

Title of Rule: Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Supervision Requirements for Registered Nurses at Local Public Health Agencies, Section 8.200

Rule Number: MSB 15-05-27-E

Division/Contact/Phone: Health Programs Benefits and Operations Division / Richard Delaney x3436 / Amanda Forsythe x6459

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 revises the supervision requirements for vaccination administration services rendered by a Registered Nurse (RN) at a Local Public Health Agency (LPHA). The proposed revision removes the requirement that the supervising provider be physically onsite for the duration of vaccination administration services rendered by RNs, and replaces it with a requirement that the supervising provider be immediately available via telephonic or other electronic means to give assistance throughout the performance of the service. This rule revision is intended to increase access to vaccinations for Colorado Medicaid clients served by LPHAs.

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:

3. Federal authority for the Rule, if any:

42 CFR 440.230(b); 42 CFR 440.60(a); and 42 CFR 440.130(c)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);
24-4-103(6)(a), C.R.S. (2015); 25.5-4-401(2), C.R.S. (2015)

Initial Review

Proposed Effective Date **04/30/2016**

Final Adoption

Emergency Adoption

03/11/2016

DOCUMENT #03

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Management Rule Concerning Supervision Requirements for Registered
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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.

The persons affected are Colorado Medicaid clients. All Colorado Medicaid clients may receive vaccinations from Local Public Health Agencies.

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

The proposed rule revision will increase access to vaccinations for Colorado Medicaid clients. It is impossible to determine the exact extent to which this rule revision will result in an increase to the number of vaccinations administered. There is no possibility that this rule revision will result in a decrease in vaccination administration.

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

The probable costs of implementation and enforcement of the proposed rule change will be limited to the Department. The rule change does not affect the \$16.28 per-shot vaccination administration fee, which will remain as is. Utilization may increase, but as LPHAs accounted for only 2.5% of all fee schedule-paid vaccinations during flu season last year, the anticipated cost to the Department is minimal. The best estimate is that the rule change will increase Department costs for LPHA vaccination administration services by 10% above last year, adding a total of \$1,000 to the Department's budget.

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

The probable costs are relatively small, and prevention of flu cases in the population will offset the additional vaccination administration costs.

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

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There is no alternative way to expand vaccination administration to the population of clients seen at LPHAs by RNs providing the services under general supervision.

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

The alternative method considered by the Department was to retain the existing direct supervision requirements at Section 8.200.D. However, this alternative was not seen as good policy at the Department, as it would not achieve the purpose of ensuring client access to vaccination administration services at LPHAs.

1 **8.200 PHYSICIAN SERVICES**

2 **8.200.1 DEFINITIONS**

3 An Advanced Practice Nurse is a provider that meets the requirements to practice advanced practice
4 nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced
5 Practice Nurse may have prescriptive authority.

6 A Licensed Psychologist is a provider that meets the requirements to practice psychology as defined in
7 Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.

8 Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of
9 Public Health and Environment, accredited by a national family planning organization and staffed by
10 medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of
11 medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.

12 Direct Supervision means the supervising provider shall be on-site during the rendering of services and
13 immediately available to give assistance and direction throughout the performance of the service.

14 General Supervision means the supervising provider need not be on-site during the rendering of services,
15 but needs to be immediately available via telephonic or other electronic means to give assistance and
16 direction throughout the performance of the service.

17 Medical Necessity is defined in 10 C.C.R. 2505-10, Section 8.076.1.8.

18 **8.200.2 PROVIDERS**

19 8.200.2.A A doctor of medicine or a doctor of osteopathy may order and provide all medical care
20 goods and services within the scope of their license to provide such goods and services that are
21 covered benefits of the Colorado Medical Assistance Program.

22 1. A provider of covered dental care surgery can be either enrolled as a dentist or oral
23 surgeon, but not both. A dentist may order and provide covered dental care.

24 8.200.2.B Physician services that may be provided without a physician order by non-physician
25 providers.

26 1. Advanced Practice Nurses may provide and order covered goods and services in
27 accordance with the scope of practice as described in the Colorado Revised Statutes
28 without a physician order.

29 2. Licensed Psychologists may provide and order covered mental health goods and
30 services in accordance with the scope of practice as described in the Colorado Revised
31 Statutes without a physician order.

