

# Colorado Medicaid State Plan Services

## Service Descriptions for Waiver Modernization Sub-Group

5/1/2013

Department of Health Care Policy and Financing

## Table of Contents

<b>Overview of Colorado Medicaid State Plan Services</b> .....	<b>1</b>
<b>Covered Benefits</b> .....	<b>5</b>
<b>Allergy</b> .....	<b>7</b>
<b>Bariatric</b> .....	<b>7</b>
<b>Health Exams</b> .....	<b>7</b>
<b>Dialysis</b> .....	<b>8</b>
<b>Eye Care</b> .....	<b>8</b>
<b>Foot Care</b> .....	<b>8</b>
<b>Hearing</b> .....	<b>9</b>
<b>Immunization</b> .....	<b>9</b>
<b>Prevention Care</b> .....	<b>9</b>
<b>Tobacco Cessation</b> .....	<b>10</b>
<b>Therapies</b> .....	<b>10</b>
Physician Services Rule (10 CCR 2505-10 8.200) .....	11
<b>Dental</b> .....	<b>14</b>
Dental Services Rule (10 CCR 2505-10 8.201).....	14
<b>Prescription Drugs</b> .....	<b>16</b>
Pharmaceutical Services Rule (10 CCR 2505-10, 8.800) .....	16
<b>Family Planning Benefit</b> .....	<b>36</b>
Abortion Services .....	36

Family Planning Services Rule (10 CCR 2505-10, 8.730) .....	36
<b>Women’s Health</b> .....	<b>40</b>
Breast and Cervical Cancer Program (10 CCR 2505-10, 8.715).....	40
<b>Maternity Services</b> .....	<b>44</b>
<b>Genetic Testing</b> .....	<b>44</b>
Prenatal Plus Program (10 CCR 2505-10, 8.748).....	44
Nurse Home Visitor Program (10 CCR 2505-10, 8.749) .....	48
Special Connection (10 CCR 2505-10, 8.745).....	49
<b>Lab and X-Ray</b> .....	<b>52</b>
Lab, X-Ray, and Diagnostics (10 CCR 2505-10, 8.600) .....	52
<b>Surgery</b> .....	<b>53</b>
Hospital Services (10 CCR 2505-10, 8.300) .....	53
<b>Drug and Alcohol</b> .....	<b>70</b>
Outpatient Substance Abuse Treatment (10 CCR 2505-10, 8.746) .....	70
<b>Hospice</b> .....	<b>72</b>
Hospice(10 CCR 2505-10, 8.550) .....	72
<b>Private Duty Nursing</b> .....	<b>80</b>
Private Duty Nursing (10 CCR 2505-10, 8.540) .....	80
<b>Durable Medical Equipment</b> .....	<b>89</b>
Durable Medical Equipment (10 CCR 2505-10, 8.590) .....	89
<b>Non-Emergent Medical Transportation</b> .....	<b>101</b>

Non-Emergent Medical Transportation (10 CCR 2505-10, 8.014) .....	101
<b>Oxygen and Supplies</b> .....	<b>102</b>
Oxygen and Supplies Rule (10 CCR 2505-10, 8.580) .....	102
<b>Home Health Services</b> .....	<b>105</b>
Home Health Rule (10 CCR 2505-10, 8.520) .....	105
<b>Screening, Brief Intervention, Referral to Treatment (SBIRT) Program</b> .....	<b>109</b>
SBIRT Rule (10 CCR 2505-10, 8.747) .....	109
<b>Nursing Facility Benefit</b> .....	<b>112</b>
Nursing Facility Rule (10 CCR 2505-10, 8.440) .....	112
<b>Mental Health Services</b> .....	<b>120</b>
Community Mental Health Rule (10 CCR 2505-10, 8.212) .....	120
<b>Early and Periodic Screening, Diagnosis &amp; Treatment (EPSDT)</b> .....	<b>127</b>
Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Rule (10 CCR 2505-10, 8.280) .....	128

## COLORADO MEDICAID STATE PLAN BENEFITS

Colorado Medicaid is public health insurance for Colorado's families, children, pregnant women, blind, disabled, and elderly residents. Clients who receive fee-for-service Medicaid can get services from any provider that accepts Medicaid clients. There is no need to get a referral to see a particular doctor, but doctors do not have to take new patients either.

Most people who are eligible for Medicaid fall into one of these categories:

### General Medicaid Requirements

1. If you are under the age of 65 and don't have dependent children, you can receive Medicaid if:
  - You are blind or disabled according to the Social Security Administration (SSA)  
AND
  - You can receive Supplemental Security Income (SSI) through SSA
    - Your income is less than \$674 a month
    - Your total assets are less than \$2,000 for an individual or \$3,000 for a couple
2. If you are age 65 or older, you can receive Medicaid if:
  - You can receive SSI or an Old Age Pension (OAP)  
AND
  - Your income is less than \$699 a month  
AND
  - Your total assets are less than \$2,000 for an individual or \$3,000 for a couple
3. If you're a parent of a dependent child, or a child between the ages of 0-18, you can receive Medicaid if:
  - You are a parent whose income equals 100% of the federal poverty level (FPL) or less
  - You are a child ages 6-18 whose family's income equals 133% FPL or less as of September 1, 2011
  - You are a child under the age of 6 or a pregnant woman whose family's income equals 133% FPL or less

### Presumptive Eligibility

4. Once you've applied for Medicaid coverage, it may take a few weeks for Colorado Medicaid to review your application. If you are younger than 18 years old or a pregnant woman, "Presumptive Eligibility" means that you can have temporary health insurance while Colorado Medicaid is reviewing your application.

### Medicaid Long-Term Care Requirements

5. Medicaid Long-Term Care (LTC) benefits help people who need medical care for long periods of time (more than 30 days). Long term care can be provided in a home or community-based setting (HCBS) or in a facility, like a nursing home. You can receive long-term care benefits if you:
  - Have a disability:
    - You are under the age of 65 and you are disabled according to the Social Security Administration.AND
  - Have low income:
    - Your income is less than \$2,022 a month. Your spouse's income is not included.AND
  - Have limited resources:
    - Your resources are less than \$2,000.AND
  - Need a high level of care:
    - A case manager will review your medical needs and how active you are to decide if you need long-term care services.

## COVERED BENEFITS FOR COLORADO STATE PLAN MEDICAID

The services that are listed in this section are only benefits when they are necessary for the client's health and wellbeing

<b>Benefit</b>	<b>Allergy Treatment</b>
What is Covered	Allergy Tests and Treatment
What is NOT Covered	Ingestion (Oral) Challenge Test
Limits	NA
<b>Benefit</b>	<b>Bariatric (Weight Loss) Surgery</b>
What is Covered	Weight loss surgery is covered if you are determined to be severely obese and can include: <ol style="list-style-type: none"> <li>1. Roux-en-Y Gastric Bypass;</li> <li>2. Adjustable Gastric Banding;</li> <li>3. Biliopancreatic Diversion with or without Duodenal Switch;</li> <li>4. Vertical-Banded Gastroplasty;</li> <li>5. Vertical Sleeve Gastroplasty.</li> </ol>
What is NOT Covered	Cosmetic Surgery associated with the results of weight loss surgery.
Limits	Only one weight loss surgery is covered per client's lifetime
<b>Benefit</b>	<b>Health Exams</b>
What is Covered	1. Regular doctor's checkups (healthy visits), and health exams when you are sick (sick visits).
What is NOT Covered	A physical exam that's required by your work or school.
Limits	Only one healthy visit every 12 months is covered.

<b>Benefit</b>	<b>Dialysis Treatment</b>
What is Covered	Treatment for acute kidney injury and end-stage renal disease.
What is NOT Covered	NA
Limits	NA
<b>Benefit</b>	<b>Eye Care</b>
What is Covered	<p>For adults (21 and older):</p> <ul style="list-style-type: none"> <li>• Eye exams if there is a problem with your eyes that is affecting your health (like glaucoma or migraines) and eyeglasses or contact lenses after you have eye surgery to treat a medical condition such as cataracts.</li> </ul> <p>For children (20 and younger):</p> <ul style="list-style-type: none"> <li>• Routine eye check-ups and glasses (both lenses and frames),</li> <li>• Repair or replacement of broken lenses or frames.</li> </ul>
What is NOT Covered	<ul style="list-style-type: none"> <li>• Surgery to allow you to see without glasses such as Lasik Surgery.</li> </ul> <p>Contact Lenses to wear instead of glasses</p>
Limits	Doctors called ophthalmologists, optometrists, or opticians can provide these services.
<b>Benefit</b>	<b>Foot Care</b>
What is Covered	Foot and ankle exams and treatments
What is NOT Covered	NA
Limits	If you need routine foot care more than once every 60 days, Medicaid will need to approve the service before you can use it.

<b>Benefit</b>	<b>Hearing Services</b>
What is Covered	<p>For adults (21 and older):</p> <ul style="list-style-type: none"> <li>• Replacement Parts and Batteries for hearing aids and cochlear implants that you have been using.</li> </ul> <p>For children (20 and younger):</p> <ul style="list-style-type: none"> <li>• Hearing aids,</li> <li>• Certain training to use hearing aids,</li> <li>• Cochlear implants, and</li> <li>• Therapy for children with hearing problems.</li> </ul>
What is NOT Covered	<p>For adults (21 and older):</p> <ul style="list-style-type: none"> <li>• Routine hearing exams</li> <li>• Hearing aids</li> </ul> <p>Cochlear Implants</p>
Limits	<p>When newborns have a hearing loss that's diagnosed by an audiologist (type of provider who focuses on hearing), the Colorado Home Intervention Program (CHIP) can offer the newborn additional services and treatment. These services are covered by Colorado Medicaid. The services focus on family and the home environment, are for children 3 years old or younger, and don't need approval from Medicaid before the service is provided.</p>
<b>Benefit</b>	<b>Immunizations</b>
What is Covered	All Advisory Committee on Immunization Practices (ACIP) recommended shots for children (20 and younger), and most of the ACIP recommended shots for adults (21 and older).
What is NOT Covered	Shots that you need to travel to other countries are not covered.
Limits	NA
<b>Benefit</b>	<b>Preventative Care</b>
What is Covered	<ul style="list-style-type: none"> <li>• Abdominal Aortic Aneurysm Screening</li> <li>• Blood Pressure Screening</li> <li>• Bone Mass Measurement</li> <li>• Breast Cancer Screening (Mammogram)</li> </ul>

	<ul style="list-style-type: none"> <li>• Cardiovascular (Cholesterol &amp; Lipids) Screening</li> <li>• Cervical and Vaginal Cancer Screening</li> <li>• Colorectal Cancer Screen</li> <li>• Diabetes Screening</li> <li>• Depression Screening (20 and younger)</li> <li>• Post-Partum Depression Screening (20 and younger)</li> <li>• Developmental Screening (0 – 4)</li> <li>• Autism Screening (0 – 2)</li> <li>• HIV Screening</li> <li>• STD Screening</li> <li>• PSA (Prostate Specific Antigen):</li> <li>• Thyroid Function</li> </ul>
What is NOT Covered	More than one of the same test for the same problem.
Limits	There are limits are certain tests. Please ask your health care provider for details.
<b>Benefit</b>	<b>Tobacco Cessation</b>
What is Covered	Covered only when your doctor writes you a prescription for a tobacco cessation product.
What is NOT Covered	NA
Limits	Includes any FDA approved smoking cessation medication for two (2), 90-day sessions in a year.
<b>Benefit</b>	<b>Therapies</b>
What is Covered	<p>Therapy after you are sick or injured, including:</p> <ul style="list-style-type: none"> <li>• Physical Therapy</li> <li>• Occupational Therapy (helps you do everyday activities)</li> <li>• Hearing and Speech Therapy</li> </ul>
What is NOT	<ul style="list-style-type: none"> <li>• For clients age 21 and older, with the exception of evaluation services, any approved PT and OT services in excess of the 24 unit limit will be considered non-covered services.</li> </ul>

Covered	<ul style="list-style-type: none"> <li>• Adult Maintenance Therapy: treatment that does not improve a condition over time for an adult, 21 years old or older</li> <li>• Recreational Activity/Therapeutic Exercises</li> </ul> <p>For example, Hippotherapy or Art Therapy</p>
Limits	<p>Your doctor will need to write a prescription for these services. After the initial evaluation, your therapist may need to get approval to continue treatment.</p> <p>As of January 1, 2012:          Outpatient therapy services are limited to 24 units of PT and 24 units of OT per year.          For clients age 20 and younger, prior authorization for PT and OT services in excess of the 24 unit limit is required.</p>
<b>PHYSICIAN SERVICES</b>	
<p><b>Rule:</b> <b>Section 8.200</b></p>	<p><b>8.200.1 DEFINITIONS</b></p> <p>An Advanced Practice Nurse is a provider that meets the requirements to practice advanced practice nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced Practice Nurse may have prescriptive authority.</p> <p>A Licensed Psychologist is a provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.</p> <p>Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.</p> <p>Medical Necessity is defined in 10 C.C.R. 2505-10, Section 8.076.1.8.</p> <p><b>8.200.2 PROVIDERS</b></p> <p>8.200.2.A A doctor of medicine or a doctor of osteopathy may order and provide all medical care goods and services within the scope of their license to provide such goods and services that are covered benefits of the Colorado Medical Assistance Program.</p> <ol style="list-style-type: none"> <li>1. A provider of covered dental care surgery can be either enrolled as a dentist or oral surgeon, but not both. A dentist may order and provide covered dental care.</li> </ol> <p>8.200.2.B Physician services that may be provided without a physician order by non-physician providers.</p> <ol style="list-style-type: none"> <li>1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.</li> <li>2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.             <ol style="list-style-type: none"> <li>a. Services ordered by a Licensed Psychologist but rendered by another provider shall be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.</li> </ol> </li> <li>3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado</li> </ol>

Revised Statutes without a physician order.

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

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

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

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

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

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

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

1. With the exception of the non-physician providers described in Sections 8.200.2.A through 8.200.2.C, a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Revised Statutes. If the Colorado Revised Statutes do not designate who has the authority to supervise, the non-physician provider shall provide services under the Direct Supervision of an enrolled physician.

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

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

### **8.200.3. BENEFITS**

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

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

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

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

a. Physical examinations are a benefit for preventive service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment for clients under the age of 21 as described in 10 C.C.R. 2505-10, Section 8.280.

b. Physical examination as a preventive service for adults is a benefit limited to one per state fiscal year.

4. Physician services for the provision of immunizations are a benefit. Vaccines provided to enrolled children that are eligible for the Vaccines for Children program shall be obtained through the Colorado Department of Public Health and Environment.

5. Physician services for laboratory testing described in 10 C.C.R. 2505-10, Section 8.660, are a benefit.

6. Occupational and physical therapy services are benefits.
7. Family planning services described in 10 C.C.R. 2505-10, Section 8.730 are benefits.
- 8.200.3.B Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.
1. Physician services may be provided as telemedicine.
  2. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.
- 8.200.3.C Services and goods generally excluded from coverage are identified in 10 C.C.R. 2505-10, Section 8.011.11.
- 8.200.4 CERTIFIED FAMILY PLANNING CLINICS**
- 8.200.4.A Laboratories at Certified Family Planning Clinics providing services must meet all Clinical Laboratory Improvement Amendment requirements.
- 8.200.4.B Services at a Certified Family Planning Clinic shall be rendered under the General Supervision of a physician. General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.
- 8.200.4.C The Certified Family Planning Clinic shall contact the client's Primary Care Provider or Primary Care Medical Provider or managed care organization, if applicable, prior to rendering services that require a referral.
- 8.200.5 REIMBURSEMENT**
- 8.200.5.A The amount of reimbursement for physician services is the lower of the following:
1. Submitted charges; or
  2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.
- 8.200.5.B Reimbursement for services may be made directly to Advanced Practice Nurses, registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed psychologists unless the non-physician practitioner is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.
- a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the employer's provider identification number.
- 8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid directly to the clinic and is the lower of the following:
1. Submitted charges; or
  2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.
- 8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural Health Center, clinic, home health agency, school, or physician.
- 8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a student in a graduate education program and the facility where the provider delivers services receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.
- 8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.

Benefit	Dental Services
What is Covered	<p>For adults (21 and older):</p> <ul style="list-style-type: none"> <li>• Emergency Services Only</li> </ul> <p>For Children (20 and younger):</p> <ul style="list-style-type: none"> <li>• Regular dental check-ups,</li> <li>• Cleanings, and</li> <li>• Fluoride applications beginning at age 1.</li> </ul> <p>Medicaid only covers orthodontics (braces) if your child has a severe problem that will get in the way of your child’s ability to chew or interfere with normal development.</p>
What is NOT Covered	<p>For adults (21 and older):</p> <ul style="list-style-type: none"> <li>• Preventive dental services (such as cleaning and regular dental checkups) not covered.</li> </ul> <p>Dentures</p>
Limits	<p>Fluoride application: two (2) times a year, or if the child is at risk, three times a year.</p>
<p>10 CCR 2505-10 8.201</p> <p><b>Dental</b></p>	
<p><b>8.201.1 DEFINITIONS</b></p> <p>Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.</p> <p>Condition of the Oral Cavity means a problem in the oral cavity requiring treatment.</p> <p>Concurrent Medical Condition means a pre-existing medically-diagnosed state that can be exacerbated by a condition present in the oral cavity.</p> <p>Emergency Treatment means the need for immediate intervention by a physician, osteopath or dentist to stabilize an oral cavity condition.</p> <p>Immediate Intervention or Treatment means services rendered within twelve (12) hours.</p> <p>Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.</p> <p><b>8.201.2 BENEFITS</b></p> <p>8.201.2.A. Treatment of a Condition of the Oral Cavity for Adult Clients with a Concurrent Medical Condition is a benefit.</p> <p>1. Allowable Concurrent Medical Conditions include:</p>	

- a. Neoplastic disease requiring chemotherapy and/or radiation.
- b. Pre and post organ transplant.
- c. Pregnancy.
- d. Chronic medical condition in which there is documentation that the medical condition is exacerbated by a Condition of the Oral Cavity.

#### 8.201.2.B. Exclusions.

- 1. The following services/treatments are not a benefit for Adult Clients under any circumstances:
  - a. Preventive services to include prophylaxis, fluoride treatment and oral hygiene instruction.
  - b. Treatment for dental caries, gingivitis and tooth fractures.
  - c. Restorative and cosmetic procedures.
  - d. Inlay and only restorations.
  - e. Crowns.
  - f. Treatment of the Oral Cavity in preparation for partial or full mouth dentures.
  - g. Assessment for, delivery of dentures or subsequent adjustments to dentures and bridges.

#### 8.201.2.C. Emergency Treatment.

- 1. Emergency Treatment can be provided to an Adult Client who:
  - a. Presents with an acute Condition of the Oral Cavity that requires hospitalization and or immediate surgical care.
  - b. 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.
- 2. Emergency Treatment provided to an Adult Client includes, but is not limited to:
  - a. Immediate Treatment or surgery to repair trauma to the jaw.
  - b. Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
  - c. Extraction of tooth or tooth structures associated with the Emergency Treatment of a Condition of the Oral Cavity.
  - d. Repair of traumatic Oral Cavity wounds.
  - e. Anesthesia services ancillary to the provision of emergency treatment.

#### **8.201.3 PRIOR AUTHORIZATION REQUEST**

##### 8.201.3.A. Prior authorization is required for treatment rendered for an Adult Client with a Concurrent Medical Condition.

- 1. Emergency Services do not require a prior authorization before services can be rendered.
- 2. All prior authorization requests shall include:
  - a. Statement identifying the chronic medical condition.
  - b. Description of Condition of the Oral Cavity that is exacerbating the chronic medical condition.
  - c. Narrative describing why the recommended treatment is necessary to prevent exacerbation of the Adult Client's chronic medical condition.

#### 8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

##### 8.201.4.A. To submit claims for treatment of oral medical conditions for Adult Clients, the provider shall meet one of the following requirements:

- 1. Enroll as a physician and bill according to all medical billing requirements including using Current Procedural Terminology (CPT) codes.
- 2. Enroll as a dentist and bill according to all dental billing requirements including using Current Dental Terminology (CDT) codes.

Benefit	Prescription Drugs
What is Covered	Certain prescription drugs are covered.
What is NOT Covered	<ul style="list-style-type: none"> <li>• Non-Rebatable Drugs</li> <li>• Fertility Drugs</li> <li>• DESI Drugs</li> <li>• Cosmetic Drugs</li> <li>• Weight-Loss Drugs</li> </ul>
Limits	<p>Colorado Medicaid uses a preferred drug list (PDL), which is a list of effective medications that Colorado Medicaid will cover prior authorization.</p> <ul style="list-style-type: none"> <li>• Non-preferred Drugs are still available, but requires a prior authorization.</li> <li>• Coverage for medications not listed on the PDL is determined by the Medicaid Program and is primarily unrestricted.</li> </ul> <p>Your health care provider or pharmacist can tell you if your prescriptions are on the PDL, require a prior authorization, or have quantity limits.</p>

10 CCR 2505-10 8.800

### Pharmaceuticals

#### 8.800.1 DEFINITIONS

340B Pharmacy means any pharmacy that participates in the Federal Public Health Service's 340B Drug Pricing Program as described in 42 U.S.C. Section 256b (2011). 42 U.S.C. Section 256b (2011) is hereby incorporated by reference into this rule. This rule does not include any later amendments or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-79524.

Average Acquisition Cost (AAC) means the average acquisition cost for like drugs grouped by Generic Code Number (GCN). For GCNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GCN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.

Conflict of Interest means having competing professional or personal obligations or personal or financial interests that would make it difficult to fulfill duties in an objective manner.

Department means the Colorado Department of Health Care Policy and Financing.

Dispensing Fee means the reimbursement amount for costs associated with filling a prescription. Costs include salary costs, pharmacy department costs, facility costs, and other costs.

Dispensing Physician means a licensed physician who prepares, dispenses and instructs clients to self administer medication.

Drug Class means a group of drugs that treat a particular disease or symptom and are in the same therapeutic class.

Emergency Situation means any condition that is life threatening or requires immediate medical intervention as determined in good faith by the pharmacist.

E-prescription means the transmission of a prescription through an electronic application.

Fiscal Agent means a private contractor that supports and operates Colorado's Medicaid Management Information System and performs operational activities that support the administration of the Medical Assistance Program.

