of a problem and motivating a client to change a health behavior. Brief intervention services are covered for clients who are identified as at-risk for a substance abuse disorder through the use of an evidence-based screening tool. Brief intervention services may occur on the same date of service as the screening or on a later date. A brief intervention may only be done after a positive full screen has been obtained. There is a limit of 4 sessions per client per state fiscal year. Each session is limited to 2 units per session, at 15 minutes per unit.

b. Eligible Providers

- i. The following licensed professionals are eligible to provide services or supervise staff who provide services:
 - Physician/Psychiatrist
 - Psychologist, Psy.D/Ph.D
 - Masters Level Clinicians:
 - Licensed Clinical Social Worker (LSCW): Provider has a Master's degree from an accredited graduate program offering full-time course work approved by the Council on Social Work Education and is licensed as an LCSW pursuant to CRS 12-43-404.
 - Licensed Marriage and Family Therapist (LMFT): Provider has a Master's degree from a graduate program with course work

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accredited by the Commission on Accreditation for Marriage and Family Therapy Education and is licensed as an LMFT pursuant to CRS 12-43-504.

- Licensed Professional Counselor (LPC): Provider has a Master's or doctoral degree in professional counseling from an accredited college or university and is licensed as an LPC pursuant to CRS 12-43-603.
- Nurse Practitioner
- Physician Assistant

ii. Non-licensed providers may deliver the SBIRT services under the supervision of licensed providers, if such supervision is within the legal scope of practice for that licensed provider. The licensed provider assumes professional responsibility for the services provided by the unlicensed provider. All non-licensed providers who deliver SBIRT services under the supervision of licensed providers must meet the following requirements:

- Complete a minimum of 60 hours professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of 4 hours of training that is directly related to SBIRT services.
- Complete a minimum of 30 hours of face-to-face client contact within their field. This may include internships, on-the-job training, or professional experience.

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Item 13.d Rehabilitative Services

Outpatient Behavioral Health Services

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary behavioral health services to certain Medicaid clients in order to restore these individuals to their highest possible functioning level. These services are provided to, or directed exclusively toward the treatment of the Medicaid client. Services are provided in accordance with Section 1902(a)(23) of the Social Security Act with regard to free choice of providers, and services may be provided by any willing, qualified provider as described below.

a. Covered Services, Definitions, and Qualified Providers.

Outpatient Behavioral Health Services are comprised of the following individual services and may be provided by the following qualified providers:

Service	Definition	Provider Types
Individual Psychotherapy	Therapeutic contact with one client of more than thirty (30) minutes, but no more than two (2) hours. This service, in conjunction with Individual Brief Psychotherapy, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505- 10, Section 8.282.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC * See definitions below
Individual Brief Psychotherapy	Therapeutic contact with one client of up to and including thirty (30) minutes. This service, in conjunction with Individual Psychotherapy, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC
Family Psychotherapy	Therapeutic contact of up to and including two (2) hours with one client, typically a child/youth, with one or more of the client's family members and/or caregivers present and included in the therapeutic process and communications.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC • RHC

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Service	Definition	Provider Types
Group Psychotherapy	Therapeutic contact with more than one client of up to and including two (2) hours.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC • RHC
Behavioral Health Assessment	An initial or ongoing diagnostic evaluation of a client to determine the presence or absence of a behavioral health diagnosis, to identify behavioral health issues that impact health and functioning, and to develop an individual service/care plan.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC • RHC
Pharmacological Management	Monitoring of medications prescribed and consultation provided to clients by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services as indicated.	<ul style="list-style-type: none"> • Physician/Psychiatrist • APN or PA with prescriptive authority • CMHC • RHC
Outpatient Day Treatment	Therapeutic contact with a client in a structured program of therapeutic activities lasting more than four (4) hours but less than 24 hours per day. Services include assessment and monitoring; individual/group/family therapy; psychological testing; medical/nursing support; psychosocial education; skill development and socialization training focused on improving functional and behavioral deficits; medication management; and expressive and activity therapies. When provided in an outpatient hospital program, may be called "partial hospitalization."	<ul style="list-style-type: none"> • CMHC • RHC • Hospital
Emergency/Crisis Services	Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to a crisis situation with a client, including associated laboratory services, as indicated.	<ul style="list-style-type: none"> • Physician/Psychiatrist • Psychologist, Psy.D/Ph.D • Master's Level Clinician • CMHC • RHC • Hospital