32 a. Services ordered by a Licensed Psychologist but rendered by another provider
33 shall be signed and dated by the Licensed Psychologist contemporaneously with
34 the rendering of the service by a non-licensed mental health provider.

35 3. Optometrists may provide covered optometric goods and services within their scope of
36 practice as described by the Colorado Revised Statutes without a physician order.

37 4. Podiatrists may provide covered foot care services within their scope of practice as
38 described by the Colorado Revised Statutes without a physician order.

1 5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in
2 accordance with the scope of practice for dental hygienists as described in the Colorado
3 Revised Statutes without a physician order.

4 a. Unsupervised dental hygiene services are limited to those clients and procedures
5 as defined by the Department of Health Care Policy and Financing.

6 8.200.2.C Physician services that may be provided by a non-physician provider when ordered by a
7 provider acting under authority described in Sections 8.200.2.A and 8.200.2.B.

8 1. Registered occupational therapists, licensed physical therapists, licensed audiologists,
9 certified speech-language pathologists, and licensed physician assistants may provide
10 services ordered by a physician.

11 a. Services shall be rendered and supervised in accordance with the scope of
12 practice for the non-physician provider described in the Colorado Revised
13 Statutes.

14 8.200.2.D Physician services that may be provided when supervised by an enrolled provider.

15 1. With the exception of the non-physician providers described in Sections 8.200.2.A
16 through 8.200.2.C [and 8.200.2.D.1.a](#), a non-physician provider may provide covered
17 goods and services only under the Direct Supervision of an enrolled provider who has the
18 authority to supervise those services, according to the Colorado Revised Statutes. If the
19 Colorado Revised Statutes do not designate who has the authority to supervise, the non-
20 physician provider shall provide services under the Direct Supervision of an enrolled
21 physician.

22 ~~a. Direct Supervision means the supervising provider shall be on-site during the rendering
23 of services and immediately available to give assistance and direction throughout the
24 performance of the service.~~

25 a. Registered Nurses (RNs) employed by Local Public Health Agencies (LPHAs)
26 may provide vaccination administration services under General Supervision.

27 8.200.2.E Licensure and required certification for all physician service providers shall be in
28 accordance with their specific specialty practice act and with current state licensure statutes and
29 regulations.

30 **8.200.3. BENEFITS**

31 8.200.3.A Physician services are reimbursable when the services are a benefit of Medicaid and
32 meet the criteria of Medical Necessity as defined in 10 C.C.R. 2505-10, Section 8.076.1.8 and are
33 provided by the appropriate provider specialty.

34 1. Physician services in dental care are a benefit when provided for surgery related to the
35 jaw or any structure contiguous to the jaw or reduction of fraction of the jaw or facial
36 bones. Service includes dental splints or other devices.

37 2. Outpatient mental health services are provided as described in 10 CCR 2505-10, Section
38 8.212.

39

40 3. Physical examinations are a benefit when they meet the following criteria:

- 1 a. Physical examinations are a benefit for preventive service, diagnosis and
2 evaluation of disease or early and periodic screening, diagnosis and treatment
3 for clients under the age of 21 as described in 10 C.C.R. 2505-10, Section 8.280.
- 4 b. Physical examination as a preventive service for adults is a benefit limited to one
5 per state fiscal year.
- 6 4. Physician services for the provision of immunizations are a benefit. Vaccines provided to
7 enrolled children that are eligible for the Vaccines for Children program shall be obtained
8 through the Colorado Department of Public Health and Environment.
- 9 5. Physician services for laboratory testing described in 10 C.C.R. 2505-10, Section 8.660,
10 are a benefit.
- 11 6. Occupational and physical therapy services are benefits.
- 12 7. Family planning services described in 10 C.C.R. 2505-10, Section 8.730 are benefits.
- 13 8.200.3.B Telemedicine is the delivery of medical services and any diagnosis, consultation,
14 treatment, transfer of medical data or education related to health care services using interactive
15 audio, interactive video or interactive data communication instead of in-person contact.
- 16 1. Physician services may be provided as telemedicine.
- 17 2. Any health benefits provided through telemedicine shall meet the same standard of care
18 as in-person care.
- 19 8.200.3.C Services and goods generally excluded from coverage are identified in 10 C.C.R. 2505-
20 10, Section 8.011.11.
- 21 8.200.3.C.2 Immunization Services Benefit Coverage Standard
- 22 All providers of vaccines through the Vaccines for Children program or the Colorado
23 Immunization Program shall be in compliance with the Colorado Medicaid Immunization
24 Services Benefit Coverage Standard (approved April 2, 2012), incorporated by reference.
25 The incorporation of the Immunization Services Benefit Coverage Standard excludes
26 later amendments to, or editions of, the referenced material.
- 27 The Benefit Coverage Standard is available from Colorado Medicaid's Benefits
28 Collaborative web site at Colorado.gov/hcpf. Click "Boards & Committees," and click
29 "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to
30 §24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its
31 entirety, available for public inspection during regular business hours at: Colorado
32 Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.
33 Certified copies of incorporated materials are provided at cost upon request.
- 34 8.200.3.D Physician Services Benefit Coverage Standards
- 35 Note: 8.200.3.D.1 Podiatry Services Benefit Coverage Standard was moved to §8.810 01/2015.
- 36 2. Speech – Language and Hearing Services Benefit Coverage Standard
- 37 a. ELIGIBLE PROVIDERS
- 38 i. Eligible providers include individual practitioners and those employed by
39 home care agencies, children's developmental service agencies, health

1 departments, federally qualified health centers (FQHC), clinics, or
2 hospital outpatient services.

3 ii. Otolaryngologists, speech-language pathologists (speech therapists),
4 and audiologists shall have a current and active license or registration
5 and be current, active and unrestricted to practice.

6 iii. Providers shall be enrolled as a Colorado Medicaid provider in order to
7 be eligible to bill for procedures, products and services in treating a
8 Colorado Medicaid client.

9 iv. Rendering Providers include:

10 1. Otolaryngologist

11 2. Speech-language pathologist

12 3. Speech-language pathology assistant

13 4. Clinical fellows

14 5. Audiologist

15 b. PROVIDER AGENCY REQUIREMENTS

16 i. Providers of in-home health who employ therapists or audiologists shall
17 apply for licensing through the Colorado Department of Public Health
18 and Environment (CDPHE). (§25-27.5-103(1) C.R.S. and 6 CCR 1011-1,
19 Chapter XXVI, Section 5.1) as a home **care** agency.

20 ii. This rule does not apply to providers delivering Early Intervention
21 Services under an Individual Family Service Plan (IFSP) and billing
22 through contracts with the Community Centered Boards.

23 c. ELIGIBLE PLACES OF SERVICE

24 i. Eligible Places of Service shall include:

25 1. Office

26 2. Home

27 3. School

28 4. FQHC

29 5. Outpatient Hospital

30 6. Community Based Organization

31 d. ELIGIBLE CLIENTS

32 i. Eligible Clients include enrolled clients ages twenty (20) and under and
33 adult clients who qualify under medically necessary services. Qualifying
34 adult clients may receive services for non-chronic conditions and acute
35 illness and injuries.

1 e. COVERED SERVICES

2 i. Newborn Screening

3 1. Screening shall include a comprehensive health assessment
4 performed soon after birth or as early as possible in a child's life
5 and repeated at periodic intervals of time as recommended by
6 the Colorado Early & Periodic Screening & Diagnostic and
7 Treatment (EPSDT) periodicity schedules.

8 ii. Early Language Intervention

9 1. Early language intervention for children 0 through three with a
10 hearing loss may be provided by audiologists, speech therapists,
11 or Colorado Home Intervention Program (CHIP) providers.

12 iii. Audiology Services

13 1. Audiological benefits include identification, diagnostic evaluation
14 and treatment for children with hearing loss, neurologic,
15 dizziness/vertigo, or balance disorders. Conditions treated may
16 be either congenital or acquired.

17 2. Assessment – Service may include testing or clinical observation
18 or both, as appropriate for chronological or developmental age,
19 for one or more of the following areas, and must yield a written
20 evaluation report.

21 a. Auditory sensitivity (including pure tone air and bone
22 conduction, speech detection and speech reception
23 thresholds).