Federal Upper Limit (FUL) means the upper limit for multiple source drugs as set by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 447.512 - 447.516 (2011). 42 C.F.R. 447.512 - 447.516 (2011) is hereby incorporated by reference into this rule. This rule does not include any later amendments or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and

Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000.

Generic Code Number (GCN) means a standard number to group together drugs that have the same ingredients, route of administration, drug strength, and dosage form.

Good Cause means failing to disclose a Conflict of Interest; participating in wrongdoing or misconduct in the case of serving as a member of a committee or other advisory body for the Department; failing to perform required duties; or missing two scheduled meetings per calendar year.

Government Pharmacy means any pharmacy whose primary function is to provide drugs and services to clients of a facility whose operating funds are appropriated directly from the State of Colorado or the federal government excluding pharmacies funded through Indian Health Services.

Institutional Pharmacy means any pharmacy whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility with which the pharmacy is associated.

Mail Order Pharmacy means any pharmacy that delivers drugs primarily by mail.

Maintenance Medication means any drug, as determined by the Department, which is used to treat a chronic illness or symptoms of a chronic illness.

Medical Assistance Program shall have the meaning defined in 25.5-1-103(5), C.R.S. (2008).

Medical Assistance Program Allowable Charge means the allowed ingredient cost plus a dispensing fee or the provider's Usual and Customary Charge, whichever is less, minus the client's copayment as determined according to 10 C.C.R. 2505-10, Section 8.754.

Medical Director means the physician or physicians who advise the Department.

Medicare Part D means the drug benefit provided to Part D Eligible Individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Medicare Part D Drugs means drugs defined at 42 U.S.C. Section 1395w-102(e) (2012) and 42 C.F.R. Section 423.100 (2012). This rule does not include any later amendments or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-79524.

Non-preferred Drug means a drug that requires a prior authorization as described in 10 C.C.R. 2505-10, Section 8.800.7, before being payable by the Medical Assistance Program.

Old Age Pension Health Care Program and Old Age Pension Health Care Supplemental Program (OAP State Only) means the program established to provide necessary medical care for clients that qualify for Old Age Pension but do not qualify for the Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes.

Over-the-Counter (OTC) means a drug that can be purchased without a physician's prescription.

Part D Eligible Individual has the same meaning as defined in 10 C.C.R. 2505-10, Section 8.1000.1.

Pharmacy and Therapeutics Committee (P&T Committee) means an advisory board that shall perform reviews and make recommendations which facilitate the development and maintenance of the Preferred Drug List as described in 10 C.C.R. 2505-10, Section 8.800.17.

Physical Hardship means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or, any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Preferred Drug means a drug that is payable by the Medical Assistance Program without first obtaining a prior authorization unless otherwise required to protect the health and safety of specific clients.

Preferred Drug List (PDL) means a list, applicable only to fee-for-service and primary care physician Medical Assistance Program non-Medicare clients, which identifies the Preferred Drugs and Non-preferred Drugs within a drug class.

Provider Bulletin means a document published and distributed by program and policy staff to communicate information to providers related to the Department.

Retail Pharmacy means any pharmacy that is not a 340B Pharmacy, Government Pharmacy, Institutional Pharmacy, Mail Order Pharmacy, or Rural Pharmacy.

Rural Pharmacy means any pharmacy that is the only pharmacy within a twenty-mile radius.

Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the Submitted Ingredient Cost means the 340B purchase price.

Total Prescription Volume means all new and refill prescriptions dispensed for all payer types. Payer types include but are not limited to Medicaid, Medicare, commercial, third-party, and uninsured.

Usual and Customary Charge means the reimbursement amount the provider charges the general public to pay for a drug.

Wholesale Acquisition Cost (WAC) means with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

#### **8.800.2 CONDITIONS OF PARTICIPATION**

8.800.2.A. A pharmacy must be licensed or certified by the appropriate regulatory body in the state in which it is located. Pharmacies located outside of Colorado must also be registered in Colorado if required by the Colorado Board of Pharmacy.

8.800.2.B. Any pharmacy or Dispensing Physician, whether in-state or out-of-state, that submits claims for reimbursement must first submit an application for participation to the Department. The provider shall be notified whether or not the application is accepted and, if accepted, the effective date. An accepted application must be on file with the Department before reimbursement shall be made. An application may be denied, terminated or not renewed for any of the grounds set forth in 10 C.C.R. 2505-10, Sections 8.050 or 8.130.

8.800.2.C. An out-of-state pharmacy may enroll as a provider and receive payment for dispensed drugs under any of the following circumstances:

1. The client has been injured or suffered a disease or illness while temporarily absent from Colorado. In that case, the Department shall reimburse an out-of-state pharmacy for drugs dispensed on an emergency basis only.

2. The out-of-state pharmacy is located in a town that is near the Colorado border and is listed in the Medical Assistance Program Manual as an approved town that borders Colorado. Such pharmacy shall be reimbursed for drugs in the same manner as in-state pharmacies.
3. The out-of-state pharmacy provides drugs to foster care children or other clients who permanently reside in other states and are wards of Colorado. Such pharmacy shall be reimbursed for drugs in the same manner as in-state pharmacies.
4. The out-of-state pharmacy provides a drug that is not available through any pharmacies located within Colorado. In that case, the Department shall reimburse the out-of-state pharmacy for those services only.
5. The out-of-state pharmacy is a Mail Order Pharmacy that mails Maintenance Medications to clients meeting the requirements of 10 C.C.R. 2505-10 Section 8.800.3.

#### **8.800.3 MAIL ORDER**

8.800.3.A. Mail order delivery of a Maintenance Medication by a Mail Order Pharmacy is a pharmacy benefit when:

1. A client has been informed that a local pharmacy may be able to provide the same services as a Mail Order Pharmacy; and
2. A client, or a client's physician, declares in writing that the client has:
  - a. A Physical Hardship that prohibits the client from obtaining a Maintenance Medication from a local pharmacy; or
  - b. Third-party insurance that allows the client to obtain a Maintenance Medication from a Mail Order Pharmacy.

#### **8.800.4 DRUG BENEFITS**

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed 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 U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. The following drug categories may be excluded from being a drug benefit or may be subject to restrictions:

1. Agents when used for anorexia, weight loss or weight gain;
2. Agents when used to promote fertility;
3. Agents when used for cosmetic purposes or hair growth;
4. Agents when used for symptomatic relief of cough and colds;
5. Agents when used to promote smoking cessation;
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
7. Non-prescription Drugs;
8. Covered outpatient drugs that 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;
9. Barbiturates;
10. Benzodiazepines; and
11. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

8.800.4.C. The following are not pharmacy benefits of the Medical Assistance Program:

1. Spirituous liquors of any kind;

2. Dietary needs or food supplements;
3. Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;
4. Medical supplies;
5. Drugs classified by the FDA as "investigational" or "experimental" ;
6. Less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program; and
7. Medicare Part D Drugs for Part D Eligible Individuals.

8.800.4.D. Aspirin, OTC insulin and medications that are available OTC and that have been designated as Preferred Drugs on the PDL, in compliance with the provisions of Section 8.800.16, are the only OTC drugs that are regular benefits without restrictions.

8.800.4.E. Restrictions may be placed on drugs in accordance with 42 U.S.C. Section 1396r-8(d) (2007), which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Without limiting the foregoing, restrictions 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, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.

8.800.4.F. Medicare Part D Drugs shall not be covered by the Medical Assistance Program for Part D Eligible Individuals.

8.800.4.G. To the extent the drug categories listed in Section 8.800.4.B are not Medicare Part D Drugs, they shall be covered for Part D Eligible Individuals in the same manner as they are covered for all other eligible Medical Assistance Program clients.

8.800.4.H. Generic drugs shall be dispensed to clients in fee-for-service programs unless:

1. Only a brand name drug is manufactured.
2. A generic drug is not therapeutically equivalent to the brand name drug.
3. The final cost of the brand name drug is less expensive to the Department.
4. The drug is in one of the following exempted classes for the treatment of:
  - a. Biologically based mental illness as defined in C.R.S. 10-16-104 (5.5) (2008). Without limiting the foregoing, restrictions 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, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.;
  - b. Treatment of cancer;
  - c. Treatment of epilepsy; or
  - d. Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.
5. The Department shall grant an exception to this requirement if:
  - a. The client has been stabilized on a 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; or
  - b. The client is started on a generic drug but is unable to continue treatment on the generic drug.

Such exceptions shall be granted in accordance with procedures established by the Department.

#### **8.800.5 DRUGS ADMINISTERED OR PROVIDED IN PHYSICIAN OFFICES OR CLINICS**

8.800.5.A. Any drugs administered in a physician's office or clinic are considered part of the physician's services and not a pharmacy benefit. Such drugs shall be billed on the physician claim form. Pharmacies may not bill for any products that shall be administered in a physician's office or clinic.

8.800.5.B. Dispensing Physicians whose offices or sites of practice are located more than 25 miles from the nearest participating pharmacy may be reimbursed for drugs that are dispensed from their offices and that shall be self-administered by the client.

**8.800.6 COMPOUNDED PRESCRIPTIONS**

8.800.6.A Compounded prescriptions shall be billed by submitting all ingredients in the prescription as one multiple-line claim. The provider will be reimbursed for each ingredient of the prescription according to Section 8.800.13.A-F, and will also be reimbursed for the dispensing fee according to Section 8.800.13.H. A compounding fee, over and above the stated dispensing fee, will not be paid.

**8.800.7 PRIOR AUTHORIZATION REQUIREMENTS**

8.800.7.A. Prior authorization shall be obtained before drugs that are subject to prior authorization restrictions may be provided as a benefit. Prior authorization requests may be made by the client's physician, any other health care provider who has authority under Colorado law to prescribe the medication being requested or any long-term-care pharmacy or infusion pharmacy that fills prescriptions on behalf of the client and is acting as the agent of the prescriber. The prior authorization request shall be made to the Fiscal Agent. The prescriber shall provide any information requested by the Fiscal Agent including, but not limited to, the following:

1. Client name, Medical Assistance Program state identification number, and birth date;
2. Name of the drug(s) requested;
3. Strength and quantity of drug(s) requested; and
4. Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier.

8.800.7.B. When the prior authorization request is received, it shall be reviewed to determine if the request is complete. If it is complete, the requesting provider shall be notified of the approval or denial of the prior authorization request via telephone and/or facsimile at the time the request is made, if possible, but in no case later than 24 hours after the request is made. Any verbal decision shall be confirmed in writing. If the prior authorization request is incomplete or additional information is needed, an inquiry to the party requesting the prior authorization shall be initiated within one working day from the day the request was received. If no response is received from that party within 24 hours of the Department's inquiry, the prior authorization shall be denied.

8.800.7.C. In an emergency situation, the pharmacy may dispense up to a 72-hour supply of a covered drug that requires a prior authorization if it is not reasonably possible to request a prior authorization for the drug before it must be dispensed to the client for proper treatment. The pharmacist may call the Prior Authorization Help Desk to receive override approval.

8.800.7.D. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed additions to the drugs that are subject to prior authorization. The list of interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any drugs become subject to prior authorization. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to prior authorization, the new drug shall also be subject to prior authorization without any comment period.

8.800.7.E. Any changes to the drugs that are subject to prior authorization or any documentation required to obtain a prior authorization shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such changes.

**8.800.8 LIMIT REQUIREMENTS**

8.800.8.A. Limits shall include a limit on the number of units of a drug that a client may receive in a 30-day or 100-day period, as applicable. Limits placed on the coverage of any drugs under the Medical Assistance Program shall result in pharmaceutical services still being sufficient in the amount, duration and scope to meet all applicable federal laws and regulations.

8.800.8.B. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed limits on drugs. The list of

interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any such drugs are limited. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to limits, the new drug shall also be subject to limits without any comment period.

8.800.8.C. Any limits on drugs or changes to the drugs that are subject to limits shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such limits or changes to the limits.

#### **8.800.9 DRUG UTILIZATION REVIEW**

##### **8.800.9.A. Prospective Drug Utilization Review**

1. A pharmacist shall review the available client record information with each drug order presented for dispensing for purposes of promoting therapeutic appropriateness by considering the following:

- a. Over-utilization or under-utilization;
- b. Therapeutic duplication;
- c. Drug-disease contraindications;
- d. Drug-drug interactions;
- e. Incorrect drug dosage or duration of drug treatment;
- f. Drug-allergy interactions; and
- g. Clinical abuse/misuse.

2. When in the pharmacist's professional judgment a potential problem is identified, the pharmacist shall take appropriate steps to avoid or resolve the problem, which may, if necessary, include consultation with the prescriber.

##### **8.800.9.B. Client Counseling**

1. A pharmacist or pharmacy intern shall offer drug therapy counseling to each Medical Assistance Program client or the caregiver of such client with a new prescription or with a refill prescription if the pharmacist or pharmacy intern believes that it is in the best interest of the client. The offer to counsel shall be face-to-face communication whenever practicable or by telephone.

2. If the offer to counsel is accepted, a pharmacist or pharmacy intern shall review the client's record and then discuss with the client or the client's caregiver those matters that, in the exercise of his or her professional judgment, the pharmacist or pharmacy intern considers significant including the following:

- a. The name and description of the drug;
- b. The dosage form, dose, route of administration, and duration of drug therapy;
- c. Intended use of the drug and expected action;
- d. Special directions and precautions for preparation, administration, and use by the client;
- e. Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- f. Techniques for self-monitoring drug therapy;
- g. Proper storage;
- h. Prescription refill information; and
- i. Action to be taken in the event of a missed dose.

3. Alternative forms of client information shall not be used in lieu of the personal discussion requirement for client counseling but may be used to

supplement this discussion when appropriate. Examples of such alternative forms of client information include written information leaflets, auxiliary or pictogram labels, and video programs.

4. Client counseling by a pharmacist or pharmacy intern as described in this section shall not be required for clients of a hospital or institution where other licensed health care professionals administer the prescribed drugs pursuant to a chart order.

5. A pharmacist or pharmacy intern shall not be required to counsel a client or caregiver when the client or caregiver refuses such consultation. The pharmacist or pharmacy intern shall keep records indicating when counseling was not or could not be provided.

#### 8.800.9.C. Retrospective Drug Utilization Review

1. The Department shall periodically review claims data in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and clients receiving drug benefits or associated with specific drugs or categories of drugs.

2. Such reviews shall be based on predetermined criteria that monitor for therapeutic problems including but not limited to therapeutic appropriateness, over-utilization, under-utilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse.

#### 8.800.9.D. Drug Utilization Review (DUR) Board

1. The DUR Board shall serve in an advisory capacity to the Department. The DUR Board's activities shall include but are not limited to the following:

a. Approving the application of standards;

b. Conducting retrospective DUR;

c. Conducting ongoing interventions with pharmacists and physicians concerning therapy problems identified in the course of the DUR program;

d. Making recommendations regarding certain Department policy issues as determined by the Department; however, the Department shall consider all such recommendations but shall not be bound by them; and

e. Engaging in any other activities as designated by the Department.

2. The DUR Board shall meet no less frequently than quarterly.

3. The DUR Board shall consist of nine members appointed by the Executive Director of the Department based upon recommendations of relevant professional associations. Membership on the Board shall consist of four physicians and four pharmacists, all of whom are licensed and actively practicing in Colorado, and one non-voting representative from the pharmaceutical industry. The physicians and pharmacists shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director. The terms shall be staggered so that in each year, there are two physician members and two pharmacist positions that are reappointed. The pharmaceutical industry representative shall serve a one-year term and shall not be reappointed.

4. The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

a. The clinically appropriate prescribing of covered outpatient drugs;

b. The clinically appropriate dispensing and monitoring of outpatient drugs;

c. Drug utilization review, evaluation and intervention; or

d. Medical quality assurance.

5. The DUR Board shall have those responsibilities as set forth in 42 U.S.C. Section 1396r-8(g)(3)(C)(2007) and 42 C.F.R. Section 456-716(d) (2008), both of which are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the

following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

6. The DUR Board is also responsible for preparing and submitting a report to the Department on an annual basis which shall include the following information:

- a. A description of the activities of the DUR Board, including the nature and scope of the prospective and retrospective drug utilization review programs;
- b. A summary of the interventions used;
- c. An assessment of the impact of these educational interventions on quality of care; and
- d. An estimate of the cost savings generated as the result of the program.

7. The DUR Board under the direction of the Department may delegate to a retrospective DUR contractor the responsibility of preparation of continuing education programs, the conduct of interventions and the preparation of any reports.

#### **8.800.10 BILLING PROCEDURES**

8.800.10.A. Charges for prescribed drugs shall be submitted on an appropriate pharmacy claim form or electronically in a Department approved format. All entries shall be legible.

8.800.10.B. Each claim must identify the client, prescribing physician, date of service, National Drug Code number of the drug actually dispensed, prescription number, quantity dispensed, days' supply, the Usual and Customary Charge and any other information required by the Department.

#### **8.800.11 PRESCRIPTION RECORD REQUIREMENTS**

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

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

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

1. Name, address, telephone number, date of birth or age, and gender;
2. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive, chronological list of medications and prescribed relevant devices; and
3. Additional comments relevant to the client's pharmaceutical care as described in the Prospective Drug Review and Client Counseling sections set forth in 10 C.C.R. 2505-10, Section 8.800.9.

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

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

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

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

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

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

- i) Void/Illegal/Copy Pantograph with or with the Reverse Rx feature. The word "Void", "Illegal", or "Copy" appears when the prescription is photocopied. If the paper has the Reverse Rx feature, the Rx symbol must disappear when photocopied at light setting. The Reverse Rx feature is not allowed as a feature by itself.
- ii) Micro-fine printed security message generated by a computer, electronic medical records system or other electronic means. The message may serve as a signature line or border. This must be printed in 0.5 font or smaller and readable when viewed at 5x magnification or greater and illegible when copied.
- iii) Coin-reactive ink or security mark. The pad or paper identifies an area on the pad/paper where the ink changes color or reveals wording or a picture when that area is rubbed by a coin. This must be accompanied by a message describing what is necessary to demonstrate authenticity.
- iv) Security print watermark. Specific wording is printed on the front or back of the prescription paper and can only be seen when viewed at an angle.
- v) Paper with a watermark. This is paper that contains a watermark that can be seen when backlit.

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

- i) An erasure-revealing background. This is a background that consists of a non-white solid color or consistent pattern that has been printed onto the paper. If an erasure or modification is attempted, the background will show marks or the color of the underlying paper where the alterations were made.
- ii) Toner fusing technology for laser-printed prescriptions. This is a treatment that is added to the surface of the paper to create a strong bond between the laser-printed text and the paper. The computer-printed information cannot be lifted from the surface of the paper without damaging the paper.
- iii) Chemical-reactive paper. This is paper that contains features that show discoloration or reveals a hidden message if solvents are used to attempt to wash the ink from its surface.
- iv) Plain bond paper combined with inkjet-printing. The inkjet printing is absorbed into the high grade paper stock. Erasures and modifications cannot be made without damaging the paper.
- v) Pre-printed quantity check-off boxes indicated in ranges of no more than 25 per range combined with a written quantity. The range box corresponding to the quantity prescribed must be checked by the prescriber for the prescription to be valid.
- vi) Pre-printed refill indicator where the number of refills allowed is marked or no refills or "NR" is marked when no refills are authorized. Refill information must be completed by the prescriber for the prescription to be valid.
- vii) Characters surrounding the authorized dispensing quantity and the number of refills. Special characters such as a series of asterisks must be repeated on both sides of the numbers indicating the quantity and the number of refills authorized (e.g., Quantity \*\*\*50\*\*\* Refill \*\*\*3\*\*\*). This is acceptable only for prescriptions that are generated by a computer, electronic medical records

system or other electronic means.

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

- i) Security features listed visibly in a box, band or border on the prescription. This must be a complete listing of all of the security features incorporated into the prescription pad/paper in order to minimize tampering.
- ii) Security threads. Metal, fluorescent or plastic security threads are embedded into the prescription pad/paper.
- iii) Thermochromic ink. All or some of the pad or paper is pre-printed with ink that changes color when exposed to heat and then changes back to its original color when cooled. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

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

- a. Prescriptions are transmitted by telephone, fax or E-prescription directly to the pharmacy by the prescriber or prescriber's staff that is authorized to act on the prescriber's behalf; or
- b. A prescriber administers or provides the drug directly to the client; or
- c. A prescriber in an institutional setting writes the order into the medical record and then the order is given by medical staff directly to the pharmacy; or
- d. A Medical Assistance Program managed care entity pays for or dispenses the prescription;

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

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

- a. Inpatient hospital services;
- b. Hospice services;
- c. Dental services (except when a State Plan authorizes direct reimbursement to the dispensing dentist);
- d. Physician services;
- e. Outpatient hospital services;
- f. Nursing facilities and intermediate care facilities for the mentally retarded;
- g. Other laboratory and x-ray services; or
- h. Renal dialysis.

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

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

8.800.11.E. Prescription tracking and claim reversals

1. The pharmacy shall keep:

- a. A chronological log that contains the client's name, his or her signature or agent's signature and date of the receipt of the prescription; or
- b. An electronic prescription tracking system that records the status of prescriptions through the fill process including the date and time that the prescription was transferred to a person whom pharmacy personnel verified was the client or agent of the client.

2. Pharmacies using a chronological log shall review all Medical Assistance Program prescriptions in shall-call status (filled but not released to the client or the client's agent) at least weekly and enter a reversal of prescriptions not picked up within 14 days of billing. In no case shall prescriptions be kept in shall-call status for more than 21 days. The pharmacy shall maintain a record of each reversal for audit purposes.
3. Pharmacies using an electronic prescription tracking system shall review all Medical Assistance Program prescriptions in shall-call status on a daily basis and enter a reversal of prescriptions not picked up within 10 days of billing. In no case shall prescriptions be kept in shall-call status for more than 14 days. The pharmacy shall maintain a record of each reversal for audit purposes.
4. Upon receipt of a written request from the Department or the Medicaid Fraud Unit for a record of Medical Assistance Program claims and reversals, the pharmacy has up to 72 hours or three working days to provide the requested information or to enter into an agreement with the Department or Unit stating the specific time within which the data shall be produced.