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Provider Type	Definition
Physician/Psychiatrist	Provider has a Doctor of Medicine or Osteopathic Medicine degree, engages in the practice of medicine as defined by, and is licensed as a physician pursuant to, the Colorado Revised Statutes (CRS) at CRS 12-36-101.
Psychologist, Psy.D/Ph.D	Provider has a doctoral degree from an accredited program offering psychology courses approved by the American Psychological Association and is licensed as a psychologist by the State Board of Psychologist Examiners pursuant to CRS 12-43-304.
Master's Level Clinician	<p>Licensed Clinical Social Worker (LCSW): Provider has a Master's degree from an accredited graduate program offering full-time course work approved by the Council on Social Work Education and is licensed as an LCSW pursuant to CRS 12-43-404.</p> <p>Licensed Marriage and Family Therapist (LMFT): Provider has a Master's degree from a graduate program with course work accredited by the Commission on Accreditation for Marriage and Family Therapy Education and is licensed as an LMFT pursuant to CRS 12-43-504.</p> <p>Licensed Professional Counselor (LPC): Provider has a Master's or doctoral degree in professional counseling from an accredited college or university and is licensed as an LPC pursuant to CRS 12-43-603.</p> <p>Advanced Practice Nurse (APN): Provider is a Registered Nurse with a master's degree in Nursing and is registered as an advanced practice nurse by the Colorado Department of Regulatory Agencies pursuant to CRS 12-38-111.5.</p>
Physician Assistant (PA)	Provider is a graduate of an education program accredited by the Accreditation Review Commission on Education for the Physician Assistant, certified by the National Commission on Certification of Physician Assistants, and licensed as a physician assistant pursuant to CRS 12-36-106.
Community Mental Health Center (CMHC)	Either a physical plant or a group of services under unified administration or affiliated with one another, and including at least the following services provided for the prevention and treatment of mental illness and behavioral disorders in persons residing in a particular community in or near the facility so situated: <ul style="list-style-type: none"> • Inpatient services; • Outpatient services; • Partial hospitalization; • Emergency services; and

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Provider Type	Definition
	<ul style="list-style-type: none"> • Consultative and educational services. <p style="text-align: right;">(CRS 27-1-201)</p>
Rural Health Center (RHC)	<p>A facility that:</p> <ul style="list-style-type: none"> • Has been determined by the Secretary of the Department of Health and Human Services to meet the requirements of Section 1861(aa)(2) of the Social Security Act and 42 CFR §§ 491; and • Has filed an agreement with the Secretary of Health and Human Services in order to provide rural health clinic services under the Medicare program. <p style="text-align: right;">(42 CFR §§ 405.2401)</p>

b. Non-Covered Services

Outpatient Behavioral Health Services do not include, and federal financial participation is not available for, any of the following:

- Room and board services
- Educational, vocational and job training services
- Habilitation services
- Services to inmates in public institutions as defined in 42 CFR §§ 435.1010
- Services to individuals residing in institutions for mental diseases as described in 42 CFR §§ 435.1010
- Recreational and social activities
- Services that must be covered elsewhere in the Medicaid State Plan

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| 14.a. Inpatient hospital services for individuals age 65 or older in institutions for mental disease. | Forty-five days per state fiscal year. Services exceeding the forty-five (45) day limit must be prior authorized for medical necessity. |
| 16. Inpatient psychiatric facility services for individuals under 22 years of age. | Forty-five days per state fiscal year. The Department will prior authorize additional services for the EPSDT population. |
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13 d. Rehabilitative Services (continued) Enhanced Behavioral Health Therapy

Service Definition:

Enhanced Behavioral Health Therapy is a highly individualized therapy service for clients who require intensive assistance and support to overcome symptoms of a diagnosed mental illness which prevent the client from functioning at his/her best possible functional level. The service is designed to provide intensive support to promote health, independence and the ability for the client to function successfully in the community. Enhanced Behavioral Health Therapy is appropriate and available only to those clients who require intensive treatment and support as a result of their behavioral health condition and for whom traditional and customary levels of treatment have been provided but have proven to be ineffective or unsuccessful.