24 b. Auditory discrimination in quiet and noise.

25 c. Impedance audiometry (tympanometry and acoustic
26 reflex testing).

27 d. Hearing aid evaluation (amplification selection and
28 verification).

29 e. Central auditory function.

30 f. Evoked otoacoustic emissions.

31 g. Brainstem auditory evoked response.

32 h. Assessment of functional communicative skills to
33 enhance the activities of daily living.

34 i. Assessment for cochlear implants (for clients ages 20
35 and under).

36 j. Hearing screening.

37 k. Assessment of facial nerve function.

38 l. Assessment of balance function.

- 1 m. Evaluation of dizziness/vertigo.
- 2 3. Treatment – Service may include one or more of the following,
3 as appropriate:
- 4 a. Auditory training.
- 5 b. Speech reading.
- 6 c. Augmentative and alternative communication training
7 including training on how to use cochlear implants for
8 clients ages 20 and under. Adults with chronic conditions
9 may qualify for augmentative and alternative
10 communication services when justified and supported by
11 medical necessity to allow the individual to achieve or
12 maintain maximum functional communication for
13 performance of Activities of Daily Living.
- 14 d. Purchase, maintenance, repairs and accessories for
15 approved devices.
- 16 e. Selection, testing and fitting of hearing aids for children
17 with bilateral or unilateral hearing loss; and auditory
18 training in the use of hearing aids.
- 19 f. Purchase and training on Department approved assistive
20 technologies.
- 21 g. Balance or vestibular therapy.
- 22 iv. Cochlear Implants
- 23 1. Cochlear implants may be indicated for clients aged 12 months
24 through 20 years under the following pre-authorization criteria:
- 25 a. Six months of age or older.
- 26 b. Limited benefit from appropriately fitted binaural hearing
27 aids (with different definitions of “limited benefit” for
28 children 4 years of age or younger and those older than
29 4 years) and a 3-6 month hearing aid trial.
- 30 c. Bilateral hearing loss with unaided pure tone average
31 thresholds of 70 dB or greater.
- 32 d. Minimal speech perception measured using recorded
33 standardized stimuli-speech discrimination scores of 50-
34 60% or below with optimal amplification at 1000, 2000
35 and 4000 Hz.
- 36 e. Family support and motivation to participate in a post-
37 cochlear aural, auditory and speech language
38 rehabilitation program.
- 39 f. Assessment by an audiologist and otolaryngologist
40 experienced in cochlear implants.

- 1 g. Bi lateral and hybrid/Electric Acoustic Stimulation
2 cochlear implantation considered on a case by case
3 basis.
- 4 h. No medical contraindications.
- 5 i. Up-to-date-immunization status as determined by the
6 **Advisory Committee on Immunization Practices**
7 **(ACIP).**
- 8 j. Replacement of an existing cochlear implant for all ages
9 is a benefit when the currently used component is no
10 longer functional and cannot be repaired.

11 v. Speech-language Services

- 12 1. Assessment – Service may include testing and/or clinical
13 observation, as appropriate for chronological or developmental
14 age, for one or more of the following areas, and must yield a
15 written evaluation report:
- 16 a. Expressive language.
- 17 b. Receptive language.
- 18 c. Cognition.
- 19 d. Augmentative and alternative communication.
- 20 e. Voice disorder.
- 21 f. Resonance patterns.
- 22 g. Articulation/phonological development.
- 23 h. Pragmatic language.
- 24 i. Fluency.
- 25 j. Feeding and swallowing.
- 26 k. Hearing status based on pass/fail criteria.
- 27 l. Motor speech.
- 28 m. Aural rehabilitation (defined by provider's scope of
29 practice).
- 30 2. Treatment – Service may include one or more of the following,
31 as appropriate:
- 32 a. Articulation/phonological therapy
- 33 b. Language therapy including expressive, receptive, and
34 pragmatic language.