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

#### **8.800.12 BASIS FOR REIMBURSEMENT**

8.800.12.A. Reimbursement shall be made for prescribed drugs provided to clients when all of the following conditions are met:

1. The item dispensed is a covered benefit under the Medical Assistance Program and meets any and all restriction requirements as set forth in 10 C.C.R. 2505-10, Section 8.800 or any policies there under;
2. The person prescribing the item is licensed to do so under applicable law;
3. The item is dispensed pursuant to a valid prescription order;
4. The prescription is dispensed in accordance with applicable federal and state laws, rules, and regulations, including those regulations governing the Medical Assistance Program; and
5. The prescription is written on a tamper-resistant prescription drug pad or paper or is excluded from the tamper-resistant prescription drug pad or paper requirements set forth in 10 C.C.R. 2505-10, Section 8.800.11.D.

#### **8.800.13 REIMBURSEMENT CALCULATION**

8.800.13.A. Covered drugs for all clients except for OAP State Only clients shall be reimbursed the lesser of:

1. The Usual and Customary Charge minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754; or
2. The allowed ingredient cost plus a Dispensing Fee minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754.

Covered drugs for the OAP State Only Program shall be reimbursed according to 10 C.C.R. 2505-10, Section 8.941.10.

8.800.13.B. The allowed ingredient cost for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies, Government Pharmacies and Mail Order Pharmacies shall be the lesser of AAC, or Submitted Ingredient Cost. If AAC is not available, the allowed ingredient cost shall be the lesser of WAC, or Submitted Ingredient Cost.

8.800.13.C. AAC rates shall be rebased monthly using invoices and/or purchase records provided to the Department through a representative group of pharmacies. If the Department cannot establish a process to obtain invoices and/or purchase records on a monthly basis, the Department shall survey one-fourth (1/4) of all Medicaid enrolled pharmacies every quarter to rebase AAC rates.

8.800.13.D. A pharmacy wanting to inquire about a listed AAC rate shall complete the Average Acquisition Cost Inquiry Worksheet posted on the Department's

website. The pharmacy shall email the completed worksheet with a copy of the receipt invoice and Medicaid billed claim for the drug in question to Colorado.SMAC@hcpf.state.co.us. The Department shall have five (5) days to provide an inquiry response to the pharmacy. If the AAC rate requires revision, the Department shall then have 5 additional days to update the AAC rate.

8.800.13.E. To address weekly fluctuations in drug prices, the Department shall apply a percent adjustment to existing AAC rates for drugs experiencing significant changes in price. The percent adjustment shall be determined using weekly changes in price based on national pricing benchmarks. Every week, the Department shall post an updated AAC price list, with the adjusted AAC rates, on the Department's website ([www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)). A percent adjustment shall only be applied to an AAC rate until the Department can rebase the rate through the process discussed in 10 C.C.R. 2505-10, 8.800.13.C.

8.800.13.F. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty mile radius may submit a letter to the Department requesting the designation as a rural pharmacy. If the designation is approved by the Department, the allowed ingredient cost shall be AAC. If AAC is not available, the allowed ingredient cost shall be WAC.

1. To reduce the burden of transitioning to an AAC reimbursement methodology for rural pharmacies, and to ensure guaranteed Medicaid access in rural communities, the Department shall include a percent increase to AAC and phase the percent increase out over a one-year period. The effective dates and corresponding percent increases shall be:

- a. February 1, 2013 to May 31, 2013 – AAC+60%
- b. June 1, 2013 to September 30, 2013 – AAC+40%
- c. October 1, 2013 to January 31, 2014 – AAC+20%
- d. February 1, 2014 forward – AAC+0%

2. In cases where WAC applies, the Department shall also include a percent increase to WAC and phase the percent increase out over a one-year period. The effective dates and corresponding percent increases shall be:

- a. February 1, 2013 to May 31, 2013 – WAC+60%
- b. June 1, 2013 to September 30, 2013 – WAC+40%
- c. October 1, 2013 to January 31, 2014 – WAC+20%
- d. February 1, 2014 forward – WAC+0%

8.800.13.G. Dispensing Fees shall be determined based upon reported dispensing costs provided through a Cost of Dispensing (COD) survey completed every two fiscal years. The Dispensing Fees for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies and Mail Order Pharmacies shall be tiered based upon annual Total Prescription Volume. The Dispensing Fees shall be tiered at:

1. Less than 60,000 total prescriptions filled per year = \$13.40
2. Between 60,000 and 90,000 total prescriptions filled per year = \$11.49
3. Between 90,000 and 110,000 total prescriptions filled per year = \$10.25
4. Greater than 110,000 total prescriptions filled per year = \$9.31

8.800.13.H. The designation of a pharmacy's Dispensing Fee shall be updated annually. Every October, the Department shall contact a pharmacy requesting the completion of an attestation letter stating the pharmacy's Total Prescription Volume for the period September 1 to August 31. A pharmacy shall have until October 31 to provide the completed attestation letter to the Department. Using the attestation letter, the Department shall update a pharmacy's Dispensing Fee effective January 1. A pharmacy failing to provide the Department an attestation letter on or before October 31, regardless of their previous Dispensing Fee, shall be reimbursed the \$9.31 Dispensing Fee.

8.800.13.I. The Department shall determine the Dispensing Fee for a pharmacy enrolling as a Medicaid provider based on the pharmacy's Total Prescription

Volume. During the enrollment process, a pharmacy shall provide the Department an attestation letter stating their Total Prescription Volume for the previous twelve (12) months. Using the attestation letter, the Department shall determine the pharmacy's Dispensing Fee effective upon approval of enrollment. If a pharmacy has been open for less than 12 months, the Department shall annualize the Total Prescription Volume to determine the pharmacy's Dispensing Fee. A pharmacy failing to provide the Department an attestation letter during the enrollment process shall be reimbursed the \$9.31 Dispensing Fee. The Dispensing Fee shall be used until it can be updated the following year in accordance with 10 C.C.R. 2505-10, 8.800.13.H.

8.800.13.J. In November of each year, the Department shall compare a pharmacy's Total Prescription Volume and Medicaid percent provided with the attestation letter to their Medicaid claims data. If the Department identifies any inconsistencies, the Department shall request a pharmacy to provide documentation that substantiates their Total Prescription Volume for the period September 1 to August 31 within thirty (30) days. If the Department determines that the pharmacy incorrectly reported their Total Prescription Volume, the pharmacy shall be reimbursed at the correct tier based on their actual Total Prescription Volume. If a pharmacy does not provide the documentation to the Department within the 30 days, the pharmacy shall be reimbursed the \$9.31 Dispensing Fee.

8.800.13.K. The tiered Dispensing Fee shall not apply to Government Pharmacies which shall instead be reimbursed a \$0.00 Dispensing Fee.

8.800.13.L. The tiered Dispensing Fee shall not apply to Rural Pharmacies which shall instead be reimbursed a \$14.14 Dispensing Fee.

8.800.13.M. Dispensing Physicians shall not receive a Dispensing Fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy. In that case, the Dispensing Physician shall instead be reimbursed a \$1.89 Dispensing Fee.

#### **8.800.14 PRESCRIPTION QUANTITIES**

8.800.14.A For chronic conditions requiring maintenance drugs, the maximum dispensing quantities for new and refill prescriptions shall be a 100-day supply. For all other drugs, the maximum dispensing quantities for new and refill prescriptions shall be a 30-day supply. The Department may set or change minimum or maximum dispensing quantities of certain drugs.

#### **8.800.15 REIMBURSEMENT FROM PHARMACIES REDISPENSING UNUSED MEDICATION**

8.800.15.A. A pharmacy participating in the Medical Assistance Program may accept unused medication from a hospital, hospital unit, hospice, nursing care facility, or assisted living residence that is required to be licensed pursuant to Section 25-3-101, C.R.S. (2008), or a licensed health care provider for the purpose of dispensing the medication to another person.

8.800.15.B. A pharmacy shall reimburse the Department for the Medical Assistance Program Allowable Charge that the Department has paid to the pharmacy if medications are returned to a pharmacy and the medications are available to be dispensed to another person.

#### **8.800.16 PREFERRED DRUG LIST**

8.800.16.A. ESTABLISHING THE PREFERRED DRUG LIST

1. To develop and maintain the PDL, the Department shall take the following steps:

- a. Determine which drugs and Drug Classes shall be reviewed for inclusion on the PDL.
- b. Refer selected drugs and Drug Classes to the P&T Committee for clinical reviews performed without consideration of drug cost-effectiveness. The P&T Committee shall make recommendations pursuant to 10 C.C.R. 2505-10, Section 8.800.17.C.
- c. Make recommendations to the Medical Director based on evaluations of relevant criteria, including but not limited to:
  - i) Drug safety;
  - ii) Drug efficacy;
  - iii) The recommendations of the P&T Committee;
  - iv) Public comments received by the Department before a drug or Drug Class is reviewed at the relevant P&T Committee meeting;

- v) Cost-effectiveness;
  - vi) Scientific evidence, standards of practice and other relevant drug information for such evaluation; and
  - vii) Compliance with the Generic Mandate, 25.5-5-501 C.R.S. (2008) and Federal Upper Limits, 42 C.F.R. Sections 447.331-447.334 (2008), is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.
2. After the P&T Committee meets, the Medical Director shall review the recommendations of the P&T Committee and the Department and determine whether a reviewed drug is designated a Preferred Drug or a Non-preferred Drug.
  3. After the Medical Director has designated a reviewed drug as Non-preferred, the Department shall refer that drug to the DUR Board for recommendations on prior authorization criteria.
  4. After the DUR Board meets, the Medical Director shall review the recommendations of the P&T Committee, the DUR Board and the Department and determine the prior authorization criteria for Non-preferred Drugs.
  5. The Department shall provide public notice of PDL updates at least thirty days before such changes take effect.
  6. Drug Classes included on the PDL shall be reviewed annually.

#### **8.800.16.B. NEW DRUGS**

1. Notwithstanding any other provision of this section, a new drug entity, including new generic drugs and new drug product dosage forms of existing drug entities, in a Drug Class already included on the PDL:
  - a. Shall be automatically designated a Non-preferred Drug; unless
  - b. A preliminary evaluation by the Department finds that a new drug must be designated a Preferred Drug because it is medically necessary; or
  - c. The new drug must be designated a Preferred Drug in order to comply with the Generic Mandate, 25.5-5-501 C.R.S. (2008) and/or Federal Upper Limits, 42 C.F.R. Sections 447.331-447.334 (2008), which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.
2. The Preferred or Non-preferred designation for a new drug shall continue until the relevant Drug Class is reviewed and the designation is changed pursuant to 10 C.C.R. 2505-10, Section 8.800.16.A.

#### **8.800.16.C. EXCLUSION OF DRUGS, DRUG CLASSES OR INDIVIDUALS FROM THE PDL**

1. The following exclusions are intended to promote good health outcomes and clinically appropriate drug utilization and to protect the most vulnerable Medical Assistance Program clients.
2. After reviewing the recommendations of the P&T Committee and the Department, the Medical Director may, notwithstanding any other provision of this section and to the extent allowed by federal and state law:
  - a. Exclude drugs or Drug Classes from consideration for inclusion on the PDL.
  - b. Determine continuity of care protocols that exempt Medical Assistance Program clients stabilized on specified Non-preferred Drugs from prior authorization requirements.

c. Exclude specific Medical Assistance Program populations from prior authorization requirements for all Non-preferred Drugs.

3. Individual Medical Assistance Program clients shall be exempted, on an annual basis, from prior authorization requirements for all Non-preferred Drugs if:

a. A client meets clinical criteria recommended by the Department and P&T Committee and approved by the Medical Director; and

b. A client's physician submits a request for exemption and meets the criteria for approval.

**8.800.16.D. AUTHORITY OF THE EXECUTIVE DIRECTOR**

1. The decisions of the Medical Director, made under the authority of this section, shall be implemented by the Department at the sole discretion of the Executive Director.

2. If the Medical Director position is unfilled, the duties and obligations of that position, as described in this section, shall be performed by the Executive Director.

**8.800.16.E. SUPPLEMENTAL REBATES** The Department may enter into supplemental rebate agreements with drug manufacturers for Preferred Drugs. The Department may contract with a vendor and/or join a purchasing pool to obtain and manage the supplemental rebates.

**8.800.16.F. ANNUAL REPORT** The Department shall prepare and publicly post an annual report that includes an estimate of cost savings generated by the PDL program.

**8.800.16.G. DRUG CLASS MORATORIUM** The following Drug Classes cannot be considered for inclusion on the PDL until after December 31, 2009:

1. Atypical and typical antipsychotic drugs;
2. Drugs used for the treatment of HIV/AIDS;
3. Drugs used for the treatment of hemophilia; and
4. Drugs used for the treatment of cancer.

**8.800.17 PHARMACY AND THERAPEUTICS COMMITTEE**

**8.800.17.A. MEMBERSHIP**

1. The P&T Committee shall consist of at least nine members, but not more than thirteen members, appointed by the Executive Director.

a. The P&T Committee membership shall include:

- i) Four pharmacists;
- ii) Two client representatives;
- iii) One physician who specializes in the practice of psychiatry;
- iv) One physician who specializes in the practice of pediatrics;
- v) One physician who specializes in the treatment of clients with disabilities; and
- vi) Four physicians from any other medical specialty.

b. Physicians and pharmacists must be licensed and actively practicing in the State of Colorado while a member of the P&T Committee.

c. The Department shall solicit recommendations for P&T Committee members from professional associations, client advocacy groups and other Medical Assistance Program stakeholders.

d. The P&T Committee may meet and conduct business when at least any nine members are appointed to the P&T Committee. A majority of the appointed P&T Committee members constitutes a quorum for the transaction of business at any P&T Committee meeting.

e. All P&T Committee members may vote on P&T Committee business when a vote is required. The affirmative vote of the majority of the appointed P&T Committee members is required to take action.

- f. P&T Committee members shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director.
  - g. The terms shall be staggered so that in each year at least two pharmacists, one consumer representative and any three physicians are reappointed.
  - h. The Executive Director may appoint initial P&T Committee members to serve less than two years to provide for staggered terms.
  - i. The Executive Director may terminate the appointment of any P&T Committee member for Good Cause.
  - j. The Executive Director shall fill a vacancy occurring in the membership of the P&T Committee for the remainder of the unexpired term. Such replacement shall meet all applicable requirements as set forth in this section.
2. Physicians and pharmacists on the P&T Committee shall have knowledge and expertise in one or more of the following:
- a. The clinically appropriate prescribing of covered outpatient drugs;
  - b. The clinically appropriate dispensing of outpatient drugs;
  - c. Drug use review, evaluation and intervention;
  - d. Medical quality assurance; or
  - e. The treatment of Medical Assistance Program clients.

#### 8.800.17.B. CONFLICT OF INTEREST

- 1. P&T Committee members must complete and sign a conflict of interest disclosure form, prior to their appointment to the P&T Committee, that discloses any financial or other affiliation with organizations that may have a direct or indirect interest in business before the P&T Committee.
- 2. At any meeting, a P&T Committee member must recuse himself or herself from discussion and decision making for an entire Drug Class if he or she has a Conflict of Interest with any drug in that Drug Class.

#### 8.800.17.C. DUTIES

- 1. Among other duties, the P&T Committee shall:
  - a. Review drugs or Drug Classes selected by the Department.
  - b. Utilize scientific evidence, standards of practice and drug information.
  - c. Consider drug safety and efficacy and other review criteria requested by the Department.
  - d. Request information, recommendations or testimony from any health care professional or other person with relevant knowledge concerning a drug or Drug Class subject to P&T Committee review, at their discretion.
  - e. Make clinical recommendations on drugs or Drug Classes. Such recommendations shall be considered by the Executive Director, when making final determinations on PDL implementation and maintenance.
  - f. Perform any other act requested by the Department necessary for the development and maintenance of the PDL as described in 10 C.C.R. 2505-10, Section 8.800.16.A.
  - g. Adopt a Department approved plan of operation that sets forth the policies and procedures that shall be followed by the P&T Committee.
  - h. Meet at least quarterly and other times at the discretion of the Department or the P&T Committee.

#### 8.800.17.D. NOTICE/OPEN MEETINGS

- 1. P&T Committee meetings and the proposed agenda shall be posted publicly at least thirty days before the meeting.
- 2. The P&T Committee meetings shall be open to the public. If a P&T Committee meeting is required to be held in executive session pursuant to state or federal law, the executive session shall be convened after conclusion of the open meeting.

**8.800.18 PRESCRIPTION DRUG CONSUMER INFORMATION AND TECHNICAL ASSISTANCE PROGRAM**

8.800.18.A The Prescription Drug Consumer Information and Technical Assistance Program provides Medical Assistance Program clients the opportunity to meet with a pharmacist to review the client's medications, receive information on the prudent use of prescription drugs and, with the approval of the appropriate prescribing health care provider, how to avoid dangerous drug interactions, improve client outcomes, and save the state money for the drugs prescribed.

**8.800.18.B. REQUIREMENTS FOR PARTICIPATION IN THE PROGRAM**

1. The Department shall refer clients to pharmacists based on location.
2. Pharmacists shall:
  - a. Have and maintain an unrestricted license in good standing to practice pharmacy in Colorado; and
  - b. Maintain liability insurance; and
  - c. Complete an application; and
  - d. Enter into a contract with the Department; and
  - e. Meet one of the following qualifications:
    - i) Provide proof of completion of a pharmacy practice residency accredited by the American Society of Health Systems Pharmacists or the American Pharmaceutical Association; or
    - ii) Earned a bachelor of pharmacy degree and completed a certificate program accredited by the Accreditation Council for Pharmacy Education (ACPE) in each area of practice, and 40 hours of on-site supervised clinical practice and training in each area in which the pharmacist is choosing to practice; or
    - iii) Earned a Doctor of Pharmacy degree and completed at least 40 hours of ACPE-approved continuing education regarding clinical practice and 40 hours of on-site supervised clinical practice and training in the area in which the pharmacist is choosing to practice; or
    - iv) Possess current board specialty certification from the Board of Pharmaceutical Specialties, current certification from the 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
3. Clients may participate in the program if they are a fee-for-service client who receives prescription drug benefits, is at high risk of complications from drug interactions and who otherwise lacks access to informational consultation with a pharmacist.

**8.800.18.C. SERVICES**

1. Pharmacists participating in the program shall:
  - a. Schedule a face-to-face meeting with the client within ten days of the referral. If the client is unable or refuses to participate in a face-to-face meeting, the pharmacist may conduct the consultation by telephone.
  - b. Collect and review client drug histories.
  - c. Hold face-to-face or telephonic consultations with clients.
  - d. Notify clients that they will provide clinical recommendations to the client, the prescribing health care provider and the Department.
  - e. Provide the client with information regarding:
    - i) The prudent use of prescription drugs.
    - ii) How to avoid dangerous drug interactions.

iii) The appropriate use of medication to optimize therapeutic outcomes.

iv) How to reduce the risk of adverse events, including adverse drug interactions.

2. The Department shall notify clients participating in the program in writing that a pharmacist has been assigned to review the client's records and that the pharmacist will contact the client within ten days from the date of notification.

8.800.18.D. REPORTING Within ten days following the consultation, the pharmacist shall provide a letter to the client, all appropriate health-care providers and the Department outlining the face-to-face meeting. The letter shall include the pharmacist's recommendations for possible alternatives available for the client.

8.800.18.E. REIMBURSEMENT The Department shall pay each pharmacist participating in the program a predetermined amount.

<b>Benefit</b>	<b>Family Planning</b>
What is Covered	<p>Services to help you decide whether you want to have kids and when to have them.</p> <p>These services include birth control, like “the pill” or condoms, and some types of surgery that will keep you from ever having children.</p>
What is NOT Covered	<ul style="list-style-type: none"> <li>Chemicals that kill sperm, condoms made for women, and treatment, counseling, and testing if you can’t get pregnant are not covered.</li> </ul>
Limits	A Teen Pregnancy Prevention Program is also offered by Medicaid for at-risk teens, 18 and under). Call the Customer Contact Center for more information.
<b>Benefit</b>	<b>Abortion Services</b>
What is Covered	Abortions when you are a victim of rape or incest, or when staying pregnant would harm your health.
What is NOT Covered	Abortions for any other reason are not covered.
Limits	The medical provider must approve the reasons for an abortion.
<b>10 CCR 2505-10 8.730</b> <b>Family Planning Services</b>	
<p><b>8.730.1 DEFINITIONS</b></p> <p>Family Planning Services means physical examinations, diagnoses, treatments, supplies, prescriptions and follow-up services provided to individuals of child-bearing age, including minors who can be considered to be sexually active, in a physician's office, physician's clinic, outpatient or inpatient hospital setting, family planning provider, Federally Qualified Health Center, Rural Health Clinic or a Colorado Department of Health and Environment facility.</p> <p>Institutionalized Individual means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or (b) confined, under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.</p> <p>Life-Endangering Circumstance means:</p> <ol style="list-style-type: none"> <li>The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term; or</li> <li>The presence of a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy</li> </ol>	

continues to term. In such cases, unless the pregnant woman has been receiving prolonged psychiatric care, the attending physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition.

Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Sterilization means any medical procedure, treatment or operation (except for a hysterectomy) for the purpose of rendering an individual permanently incapable of reproducing and requires informed consent.

### **8.730.2 STERILIZATION**

8.730.2.A. Sterilization may be provided as a benefit of the Colorado Medical Assistance Family Planning benefit when the individual has voluntarily given written informed consent and at least 30 days, but no more than 180 days have passed between the date of informed consent and the date of sterilization.

8.730.2.B. The time limitations in 8.730.2A do not apply in the case of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since the date of consent. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

8.730.2.C. Sterilization is not a Colorado Medical Assistance Family Planning benefit for an individual who is under the age of 21, mentally incompetent, or institutionalized.

8.730.2.D. An individual shall have given informed consent for sterilization when the person to whom consent was given offered to answer any questions concerning the procedure, provided a copy of the consent form, obtained a signed copy of the consent form and orally provided the following information:

1. The individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.
2. A description of available alternative methods of family planning and birth control.
3. The sterilization procedure is considered to be irreversible.
4. An explanation of the specific sterilization procedure to be performed.
5. A description of the discomforts and risks that may accompany or follow the sterilization procedure including an explanation of the type and possible effects of any anesthetic to be used.
6. A description of the benefits or advantages that may be expected as a result of the sterilization.
7. The sterilization will not be performed for at least 30 days from consent except under the circumstances specified in 8.730.2.B.