The following are elements of Enhanced Behavioral Health Therapy benefit:

1. Frequent, intensive face-to-face interventions. Up to 3 sessions per week of psychiatric management and psychotherapy. These sessions are similar to other behavioral health therapeutic contacts and consist of some of the same psychotherapeutic strategies, but are different in two ways. First, therapists for clients who need Enhanced Behavioral Health Therapy must actively manage the client-therapist relationship during therapy, in addition to providing the therapy itself. Therapists must work to actively build a strong therapeutic alliance. Second, clients in need of enhanced therapy have frequent crises, and therapists must constantly assess and monitor self-destructive and suicidal behaviors during sessions.
2. An individualized plan of care. The enhanced behavioral health therapist develops and implements a plan of care that is flexible and draws from diverse therapeutic disciplines. The plan includes strategies for managing the therapist-client relationship, which requires particular attention for clients who need this therapy.
3. A behavior management plan. The therapist must develop, adjust, and implement plans to manage the client's impulsive and self-destructive behaviors, both during therapy sessions and in between sessions. Clients may go through periods of time in which their demands on the therapist are great, and they seek contact multiple times per week or day. During other times, the client may be in less contact, but engaging in more self-destructive behaviors. The behavior management plan must be flexible enough to address both situations.

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13 d. Rehabilitative Services (cont'd) Enhanced Behavioral Health Therapy (cont'd)

4. Coordination of the behavioral health care services. The therapist takes an active role in ensuring that behavioral health is coordinated, and that anyone involved in the client's behavioral health care is giving the client consistent messages. Conflicting messages from different care providers pose a serious risk to the success of the treatment of those in need of enhanced behavioral health therapy.
5. Crisis prevention and intervention. Therapists must creatively and actively try to prevent client crises (particularly episodes of self-destructive behavior), and respond to these crises when they occur. These crises can occur frequently during the course of treatment.

Service Limitations:

1. Up to three (3) sessions per week may be reimbursed per client per provider. One session is equal to between one and three (1-3) units of service, where one unit of service equals 45-50 minutes of Enhanced Behavioral Health Therapy. No more than three (3) units of service may be reimbursed per client per provider on any one date of service.
2. A client must be exempt from participation in, or with a non-covered diagnosis under, the Colorado Medicaid Community Mental Health Services Program.

Qualified Practitioners:

Reimbursement is only available to those providers who have been approved by the Department to provide Enhanced Behavioral Health Therapy to individual clients on a case-by-case basis. The Department will expect that each practitioner will have proven experience in working with clients who have complex mental illnesses that lead to frequent crisis situations and require intensive, consistent therapy services. Practitioners with any of the qualifications are eligible to provide Enhanced Behavioral Health Therapy:

- a. Psychologist, PhD or PsyD – Doctoral degree from an accredited program offering psychology courses approved by the American Psychological Association and licensed by the State Board of Psychologist Examiners.
- b. Psychiatric/Mental Health Nurse Practitioner (PMHNP-BC) – Registered Nurse with a master's degree in Nursing, licensed by the Colorado Department of Regulatory Agencies as an advanced practice psychiatric/mental health nurse practitioner.
- c. Licensed Clinical Social Worker (LCSW) – Master's degree from an accredited graduate program offering full time course work approved by the Council on Social Work Education, licensed as a LCSW by the Colorado Department of Regulatory Agencies.
- d. Licensed Professional Counselor (LPC) – Master's or doctoral degree in professional counseling from an accredited college or university, licensed by the Colorado Department of Regulatory Agencies.

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Substance Use Disorder Treatment Services

Outpatient substance abuse treatment services are provided to all Medicaid clients based on medical necessity. Approved services must be offered in facilities that have been licensed by the Office of Behavioral Health (OBH), formerly known as the Alcohol and Drug Abuse Division (ADAD), of the Department of Human Services or by physicians or other identified licensed practitioners of the healing arts licensed and certified by the Department of Regulatory Agencies (DORA) or nationally licensed and certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC), the American Society of Addiction Medicine (ASAM), or the American Board of Psychiatry and Neurology (ABPN).

1. Licensed practitioners include:

- a. Psychologist, PhD. Doctoral degree from an accredited program offering psychology courses approved by the American Psychological Association and licensed by the State Board of Psychologist Examiners with certification in addiction counseling.
- b. Nurse Practitioner. Registered Nurse with a master's degree in Nursing licensed by DORA as an advanced practice nurse and certified in addiction counseling.
- c. Licensed Clinical Social Worker (LCSW). Master's degree from an accredited graduate program offering full time course work approved by the Council on Social Work Education, licensed as an LCSW by DORA and certified in addiction counseling.
- d. Licensed Professional Counselor (LPC). Holds a master's or doctoral degree in professional counseling from an accredited college or university, licensed by DORA and certified in addiction counseling.
- e. Marriage and Family Therapist. Master's degree from a graduate program with course study accredited by the Commission on Accreditation for Marriage and Family Therapy Education, licensed by DORA and certified in addiction counseling.
- f. Licensed Addiction Counselor (LAC). Holds a master's degree in the healing arts. Licensed in addiction counseling by NAADAC/National Board for Certified Counselors (NBCC).