- 1 c. Augmentative and alternative communication therapy.
2 Adults with chronic conditions may qualify for
3 augmentative and alternative communication services
4 when justified and supported by medical necessity to
5 allow the individual to achieve or maintain maximum
6 functional communication for performance of Activities of
7 Daily Living
- 8 d. Auditory processing/discrimination therapy
- 9 e. Fluency therapy.
- 10 f. Voice therapy.
- 11 g. Oral motor therapy.
- 12 h. Swallowing therapy.
- 13 i. Speech reading.
- 14 j. Cognitive treatment.
- 15 k. Necessary supplies and equipment.
- 16 l. Aural rehabilitation (defined by provider's scope of
17 practice)

18 f. DOCUMENTATION

- 19 i. General Requirements for Client's Record of Service:
 - 20 1. Rendering providers shall document all evaluations, re-
21 evaluations, services provided, client progress, attendance
22 records, and discharge plans. All documentation must be kept in
23 the client's records along with a copy of the referral or
24 prescribing provider's order.
 - 25 2. Documentation shall support both the medical necessity of
26 services and the need for the level of skill provided.
 - 27 3. Rendering providers shall copy the client's prescribing provider
28 and medical home/primary care provider on all relevant records.
- 29 ii. Documentation shall include all of the following:
 - 30 1. The client's name and date of birth.
 - 31 2. The date and type of service provided to the client.
 - 32 3. A description of each service provided during the encounter
33 including procedure codes and time spent on each.
 - 34 4. The total duration of the encounter.
 - 35 5. The name or names and titles of the persons providing each
36 service and the name and title of the therapist supervising or
37 directing the services.

- 1 f. Proposed duration and frequency of each service to be
2 provided.
- 3 g. Estimated duration of episode of care.
- 4 7. The therapist's Plan of Care must be reviewed, revised if
5 necessary, and signed, as medically necessary by the client's
6 physician, or other licensed practitioner of the healing arts within
7 the practitioner's scope of practice under state law at least once
8 every 90 days. The care plan should not cover more than a 90-
9 day period or the time frame documented in the Individual Family
10 Service Plan (IFSP). (Senate bill 07-004 states the IFSP "shall
11 qualify as meeting the standard for medically necessary
12 services." Therefore no physician is required to sign a work order
13 for the IFSP.)
- 14 8. A plan of care must be certified. Certification is the physician's,
15 physician's assistant or nurse practitioner's approval of the plan
16 of care. Certification requires a dated signature on the plan of
17 care or some other document that indicates approval of the plan
18 of care. If the service is a Medicare covered service and is
19 provided to a recipient who is eligible for Medicare, the plan of
20 care must be reviewed at the intervals required by Medicare.
- 21 9. Re-evaluation. A re-evaluation must be done whenever there is
22 an unanticipated change in the client's status, a failure to
23 respond to interventions as expected or there is a need for a new
24 Plan of Care based on new problems and goals that require
25 significant changes to the Plan of Care. The documentation for a
26 re-evaluation need not be as comprehensive as the initial
27 evaluation, but must include at least the following: Reason for re-
28 evaluation; Client's health and functional status reflecting any
29 changes; findings from any repeated or new examination
30 elements; and, Changes to plan of care.
- 31 iv. Visit/Encounter Notes
- 32 1. Written documentation of each encounter must be in the client's
33 record of service. These visit notes document the
34 implementation of the plan of care established by the therapist at
35 the initial evaluation. Each visit note must include the following:
- 36 a. The total duration of the encounter.
- 37 b. The type and scope of treatment provided, including
38 procedure codes and modifiers used.
- 39 c. The time spent providing each service. The number of
40 units billed/requested must match the documentation.
- 41 d. Identification of the short or long term goals being
42 addressed during the encounter.
- 43 2. Colorado Medicaid recommends but does not require that
44 documentation follow the Subjective, Objective, Assessment and
45 Plan (SOAP) format. In addition to the above required
46 information, the visit note should include:

- 1 a. A *subjective* element which includes the reason for the
2 visit, the client or caregiver's report of current status
3 relative to treatment goals, and any changes in client's
4 status since the last visit;
- 5 b. An *objective* element which includes the practitioner's
6 findings, including abnormal and pertinent normal
7 findings from any procedures or tests performed;
- 8 c. An *assessment* component which includes the
9 practitioner's assessment of the client's response to
10 interventions provided, specific progress made toward
11 treatment goals, and any factors affecting the
12 intervention or progression of goals; and
- 13 d. A *plan* component which states the plan for next visit(s).
- 14 v. Discharge Summary
- 15 1. At the conclusion of therapy services, a discharge summary
16 must be included in the documentation of the final visit in an
17 episode of care. This may include the following:
- 18 a. Highlights of a client's progress or lack of progress
19 towards treatment goals.
- 20 b. Summary of the outcome of services provided during the
21 episode of care.
- 22 g. NON-COVERED SERVICES AND GENERAL LIMITATIONS
- 23
- 24 i. Colorado Medicaid does not cover items and services which generally
25 enhance the personal comfort of the eligible person but are not
26 necessary in the diagnosis of, do not contribute meaningfully to the
27 treatment of an illness or injury, or the functioning of a malformed body
28 member.
- 29 ii. Maintenance programs beginning when the therapeutic goals of a
30 treatment plan have been achieved and no further functional progress is
31 apparent or expected to occur, are **not** covered for adult clients.
- 32 iii. Services provided without a written referral from a physician or other
33 licensed practitioner of the healing arts within the practitioner's scope of
34 practice under state law are not covered, unless they are covered by an
35 Individual Family Service Plan (IFSP).
- 36 iv. Treatment of speech and language delays not associated with an
37 acquired or chronic medical condition, neurological disorder, acute
38 illness, injury, or congenital defect are not covered, unless they are
39 covered by an Individual Family Service Plan (IFSP).
- 40 v. Any service that is not determined by the provider to be medically
41 necessary according to the definition of medical necessity in the Speech
42 Language-Hearing Services Benefit Coverage Standard is not covered.
- 43 vi. Hearing aids for adults are not a covered service.

1 8.200.4.C The Certified Family Planning Clinic shall contact the client's Primary Care Provider or
2 Primary Care Medical Provider or managed care organization, if applicable, prior to rendering
3 services that require a referral.

4 **8.200.5 REIMBURSEMENT**

5 8.200.5.A The amount of reimbursement for physician services is the lower of the following:

- 6 1. Submitted charges; or
7 2. Fee schedule as determined by the Department of Health Care Policy and Financing
8 which may be a manual pricing.

9 8.200.5.B Reimbursement for services may be made directly to Advanced Practice Nurses,
10 registered occupational therapists, licensed physical therapists, licensed audiologists, certified
11 speech-language pathologists, and licensed psychologists unless the non-physician practitioner
12 is acting within the scope of his/her contract with a physician or public or private institution or
13 employment as a salaried employee of a physician or public or private institution.

14 8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.

- 15 a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the
16 employer's provider identification number.

17 8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid
18 directly to the clinic and is the lower of the following:

- 19 1. Submitted charges; or
20 2. Fee schedule as determined by the Department of Health Care Policy and Financing
21 which may be a manual pricing.

22 8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a
23 contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural
24 Health Center, clinic, home health agency, school, or physician.

25 8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a
26 student in a graduate education program and the facility where the provider delivers services
27 receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section
28 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.

29 **8.200.6 INCREASED MEDICAL PAYMENTS TO PRIMARY CARE PHYSICIANS PROGRAM**

30 The Increased Medical Payments to Primary Care Physicians Program provides reimbursement above
31 the fee schedule to defined and attested primary care physicians for certain services provided in calendar
32 years 2013 and 2014.

33 8.200.6.A Authority

34 This rule is made pursuant to title 42 of the Code of Federal Regulations, Section 438.6, Section 438.804,
35 Part 441 Subpart L, and Part 447 Subpart G (2012).

36 8.200.6.B Definitions

- 37 1. Primary Care Physician means a medical doctor who attests to the Department that he or
38 she has a primary specialty designation of family medicine, general internal medicine, or
39 pediatric medicine or a subspecialty recognized by the American Board of Medical