8.730.2.E. Arrangements shall be made to ensure the information specified in 8.730.2.D is effectively communicated to any individual who is blind, deaf or otherwise handicapped.

8.730.2.F. An interpreter shall be provided if the individual to be sterilized does not understand the language used on the consent form or the language used by the person obtaining consent.

8.730.2.G. The individual to be sterilized may have a witness of his or her choice present when consenting to the procedure.

8.730.2.H. The consent form requirements of 8.730.2.J shall be met.

8.730.2.I. Informed consent for sterilization cannot be obtained when an individual is:

1. In labor or childbirth;
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of substances that impair the individual's decision making capabilities.

8.730.2.J. A sterilization consent form shall be signed and dated by:

1. The individual to be sterilized;
2. The interpreter, if one was provided;
3. The person who obtained the consent; and
4. The physician who will perform the sterilization procedure.

8.730.2.K. If an interpreter is provided, the interpreter shall, by signing the consent form, certify that he or she translated the information presented orally, read the consent form and explained its contents to the individual and that to the best of the interpreter's knowledge the individual understood the information provided.

8.730.2.L. The person who obtained the consent shall, by signing the consent form, certify that he or she provided the individual with all of the information set forth in 8.730.2.D above and to the best of best or her knowledge, the individual appeared mentally competent, and knowingly and voluntarily consented to be sterilized.

8.730.2.M. The physician performing the sterilization shall, by signing the consent form, certify that:

1. He or she provided the individual with all of the information set forth in 8.730.2.D above.
2. To the best of his or her knowledge the individual appeared mentally competent, and knowingly and voluntarily consented to be sterilized.
3. Except in the case of premature delivery or emergency abdominal surgery, the physician shall further certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed.
  - a. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery, and
  - b. In the case of premature delivery, shall state the expected date of delivery, or
  - c. In the case of abdominal surgery, shall describe the emergency.

### **8.730.3 HYSTERECTOMIES**

8.730.3.A. A hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons and when the following conditions are met:

1. The person who secures the authorization to perform the hysterectomy has informed the individual or her representative if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and;
2. The individual or her representative, if any, has acknowledged in writing receiving that information.

8.730.3.B. The fiscal agent for the Medical Assistance Program shall be provided with a copy of that written acknowledgment. The acknowledgement must be received before reimbursement for any services related to the procedure will be made.

8.730.3.C. Hysterectomy is not a benefit of the Medical Assistance Program when:

1. It is performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
2. There was more than one purpose to the procedure and the hysterectomy would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

8.730.3.D. A written acknowledgment of sterility from the recipient is not required if the following circumstances exist:

1. The individual is already sterile at the time of the hysterectomy; or

2. The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines prior acknowledgement is not possible.

8.730.3.E. If an acknowledgement of sterility is not required because of the above exceptions, the physician who performs the hysterectomy must certify in writing either

1. The individual was already sterile, stating the cause of that sterility; or
2. The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgement was not possible. The physician must include a description of the emergency.

8.730.3 F. The fiscal agent must receive the physician's certification before reimbursement for the services will be made.

#### **8.730.4 ABORTION SERVICES**

8.730.4.A. Abortion services shall only be a benefit of the Colorado Medical Assistance Program when the pregnancy is causing a life-endangering circumstance or in cases of sexual assault or incest.

8.730.4.B. In cases of a life-endangering circumstance, the physician must make every reasonable effort to preserve the lives of the pregnant woman and the unborn child. A licensed physician shall perform the procedure in a licensed health care facility. Such services may be performed in other than a licensed health care facility if, in the medical judgment of the physician, the life of the pregnant woman is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

8.730.4.C. Any claim for payment must be accompanied by a case summary which includes the following information:

1. Name, address and age of the pregnant woman;
2. Gestational age of the unborn child;
3. Description of the medical condition which necessitated the abortion;
4. Services performed;
5. Facility in which the abortion was performed; and
6. Date of service

8.730.4D. A claim for payment must also be accompanied by at least one of the following forms with additional supporting documentation that confirms the life-endangering circumstances:

1. Hospital admission summary.
2. Hospital discharge summary.
3. Consultant findings and reports.
4. Laboratory results and findings.
5. Office visit notes.
6. Hospital progress notes.

8.730.4.E. An evaluation by a licensed physician specializing in psychiatry must accompany the claim for reimbursement for the abortion if a psychiatric condition represents a serious and substantial threat to the pregnant woman's life if the pregnancy continues to term.

Benefit	<b>Women's Health</b>
What is Covered	Services for women like yearly exams, and screenings for cancers and other problems. The HPV vaccine is also covered for women between the ages of 9-26.
What is NOT Covered	NA
Limits	One wellness exam per year.
<b>10 CCR 2505-10 8.715</b> <b>Breast and Cervical Cancer Program</b>	
<p>8.715.1 DEFINITIONS</p> <p>Breast and Cervical Cancer Program (BCCP) means the Medicaid program established, operated and monitored by the Department.</p> <p>Colorado Women's Cancer Control Initiative (CWCCI) means the program administered by the Colorado Department of Public Health and Environment and funded by the Centers for Disease Control and the National Breast and Cervical Cancer Early Detection Program.</p> <p>In Need of Treatment means services necessary to determine the extent and proper course of cancer or precancerous treatment as well as definitive cancer treatment itself. Treatment can include surgery, radiation, chemotherapy and approved medications following treatment as determined by the client's physician and the Department.</p> <p>National Breast and Cervical Cancer Early Detection Program (NBCCEDP) means the program where the Centers for Disease Control (CDC) provides breast and cervical screening services to underserved women. In Colorado, the CDC provider is the Department of Public Health and Environment's Colorado Women's Cancer Control Initiative.</p> <p>Presumptive Eligibility for BCCP means the temporary eligibility for benefits that begin on the date a Qualified Entity determines the client meets eligibility requirements for the BCCP and the client signs the presumptive eligibility form. Women identified by the CWCCI as being In Need of</p> <p>Treatment for breast or cervical cancer or a precancerous condition shall apply for presumptive eligibility on a simplified Medicaid application.</p> <p>Qualified Entity means a provider contracted with the Department of Public Health and Environment under a cooperative agreement with the CDC to support activities related to the NBCCEDP. A qualified entity shall provide breast and cervical cancer assessment services for the CWCCI.</p>	

State Designated Entity means an agency acting on behalf of and at the direction of the Department and whose function may include, but is not limited to, processing eligibility determinations and assisting clients with the application process.

### **8.715.2 ELIGIBILITY REQUIREMENTS**

8.715.2.A. Clients shall meet all requirements of the CWCCI program.

8.715.2.B. Clients shall enroll for screening at participating Breast and Cervical Cancer assessment sites through the CWCCI.

8.715.2.C. Clients shall:

1. Be a woman who has not yet attained the age of 65.
2. Be a resident of Colorado.
3. Be a citizen of the United States or a qualified alien as described in 8.100.53(A)(2) through 8.100.53(A)(4).
4. Have been screened by a Qualified Entity and found to be In Need of Treatment for breast or cervical cancer, including precancerous conditions as determined through pathological tests.
5. Not have creditable coverage as described in 8.715.3.
6. Not be eligible under another Medicaid program.
7. Be a client who has previously qualified and enrolled in a NBCCED program in another state and chooses to transfer her enrollment to CWCCI.

8.715.2.D. Clients shall not have been previously screened or received treatment for breast or cervical cancer prior to July 1, 2002.

8.715.2.E. Clients shall not be considered to be In Need of Treatment if it is determined she only requires routine follow-up monitoring services.

8.715.2.F. Clients shall be willing to seek Medicaid approved breast or cervical cancer or precancerous treatment within three months of the date of eligibility. If a client does not seek such treatment within three months of the date of presumptive eligibility, the client shall be removed from the program on the last day of the third month. The client will be re-entered in the BCCP program at such time as treatment is scheduled to begin. If treatment has not been started within one month of the scheduled date, the client will be disenrolled.

### **8.715.3 CREDITABLE COVERAGE**

8.715.3.A. Creditable coverage shall include coverage of any individual as defined at 10-16-102, C.R.S. (2002).

8.715.3.B. The following are not considered creditable coverage:

1. Limited scope coverage such as that which covers only dental, vision or long term care;
2. Coverage only for a specific disease or illness (unless the specific disease or illness includes breast or cervical cancer); or
3. A medical care program run by the Indian Health Services or a tribal organization.

8.715.3.C. An individual who otherwise has creditable coverage may qualify for the program if:

1. The individual is in a period of exclusion for treatment of breast or cervical cancer; or
2. The individual has exhausted her lifetime limits on benefits under the plan for breast or cervical cancer.

8.715.3.D. Individuals who have coverage that contains yearly limited drug benefits, yearly limits on outpatient visits or high deductibles shall be considered to have creditable coverage.

**8.715.4 PRESUMPTIVE ELIGIBILITY**

8.715.4.A. Presumptive eligibility shall be determined by Qualified Entities.

8.715.4.B. The Department shall make available to Qualified Entities:

1. Information on the BCCP presumptive eligibility form and card;
2. Information on how to obtain the Medicaid application; and
3. Information on how to assist CWCCI personnel and individuals on application completion and filing.

8.715.4.C. Qualified Entities shall determine presumptive eligibility based on verbal confirmation by the potential client that she meets CWCCI criteria and shall enroll the clients who appear to be eligible.

8.715.4.D. Presumptive eligibility shall begin on the date the client completes the BCCP presumptive eligibility form and the Qualified Entity determines the client meets all eligibility criteria.

8.715.4.E. All potential clients shall be required to complete the BCCP presumptive eligibility form and the Medicaid application at the same time.

8.715.4.F. The Qualified Entity shall submit the presumptive eligibility form, a copy of the presumptive eligibility card, the CWCCI history and physical, the diagnosis pathology report and the signed consent form to the Department.

8.715.4.G. The Designated Entity shall process the Medicaid application within thirty calendar days of receipt.

8.715.4.H. The presumptive eligibility period shall end on the following:

1. The date on which a formal determination is made on the client's Medicaid application; or
2. If a full determination cannot be made on the basis of the BCCP presumptive eligibility form and the client fails to complete the Medicaid application, then eligibility will end on last day of the month following the month in which the client was determined to be presumptively eligible.

**8.715.5 ELIBILITY PERIOD**

8.715.5.A. Eligibility shall begin on the date the client is determined to be presumptively eligible.

8.715.5.B. The client shall be eligible to receive services for up to one year from the date of initial eligibility unless she is no longer In Need of Treatment or no longer meets program eligibility requirements.

8.715.5.C. If the client remains in treatment beyond one year, renewed eligibility shall be determined consistent with BCCP and Medicaid requirements.

8.715.5.D. A period of renewed eligibility begins each time the client is screened under the CWCCI program and is found to be In Need of Treatment for breast or cervical cancer and meets all other eligibility criteria.

8.715.5.E. A client may be determined no longer eligible for the program if:

1. She does not complete the Medicaid application; or
2. She is no longer In Need of Treatment for breast or cervical cancer or qualified precancerous conditions when the client's provider notifies the Department; or
3. She reaches the age of 65; or
4. She obtains other creditable coverage describe in 8.715.3.

8.715.5.F. Clients who are determined no longer eligible shall be notified in writing as described in 8.715.6(B).

**8.715.6 NOTIFICATION**

- 8.715.6.A. The BCCP presumptive eligibility form shall include a statement of the applicant's rights and responsibilities.
- 8.715.6.B. The Department shall notify clients who are no longer In Need of Treatment for the BCCP in writing thirty days prior to their disenrollment date. This notice will be provided only to those clients who have completed their course of treatment per their provider.
1. Copies of the notice shall be sent to the client, her designated representative if applicable, the CWCCI site, the State Designated Entity and the client's provider.
  2. The notification shall include information regarding appeal rights described in 10 C.C.R. 2505-10, Section 8.057.
- 8.715.6.C. The Department shall notify clients who no longer meet the BCCP eligibility criteria at least ten days prior to program termination.

#### **8.715.7 BENEFITS**

- 8.715.7.A. Eligible clients shall receive all Medicaid benefits included in the State Plan.
- 8.715.7.B. Breast reconstructive surgery shall be a covered benefit when completed up to seven months following a mastectomy.
- 8.715.7.C. Breast or cervical cancer or precancerous treatment provided prior to the NBCCED program implementation or client enrollment into the BCCP is not a covered benefit.
- 8.715.7.D. Clients eligible for this program shall receive all mental health services through the Mental Health Assessment Service Agency of the county in which the client resides.

#### **8.715.8 ROLES/RESPONSIBILITIES**

- 8.715.8.A. County Departments of Human/Social Services shall:
1. Assist in providing information to the client about services and benefits available through the program;
  2. Assist the client in accessing health care services or contact the appropriate agencies for services, such as the enrollment broker, mental health provider and transportation provider;
  3. Assist the client in applying for and accessing other benefits for which she may qualify, such as home care allowance, food stamps and financial assistance; and
  4. Assist the Department by notifying the Department when a client's eligibility status changes.
- 8.715.8.B. Clients shall notify the Department and healthcare providers if the client receives creditable coverage or if a third party is responsible for illness or injury to the client.
- 8.715.8.C. Providers shall respond to inquiries from the Department and provide information required to verify the client's In Need of Treatment status within ten calendar days of the Department's request.
- 8.715.8.D. Provider's shall follow Medicaid billing instructions and obtain prior authorizations when necessary.
- 8.715.8.E. The State Designated Entities shall have the following responsibilities:
1. To determine whether a client is eligible for Medicaid in any other eligibility group;
  2. To complete review of the Medicaid application form within fifteen days of receipt;
  3. To notify the client she has thirty days to submit addition information if needed and if the information is not received the client will be found ineligible;
  4. To inform the client of her appeal rights if eligibility is denied; and
  5. To disenroll the client from the BCCP when notified the client is no longer in Need of Treatment.

Benefit	<b>Maternity Services</b>
What is Covered	Services like doctor's visits, ultrasounds to check on your baby's health and growth, delivery, home births, and help with breast feeding.
What is NOT Covered?	Home pregnancy tests, testing to determine the baby's father, birthing and parenting classes, and ultrasounds only to find out if it's a boy or a girl are not covered.
Limits	There are a few special programs available to women through Medicaid, including: <ul style="list-style-type: none"> <li>• Prenatal Plus</li> <li>• Nurse Home Visitor Program</li> <li>• Special Connections Program</li> <li>• State-Only Prenatal Program</li> </ul> Ask your health care provider for more details about these programs.
Benefit	<b>Genetic Testing</b>
What is Covered	Prenatal testing for genetic disorders when the fetus is at high risk.  Testing when required to treat or to diagnose a condition.
What is NOT Covered?	Genetic testing is not covered when used to determine your risk for developing a particular disease.
Limits	Please contact Colorado Medicaid for details on which genetic test is covered.
<b>10 CCR 2505-10, 8.748</b>	
<b>Prenatal Plus Program</b>	
8.748.1 DEFINITIONS	
Initial Assessment Form means the Prenatal Plus Program risk assessment tool that must be used by all Prenatal Plus Program Providers to further assess and document a client's needs.	
Program Eligibility Screening Form means the Prenatal Plus Program eligibility tool that must be used by all Prenatal Plus Program Providers to determine if a client is eligible for Prenatal Plus Program services.	

Prenatal Plus Program Provider means an entity or agency that meets the qualifications described in Section 8.748.4 and has been accepted as such by the Department of Health Care Policy and Financing (the Department).

#### **8.748.2 PROGRAM PURPOSE**

The purpose of the Prenatal Plus Program is to improve the maternal and infant health outcomes of at-risk Medicaid clients by providing comprehensive and coordinated prenatal and early postpartum support services that complement traditional clinical prenatal care. The primary goal of the program is to reduce the incidence of low birth weight babies while also addressing other lifestyle, behavioral, and non-medical aspects of a woman's life that may affect her and/or her baby's health and well-being. By focusing on case management, nutrition counseling and support, psychosocial counseling and support, client education and health promotion, the Prenatal Plus Program seeks to ensure that women have access to the services and information needed to have healthy pregnancies and healthy babies.

#### **8.748.3 CLIENT ELIGIBILITY**

8.748.3.A To be eligible for services provided through the Prenatal Plus Program, a Colorado Medicaid client shall:

1. Be pregnant (self-declared or medically verified) or in the postpartum period (but participated in the Prenatal Plus Program during the prenatal period); and
2. Be determined by a Prenatal Plus Program Provider using the Program Eligibility Screening Form to be at risk of having a negative maternal and/or infant health outcome(s) due to identified risk factors which shall be further assessed and documented using the Initial Assessment Form.

#### **8.748.4 PROVIDER ELIGIBILITY AND QUALIFICATIONS**

8.748.4.A Providers wishing to render and be reimbursed for Prenatal Plus Program services, as a condition of being a Prenatal Plus Program Provider, shall:

1. Be a Colorado Medicaid provider enrolled as one of the following Colorado Medicaid Billing Provider Types: Clinic, Federally Qualified Health Center, Rural Health Center, Non-Physician Practitioner Group, Physician, Nurse Practitioner, Certified Nurse-Midwife, or Physician's Assistant;
2. Execute and submit a Prenatal Plus Program addendum to the Colorado Medical Assistance Program Provider Participation Agreement for review and acceptance by the Department; and
3. Manage a Prenatal Plus Program multidisciplinary team(s) of personnel. The multidisciplinary team shall include:
  - a. A care coordinator(s) who acts as the hub of the multidisciplinary team and is the person primarily responsible for organizing resources and assisting clients in accessing services to meet their individual needs. The care coordinator(s) shall, at minimum, hold a bachelor's degree in a relevant human/social services discipline or be a registered nurse;
  - b. A registered dietitian(s) who is currently registered with the Commission on Dietetic Registration as a registered dietitian, or a dietetic intern(s) in an internship accredited by the American Dietetic Association and supervised by a registered dietitian who has agreed to serve as a preceptor for the dietetic intern;
  - c. A mental health professional(s) who, at minimum, is a master's level professional in the field of social work, marriage and family therapy, professional counseling, or other mental health specialty, or an intern(s) in an accredited mental health internship and supervised by a master's level mental health professional; or the Prenatal Plus Program Provider must have a consistent, documented referral relationship with a mental health provider(s) not part of the multidisciplinary team but participating with the Colorado Medicaid Community Mental Health Services Program. Prenatal Plus Program Providers who do not include a mental health professional as part of their multidisciplinary

team shall not be eligible for reimbursement of psychosocial counseling and support through the Prenatal Plus Program; and  
d. A Colorado Medicaid-enrolled physician, nurse practitioner, certified nurse-midwife, or physician's assistant who is the rendering provider that delegates the provision of Prenatal Plus Program services to the multidisciplinary team.

4. Retain in the record of each client to whom Prenatal Plus Program services are rendered:
  - a. Identification of qualifying risk factors using the Program Eligibility Screening Form; and
  - b. A client risk assessment using the Initial Assessment Form.

#### **8.748.5 REIMBURSABLE SERVICES**

8.748.5.A Services reimbursable through the Prenatal Plus Program include:

1. Nutrition counseling and support provided by the registered dietitian/dietetic intern consisting of the following components which may be provided on an individual basis or in a group setting based on client need:
  - a. Nutrition screening;
  - b. General nutrition education;
  - c. Comprehensive nutrition status assessment; and
  - d. Nutrition counseling and targeted nutrition education based on client-specific need. Nutrition counseling shall be considered inclusive of nutrition care-planning, goal-setting, monitoring, follow-up, and nutrition care plan revision.
2. Psychosocial counseling and support provided by the mental health professional consisting of the following components which may be provided on an individual basis or in a group setting based on client need:
  - a. Psychosocial health screening;
  - b. Comprehensive psychosocial health assessment; and
  - c. Psychosocial health counseling and support. Psychosocial counseling and support shall be considered inclusive of psychosocial care-planning, goal-setting, monitoring, follow-up, and psychosocial care plan revision.
    - i. Psychosocial counseling and support does not include clinical psychotherapy services, traditional medication management, or other clinical services specifically related to treatment of a diagnosed mental health disorder. When clinical mental health disorders are identified, including substance use disorders, clients shall be referred to a provider who participates in the Colorado Medicaid Community Mental Health Services Program or a Medicaid-enrolled substance use disorder treatment provider.
3. General client education and health promotion provided by the care coordinator which may be provided on an individual basis or in a group setting based on client need, regarding topics that may include:
  - a. Basic understanding of the prenatal period
    - i. Physical and emotional changes related to pregnancy including fetal development;
    - ii. Healthy and appropriate weight gain during pregnancy;
    - iii. Healthy prenatal diet and food precautions;
    - iv. Physical activity precautions and appropriate exercise;
    - v. Substance use and how it can affect maternal and infant health outcomes;
    - vi. Sexually transmitted diseases/infections and how they can affect maternal and infant health outcomes;
    - vii. Bonding with the baby before birth;

- viii. Importance of oral hygiene;
  - ix. Warning signs of preterm labor; and
  - x. Common terminology;
- b. Common concerns related to childbirth and breastfeeding
    - i. Birth planning, hospital packing/preparation, and attending birth classes;
    - ii. Pain management options during delivery; and
    - iii. Benefits of breastfeeding, preparing for breastfeeding and breastfeeding basics;
  - c. The postpartum period and healthy infancy
    - i. Postpartum mood disorders ("baby blues" and postpartum depression);
    - ii. Postpartum recovery issues and adjustment including body changes, self-esteem, and relationship stressors;
    - iii. Managing stress, day-to-day problem-solving, positive communication techniques, building and using support networks;
    - iv. Family planning and contraception;
    - v. Comforting and stimulating infants (including education on shaken baby syndrome risk reduction, recognizing an infant's distress cues, and bonding/attachment postpartum);
    - vi. Appropriate expectations for infant behavior, sleeping patterns, teething and crying;
    - vii. Infant health including newborn feeding, immunizations, pediatrician visits, and car-seat safety; and
    - viii. Environmental risk factors including violence in the home, smoke, substance use and how they can affect infant health; and
4. Targeted case management provided by the care coordinator. Targeted case management is a service provided to assist clients in gaining access to needed medical, social, educational, and other services, and includes the following components:
- a. Comprehensive assessment and periodic reassessment of the client's needs to determine the necessity for any medical, educational, social, or other services;
  - 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 and identifies a course of action to respond to the assessed needs;
  - c. Referral and related activities to help the client obtain needed services including activities that help link the client with medical, social, or educational providers, or other programs and services that are capable of providing needed services; and
  - d. Monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the client's needs, and which may be with the client, family members, providers, or other entities or individuals.
  - e. Targeted case management provided by the care coordinator may include, but is not limited to, screening for nutrition and psychosocial risk factors.
  - f. Note: Targeted case management does not include case management activities that are an integral component of another covered Medicaid service; the direct delivery of an underlying medical, educational, social, or other service to which a client has been referred; activities integral to the administration of foster care programs; or activities for which a client may be eligible that are integral to the administration of another non-medical program.