2. Allowable services include:

- a. Substance use disorder assessment. An evaluation designed to determine the level of drug or alcohol abuse or dependence, and the comprehensive treatment needs of a client. Assessment is limited to two annual assessments which may involve more than one session per state fiscal year. This service can be provided by all licensed practitioners identified above.
- b. Individual and family therapy. Therapeutic substance abuse counseling and treatment services with one client per session. Family therapy will be directly related to the client's treatment for substance use or dependence. Individual and family therapy is limited to 35 sessions at 15

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Item 13.d Rehabilitative Services (continued)

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minutes per unit, four units (one hour) per session per state fiscal year. This service can be provided by all licensed practitioners identified above.

- c. Group therapy. Therapeutic substance abuse counseling and treatment services with more than one client. One unit of service equals one hour, and a maximum of three units shall be reimbursed per session. A maximum of 36 sessions shall be reimbursed per state fiscal year. This service can be provided by all licensed practitioners identified above.
- d. Alcohol/drug screening counseling. Counseling services provide in conjunction with the collection of urine to test for the presence of alcohol or drugs. Alcohol/drug screening counseling is limited to 52 specimen collections per state fiscal year. This service can be provided by all licensed practitioners identified above.
- e. Social/ambulatory detoxification. Social/ambulatory detoxification services exclude room and board, and are limited to a maximum of five sessions of three days each per state fiscal year. These services can be provided by all licensed practitioners identified above. Social/ambulatory detoxification includes the following services and limitations:
 - i. Physical assessment of detoxification progression where one unit of service equals fifteen minutes. A maximum of three units of service shall be reimbursed per date of service.
 - ii. Evaluation of level of motivation for treatment where one unit of service equals fifteen minutes. A maximum of three units of service shall be reimbursed per date of service.
 - iii. Safety assessment, including suicide ideation and other mental health issues. A maximum of one unit of service shall be reimbursed per date of service.
 - iv. Provision of daily living needs where one unit of service equals fifteen minutes. A maximum of three units of service shall be reimbursed per date of service.
- f. Medication Assisted Treatment (MAT). MAT consists of administration, management, and oversight of methodone or another approved controlled substance to an opiate dependent person for the purpose of decreasing or eliminating dependence on opiate substances. A maximum of one unit of service shall be reimbursed per date of service. Administration, management and oversight of methodone or another approved controlled substance shall only be provided by:
 - i. Physicians;
 - ii. Physician Assistants; and
 - iii. Nurse Practitioners.

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13.e. Mental Health
and Substance Abuse
Rehabilitation Services
for children

Mental health rehabilitative services treatment, including substance abuse treatment, are ordered by a licensed physician or licensed mental health provider in accordance with Colorado state laws governing their practice, and are for the maximum reduction of mental disability and restoration of function to the best possible level. Recipients of these services may reside in a congregate setting, however, these clients are not residents of an Institution for Mental Disease (IMD). The determination of individual recipient disability, treatment goals, care plan to achieve treatment goals, progress benchmarks and assessment of progress will be made by a licensed practitioner in keeping with accepted standards and/or best practices of mental health treatment and documented in the recipient's record. Licensed mental health providers include licensed psychologist, licensed psychiatrist, licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor, and licensed social worker supervised for a licensed clinical social worker.

Psychiatric diagnostic interview examination upon out-of-home placement is limited to one unit upon admission into treatment, unless justification for additional units is documented in the recipient's plan of care and ordered by a licensed physician or licensed mental health provider.

The following benefits are limited to a maximum of one unit per day, unless multiple units and/or procedures are ordered by a licensed physician or licensed mental health provider and documented in the recipient's plan of care.

- Individual psychotherapy (brief), insight oriented behavior modifying and/or supportive, including, when indicated, therapy for substance abuse, in an office or outpatient clinic provided by an individual licensed to practice medicine or mental health care; or
- Individual psychotherapy (long), insight oriented behavior modifying and/or supportive, including, when indicated,

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therapy for substance abuse, in an office or outpatient clinic face-to-face with the patient, provided by an individual licensed to practice medicine or mental health care.

Family psychotherapy (conjoint therapy) for the exclusive benefit of the child recipient and with the recipient present, unless recipient and family contact is contraindicated, including, when indicated, therapy for substance abuse, provided by a licensed physician or licensed mental health provider, limited to a maximum of one unit per day, unless units in excess of one per day are ordered by a licensed physician or licensed mental health provider and documented in the recipient's plan of care.