- 1 Specialties, the American Board of Physician Specialties, or the American Osteopathic
2 Association.
- 3 2. Personal Supervision means the physician accepts professional responsibility and legal
4 liability for the services provided by the non-physician provider. Personal Supervision
5 does not require physical presence at the location of the services.
- 6 8.200.6.C Attestation
- 7 1. A Primary Care Physician is required to self-identify, using the form available on the
8 www.colorado.gov/hcpf, provider's web page, to a specialty designation of family
9 medicine, general internal medicine or pediatric medicine or a subspecialty recognized by
10 the American Board of Medical Specialties, the American Board of Physician Specialties
11 or the American Osteopathic Association. A physician must self-attest that he/she:
- 12 a. Is Board certified with such a specialty or subspecialty; and/or
- 13 b. Has furnished evaluation and management services and vaccine administration
14 services under codes described in 8.200.6.E that equal at least 60 percent of the
15 Medicaid codes he or she has billed during the most recently completed calendar
16 year or, for newly eligible physicians, the prior month.
- 17 8.200.6.D Reimbursable Services
- 18 1. Primary care services with procedure codes listed in 8.200.6.E provided by a Primary
19 Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.
- 20 2. Primary care services with procedure codes listed in 8.200.6.E provided by a Physician
21 Assistant or Advanced Nurse Practitioner under the personal supervision of a Primary
22 Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.
- 23 a. For this program, when services by a non-physician provider are provided under
24 the personal supervision of a physician, the physician may be identified as the
25 rendering provider on claims.
- 26 8.200.6.E Procedure Codes
- 27 The procedure codes covered by the Colorado Medical Assistance program designated in the Healthcare
28 Common Procedure Coding System (HCPCS) for increased reimbursement shall be 99201-99499 and
29 Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472,
30 90473, and 90474.
- 31 8.200.6.F Supplemental Payment Procedure
- 32 1. Supplemental payments to eligible providers are calculated in the manner defined in 42
33 C.F.R. part 447.405 and identified in the schedule of maximum payments published on
34 the website of the Department of Health Care Policy and Financing. Title 42 of the Code
35 of Federal Regulations, Part 447.405 (2012) is hereby incorporated by reference into this
36 rule. Such incorporation, however, excludes later amendments to or additions of the
37 referenced material. These regulations are available for public inspection at the
38 Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado
39 80203.
- 40 2. Supplemental payments will be made on a quarterly basis.
- 41 3. The initial supplemental payment will be made after approval of the State Plan
42 Amendment approving the increase.

1 8.200.6.G Audits

2 1. Eligible providers shall maintain all increased payment to primary care provider program-
3 related records including documentation to support attestations.

4 2. Eligible providers shall permit the Department, the federal government, the Medicaid
5 Fraud Control Unit and any other duly authorized agent of a governmental agency:

6 a. To audit, inspect, examine, excerpt, copy and/or transcribe the records related to
7 this incentive program, to assure compliance with the program requirements,
8 Corrective Action Plans and attestations.

9 b. To access the provider's premises, to inspect and monitor, at all reasonable
10 times, the provider's compliance with program requirements, Corrective Action
11 Plans and attestations. Monitoring includes, but is not limited to, internal
12 evaluation procedures, examination of program data, special analyses, on-site
13 checking, observation of employee procedures and use of electronic health
14 information systems, formal audit examinations, or any other procedure.

15 3. Eligible providers shall cooperate with the State, the federal government, the Medicaid
16 Fraud Control Unit and any other duly authorized agent of a governmental agency
17 seeking to audit a provider's compliance with program requirements.

18 4. The Department may recoup by offset from any payment due to the provider any
19 supplemental payment made to the provider for services rendered during the period that
20 the provider did not meet the requirements for attestation in 8.200.6.C or does not have
21 documentation supporting the required attestation. The Department may recoup by offset
22 any improper or overpaid medical services paid to or on behalf of an eligible provider.

23 8.200.6.H Informal Reconsideration and Appeal

24 1. A provider may request an informal reconsideration of his or her exclusion from
25 participation in the Increased Medical Payments to Primary Care Providers Program by
26 submitting a written request within 30 days of date of notice that the provider is not
27 eligible to participate in the program.

28 2. A provider may request an informal reconsideration of the supplemental payment amount
29 by submitting a written request within 30 days of the receipt of the supplemental
30 payment.

31 3. The Department shall respond to the request for informal reconsideration with a decision
32 no later than 45 days after receipt of the request.

33 4. A provider dissatisfied with the Department's decision may appeal the informal
34 reconsideration decision according to the procedures set forth in 10 C.C.R. 2505-10
35 Section 8.050.3 PROVIDER APPEALS.