**8.748.6 REIMBURSEMENT**

8.748.6.A Reimbursement shall be the lower of:

1. Submitted charges; or
2. Fee schedule for Prenatal Plus Program services as determined by the Department.

10 CCR 2505-10, 8.749

### **Nurse Home Visitor Program**

#### **8.749.1 DEFINITIONS**

Nurse means a person licensed as a professional nurse pursuant to §12-38-102,C.R.S., et seq., or accredited by another state or voluntary agency that the state board of nursing has identified by rule pursuant to §12-38-108(1)(a),C.R.S., as one whose accreditation may be accepted in lieu of board approval.

Nurse Home Visitors means registered nurses who provide targeted case management services.

Provider Agency means an agency that has met the Nurse Home Visiting Program provider requirements and has been certified by the Department of Public Health and Environment.

Targeted Case Management means services which will assist individuals in gaining access to needed medical, social, education and other services to promote healthy first pregnancies, improve the health and development of a woman's first child and to encourage self-sufficiency.

#### **8.749.2 PROGRAM DESCRIPTION**

Nurse Home Visitor Program (NHVP) means a program established pursuant to §25-31-101,C.R.S. et seq., including the provision of targeted case management services to first-time pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. Services are offered through the child's second birthday plus one month.

#### **8.749.3 CLIENT ELIGIBILITY**

First-time (defined as no previous live births), pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level are eligible for the NHVP.

#### **8.749.4 PROVIDER REQUIREMENTS**

8.749.4.A. A participating provider shall be:

1. Certified by the Colorado Department of Public Health and Environment; and
2. Allowed to bill as a clinic including, but not limited to Certified Public Health Clinics, Federally Qualified Health Centers and Rural Health Centers.

#### **8.749.5 PROVIDER RESPONSIBILITIES**

**8.749.5.A. Targeted Case Management Services**

1. Providers shall provide Targeted Case Management services including:
  - a. Assessment of the first time pregnant woman and her first child's needs for health, mental health, social services, education, housing, childcare and related services.
  - b. Development of care plans to obtain the needed services.
  - c. Referral to resources to obtain the needed services including medical providers who provide care to a first time pregnant woman and her first child.
  - d. Routine monitoring and follow-up visits with the women where progress in obtaining the needed services is monitored, problem-solving assistance is provided and the care plans are revised to reflect the women and children's current needs.
2. Providers shall document and chart Targeted Case Management activities and complete assessment and referral forms.

**8.749.6 REIMBURSEMENT****8.749.6.A. Monthly payments for Targeted Case Management shall be made for each child/family visited under the program.**

1. Services to the mother shall be limited to 3 units per month with a lifetime maximum limit of 30 units.
2. Services to the child shall be limited to 3 units per month with a lifetime maximum of 75 units.
3. A different rate shall be calculated for each provider agency based on their actual historical cost and their projected budget for the next fiscal year.
4. At the end of the fiscal year, payments will be reconciled with the actual costs for each agency based on agency cost reports, to assure that payment was not more than the actual cost of providing services. Overages shall be recovered.

**10 CCR 2505-10, 8.745****Special Connections****8.745.1 DEFINITIONS**

Assessment means an evaluation by a certified drug/alcohol treatment counselor that is designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a drug/alcohol abusing pregnant client.

Case Management means services provided by a certified drug/alcohol treatment counselor to include Medicaid and non-Medicaid service planning, linkage to other service agencies and monitoring, and those actions necessary to obtain both Medicaid and non-Medicaid reimbursable services for the eligible client with multiple treatment needs.

Drug/Alcohol Individual Therapy means substance abuse counseling services provided by a certified drug/alcohol treatment counselor to a client in a licensed drug and alcohol treatment program.

Drug/Alcohol Group Therapy means substance abuse counseling services provided by a certified drug/alcohol treatment counselor to a group of not more than twelve clients in a licensed drug and alcohol treatment program.

Health Maintenance Group means services facilitated by a certified drug/alcohol treatment counselor to help a client develop health and life management skills.

#### **8.745.2 DETERMINATION OF CLIENT ELIGIBILITY**

8.745.2.A. To receive an Assessment, the client shall be:

1. Medically verified to be pregnant.
2. Determined either presumptively eligible or eligible for Medicaid.
3. Self referred or referred by a health care practitioner as being at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk.

8.745.2.B. To receive drug/alcohol treatment services, the client shall meet the following conditions:

1. Received an Assessment and met the screening criteria as determined by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services.
2. Be prior authorized by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services to receive services.

#### **8.745.3 PROVIDER ELIGIBILITY**

8.745.3.A. The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall be the only provider to receive reimbursement for Assessments and drug/alcohol treatment services provided to Program enrolled clients.

8.745.3.B. The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall contract with certified and approved drug/alcohol treatment programs for the delivery of services.

#### **8.745.4 REIMBURSABLE SERVICES**

8.745.4.A. Special Connections Program services are limited to:

1. One Assessment per pregnancy.
2. Drug/alcohol treatment services including Case Management, Drug/Alcohol Individual Therapy, Drug/Alcohol Group Therapy and/or Health Maintenance Group Services.
3. Urine screening and monitoring.

8.745.4.B. All services must be prior approved by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services. Services may be provided as outpatient or residential. Room and board are not covered services.

#### **8.745.5 REIMBURSEMENT**

Reimbursement for services provided shall be the lowest of:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

DRAFT

Benefit	Lab, X-Ray, Diagnostic Imaging
What is Covered	<p>Tests and services to find out what is causing a problem with your health which includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• EKG (electrocardiograms) and other tests to detect heart problems</li> <li>• MRI, CT, and PET Scans</li> <li>• Ultrasounds</li> </ul> <p>Labs for children includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Lead Toxicity</li> <li>• Sickle Cell Disease</li> <li>• Anemia</li> <li>• Tuberculosis (TB)</li> <li>• Diabetes</li> </ul>
What is NOT Covered?	More than one of the same test for the same problem and drug testing for your job are not covered.
Limits	There are limits are certain tests. Please ask your health care provider for details.

**10 CCR 2505-10, 8.600**  
**Lab and X-Ray**

**8.660.1 DEFINITIONS**  
 Independent Certified Laboratory means a certified laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital except where a hospital laboratory has obtained Medicare certification as an independent laboratory and is billing for recipients who are not admitted as patients in the hospital.

Clinical Laboratory Services mean microbiological, serological, chemical, hematological, radiobioassay, cytological, immunoheamatological, pathological or other examinations of fluids derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or the assessment of a medical condition.

Anatomical Laboratory Services mean examinations of tissues derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or the assessment of a medical condition.

Certified Clinical Laboratory means a provider who possesses a certificate of waiver or a certificate of registration from the Centers for Medicare and Medicaid

Services or its designated agency as meeting Centers for Medicare and Medicaid Services guidelines and whose personnel and director are qualified to perform laboratory services.

X-Ray Services mean services performed by a provider whose x-ray equipment has been certified by the Colorado Department of Public Health and Environment as meeting Medicare guidelines and whose personnel and director are qualified to operate said equipment.

#### **8.660.2 CONDITIONS OF PARTICIPATION**

8.660.2. A Certified Clinical Laboratories and providers of X-Ray Services shall enroll as providers in the Medical Assistance Program.

8.660.2.B. All participating laboratories, including out-of-state independent clinical laboratories, shall be certified by the state agency to participate under Medicaid. All laboratories shall provide proof of certification status through the provision of the CLIA (Clinical Laboratory Improvement Amendments of 1988) number to the Department.

8.660.2.C. Providers of X-Ray Services shall be certified by the Colorado Department of Public Health and Environment and shall provide proof of Medicare certification on the Medicaid provider enrollment forms.

#### **8.660.3 LIMITATIONS AND BENEFITS**

8.660.3.A. Laboratory and X-Ray Services are a benefit under all of the following conditions:

1. The services have been authorized by a licensed physician.
2. The services are performed to diagnose conditions and illnesses with specific symptoms.
3. The services are performed to prevent or treat conditions that are benefits under the Medical Assistance Program.
4. The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury.
5. The laboratory services are performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
6. The X-Ray Services are performed by a provider certified by the Colorado Department of Public Health and Environment and enrolled as a Medicaid provider.

8.660.3.B. Collection, handling and/or conveyance of specimens for transfer from physicians' offices to a Certified Clinical Laboratory is reimbursable to the physician.

8.660.3.C. Transfer of a specimen from one Certified Clinical Laboratory to another is a benefit and is reimbursable to the first certified laboratory if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

#### **8.660.4 BILLING PROCEDURES**

1300042 8.660.4.A. Certified providers of clinical laboratory and X-Ray Services shall bill the Department directly using the designated billing method, the correct Current Procedural Terminology and Healthcare Common Procedure Coding System procedure codes and modifiers as required. Providers shall bill the amount of their usual and customary charges to the general public.

8.660.4.B. Laboratory tests and x-rays performed under the personal supervision of the authorizing physician must be billed directly on the physician's services claim form.

8.660.4.C. Laboratory tests and x-rays not performed by the authorizing physician or under his/her direct personal supervision cannot be billed by the physician except for physicians in a Certified Clinical Laboratory group practice. A Certified Clinical Laboratory group practice may only bill for those laboratory and X-Ray Services actually performed or supervised by a physician member of the group or performed by a qualified employee of the group. Payment shall be

made to the authorizing physician or the group practice.

8.660.4.D. Laboratory and X-Ray Services performed by a hospital-based or independent laboratory or x-ray provider and submitted to an unrelated physician for interpretation may only be billed by the laboratory or x-ray provider for the technical component.

8.660.4.E. Practitioner and clinic providers rendering professional interpretation and not direct laboratory or X-Ray Services may only bill the professional component.

**8.660.5 REIMBURSEMENT**

8.660.5.A. Reimbursement for certified laboratory and X-Ray Services shall be the lowest of the following:

1. Submitted charges.
2. Fee schedule as determined by the Department.

8.660.5.B. Services rendered by a hospital-based laboratory during an inpatient stay are included in the hospital Diagnosis Related Group or inpatient rate and shall not be billed or reimbursed separately.

8.660.5.C. Each certified laboratory provider shall be reimbursed for only those tests performed in the specialties or sub-specialties for which it is certified.

8.660.5.D. Reimbursement for out-of-state certified independent clinical laboratory or X-Ray Services shall be subject to Department reimbursement rates.

8.660.5.E. The reimbursement methodology at 8.660.5.A - 8.660.5.D does not apply to payments for those services/procedures that are reimbursed under a capitated or contracted agreement accomplished through competitive bid or other arrangement.

Benefit	<b>SURGERY</b>
What is Covered	<p>Surgery and services that are needed after surgery includes:</p> <ul style="list-style-type: none"> <li>• Outpatient and Inpatient Surgery</li> <li>• Transplant Surgery <ul style="list-style-type: none"> <li>○ Bone Marrow</li> <li>○ Kidney</li> <li>○ Liver</li> <li>○ Lung</li> <li>○ Heart</li> <li>○ Corneal</li> <li>○ Small Bowel</li> <li>○ Pancreas</li> </ul> </li> <li>• Reconstructive Surgery</li> </ul> <p>Breast Surgery and Breast Reconstruction</p>
What is NOT Covered?	Cosmetic Surgeries to enhance your appearance
Limits	For some surgeries, Medicaid will need to approve the service before you use it. Ask your health care provider for more details.
<b>10 CCR 2505-10 8.300</b> <b>Hospital Services</b>	
<p><b>8.300.1 Definitions</b></p> <p>Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.</p> <p>Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.</p> <p>Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.</p> <p>Department means the Department of Health Care Policy and Financing.</p> <p>Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.</p>	

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater than twenty-five (25) days.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medically Necessary, or Medical Necessity, means a Medicaid 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 client's needs.

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

Outpatient means a client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum

reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

Relative Weight (DRG weight) means a numerical value which reflects the relative resource consumption for the DRG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost of claims for each DRG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."

Trim Point Day (Outlier Threshold Day) means the day which would occur 1.94 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

### **8.300.2 Requirements for Participation**

#### **8.300.2.A In-Network Hospitals**

1. In order to qualify as an in-network Hospital, a Hospital must:
  - a. be located in Colorado
  - b. be certified for participation as a Hospital in the Medicare Program;
  - c. have an approved Application for Participation with the Department; and

d. have a fully executed contract with the Department.

2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-network Hospital by meeting the requirements of 10 CCR 2505-10 Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.
3. In-network and out-of-network Hospitals located in Colorado shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

#### 8.300.2.B Out-of-Network Hospitals

An out-of-network Hospital, including out-of-state Hospitals, may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;
2. the services are covered benefits;
3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and
4. the Hospital has an approved Application for Participation with the Department.

#### 8.300.2.C Out-of-State Hospitals

Out-of-state Hospitals may receive reimbursement for non-emergent Hospital services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a written prior authorization.

#### 8.300.2.D Hospitals with Swing-Bed Designation

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.
2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.
3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.
4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.
  - a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).
  - b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).
  - c. Client behavior and facility practices: 42 C.F.R. Section 483.13.
  - d. Client activities: 42 C.F.R. Section 483.15(f).
  - e. Social Services: 42 C.F.R. Section 483.15(g).
  - f. Discharge planning: 42 C.F.R. Section 483.20(e)
  - g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.
  - h. Dental services: 42 C.F.R. Section 483.55.
5. Personal Needs Funds and Patient Payments

Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

### **8.300.3 Covered Hospital Services**

#### **8.300.3.A Covered Hospital Services - Inpatient**

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

- a. bed and board, including special dietary service, in a semi-private room to the extent available;
- b. professional services of hospital staff;
- c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;
- d. emergency room services;
- e. drugs, blood products;
- f. medical supplies, equipment and appliances as related to care and treatment; and
- g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

4. Psychiatric Hospital Services

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

- a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.
- b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:
  - i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and
  - ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.
- c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

#### 5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

- a. an acute medical condition for which dialysis treatments are required; or
- b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or
- c. placement or repair of the dialysis route (“shunt” , “cannula” ).

#### **8.300.3.B Covered Hospital Services – Outpatient**

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20.

##### 1. Observation Stays

Observation stays are a covered benefit as follows:

- a. Clients may be admitted as Outpatients to Observation Stay status.
- b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.
- c. A physician’s order must be written prior to initiation of the Observation Stay.
- d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.
- e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.

##### 2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at DRG Hospitals.

- a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals.

##### 3. Emergency Care

- a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.
- b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

#### **8.300.4 Non-Covered Services**

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.
2. Inpatient Hospital Services which are not a covered Medicare benefit.
3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department’s utilization review vendor or other Department representative.
4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.

5. Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.

### **8.300.5 Payment for Inpatient Hospital Services**

#### **8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services**

##### **1. Peer Groups**

For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups:

- a. Pediatric Hospitals
- b. Rehabilitation Hospitals and Long-Term Care Hospitals
- c. Urban Safety Net Hospitals
- d. Rural Hospitals
- e. Urban Hospitals
- f. Hospitals which do not fall into the peer groups described in a through c above shall default to the peer groups described in d and e based on geographic location.

##### **2. Base Payment and Outlier Payment**

DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

- a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in 10 CCR 2505-10 Section 8.300.5.A.3 – 6.
- b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.
- c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.
- d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

##### **3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals**

###### **a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate**

- i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.
- ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.
- iii For Rehabilitation Hospitals and Long-Term Care Hospitals, the starting point shall be set as a cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year.

iv For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in 10 CCR 2505-10 Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

e. Annual Adjustments

The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department.

4. Medicaid Inpatient Base Rate for New In-Network Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-network Hospitals

a. The Medicaid Inpatient base rate for out of network Hospitals, including out-of-state Hospitals, shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

8.300.5.B Abbreviated Client Stays

1. DRG Hospitals shall receive the DRG base payment and any corresponding outlier payment for Abbreviated Client Stays. The DRG base payment and outlier payment shall be subject to any necessary reduction for ineligible days.

8.300.5.C Transfer Pricing

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.

2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.

3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.

4. Rehabilitation Hospitals and Long-Term Care Hospitals shall not be subject to DRG transfer pricing.

8.300.5.D Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals

a. Inpatient services provided to Medicaid clients in Psychiatric Hospitals shall be reimbursed on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:

i Step 1: day 1 through day 7

ii Step 2: day 8 through remainder of care at acute level

b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.

2. Payment to State-Owned Psychiatric Hospitals

State-owned Psychiatric Hospitals shall receive reimbursement on an interim basis according to a per diem rate. The per diem rate shall be determined based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. A periodic cost audit is conducted and any necessary cost settlement is done to bring reimbursement to 100% of actual audited Medicaid costs.

### **8.300.6 Payments For Outpatient Hospital Services**

#### **8.300.6.A Payments to DRG Hospitals for Outpatient Services**

##### **1. Payments to In-Network Colorado DRG Hospitals**

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

##### **2. Payments to Out-of-Network DRG Hospitals**

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a

case-by-case basis in accordance with supporting documentation submitted by the Hospital.

#### 8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs for Medicaid managed care clients shall be paid directly to qualifying Hospitals rather than to managed care organizations (MCOs).

##### 8.300.7.A GME for Medicaid Managed Care – Inpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are recalculated each year.
2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

##### 8.300.7.B GME for Medicaid Managed Care – Outpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are recalculated each year.
2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

#### **8.300.8 Disproportionate Share Hospital Adjustment**

8.300.8.A Federal regulations require that Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

1. A Hospital must have a Medicaid Inpatient utilization rate at least one standard deviation above the mean Medicaid Inpatient utilization rate for Hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
2. A Hospital must have at least two obstetricians with staff privileges at the Hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.
  - a. In the case where a Hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital to perform non-emergency obstetric procedures.

3. Number (2) above does not apply to a Hospital in which:
  - a. the Inpatients are predominantly under 18 years of age; or
  - b. does not offer non-emergency obstetric services as of December 21, 1987.
4. The Medicaid Inpatient utilization rate for a Hospital shall be computed as the total number of Medicaid Inpatient days for a Hospital in a cost reporting period, divided by the total number of Inpatient days in the same period.
5. The low income utilization rate shall be computed as the sum of:
  - a. The fraction (expressed as a percentage),
    - i. the numerator of which is the sum (for a period) of
      - 1) total revenues paid the Hospital for client services under a State Plan under this title and
      - 2) the amount of the cash subsidies for client services received directly from state and local governments; and
    - ii. the denominator of which is the total amount of revenues of the Hospital for client services (including the amount of such cash subsidies) in the period; and
  - b. a fraction (expressed as a percentage),
    - i. the numerator of which is the total amount of the Hospital's charge for Inpatient Hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) of Section 1923 of the Social Security Act, in the period reasonably attributable to Inpatient Hospital services, and
    - ii the denominator of which is the total amount of the Hospital's charges for Inpatient Hospital services in the Hospital in the period.
6. The numerator under subparagraph (b)(i) shall not include contractual allowances and discounts.

#### 8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a CICP Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.2000.
2. Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital Payment defined in 10-CCR 2505-10 section 8.2000.

#### 8.300.9 Supplemental Inpatient Hospital Payments

##### 8.300.9.A Family Medicine Residency Training Program Payment

A Hospital qualifies for a Family Medicine Residency Training Program payment when it is recognized by the Commission on Family Medicine and has at least 10 residents and interns. The Family Medicine Residency Training Program payment will only be made to Medicaid in-network Hospitals. For each program which qualifies under this section, the additional Inpatient Hospital payment will be calculated based upon historical data and paid in 12 equal monthly installments. The Family Medicine Residency Training Program payment is a fixed amount subject to annual appropriation by the General Assembly.

##### 8.300.9.B State University Teaching Hospital Payment

State University Teaching Hospitals shall receive a supplemental Inpatient Hospital payment for GME costs associated with Inpatient Hospital Services provided

to Medicaid fee-for-service and managed care clients. The State University Teaching Hospital payment is calculated based on GME costs and estimated Medicaid discharges using the same methodology as that used to calculate the GME add-on to the Medicaid Inpatient base rate described in 10 CCR 2505-10 Section 8.300.5.A.3.c., and the GME payments to Hospitals for Medicaid managed care described in 10 CCR 2505-10 Section 8.300.7. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the General Assembly.

#### 8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized

8.300.10.A When an eligible client is admitted to the Hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies, using form AP-5615. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the Hospital of the amount. If directed by the county department, the nursing facility shall transfer the excess amount to the Hospital and this payment will be shown as a patient payment when the Hospital submits a claim to the Medicaid Program.

8.300.10.B The Hospital is responsible for collecting the correct amount of patient payment due from the client, the client's family, or representatives. Failure to collect patient payment, in whole or in part, does not allow the Hospital to bill Medicaid for the patient payment.

#### **8.300.11. Payment for Hospital Beds Designated as Swing Beds**

##### 8.300.11.A Swing Bed Payment Rates

1. Payment for swing-bed services will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year.
2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.
3. Clients shall be required to contribute their patient payment to the cost of their nursing care. Collection as well as determination of the patient payment amount shall be in accordance with 10 CCR 2505-10, Section 8.482.

##### 8.300.11.B Swing Bed Claim Submission

1. Hospitals shall submit claims for swing-bed routine services as nursing facility claims.
2. Ancillary services (services not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but reimbursable under Medicaid, including but not limited to laboratory and radiology) shall be billed separately on the appropriate claim form.

