

Title of Rule: Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number: MSB 15-04-23-A
Division / Contact / Phone: Client and Clinical Care / Carrie Smith / 303-866-3406

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The proposed rule will increase the DME encounter rate by 0.5% to account for General Assembly funding appropriation.

2. An emergency rule-making is imperatively necessary

to comply with state or federal law or federal regulation and/or

for the preservation of public health, safety and welfare.

Explain:

This rule is being changed to comply with the Long Appropriations Bill, Senate Bill 15-234, which mandates a 0.5% increase for the Durable Medical Equipment encounter rate, effective July 1, 2015.

3. Federal authority for the Rule, if any:

Two state plan amendments (SPAs) will be submitted to CMS with a requested effective date of July 1, 2015. Reimbursement for the Durable Medical Equipment encounter rate will be made under the current rate until the SPAs are approved. Once approval is received, any such reimbursements made after July 1, 2015 will be adjusted to reflect the new rate contained in the rule.

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2014);
Senate Bill 15-234

Initial Review

Proposed Effective Date

07/01/2015

Final Adoption

Emergency Adoption

06/12/2015
DOCUMENT #02

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REGULATORY ANALYSIS

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

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

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

Reimbursement to DME providers is estimated to be increased by \$765,579 for FY 2015-16.

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

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

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

The rate increase will give providers the ability to continue supplying DME items to clients at their incremental threshold margin. Inaction can result in decreased client services and access to benefits, as well as noncompliance with SB 15-234.

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

There is not a less costly method for achieving the purpose of the proposed rule which is to comply with SB 15-234.

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

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

1 **8.590.7 REIMBURSEMENT**

2 8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted.
3 Only invoices received from unrelated manufacturers or wholesale distributors shall be
4 recognized as allowable invoices.

5 8.590.7.B. The provider shall not bill the Department for authorized accessory items
6 included by the manufacturer as part of a standard package for an item.

7 8.590.7.C. The provider shall credit the cost of any accessory or part removed from a
8 standard package to the Department.

9 8.590.7.D. Clients and providers may negotiate in good faith a trade-in amount for DME
10 items no longer suitable for a client because of growth, development or a change in
11 anatomical and or medical condition. Such trade-in allowances shall be used to reduce
12 the cost incurred by the Department for a replacement item.

13 8.590.7.E. The refund amount due the Department on a returned Wheelchair or Facilitative
14 Device shall be agreed upon by the dealer or manufacture; wherever the item was
15 returned, and the Department.

16 8.590.7.F. Reimbursement for allowable modifications, service, and repairs on durable
17 medical equipment is as follows:

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

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

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

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

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

32 8.590.7.G. Reimbursement for used equipment shall include:

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

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

- 4 8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not
5 limited to:
 - 6 1. All elements of the manufacturer's warranties or express warranties.
 - 7 2. All adjustments and modification needed by the client to make the item useful
8 and functional.
 - 9 3. Delivery, set-up and installation of equipment in the home, and if appropriate to a
10 specific room in the home.
 - 11 4. Training and instruction to the client or caregiver in the safe, sanitary, effective
12 and appropriate use of the item and necessary servicing and maintenance to be
13 done by the client or caregiver.
 - 14 5. Training and instruction on the manufacturer's instructions, servicing manuals
15 and operating guides.

- 16 8.590.7.I. Reimbursement rate for a purchased item shall be as follows:
 - 17 1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable
18 reimbursement rate shall be reimbursed at the lesser of submitted charges or the
19 Department fee schedule rate.
 - 20 2. Manually priced items that do not have an assigned Fee Schedule rate shall be
21 reimbursed at the lesser of submitted charges or current manufacturer suggested
22 retail price (MSRP) less 19.486 percent.
 - 23 3. Manually priced items that do not have an MSRP or Fee Schedule rate shall be
24 reimbursed at the lesser of submitted charges or by invoice of actual acquisition
25 cost, minus any discount to the provider as set forth in policy, plus 17.8526
26 percent.

- 27 8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments
28 unless otherwise indicated in the Medicaid Bulletin.

- 29 8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made
30 in the following manner:
 - 31 1. The provider shall bill Medicare first unless otherwise authorized by the
32 Department.
 - 33 2. If Medicare makes payment, Medicaid reimbursement will be based on
34 appropriate deductibles and co-payments.

- 1 3. If Medicare denies payment, the provider shall be responsible for billing the
2 Department. Reimbursement is dependent upon the following conditions:
- 3 a. A copy of the Explanation of Medicare Benefits' shall be maintained in
4 the provider's files when billing electronically or attached to the claim if it
5 is billed manually; or
- 6 b. Medicaid reimbursement shall not be made if the Medicare denial is
7 based upon provider submission error.

8 8.590.7.L. Reimbursement for Complex Rehabilitation Technology provided to clients shall
9 be made when the following conditions are met:

- 10 1. The billing provider is a Complex Rehabilitation Technology Supplier;
- 11 2. The client has been evaluated or assessed, for selected Complex Rehabilitation
12 Technology identified in the Medicaid Bulletin, by:
- 13 a. A Qualified Health Care Professional; and
- 14 b. A Complex Rehabilitation Technology Professional employed by the
15 billing provider.
- 16 3. The Complex Rehabilitation Technology is provided in compliance with all
17 applicable federal and state laws, rules, and regulations, including those rules
18 governing the Medical Assistance Program.

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