Group psychotherapy, excluding a multifamily group, including, when indicated, therapy for substance abuse, provided by a physician, or licensed mental health provider, limited to eight 15-minute units per day, unless units in excess of eight per day are ordered by a licensed physician or licensed mental health provider and justification is documented in the recipient's plan of care.

The following benefits are limited to a maximum of one unit per day, unless units in excess of one per day are ordered by a licensed physician or licensed mental health provider and documented in the recipient's plan of care.

- Psychological testing (professional) includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report, provided by a physician, or licensed mental health provider. Face-to-face with the patient time only; or
- Psychological testing (technician) includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI

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and WAIS), with licensed mental health provider interpretation and report, administered by technician, per hour of technician time, under the supervision of a licensed physician or licensed mental health provider. Face-to-face with the patient time only.

Interactive group psychotherapy provided by a licensed physician or licensed mental health provider, including, when indicated, therapy for substance abuse, limited to a maximum of one unit per day, unless units in excess of one per day are ordered by a licensed physician or licensed mental health provider as medically necessary and documented in the recipient's plan of care.

Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy, provided by a licensed physician, licensed nurse practitioner or licensed physician assistant is limited to a maximum of one unit per day, unless units in excess of one per day are ordered by a licensed physician, nurse practitioner or physician assistant as medically necessary and documented in the recipient's plan of care.

Exclusions

Mental Health and Substance Abuse Rehabilitative Services for Children do not include the following:

- Room and board services;
- Educational, vocational and job training services;
- Recreational or social activities;
- Habilitative care for children who are developmentally disabled or mentally retarded;
- Services provided to inmates of public institutions or residents of institutions for mental diseases; and
- Services that are covered elsewhere in the state Medicaid plan

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Provider Qualifications

Physicians and Osteopaths:

- Proof of graduation from medical school;
- Passage of national recognized examinations;
- Satisfactory completion of postgraduate education;
- Verification of Federation of State Medical Boards disciplinary history; and
- Submission of reference letters from previous practice locations

Physician Assistants:

- Graduation from an NCCPA-approved physician assistance program;
- Verified practice history;
- Passage of the NCCPA National Board Exam; and
- Verification of Federation of State Medical Boards disciplinary history

Advance Practice Nurses:

- Graduate degree or higher as a nurse practitioner or graduate degree in nursing and post-graduate degree or post graduate certificate as a Nurse Practitioner; and
- Active, unencumbered Colorado Registered Nurse license or an active, unencumbered Multi-state Compact Registered Nurse license.

Licensed psychologist

- At least 21 years old
- Doctoral degree with a major in psychology from an APA-approved program or equivalent as approved by the Examiners Board;
- Passage of psychologist board exam;
- At least 1 year experience practicing under supervision; and;
- Passage of an Examiner's Board developed mail-in jurisprudence law and ethics exam

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Master's Level Licensed Clinicians

- Licensed Clinical Social Worker (LCSW). Master's degree from an accredited graduate program offering full time course work approved by the Council on Social Work Education, and licensed as a LCSW by DORA.
- Licensed Professional Counselor (LPC). Holds a master's degree or doctoral degree in professional counseling from an accredited college or university, and licensed by DORA.
- Marriage and Family Therapist. Master's degree from a graduate program with course study accredited by the Commission on Accreditation for Marriage and Family Therapy Education, and licensed by DORA.

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LIMITATIONS TO CARE AND SERVICES

18. Hospice Care

1. Hospice care is available to any Medicaid client if:
 - a. The client elects to receive the hospice benefit, and
 - b. The client's attending physician has certified a prognosis of nine months or fewer to live, if the individual has an attending physician. Otherwise, Medical Director of the hospice or the physician member of the Interdisciplinary Team will certify the prognosis.