#### 8.300.12 Utilization Management

All participating in-network Hospitals are required to comply with utilization management and review, program integrity and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

##### 8.300.12.A Conduct of Reviews

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.076, Program Integrity, and 8.079, Quality Improvement.
2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.
3. The types of reviews conducted may include, but are not limited to the following:
  - a. Prospective Reviews;
  - b. Concurrent Reviews;
  - c. Reviews for continued stays and transfers;
  - d. Retrospective Reviews.
4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:
  - a. Medical Necessity;
  - b. Appropriateness of care;
  - c. Service authorizations;
  - d. Payment reviews;
  - e. DRG validations;
  - f. Outlier reviews;
  - g. Second opinion reviews; and
  - h. Quality of care reviews.
5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.
  - a. When appropriate, payment may be adjusted, denied or recouped.
6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

#### 8.300.12.B Corrective Action

1. Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization or questionable quality of care.
2. If corrective action does not resolve the problem, the Department shall initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076.
3. Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.

#### 8.300.12.C Prior Authorization of Swing-Bed Care

Care for Medicaid clients in hospital beds designated as swing beds shall be prior authorized and subject to the Continued Stay Review process in accordance with the criteria and procedures found in 10 CCR 2505-10, Sections 8.393 and 8.400 through 8.415. Prior authorization requires a level of care determination using the Uniform Long Term Care 100.2 and a Pre-Admission Screening and Resident Review (PASRR) screening.

[8.300.13 – 8.375.60 Repealed effective 11/30/2009]

Benefit	<b>Drug and Alcohol Abuse Treatment</b>
What is Covered	Treatment for a drug or alcohol problem on a one-on-one basis, in a group, or with your family.
What is NOT Covered?	Treatment using prescription drugs and inpatient treatment is not covered. (Inpatient means that you're admitted to a hospital or treatment center to stay overnight.)
Limits	<p>There are three basic limits to drug and alcohol treatment:</p> <ul style="list-style-type: none"> <li>• 25 sessions of treatment on a one-on-one basis or with your family</li> <li>• 36 sessions of group treatment</li> <li>• 7 days of detox</li> </ul>
<b>10 CCR 2505-10 8.746</b> <b>Outpatient Substance Abuse Treatment</b>	
<p><b>8.746.1 DEFINITIONS [Emer. Rule eff 9/ 8 /06; Perm. Rule eff 10/1/06]</b></p> <p>Alcohol and/or drug screening means the collection of urine to test for the presence of alcohol and/or drugs.</p> <p>Group Therapy means therapeutic substance abuse counseling and treatment services with more than one client.</p> <p>Individual and Family Therapy means therapeutic substance abuse counseling services with one client per session. Family therapy shall be directly related to the client's treatment for substance abuse and/or dependence.</p> <p>Social/Ambulatory Detoxification means services provided on a residential basis by a facility licensed by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services based on American Society of Addiction Medicine (ASAM) criteria.</p> <p>Substance Abuse Assessment means an evaluation designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a client.</p> <p>Targeted Case Management means medically necessary coordination and planning services provided with or on behalf of a client with a substance abuse diagnosis.</p> <p><b>8.746.2 Client Eligibility [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]</b></p> <p>8.746.2.A. Clients identified as being appropriate for the Substance Abuse Treatment program shall be assessed as having drug/alcohol abuse or dependence.</p>	

8.746.3 Provider Requirements [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]

8.746.3.A. Outpatient substance abuse services shall be provided in an approved facility or by certain licensed health care practitioners with certification in addiction counseling.

8.746.3.B. Providers shall be one of the following:

- a. Facilities licensed by ADAD to offer outpatient services.
- b. Licensed physicians who are also:
  - i) Certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM), or
  - ii) Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by Department of Regulatory Agencies (DORA), or
  - iii) Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC.
  - iv) Certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN).
- c. Licensed non-physician practitioners are any of the following:
  - i) Psychologist, PhD.
  - ii) Nurse Practitioner.
  - iii) Licensed Clinical Social Worker (LCSW).
  - iv) Marriage and Family Therapist.
  - v) Licensed Professional Counselor (LPC).
  - vi) Licensed Addiction Counselor (LAC).
- d. The above licensed non-physician practitioners shall also be certified addiction counselors with one of the following credentials:
  - i) Certified by DORA as a CAC II, CAC III.
  - ii) Certified by NAADAC as an NCAC II or MAC.

8.746.4 Covered Services [Emer. Rule eff 9/8/06; Perm. Rule eff 10/1/06]

1. Outpatient Substance Abuse Treatment services are limited to:

- a. Substance Abuse Assessment, which shall be limited to three sessions per state fiscal year.
- b. Individual and Family Therapy, which shall be limited to 25 sessions at 15 minutes per unit, up to four units per session per state fiscal year.
- c. Group Therapy sessions, which shall be up to an including three hours per session and limited to 36 sessions per state fiscal year.
- d. Alcohol/Drug Screening, which shall be limited to 36 specimen collections per state fiscal year. Substance abuse counseling services shall be provided along with screening to discuss results with client.
- e. Targeted Case Management, which shall be limited to 36 contacts per state fiscal year. Services may include service planning, advocacy and linkage to other medical services related to substance abuse diagnosis, monitoring, and care coordination.
- f. Social/Ambulatory Detoxification, which shall be limited to seven days per state fiscal year and includes supervision, observation and support for individuals whose intoxication/withdrawal signs and symptoms are severe enough to require a 24 hour structured program but do not require hospitalization.

Benefit	Hospice
What is Covered	Special care if you are expected to live for less than six months.
What is NOT Covered?	Services for family members are not covered.
Limits	NA
<b>10 CCR 2505-10 8.550</b> <b>Hospice</b>	
<p>8.550.1 DEFINITIONS</p> <p>Benefit Period means a period during which the client has made an Election to receive hospice care defined as one or more of the following:</p> <ol style="list-style-type: none"> <li>(1) An initial 90-day period.</li> <li>(2) A subsequent 90-day period.</li> <li>(3) An unlimited number of subsequent 60-day periods.</li> </ol> <p>The periods of care are available in the order listed and may be Elected separately at different times.</p> <p>Certification means that the client's attending physician and/or the Hospice medical director have affirmed that the client is Terminally Ill.</p> <p>Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services.</p> <p>Home Care Services means Hospice Services that are provided primarily in the client's home but may be provided in a residential facility and/or licensed or certified health care facility.</p> <p>Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill clients and their families.</p> <p>Hospice Services means counseling, home health aide, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteers.</p>	

Interdisciplinary Team or Interdisciplinary Group means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice clients/families.

Palliative and Supportive Medical Services means those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

#### **8.550.2 CERTIFICATION**

8.550.2.A. The Hospice shall obtain Certification that a client is Terminally Ill in accordance with the following procedures:

1. For the first Benefit Period of Hospice coverage or re-Election following revocation or discharge from the Hospice benefit, the Hospice shall obtain:
  - a. A written Certification signed by either the medical director of the Hospice or the physician member of the Hospice Interdisciplinary Group and the client's attending physician. The written Certification shall be obtained and on file prior to submitting any claim for reimbursement to the Medicaid fiscal agent. The written Certification shall include:
    - i) A statement of the client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and Terminal Illness.
    - ii) The approval of the physician(s) for Hospice care.
  - b. A verbal Certification statement from either the medical director of the Hospice or the physician member of the Hospice Interdisciplinary Group and the client's attending physician, if written certification cannot be obtained within two calendar days after Hospice care is initiated. The verbal Certification shall be documented, filed in the medical record, and include the information described at 8.550.2.A.1.a.i and ii. Written Certification documentation shall follow and be filed in the medical record prior to submitting a claim for payment.
2. At the beginning of each subsequent period, the Hospice shall obtain a written re-Certification prepared by either the attending physician, the medical director of the Hospice or the physician member of the Hospice Interdisciplinary Group.

#### **8.550.3 ELECTION PROCEDURES**

8.550.3.A. An Election of Hospice care continues as long as there is no break in care and the client remains with the Elected Hospice.

1. If a client Elects to receive Hospice care, the client or client representative shall file an Election statement with the Hospice including:
  - a. Designation of the Hospice provider.
  - b. Acknowledgment that the client or client representative has been given a full understanding of the palliative rather than curative nature of Hospice care.
  - c. Designation by the client or client representative of the effective date for the Election period that begins with the first day of Hospice care.
  - d. An acknowledgement that for the duration of the Hospice Services, the client waives all rights to Medicaid payments for the following services:
    - i) Hospice Services provided by a Hospice other than the Hospice provider designated by the client (unless provided under

arrangements made by the designated Hospice).

ii) Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was Elected or a related condition or that are equivalent to hospice care except for services that are:

- a) Provided by the designated hospice,
- b) Provided by another hospice under arrangements made by the designated hospice,
- c) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

e. A signature of either the client or client representative as allowed by Colorado law.

2. A client or client representative may revoke the Election of Hospice care by filing a signed statement of revocation with the Hospice. The statement shall include the effective date of the revocation. The client shall not designate an effective date earlier than the date that the revocation is made.

Revocation of the Election of hospice care ends the current hospice benefit period.

3. The client may resume coverage of the waived benefits as described at 8.550.3.A.1.d. upon revoking the Election of Hospice care.

4. The client may re-Elect to receive Hospice care at any time after the services are discontinued due to discharge, revocation, or loss of Medicaid eligibility, should the client thereafter become eligible.

5. The client may change the designation of the Hospice provider once each Benefit Period. A change in designation of Hospice provider is not a revocation of the client's Hospice Election. To change the designation of the Hospice provider the client shall file a statement with the current and new provider which includes:

- a. The name of the Hospice from which the client is receiving care and the name of the Hospice from which he or she plans to receive care.
- b. The date the change is to be effective.
- c. The signature of the client or client representative.

#### **8.550.4 BENEFITS**

8.550.4.A. Hospice Services shall be reasonable and necessary for the palliation or management of the Terminal Illness as well as any related condition, but not for the prolongation of life.

8.550.4.B. Covered Hospice Services include, but are not limited to:

1. Nursing care provided by or under the supervision of a registered nurse.
2. Medical social services provided by a qualified social worker or counselor under the direction of a physician.
3. Counseling services, including dietary and spiritual counseling, provided to the Terminally Ill client and his or her family members or other persons caring for the client.
4. 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).
5. Short-term general inpatient care necessary for pain control and/or symptom management up to 20 percent of total Hospice days.
6. 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.
7. Medical appliances and supplies, including drugs and biologicals which are used primarily for symptom control and relief of pain related to the

**Terminal Illness.**

8. Intermittent home health aide services available and adequate in frequency to meet the needs of the client. A home health aide is a certified nurse aide under the general supervision of a registered nurse. Home health aide services may include unskilled personal care and homemaker services that are incidental to a visit.

9. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills.

10. Trained volunteer services.

11. 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.

8.550.4.C. Services not covered as part of the hospice benefit include, but are not limited to:

1. Services provided before or after the Hospice Election period.

2. Services of the client's attending or consulting physician that are unrelated to the terminal condition which are not waived under the Hospice benefit.

3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition.

4. Services which are not otherwise included in the Hospice benefit, such as electronic monitoring, non-medical transportation, and home modification under a Home and Community-Based Services (HCBS) program.

5. Personal care and homemaker services beyond the scope provided under Hospice which are contiguous with a home health aide visit.

**8.550.5 ELIGIBILITY**

8.550.5.A. A client shall be eligible to Elect Hospice care when the following requirements are met:

1. The client's residence is either a private residence, residential care facility, licensed Hospice facility, intermediate care facility for the mentally retarded (ICF-MR) or a skilled nursing facility (SNF), unless the client is in a waiver program which does not allow residency in an ICF-MR or SNF.

2. The client has been certified as being Terminally Ill by an attending physician and/or Hospice medical director.

3. An initial plan of care has been established by the Hospice provider before services are provided.

4. Hospice clients residing in an ICF-MR or SNF shall meet the Hospice eligibility criteria pursuant to 8.550 et. seq., together with functional eligibility, medical eligibility criteria, and the financial eligibility criteria for institutional care as required by 10 C.C.R. 2505-10, Sections 8.400, 8.401, and 8.482.

8.550.5.B. Eligibility for, and access to, Hospice shall not fall within the purview of the long term care Single Entry Point system for prior authorization.

Nursing facility placement for a client who has Medicaid and has Elected Hospice care in a nursing facility does not require a long term care ULTC 100.2 assessment. The nursing facility shall complete a Pre Admission Screening and Resident Review (PASRR).

**8.550.6 DISCHARGE**

8.550.6.A. A Hospice may discharge a client when:

1. The client moves out of the Hospice's service area or transfers to another Hospice.

2. The hospice determines that the client is no longer Terminally Ill.

3. The Hospice determines, under a policy set by the Hospice for the purpose of addressing discharge for cause that meets the requirements of 42

C.F.R. Section 418.26 (2005), that the client's (or other person in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care or the Hospice's ability to operate effectively is seriously impaired. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library.

4. The Hospice shall advise the client that a discharge for cause is being considered, make a serious effort to resolve the problem presented by the situation, ascertain that the proposed discharge is not due to the client's use of necessary Hospice services, document the problem and the effort made to resolve the problem, and enter this documentation into the client's medical record.

5. The Hospice shall obtain a written discharge order from the Hospice medical director prior to discharging a client for any of the reasons in this section.

6. The Hospice medical director shall document that the attending physician involved in the client's care has been consulted about the discharge and include the attending physician's review and decision in the discharge note.

7. The Hospice shall have in place a discharge planning process that takes into account the prospect that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as Terminally Ill. The discharge planning process shall include planning for any necessary family counseling, patient education, or other services before the client is discharged because he or she is no longer Terminally Ill.

#### **8.550.7 PROVIDER QUALIFICATIONS**

8.550.7.A. The Hospice shall be licensed by the Colorado Department of Public Health and Environment, have a valid provider agreement with the Department and meet the Medicare conditions of participation for a Hospice as set forth at 42 C.F.R. Sections 418.50 through 418.98 (2005) and 42 C.F.R. Section 418.100 (a)-(c) (2005). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library.

8.550.7.B. Laboratory services provided by Hospices are subject to the requirements of 42 U.S.C. Section 263 (a) (2005) entitled the Clinical Laboratory Improvement Act of 1967 (CLIA). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library.

8.550.7.C. Hospices shall obtain a CLIA waiver from the Department of Public Health and Environment to perform laboratory tests. A Hospice Provider that collects specimens, including drawing blood, but does not perform testing of specimens is not subject to CLIA requirements.

#### **8.550.8 PROVIDER RESPONSIBILITIES**

8.550.8.A. The Hospice provider shall determine and document the amount, frequency, and duration of services in accordance with the client's plan of care developed in consultation with the client and his or her physician.

8.550.8.B. An individual client record shall be maintained by the designated Hospice including:

1. Eligibility for and Election of Hospice.
2. The amount, frequency, and duration of services delivered to the client based on the client's plan of care.
3. Documentation to support the care level for which the Hospice provider has claimed reimbursement.

8.550.8.C. Inadequate documentation shall be a basis for recovery of overpayment.

8.550.8.D. Notice of the client's Election and Benefit Periods shall be provided to the Medicaid fiscal agent in such form and manner as prescribed by the Department.

8.550.8.E. The Hospice provider shall provide reports and keep records as the Department determines necessary including records that document the cost of providing care.

8.550.8.F. The Hospice provider shall perform case management for the client. Medicaid shall not reimburse the Hospice provider separately for this responsibility.

#### **8.550.9 REIMBURSEMENT**

8.550.9.A. Reimbursement follows the method prescribed in 42 C.F.R. Sections 418.302 through .306 (2005). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library.

1. Reimbursement rates are determined by the following:
  - a. Rates are published by the Department annually in compliance with the Centers for Medicare and Medicaid Services (CMS) state Medicaid Hospice reimbursement.
  - b. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.
  - c. The Hospice wage indices are published annually in the Federal Register.
  - d. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.
  - e. Continuous home care is reimbursed at the applicable hourly rate, the per-diem rate divided by 24 hours, times the number of hourly units billed from eight up to 24 hours per day of continuous care.
  - f. Reimbursement for routine home care and continuous home care shall be based upon the geographic location at which the service is furnished and not on the business address of the Hospice provider.

8.550.9.B. Reimbursement for Hospice care shall be made at one of four predetermined care level rates, including the routine home care rate, continuous home care rate, inpatient respite care rate, and general inpatient care rate. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.

1. Care level determination and reimbursement guidelines:
  - a. The routine home care rate is reimbursed for each day the client is at home and not receiving continuous home care. This rate is paid

without regard to the volume or intensity of Home Care Services provided.

b. The continuous home care rate is reimbursed when continuous home care is provided and only during a period of medical crisis to maintain a client at home. A period of crisis is a period in which a client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Either a registered nurse or a licensed practical nurse shall provide nursing care. A nurse shall provide more than half of the period of care. Homemaker and certified nurse aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours shall be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day.

c. The inpatient respite care rate is paid for each day on which the client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9. D.

d. The general inpatient rate shall be paid only during a period of medical crisis in which a client requires 24 hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in 8.550.9. D.

2. Hospice is paid a room and board fee in addition to the Hospice per diem for each routine home care day and continuous care day provided to clients residing in an ICF-MR or SNF.

a. The payment for room and board is billed by and reimbursed to the Hospice provider on behalf of the client residing in the facility. The Department reimburses 95 percent of the facility per diem amount less any patient payments.

b. Payments for room and board are exempt from the computation of the Hospice payment cap.

c. The Hospice provider shall forward the room and board payment to the SNF or ICF-MR.

d. Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice. The Hospice shall submit claims on behalf of the client and nursing facility or ICF-MR.

e. Patient payments for room and board charges shall be collected for Hospice clients residing in a SNF or ICF-MR as required by 10 C.C.R. 2505-10, Section 8.482. While the Medicaid SNF and ICF-MR room and board payments shall be made directly to the Hospice provider, the patient payment shall be collected by the nursing facility or ICF-MR.

f. Nursing facilities, ICF-MRs, and Hospice providers shall be responsible for coordinating care of the Hospice client and payment amounts.

3. Reimbursement for date of discharge shall be:

a. Reimbursement shall be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the client dies at an inpatient level of care. When the client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.

b. Reimbursement for nursing facility and ICF-MR residents is made for services delivered up to the date of discharge when the client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

8.550.9.C. Aggregate payment to the Hospice provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (2005). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570

Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library.

8.550.9.D. Aggregate days of care provided by the Hospice are subject to an annual limitation of no more than 20 percent general and respite inpatient care days. The method for determining and reporting the inpatient days percentage shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Section 418.302 (2005). No amendments or later editions are incorporated. Copies are available for inspection from the Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Material that has been incorporated by reference in this rule may be examined at any state publications depository library. Inpatient days in excess of the 20 percent limitation shall be reimbursed at the routine home care rate.

8.550.9.E. The Hospice provider shall not collect co-payments, deductibles, cost sharing or similar charges from the client for Hospice care benefits including biologicals and respite care.

8.550.9.F. The Hospice provider shall submit all billing to the Medicaid fiscal agent within such timeframes and in such form as prescribed by the Department.

Benefit	Private Duty Nursing
What is Covered	Nursing care provided in your home or in your community
What is NOT Covered?	Personal care services or comfort care
Limits	Medicaid will need to approve this service. Children may receive up to 24 hours a day of care. Adults may receive up to 16 hours a day of care.
<b>10 CCR 2505-10 8.540</b> <b>Private Duty Nursing</b>	
<p>8.540.1 DEFINITIONS</p> <p>Family/In-Home Caregiver means an unpaid individual who assumes a portion of the client's Private Duty Nursing care in the home, when Home Health Agency staff is not present. A Family/In-Home Caregiver may either live in the client's home or go to the client's home to provide care. [Eff 08/01/2006]</p> <p>Home Health Agency means a public agency or private organization or part of such an agency or organization which is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act. [Eff 08/01/2006]</p> <p>Plan of Care means a care plan developed by the Home Health Agency in consultation with the client, that has been ordered by the attending physician for provision of services to a client at his/her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements at 42 C.F.R. 484.18. [Eff 08/01/2006]</p> <p>Private Duty Nursing (PDN) means 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. [Eff 08/01/2006]</p> <p>Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition. [Eff 08/01/2006]</p> <p>Skilled Nursing means services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, Title 12 Article 38 of the Colorado Revised Statutes, performed by a registered nurse (RN) under the direction of a physician, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician. [Eff 08/01/2006]</p> <p>Technology Dependent means a client who: [Eff 08/01/2006]</p>	

- a. Is dependent at least part of each day on a mechanical ventilator; or [Eff 08/01/2006]
- b. Requires prolonged intravenous administration of nutritional substances or drugs; or [Eff 08/01/2006]
- c. Is dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support or tube feedings when they are not intermittent. [Eff 08/01/2006]

**8.540.2 BENEFITS**

8.540.2.A. All PDN services shall be prior authorized by the Department's Utilization Review Contractor (URC). [Eff 08/01/2006]

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable. [Eff 08/01/2006]

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy. [Eff 08/01/2006]
2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours. [Eff 08/01/2006]
3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations. [Eff 08/01/2006]

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year. [Eff 08/01/2006]

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day. [Eff 08/01/2006]

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home. [Eff 08/01/2006]

**8.540.3 BENEFIT LIMITATIONS**

8.540.3.A. A client who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care under PDN or under home health. The client may choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the client. [Eff 08/01/2006]

8.540.3.B. Hours of PDN shall never exceed the hours per day that the URC determines are medically necessary. [Eff 08/01/2006]

**8.540.4 ELIGIBILITY**

8.540.4.A. A client shall be eligible for PDN services when the client is: [Eff 08/01/2006]

1. Technology Dependent. [Eff 08/01/2006]
2. Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician. [Eff 08/01/2006]

3. Able to be safely served in their home by a home health agency under the agency requirements and limitations of the PDN benefit and with the staff services available. [Eff 08/01/2006]
4. Not residing in a nursing facility or hospital at the time PDN services are delivered. [Eff 08/01/2006]
5. Eligible for Medicaid in a non-institutional setting. [Eff 08/01/2006]
6. Able to meet one of the following medical criteria: [Eff 08/01/2006]
  - a. The client needs PDN services while on a mechanical ventilator. [Eff 08/01/2006]
  - b. The client needs PDN services for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%. [Eff 08/01/2006]
  - c. The pediatric client needs PDN services after tracheostomy decannulation during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%. [Eff 08/01/2006]
  - d. The pediatric client needs PDN services during the hours spent on continuous positive airway pressure (C-PAP), until the client is medically stable. [Eff 08/01/2006]
  - e. The pediatric client needs PDN services for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes. If oxygen is the only technology present, the URC shall review for an individual determination of medical necessity for PDN. [Eff 08/01/2006]
  - f. The pediatric client needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids. [Eff 08/01/2006]
  - g. The URC shall consider combinations of technologies and co-morbidities when making medical determinations for the following medical conditions: [Eff 08/01/2006]
    - i) A pediatric client with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube, whether intermittent or not, who is not on mechanical ventilation. [Eff 08/01/2006]
    - ii) An adult client with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation. [Eff 08/01/2006]
    - iii) An adult client with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation. [Eff 08/01/2006]
    - iv) An adult client who has Continuous Positive Airway Pressure (C-PAP), but is not on mechanical ventilation or being weaned from mechanical ventilation. [Eff 08/01/2006]
    - v) An adult client with oxygen supplementation, who is not on mechanical ventilation or being weaned from mechanical ventilation. [Eff 08/01/2006]
    - vi) An adult client receiving prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids who is not on mechanical ventilation or being weaned from mechanical ventilation. [Eff 08/01/2006]
    - vii) An adult client with tube feedings that are continuous, including nasogastric tube, gastric tube, gastric button and jejunostomy tube who is not on mechanical ventilation nor being weaned from mechanical ventilation. [Eff 08/01/2006]

7. The medical judgment of the attending physician and the URC shall be used to determine if the criteria are met wherever the medical criteria are not defined by specific measurements. [Eff 08/01/2006]

#### **8.540.5 APPLICATION PROCEDURES**

8.540.5.A. The hospital discharge planner shall coordinate with the Home Health Agency to: [Eff 08/01/2006]

1. Refer the client or the client's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed. [Eff 08/01/2006]
2. Plan for the client's hospital discharge by: [Eff 08/01/2006]
  - a. Arrange services with the Home Health Agency, medical equipment suppliers, counselors and other health care service providers as needed. [Eff 08/01/2006]
  - b. Coordinate, in conjunction with the physician and the Home Health Agency, a home care plan that is safe and meets program requirements. [Eff 08/01/2006]
  - c. Advise the Home Health Agency of any changes in medical condition and care needs. [Eff 08/01/2006]
  - d. Ensure that the client, family and caregivers are educated about the client's medical condition and trained to perform the home care. [Eff 08/01/2006]
3. Submit an application to determine PDN eligibility to the URC if the client is hospitalized when services are first requested or ordered. [Eff 08/01/2006]

8.540.5.B. The Home Health Agency case coordinator shall submit the application for PDN services to the URC if the client is not in the hospital. [Eff 08/01/2006]

8.540.5.C. An application may be submitted up to six months prior to the anticipated need for PDN services. Updated medical information shall be sent to the URC as soon as the service start date is known. [Eff 08/01/2006]

8.540.5.D. The application shall be submitted on a Department PDN application form. Any medical information necessary to determine the client's medical need shall be included with the application form. [Eff 08/01/2006]

8.540.5.E. If the client has other insurance that has denied PDN coverage, a copy of the denial letter, explanation of benefits or the insurance policy shall be included with the application. [Eff 08/01/2006]

8.540.5.F. If services are being requested beyond the 16 hour per day benefit as a result of an EPSDT medical screening, written documentation of those screening results shall be included with the application. The EPSDT claim form shall not meet this requirement. [Eff 08/01/2006]

8.540.5.G. The URC nurse reviewer shall review applications for PDN according to the following procedures: [Eff 08/01/2006]

1. Review the information provided and apply the medical criteria. [Eff 08/01/2006]
2. Return the application to the submitting party for more information within seven working days of receipt of an incomplete application if the application is not complete. [Eff 08/01/2006]

3. Approve the application, or refer the application to the URC physician reviewer within 10 working days of receipt of the complete application. The physician reviewer shall have 10 working days to determine approval or denial of the application for PDN. [Eff 08/01/2006]
4. Notify the client or the client's designated representative and the submitting party of application approval. [Eff 08/01/2006]
5. Notify the client, the client's designated representative and the submitting party of the client's appeal rights by placing written notification in the mail within one working day of a denial decision. [Eff 08/01/2006]

8.540.5.H. Clients who are approved and who subsequently discontinue PDN for any reason do not need an application to request resumption of PDN services within six months of discontinuing PDN services. Services may be resumed upon approval of a Prior Authorization Request (PAR). [Eff 08/01/2006]

#### **8.540.6 PROVIDER REQUIREMENTS**

- 8.540.6.A. A certified Home Health Agency may be authorized to provide PDN services if the agency meets all of the following: [Eff 08/01/2006]
1. Employs nursing staff currently licensed in Colorado with experience in providing PDN or care to Technology-Dependent persons. [Eff 08/01/2006]
  2. Employs nursing personnel with documented skills appropriate for the client's care. [Eff 08/01/2006]
  3. Employs staff with experience or training, in providing services to the client's particular demographic or cultural group. [Eff 08/01/2006]
  4. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client. [Eff 08/01/2006]
  5. Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements. [Eff 08/01/2006]
  6. Provides appropriate nursing skills orientation and on going in-service education to nursing staff to meet the client's specific nursing care needs. [Eff 08/01/2006]
  7. Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years. [Eff 08/01/2006]
  8. Provides adequate supervision and training for all nursing staff. [Eff 08/01/2006]
  9. Designates a case coordinator who is responsible for the management of home care which includes the following: [Eff 08/01/2006]
    - a. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician regarding the home care plan. [Eff 08/01/2006]
    - b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance. [Eff 08/01/2006]
    - c. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested. [Eff 08/01/2006]
    - d. Refers the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed. [Eff 08/01/2006]
    - e. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires. [Eff 08/01/2006]
    - f. Provides overall coordination of home services and service providers. [Eff 08/01/2006]
    - g. Involves the client and Family/In Home Caregiver in the plan for home care and the provision of home care. [Eff 08/01/2006]
    - h. Assists the client to reach maximum independence. [Eff 08/01/2006]
    - i. Communicates changes in the case status with the attending physician and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs. [Eff 08/01/2006]
    - j. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician, specialists and the primary Home Health Agency as needed. [Eff 08/01/2006]

- k. Makes regular on-site visits to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary. [Eff 08/01/2006]
  - l. Ensures that complete and current care plans and nursing charts are in the client's home at all times. Charts shall include interim physician orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans. [Eff 08/01/2006]
  - m. Communicates with Single Entry Point or other case managers as needed regarding service planning and coordination. [Eff 08/01/2006]
10. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services. [Eff 08/01/2006]
11. Documents that the Family/In-Home Caregiver: [Eff 08/01/2006]
- a. Is able to assume some portion of the client's care. [Eff 08/01/2006]
  - b. Has the specific skills necessary to care for the client. [Eff 08/01/2006]
  - c. Has completed CPR instruction or certification and/or training specific to the client's emergency needs prior to providing PDN services. [Eff 08/01/2006]
  - d. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations. [Eff 08/01/2006]
  - e. Participates in the planning, implementation and evaluation of PDN services. [Eff 08/01/2006]
  - f. Communicates changes in care needs and any problems to health care providers and physicians as needed. [Eff 08/01/2006]
  - g. Works toward the client's maximum independence, including finding and using alternative resources as appropriate. [Eff 08/01/2006]
  - h. Has notified power companies, fire departments and other pertinent agencies, of the presence of a special needs person in the household. [Eff 08/01/2006]
12. Performs an in-home assessment and documents that the home meets the following safety requirements: [Eff 08/01/2006]
- a. Adequate electrical power including a back up power system. [Eff 08/01/2006]
  - b. Adequate space for equipment and supplies. [Eff 08/01/2006]
  - c. Adequate fire safety and adequate exits for medical and other emergencies. [Eff 08/01/2006]
  - d. A clean environment to the extent that the client's life or health is not at risk. [Eff 08/01/2006]
  - e. A working telephone available 24 hours a day. [Eff 08/01/2006]
- 8.540.6.B. The Home Health Agency shall coordinate with the client's attending physician to: [Eff 08/01/2006]
- 1. Determine that the client is medically stable, except for acute episodes that can be managed under PDN, and that the client can be safely served under the requirements and limitations of the PDN benefit. [Eff 08/01/2006]
  - 2. Cooperate with the URC in establishing medical eligibility. [Eff 08/01/2006]
  - 3. Prescribe a plan of care at least every 60 days. [Eff 08/01/2006]
  - 4. Coordinate with any other physicians who are treating the client. [Eff 08/01/2006]
  - 5. Communicate with the Home Health Agency about changes in the client's medical condition and care, especially upon discharge from the hospital. [Eff 08/01/2006]
  - 6. Empower the client and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the client's independence. [Eff 08/01/2006]

**8.540.7 PRIOR AUTHORIZATION PROCEDURES**

8.540.7.A. The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN. [Eff 08/01/2006]

8.540.7.B. The PAR shall be approved for up to six months for a new client and up to one year for ongoing care depending upon prognosis for improvement or recovery, according to the medical criteria. [Eff 08/01/2006]

8.540.7.C. The PAR information shall: [Eff 08/01/2006]

1. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN. [Eff 08/01/2006]
2. Be submitted with the plan of care that: [Eff 08/01/2006]
  - a. Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed. [Eff 08/01/2006]
  - b. Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR. [Eff 08/01/2006]
  - c. Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home. [Eff 08/01/2006]
  - d. Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated. [Eff 08/01/2006]
3. Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN. [Eff 08/01/2006]
4. Cover a period of up to one year depending upon medical necessity determination. [Eff 08/01/2006]
5. Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it. [Eff 08/01/2006]
6. Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form. [Eff 08/01/2006]
7. Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency. [Eff 08/01/2006]
8. Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the

PAR. The revision is to the end date and the number of service units. [Eff 08/01/2006]

8.540.7.D. The URC shall review PARs according to the following procedures: [Eff 08/01/2006]

1. Review information provided and apply the medical criteria as described herein. [Eff 08/01/2006]
2. Return an incomplete PAR to the Home Health Agency for correction within seven working days of receipt. [Eff 08/01/2006]
3. Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR. [Eff 08/01/2006]
4. Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services. [Eff 08/01/2006]
5. Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision. [Eff 08/01/2006]
6. Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed. [Eff 08/01/2006]
7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen. [Eff 08/01/2006]
8. Notify the submitting party of all PAR approvals. [Eff 08/01/2006]
9. Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health. [Eff 08/01/2006]

8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted. [Eff 08/01/2006]

8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter. [Eff 08/01/2006]

#### **8.540.8 REIMBURSEMENT**

8.540.8.A. No services shall be authorized or reimbursed if hours of service, regardless of funding source, total more than 24 hours per day. [Eff 08/01/2006]

8.540.8.B. No services shall be reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health or other insurance. [Eff 08/01/2006]

8.540.8.C. Approval of the PAR by the URC shall authorize the Home Health Agency to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the provider's use of correct billing procedures. [Eff 08/01/2006]

8.540.8.D. No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the URC. [Eff 08/01/2006]

8.540.8.E. Skilled Nursing services under the PDN shall be reimbursed in units of one hour, at the provider's usual and customary charge or the maximum Medicaid allowable rates established by the Department, whichever is less. Units of one hour may be billed for RN, LPN, RN group rate (registered nurse providing PDN to more than one client at the same time in the same setting), LPN group rate (licensed practical nurse providing PDN to more than one client at the same time in the same setting) or Blended RN/LPN rate (group rate by request of the Home Health Agency only). [Eff 08/01/2006]

DRAFT

Benefit	Durable Medical Equipment (DME) and Supplies
What is Covered	Medical equipment and supplies help individuals increase their abilities to perform activities of daily living.
What is NOT Covered?	For a brief list of non-covered items, see the section in this handbook on Durable Medical Equipment and Supplies. For specific questions, call customer service or ask your doctor.
Limits	For equipment and supplies you will need a prescription from your doctor and Medicaid may need to approve it before you can get it. Some items are only available for children age 20 and under.

## 10 CCR 2505-10 8.590

**Durable Medical Equipment and Disposable Services**

## 8.590.1 DEFINITIONS

Abuse, for purposes of this rule only, means the intentional destruction of or damage to equipment that results in the need for repair or replacement.

Cochlear Implant or cochlear prosthesis means an electrode or electrodes surgically implanted in the cochlea which are attached to an induction coil buried under the skin near the ear, and the associated unit which is worn on the body.

Disposable Medical Supplies (Supplies) means supplies prescribed by a physician that are specifically related to the active treatment or therapy for an illness or physical condition. Supplies are non-durable, disposable, consumable and/or expendable.

Durable Medical Equipment (DME) means medically necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.

Facilitative Device means DME with a retail price equal to or greater than one hundred dollars that is exclusively designed and manufactured for a client with disabilities to improve, maintain or restore self-sufficiency or quality of life through facilitative technology. Facilitative Devices do not include Wheelchairs.

Hearing Aid means a wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories thereto, including ear molds but excluding batteries and cords.

Medical Necessity, for purposes of rule 8.590, means DME, Supplies and Prosthetic or Orthotic Devices that are necessary in the treatment, prevention or alleviation of an illness, injury, condition or disability.

Misuse means failure to maintain and/or the intentional utilization of DME, Supplies and Prosthetic or Orthotic Device in a manner not prescribed,

recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME, Supply or Prosthetic Device use by someone other than the client for whom it was prescribed.

Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.

Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME,

Supplies and Prosthetic or Orthotic Device. An owner related individual shall be considered an individual who is a member of an owner's immediate family, including a spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the client.

Wrongful Disposition means the mismanagement of DME, Supplies and Prosthetic or Orthotic Devices by a client by selling or giving away the item reimbursed by the Department.

### **8.590.2 BENEFITS**

8.590.2.A. DME, Supplies and Prosthetic or Orthotic Devices are a benefit when Medically Necessary. To determine Medical Necessity the equipment, supplies, and Prosthetic or Orthotic Device shall:

1. Be prescribed by a physician and when applicable, be recommended by an appropriately licensed practitioner.
2. Be a reasonable, appropriate and effective method for meeting the client's medical need.
3. Have an expected use that is in accordance with current medical standards or practices.
4. Be cost effective, which means that less costly and medically appropriate alternatives do not exist or do not meet treatment requirements.
5. Provide for a safe environment.
6. Not be experimental or investigational, but generally accepted by the medical community as standard practice.
7. Not have as its primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker.

8.590.2.B. DME, Supplies and Prosthetic or Orthotic Devices shall not be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement except under the following circumstances:

1. DME, Supplies and Prosthetic or Orthotic Devices may be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement if the client is within fourteen days of discharge and when prior authorization and/or training are needed to assist the client with equipment usage and the equipment is needed immediately upon discharge from the facility.

2. Repairs and modifications to client owned DME, Prosthetic or Orthotic Devices not required as part of the per diem reimbursement shall be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement.
3. Prosthetic or Orthotic Devices may be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facilities' per diem rate.

8.590.2.C. DME, Supplies and Prosthetic or Orthotic Devices shall not be duplicative or serve the same purpose as items already utilized by the client unless it is medically required for emergency or backup support. Backup equipment shall be limited to one.

8.590.2.D. All items purchased by the Department shall become the property of the client unless the client and provider are notified otherwise by the Department at the time of purchase.

8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary.

8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage.

8.590.2.G. The following DME and Supplies are benefits for clients regardless of age:

1. Ambulation devices and accessories including but not limited to canes, crutches or walkers.
2. Bath and bedroom safety equipment.
3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays.
4. Manual or power Wheelchairs and accessories.
5. Diabetic monitoring equipment and related disposable supplies.
6. Elastic supports/stockings.
7. Blood pressure, apnea, blood oxygen, Pacemaker and uterine monitoring equipment and supplies.
8. Oxygen and oxygen equipment in the client's home, a nursing facility or other institution. The institutional oxygen benefit is fully described in 10 C.C.R. 2505-10, Section 8.580.
9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies.
10. Trapeze, traction and fracture frames.
11. Lymphedema pumps and compressors.
12. Specialized use rehabilitation equipment.
13. Oral and enteral formulas and supplies.
14. Parenteral equipment and supplies.
15. Environmental controls for a client living unattended if the controls are needed to assure medical safety.
16. Facilitative Devices.
  - a. Telephone communication devices for the hearing impaired and other facilitative listening devices, except hearing aids, and cochlear implants.
  - b. Computer equipment and reading devices with voice input or output, optical scanners, talking software, Braille printers and other devices

that provide access to text.

c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices.

d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities.

e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear.

8.590.2.H. The following DME are benefits to clients under the age of 21:

1. Hearing aids and accessories.
2. Phonic ear.
3. Therapy balls for use in physical or occupational therapy treatment.
4. Selective therapeutic toys.
5. Computers and computer software when utilization is intended to meet medical rather than educational needs.
6. Vision correction unrelated to eye surgery.

8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for clients regardless of age:

1. Artificial limbs.
2. Facial Prosthetics.
3. Ankle-foot/knee-ankle-foot orthotics.
4. Recumbent ankle positioning splints.
5. Thoracic-lumbar-sacral orthoses.
6. Lumbar-sacral orthoses.
7. Rigid and semi-rigid braces.
8. Therapeutic shoes.
9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements.
10. Specialized eating utensils and other medically necessary activities of daily living aids.
11. Augmentative communication devices and communication boards.

8.590.2.J. Repairs and replacement parts are covered under the following conditions:

1. The item was purchased by Medicaid; or
2. The item is owned by the client, client's family or guardian; and
3. The item is used exclusively by the client; and
4. The item's need for repair was not caused by client misuse, abuse or neglect; and
5. The item is no longer under the manufacturer warranty.

8.590.2.K. Repairs, replacement, and maintenance shall be based on the manufacturer's recommendations and shall be performed by a qualified rehabilitation

professional. Repairs, replacement and maintenance shall be allowed on the client's primary equipment and/or one piece of backup equipment. Multiple backup equipment will not be repaired, replaced or maintained.

8.590.2.L. If repairs are frequent and repair costs approach the purchase price of new equipment, the provider shall make a request for the purchase of new equipment. The prior authorization request shall include supporting documentation explaining the need for the replacement equipment and the cost estimates for repairs on both the old equipment and the new equipment purchase.

8.590.2.M. Supplies are a covered benefit when related to the following:

1. Surgical, wound or burn care.
2. Syringes or needles.
3. Bowel or bladder care.
4. Antiseptics or solutions.
5. Gastric feeding sets and supplies.
6. Tracheostomy and endotracheal care supplies.
7. Diabetic monitoring.

8.590.2.N. Quantities of supplies shall not exceed one month's supply unless they are only available in larger quantities as packaged by the manufacturer.

8.590.2.O. Medicaid clients for whom Wheelchairs, Wheelchair component parts and other specialized equipment were authorized and ordered prior to enrollment in a Managed Care Organization, but delivered after the Managed Care Organization enrollment shall be the responsibility of the Department. All other DME and disposable supplies for clients enrolled in a Managed Care Organization shall be the responsibility of the Managed Care Organization.

8.590.2.P. Items used for the following are not a benefit to a client of any age:

1. Routine personal hygiene.
2. Education.
3. Exercise.
4. Participation in sports.
5. Client or caretaker convenience.
6. Cosmetic purposes.
7. Personal comfort.

8.590.2.Q. For clients age 21 and over, the following items are not a benefit:

1. Hearing aids and accessories.
2. Phonic ears.
3. Therapeutic toys.
4. Vision correction unrelated to eye surgery.

**8.590.2.R. Rental Policy.**

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the Medicaid bulletin. The provider is responsible for all maintenance and repairs as described at 8.590.4.P-Q, until the cap is reached.
2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the client. The provider shall give the client and/or caregiver all applicable information regarding the equipment as described at 8.590.4.C.4. The equipment shall not be under warranty after the rental period ends.
3. The rental period may be interrupted, for a maximum of sixty consecutive days.
4. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained in the provider file.
5. If the client changes providers, the current rental cap remains in force.

**8.590.3 PRIOR AUTHORIZATION**

8.590.3.A. Selected DME, Supplies, and Prosthetic or Orthotic Devices require prior authorization before they will be provided. All items requiring prior authorization are listed in the Medicaid bulletin.

8.590.3.B. Prior authorization shall not be required for Medicare Crossover claims.

8.590.3.C. Prior authorization shall be required for clients who have other primary insurance besides Medicare.

8.590.3.D. Prior authorization requests shall include the following information:

1. A full description of the item(s).
2. The requested number of items.
3. A full description of all attachments, accessories and/or modifications needed to the basic item(s).
4. The effective date and estimated length of time the item(s) will be needed.
5. The diagnosis, prognosis, previous and current treatments and any other clinical information necessary to establish Medical Necessity for the client.
6. Any specific physical limitations the client may have that are relevant to the prior authorization consideration.
7. The client's prescribing physician's, primary care physician's and provider's name and identification numbers.
8. The serial numbers for all Wheelchair repairs.
9. The ordering physician's signature. The physician can either sign the authorization or attach a written prescription or letter of medical necessity to the authorization.

8.590.3.E. Diagnostic and clinical information shall be completed prior to the physician's signature. The provider shall not complete or add information to the prior authorization after the physician has signed the request.

8.590.3.F. Requests for prior authorization shall be submitted in a timely fashion. Requests submitted with a begin date in excess of three months prior to the date of submission shall include additional, updated documentation indicating the continued Medical Necessity of the request. Retroactive approval beyond three months without such documentation shall be considered only in cases of client retroactive program eligibility.

8.590.3.G. Approval of a prior authorization does not guarantee payment or constitute a waiver of any claims processing requirements including eligibility and timely filing.

#### **8.590.4 PROVIDER RESPONSIBILITIES**

Providers shall issue express warranties for Wheelchairs and Facilitative Devices and shall assure that any refund resulting from the return of a Wheelchair or other Facilitative Device is returned to the Department in compliance with Sections 6-1-401 to 6-1-412, C.R.S. (2005) and Sections 6-1-501 to 6-1-511, C.R.S. (2005). Sections 6-1-401 to 6-1-412 and 6-1-501 to 6-1-511, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager, Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of the statute, or the materials may be examined at any publications depository library.

8.590.4.A. The Provider shall implement a system that supports client autonomy and describes how equipment will be serviced and maintained, routine follow-up and response procedures to prevent any interruption of services to the clients. This system shall include provisions describing how service and repairs may occur at the client's location when appropriate.

8.590.4.B. The Provider shall implement and maintain a process for honoring all warranties expressed and implied under applicable State laws.