2. Hospice care includes the following services:
 - a. Nursing care provided by or under the supervision of a registered nurse;
 - b. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.;
 - c. Counseling services, including dietary and spiritual counseling, provided to the client and his or her family members or other persons caring for the client;
 - d. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient);
 - e. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total hospice days;
 - f. Short-term inpatient care of up to five consecutive days per benefit period to provide respite for the client's family or other home caregiver, that conforms to the written plan of care;
 - g. Medical appliances and supplies, including drugs and biologicals which are used primarily for symptom control and relief of pain related to the terminal illness;
 - h. Intermittent hospice home health aide services available and adequate in frequency to meet the needs of the client. Hospice home health aide services may include unskilled personal care and homemaker services that are incidental to a visit;
 - i. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom

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control or to enable the terminal client to maintain activities of daily living and basic functional skills;

- j. Physician services provided by a physician as defined in 42 CFR 410.20, except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy; and
 - k. Any other service that is specified in the client's plan of care as reasonable and necessary for the palliation and management of the client's terminal illness and related conditions and for which payment may otherwise be made under Medicaid.
3. A client aged 21 and over who has elected hospice is not eligible to receive services that are related to the treatment of the client's condition for which a diagnosis of terminal illness has been made. A client under the age of 21 is eligible to receive hospice services concurrently with services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental Disability

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Medicaid recipients who have been determined by a Community Centered Board to have a developmental disability and are actively enrolled in the Home and Community Based Services waiver for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services waiver (HCBS-SLS), HCBS-Children's Extensive Support waiver (HCBS-CES), and Early Intervention Services. Excluded are children with developmental disabilities or delays enrolled in the Children's HCBS waiver, HCBS Children's Residential Habilitation Program, adults with developmental disabilities who are enrolled in other Medicaid waiver programs, and persons residing in Class I nursing facilities or ICF-MR.

 Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
 Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Targeted Case Management (TCM) services to this population will consist of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources.

Targeted Case Management services will involve at least one activity regarding the individual each month in which Targeted Case Management services are billed for one or more of the following purposes:

- a. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;

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- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Comprehensive assessment shall be completed at the time of enrollment. Assessment information shall be reviewed at least annually. Reassessment shall occur when the client experiences significant change in need or in level of support.

- b. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.
- c. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
- d. Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring shall be completed as necessary to ensure implementation of the care plan and to evaluate health and welfare. Follow up actions shall be performed when necessary to address health and safety concerns or services in the care plan. Monitoring shall include direct contact and observation with the client in a place where services are delivered and at a frequency as follows:

- HCBS-DD at least once per quarter;
- HCBS-SLS at least once per quarter;

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- HCBS-CES at least once per quarter; or
- Early Intervention at least every six months

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Case Management services will be provided by Community Centered Boards (CCB) which are private, for profit or not-for-profit, corporations designated on an annual basis by the Colorado Department of Human Services pursuant to CRS 27-10.5-105, as amended to serve the needs of individuals with developmental disabilities within specific geographic service areas. Providers must meet established program requirements. Community Centered Boards are the only agencies legally authorized to provide targeted case management services to individuals with developmental disabilities in community-based settings in Colorado. Case Managers who provide Targeted Case Management services will have, at a minimum, 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.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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19. TARGETED CASE MANAGEMENT SERVICES: Persons with a Developmental Disability

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the *direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred*, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an *individualized education program or individualized family service plan consistent with §1903(c) of the Act.* (§§1902(a)(25) and 1905(c))

Effective April 1, 2012, the total number of units per client is limited to 60 units through June 30, 2012. Effective July 1, 2012, the total number of units per client is limited to 240 units per fiscal year per person for each state fiscal year (~~June 1~~ through June 30). One unit is equal to 15 minutes.

July 1

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LIMITATIONS TO CARE AND SERVICES

20. Extended Services for Pregnant Women

Drug and alcohol abuse treatment services for pregnant women with substance use disorders who are assessed to be at risk of a poor birth outcome shall be covered when provided in accordance with 42 CFR 440.60 by a practitioner who is, at minimum, a licensed addiction counselor or certified addiction counselor, level II or higher.

Enhanced prenatal care services include care coordination, counseling, nutrition counseling, and home visits and may be provided to pregnant women who are assessed to be at risk of a poor birth outcome due to lifestyle behaviors and psychosocial circumstances such as tobacco use, unstable living environment, or young age.

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LIMITATIONS TO CARE AND SERVICES

Services

Limitations

21. Ambulatory Prenatal Care

Outpatient services only. Labor and delivery are not covered.

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LIMITATIONS TO CARE AND SERVICES

24a. TRANSPORTATION

- Non-emergent medical transportation shall be provided, with limitations, as an administrative service. See Attachment 3.1-D: Methods of Assuring Transportation.
- Emergency medical transportation shall be provided as a medical service.
 - Emergency medical transportation shall include land and air ambulance as certified by the health care provider to be appropriate for the particular circumstances.
 - Coverage of emergency medical transportation shall require a physician's statement of medical necessity or a trip report.
 - Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized without risk to the client's health.

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