8.590.4.C. Providers of custom Wheelchairs, seating products and any other DME shall be able to appropriately assess and provide adequate repairs, adjustment and service by qualified rehabilitation professionals for all products they distribute.

8.590.4.D. Providers shall maintain the following for all items provided to a client:

1. Physician prescriptions.
2. Approved prior authorization requests.
3. Additional documentation received from physicians or other licensed practitioners.
4. Documentation that the client and/or caregiver have been provided with the following:
  - a. Manufacturer's instructions.
  - b. Warranty information.
  - c. Registration documents.
  - d. Service manual.
  - e. Operating guides.
5. Documentation on all reimbursed equipment, which shall include:
  - a. Manufacturer's name and address.
  - b. Date acquired.

- c. Acquisition cost.
- d. Model number.
- e. Serial number.
- f. Accessories, attachments or special features included in the item.
6. Providers shall verify that equipment requiring repairs belongs to the presenting client.

8.590.4.E. Providers shall retain all documentation for a period of six years.

8.590.4.F. Providers shall provide a copy of all documentation to a client or his/her representative, if requested.

8.590.4.G. Providers shall be responsible for delivery of and instructing the client on the proper use of the ordered/authorized equipment or supplies appropriate for the stated purpose consistent with the requirements, goals and desired outcomes at the time of the prescription and delivery.

8.590.4.H. The provider shall be responsible for client evaluation, wheelchair measurements and fittings, client education, adjustments, modifications and delivery set-up installation of equipment in the home. If modifications require the provider to fabricate customized equipment or orthotics to meet client needs, the provider shall justify the necessity and the cost of additional materials of the modifications. Modifications shall not alter the integrity, safety or warranty of the equipment.

8.590.4.I. The provider shall pick-up inappropriate or incorrect items within five business days of being notified. The provider shall not bill the Department for items known to be inappropriate or incorrect and awaiting pick-up. The provider shall submit a credit adjustment to the Department within twenty business days following the pick-up date if a claim was submitted prior to notification an item was inappropriate or incorrect.

8.590.4.J. Providers shall confirm continued need for disposable supplies with the client or caretaker prior to supply shipment.

8.590.4.K. All purchased equipment shall be new at the time of delivery to the client unless an agreement was reached in advance with the client and Department.

8.590.4.L. Providers shall provide DME, Supplies, Prosthetic or Orthotic Devices, repairs and all other services in the same manner they provide these services to non-Medicaid clients.

8.590.4.M. Providers shall ensure the equipment provided will be warranted in accordance with the manufacturer's warranty. The provider shall not bill Medicaid or the client for equipment, parts, repairs, or other services covered by the warranty.

8.590.4.N. The following requirements shall apply to warranted items:

1. The provider shall be able to provide adequate repairs, adjustments and services by appropriately trained technicians for all products they distribute.

2. The provider shall complete services or repairs in a timely manner and advise the client on the estimated completion time.
3. The provider shall arrange for appropriate alternative, like equipment in the absence of client owned backup equipment. The provider shall provide the alternative equipment at no cost. If the backup equipment is not available as loan equipment, the provider shall arrange for a temporary equipment rental through the Department.
4. The provider shall exclude from warranty provisions, replacement or repairs to equipment that are no longer able to meet client needs due to changes in anatomical and/or medical condition that occurred after purchase.
5. The provider may refuse warranty services on items for which there have been documented patterns of specific client abuse, misuse or neglect. The provider shall notify the Department in all documented cases of abuse, misuse or neglect within ten business days of learning of the incident of abuse.

8.590.4.O. Previously used or donated DME may be provided to the client if agreed upon by the client and the Department. Departmental approval will be coordinated by the Acute Care Benefits Section.

8.590.4.P. The Provider shall assure the item provided meets the following conditions:

1. The item is fully serviced and reconditioned.
2. The item is functionally sound and in good operating condition.
3. The item will be repaired and have parts replaced in a manner equivalent to an item that is new. The item will have parts available for future repairs in a manner equivalent to the manufacturer's warranty on a like item which is new.
4. The provider will make all adjustments and modifications needed by the client during the first year of use, except for changes and adjustments required due to growth or other anatomical changes or for repairs not covered by the manufacturer's warranty on a like new item.

8.590.4.Q. The provider shall receive and perform service and repairs in the same manner they provide services for non-Medicaid clients for rental equipment.

8.590.4.R. The provider shall assure the following for rental equipment:

1. Appropriate service to the item.
2. Complete services or repairs in a timely manner with an estimate of the approximate time required.
3. Appropriate alternative equipment during repairs.
4. Provision and replacement of all expendable items, including but not limited to hoses, fuses, and batteries.

#### **8.590.5 PROVIDER REQUIREMENTS**

8.590.5.A. Providers are required to have one or more physical location(s), within the State of Colorado, or within fifty (50) miles of any Colorado border.

8.590.5.B. The above providers must also have:

1. A street address; and
2. A local business telephone number;
3. An inventory; and

4. Sufficient staff to service or repair products.

8.590.5.C. Providers who do not meet the requirements of 8.590.5.A may apply to become a Medical provider if the DME or disposable medical supplies are medically necessary and cannot otherwise be purchased from a provider who meets the requirements of 8.590.5.A.

1. Applications from providers who do not meet the requirements of 8.590.5.A must be submitted to the DME Program Coordinator for approval.
2. Applications submitted pursuant to this section will be reviewed for approval on a case-by-case basis for those specialty items only.

#### **8.590.6 CLIENT RESPONSIBILITIES**

8.590.6.A. Clients or client caregivers shall be responsible for the prudent care and use of DME, Supplies, and Prosthetic or Orthotic Devices. Repairs, servicing or replacement of items are not a benefit if there is documented evidence of client Abuse, Misuse, Neglect or Wrongful Disposition.

8.590.6.B. Clients shall be responsible for the cost of any additional items or enhancements to equipment not deemed Medically Necessary. The client shall sign an agreement with the provider that states:

1. The cost of the items.
2. That the client was not coerced into purchasing the items.
3. That the client is fully responsible for the cost, servicing and repairs to the items after the warranty period is completed.

8.590.6.C. The client shall contact the point of purchase for service and repairs to covered items under warranty. Clients may contact a participating provider of their choice for service and repairs to covered items not under warranty or for an item under warranty if the original point of purchase is no longer a participating provider.

8.590.6.D. The client shall become the owner of any equipment purchased by the Department and remains subject to Medicaid DME rules unless otherwise notified by the Department at the time of purchase.

8.590.6.E. The client shall be responsible for obtaining a police report for items being replaced due to theft, fire damage or accident. The police report shall be attached to the prior authorization requesting replacement of the item.

8.590.6.F. The client shall be responsible for reporting to the manufacturer, dealer or alternative warranty service provider instances where a Wheelchair or Facilitative Device does not conform to the applicable express warranty.

8.590.6.G. The client or caregiver shall be responsible for routine maintenance on all equipment purchased or rented by the Department. Routine maintenance is the servicing described in the manufacturer's operating manual as being performed by the user to properly maintain the equipment. Non-performance of routine maintenance shall be considered Neglect. Routine maintenance includes, but is not limited to:

1. Cleaning and lubricating moving parts.
2. Adding water to batteries.
3. Checking tire pressure.

4. Other prescribed Manufacturer procedures.

8.590.6.H. The client utilizing rental equipment shall be responsible for notifying the provider of any change of address. The client shall be responsible for any rental fee accrued during the time the equipment's location is unknown to the provider.

8.590.6.I. The client shall not remove rental equipment from Colorado.

#### **8.590.7 REIMBURSEMENT**

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

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

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

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

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

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

1. Labor for modifications, service, and repairs on durable medical equipment shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.
2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.
3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.I.
4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.
5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.G. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the client accepting the equipment.
2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.
2. All adjustments and modification needed by the client to make the item useful and functional.
3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home.
4. Training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the client or caregiver.
5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the department fee schedule.
2. Manually priced items that have no maximum allowable reimbursement rate assigned, but have a Manufacture Suggested Retail Price (MSRP) shall be reimbursed the MSRP less 22.97 percent.
3. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a MSRP shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus 12.71 percent.

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

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.
2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.
3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:
  - a. A copy of the Explanation of Medicare Benefits' shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or
  - b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

Benefit	Non-Emergent Medical Transportation Services
What is Covered	Transportation to and from an appointment for a Medicaid covered service.
What is NOT Covered?	Services like rides to the grocery store or to run errands are not covered.
Limits	<p>For these services, the transportation broker or the county will need to approve the service before you can use it.</p> <p>If you reside within the following nine (9) counties:</p> <ul style="list-style-type: none"> <li>• Adams</li> <li>• Arapahoe</li> <li>• Boulder</li> <li>• Broomfield</li> <li>• Denver</li> <li>• Douglas</li> <li>• Jefferson</li> <li>• Larimer</li> <li>• Weld Counties</li> </ul> <p>Please call First Transit at 1-855-CO4-NEMT (1-855-264-6368) for your Non-Emergency Medical Transportation needs.</p> <p>If you reside within any county not listed above please contact your local County Office for your transportation needs.</p>
<p>10 CCR 2505-10, 8.014</p> <p><b>Non-Emergent Medical Transportation</b></p>	
<p>8.014 NON EMERGENT MEDICAL TRANSPORTATION</p> <p>8.014.1 The Department shall assure transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation. Payment will be made for the least expensive means suitable to the client's condition. The distance to be traveled, transportation and treatment facilities available and the physical condition and welfare of the client shall all determine the type of transportation service authorized</p>	

Benefit	Oxygen and Oxygen Supplies
What is Covered	Concentrators, system rental and contents are a benefit.
What is NOT Covered?	NA
Limits	A Certificate of Medical Necessity is needed for long term oxygen benefits. Long term is when you need oxygen for more than three months. Your provider will keep this in their records,
<b>10 CCR 2505-10 8.580</b> <b>Oxygen and Oxygen Equipment</b>	
<p><b><u>8.580.1 OXYGEN AND OXYGEN EQUIPMENT PROVIDED IN CLIENT HOMES</u></b></p> <p>8.580.1.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician, are a Medicaid benefit if provided in the client's home, or place of residence, not to include intermediary or skilled nursing facilities.</p> <p>8.580.1.B. The oxygen provider shall directly bill the Department for medically necessary liquid or gaseous oxygen equipment and supplies provided in a client's home or place of residence, not to include intermediary or skilled nursing facilities. Reimbursement shall be the lower of the provider's billed charge or the Department's fee schedule.</p> <p><b><u>8.580.2 OXYGEN, AND OXYGEN EQUIPMENT, PROVIDED TO HOSPITAL CLIENTS</u></b></p> <p>8.580.2.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting are a benefit.</p> <p>8.580.2.B. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting shall be provided by the hospital and is included in the Medicaid payment for inpatient hospital services.</p> <p><b><u>8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS</u></b></p> <p>8.580.3.A. Oxygen, oxygen equipment and/or supplies when medically necessary and prescribed by the physician for clients residing in an intermediary or skilled nursing facility are a benefit.</p> <p>8.580.3.B. Oxygen equipment and/or supplies for clients residing in a nursing facility being reimbursed a per diem amount, shall be provided by the nursing facility, except when the facility orders oxygen equipment and/or supplies specifically for the unique needs of an individual client. In such cases, the oxygen equipment and/or supply provider shall bill the Department directly.</p>	

8.580.3.C. Oxygen concentrators for use by clients residing in a nursing facility being reimbursed a per diem rate shall be provided in one of the following ways:

1. Oxygen concentrators purchased by the facilities shall be included in the facility cost report and reimbursed through the per diem. All necessary oxygen-related supplies shall be provided by the facility in accordance with 10 C.C.R. 2505-10, Section 8.441.5.K.
2. Clients residing in facilities that do not purchase oxygen concentrators shall obtain equipment and supplies from an authorized Medicaid oxygen provider. The oxygen provider shall provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's physician, and shall bill on the state approved form.

8.580.3.D. The oxygen provider shall bill the Department directly for medically necessary liquid or gaseous oxygen provided to clients residing in intermediary or skilled nursing facilities that are reimbursed a per diem amount.

8.580.3.E. The oxygen provider shall bill based on the information provided by the nursing facility. Claims shall be coded appropriately as defined by the Department. Reimbursement shall be the lower of the provider's billed charges or the Department's fee schedule.

#### **8.585 OXYGEN, OXYGEN EQUIPMENT, AND SUPPLIES**

Medically necessary oxygen, oxygen equipment, and supplies are a benefit of the Colorado Medicaid Program. Medical necessity shall be provided in a manner approved by the Department, and shall be maintained in the provider's files for a minimum of six (6) years. The Department reserves the right to request copies of documentation of medical necessity.

.01 With the exception of liquid or gaseous oxygen provided in a nursing facility, and the supplies and equipment necessary to administer each, medical equipment and/or supplies for Medicaid clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, must be provided by the facility. Costs of equipment and/or supplies unrelated to the use of gaseous or liquid oxygen are included in the facility's cost report and reimbursed through the Medicaid per diem.

.02 Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital and is included in the Medicaid payment. Oxygen concentrators for use by clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, may be provided in one of two ways.

A. Nursing facilities or group homes committed to a program of purchasing concentrators for use by their Medicaid residents may bill a monthly fee to the Department using the Nursing Home Claim Form, in accordance with 8.465. All necessary oxygen -related disposable supplies shall also be provided by the facility.

B. Residents of facilities which do not wish to purchase concentrators for patient use shall obtain needed equipment from an authorized Medicaid oxygen supplier. The oxygen supplier shall bill a monthly fee using the Supply Claim. Reimbursement will be the lower of billed charges or the Department's fee schedule.

.03 Liquid and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility

or group home, shall be billed directly to the Department's fiscal agent by a Medicaid supply provider, in accordance with Department policy.

.04 Medical suppliers providing oxygen to Medicaid clients shall provide equipment, supplies and oxygen for use by a specific client, based upon the physician's prescription.

.05 In order to assure accurate and appropriate billing by the medical supplier, the nursing facility or group home shall be responsible for providing the following information to the medical supplier within 20 days following the date the supplier delivers the item to be billed. The required information shall be in the form of a certification statement and shall contain the following, as a minimum:

- A. the name and state ID number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment/supplies necessary for administration by the medical supplier.
- B. an indicator of Medicare Part A or B, or other third party resources.
- C. the name and state ID number for all Medicaid clients utilizing an oxygen concentrator being rented from the oxygen supplier. This applies only to patients in those facilities which choose not to commit to the purchase of concentrators.
- D. certification guaranteeing that equipment, supplies, and oxygen were used only by the patient for which they were supplied; or in the case of centralized oxygen systems, each client's oxygen usage, expressed in liters.

.06 The medical supplier shall bill the Medicaid program based upon the above information provided by the nursing facility, using the appropriate HCPCS coding. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

Benefit	Home Health Services
What is Covered	Care provided in your home after you are sick or injured. Care must be provided by nurses, certified nursing assistants, physical therapists, occupational therapists or speech therapists.
What is NOT Covered?	Physical, occupational, or speech therapies that do not help you recover from your sickness or injury
Limits	If you need home health care for more than 60 days, Medicaid will need to approve the service as long term care.

## 10 CCR 2505-10 8.520

**Home Health Services****8.521 LEGAL BASIS**

The Medicaid Home Health Program in Colorado is authorized under 1905(a)(7) of the Social Security Act (P.L. 74-271); and by state law at 26-4-202(1) f, C.R.S. (1994 Supp.) and 26-4-302(l) m, C.R.S. (1994 Supp.).

**8.522 COVERED SERVICES**

All Home Health providers enrolled in the Medicaid program shall be in compliance with the Colorado Medicaid Home Health Services Benefit Coverage Standard, effective January 1, 2013, incorporated by reference. The incorporation of the Home Health Benefit Policy Statement excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at [Colorado.gov/hcpf](http://Colorado.gov/hcpf). Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Standards." Pursuant to 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided, at cost, upon request. Any material that has been incorporated by reference may be examined in any Colorado State Publications Depository Library.

**8.523 ELIGIBILITY**

.10 Home Health services are a benefit available to all Medicaid clients and to all Modified Medical Program clients when all program and services requirements are met. To be eligible for Long Term Home Health services, as set forth at Section 8.523.11.K, Medicaid clients 18 and over shall meet the Level of Care Screening Guidelines for Long Term Care Services at Section 8.401. Medicaid clients under the age of twenty-one may be eligible for special Home Health benefits according to rules at 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES.

.11 Home Health services are eligible for reimbursement under Medicaid only when the services meet all of the following requirements:

- A. Services are provided for the treatment of an illness, injury, or disability which may include mental disorders.
- B. Services are medically necessary.

C. Services are reasonable in amount, duration, and frequency.

D. Services are provided under a plan of care as defined at Section 8.524 DEFINITIONS.

E. Services are provided on an intermittent basis, as defined at Section 8.524, DEFINITIONS.

F. The only alternative to Home Health services is hospitalization or the emergency room; or the client's medical records accurately justify a medical reason that the services should be provided in the client's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

1. The client, due to the client's illness, injury or disability, is not able to go to a physician's office, clinic or other out-patient setting for the needed service, for example, a client with quadriplegia who needs aide services to get in and out of bed.
2. If, because of the client's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the client. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the client's medical records. Examples of medical hardship would include: a client who would require ambulance transportation, a client in severe pain, or a client who is just out of the hospital after major surgery. Some examples of conditions that would not by themselves be considered creation of a medical hardship would include: a client who is on oxygen, a client who walks with a limp, or a client who uses a cane.
3. Going to a physician's office, clinic, or other out-patient setting for the needed service is contra-indicated by the client's documented medical condition, for example, a client who must be protected from exposure to infections.
4. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service. Examples include a young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located; clients living in regions where traveling to out-patient therapy would require hours of travel; a client who needs a service repeated at frequencies that would be extremely difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as IV care three times per day, or daily insulin injections; a client who needs regular and prn catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dis-lodgement or blockage; a client who, because of the client's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered adverse health consequences as a result, including use of emergency room and hospital admissions.
5. The client's medical condition requires teaching which is most effectively accomplished in the client's home on a short-term basis.

G. Services are provided in the client's place of residence. The client's place of residence is where the client lives, except that home health services shall not be reimbursed if the client's place of residence is a nursing facility or hospital. Assisted living facilities of any kind are places of residence. If a client is visiting relatives or staying in a hotel during a trip, or similar temporary accommodations, the place where the client is staying will be considered the temporary place of residence for purposes of this rule. Services shall not be reimbursed if provided at the workplace, school, child day care, adult day care, or any other place that is not the client's place of residence, except when the services are prior authorized according to 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES, or Section 8.531 through 8.539, HOME HEALTH AIDE PILOT PROGRAM.

1. Monitoring of health care status may be provided remotely through Home Health Telehealth services.

H. Services are provided by a Medicaid-certified Home Health agency.

I. The Client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver able and willing to perform the tasks.

J. When the client has Medicare or other third-party insurance, Medicaid Home Health shall be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

K. The Client's care falls under one of the following three categories:

1. Acute Home Health, which means Medicaid-reimbursed Home Health services that are:
  - a. Provided for 60 calendar days; and
  - b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
    - 1) Infections.
    - 2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.
    - 3) Care related to post-surgical recovery.
    - 4) Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.
    - 5) Exacerbation or severe instability of a chronic condition.
    - 6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.
    - 7) Complications of pregnancy.
2. Long Term Home Health, which means Medicaid-reimbursed Home Health services that are:
  - a. Provided for 61 calendar days or longer; or
  - b. Provided for less than 61 calendar days when services are provided solely for the care of chronic conditions.
3. Long Term with Acute Episode Home Health, which means Medicaid-reimbursed Home Health services that are:
  - a. Provided for care of long-term chronic conditions; and
  - b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
    - 1) Infections.
    - 2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, decubitus.
    - 3) Care related to post-surgical recovery.
    - 4) Post-hospital care provided as follow-up care for the condition that required hospitalization.
    - 5) Exacerbation of a chronic condition.
    - 6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.
    - 7) Complications of pregnancy.

#### **DEFINITIONS**

**.10 HOME HEALTH AIDE ASSIGNMENT FORM**

Home health aide assignment form means the form which the home health agency uses to list the duties to be performed by the home health aide at each visit.

**.11 HOME HEALTH SERVICES**

Home Health Services means those services listed at Section 8.522, COVERED SERVICES, and described at Section 8.525, SERVICES REQUIREMENTS.

.12 HOME HEALTH TELEHEALTH

Home Health Telehealth means the remote monitoring of clinical data through electronic information processing technologies.

.13 INTERMITTENT

Intermittent is defined as no more than the combined number of all visits and/or other units of service which will cause the reimbursement per calendar day to equal the maximum reimbursement limits as set forth in the Reimbursement section of these rules. Visits and/or units or combinations thereof may directly follow each other without any break and still be considered intermittent, as long as the maximum reimbursement limit per day is not exceeded.

.14 PLAN OF CARE

A plan of care means a coordinated plan developed by the Home Health agency as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

.15 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

Benefit	Screening, Brief Intervention, Referral to Treatment Program (SBIRT)
What is Covered	<p>SBIRT are special services for people with drug or alcohol issues, and people who are at risk of having these issues. Primary care centers, hospital emergency rooms, trauma centers, schools and other community settings can help these people early on before the problem gets worse.</p> <ul style="list-style-type: none"> <li>• “Screening” will show how severe the drug and alcohol use is and determine the right treatment</li> <li>• “Brief intervention” will provide education on drug and alcohol use and motivation to change risky behaviors.</li> </ul> <p>“Referral to treatment” helps guide people who need treatment to the right resources and care.</p>
What is NOT Covered?	Screening or intervention for tobacco use.
Limits	Services are provided when risky substance use is seen. A parent can request for a provider to give this service to their child

10 CCR 2505-10 8.747

### Screening, Brief Intervention, Referral to Treatment (SBIRT) Program

#### **8.747.1 DEFINITIONS**

Brief Intervention means a provider interaction with a client that is intended to induce a positive change in a health-related behavior. Brief intervention may include an initial intervention, a follow-up intervention and/or a referral.

Brief Screen or Pre-screen means several short questions related to the client’s substance use. A brief screen or pre-screen is designed to determine if a full screen is necessary.

Follow-up Intervention means services to reassess a client’s status, assess progress and promote or sustain a reduction in substance use. Follow-up services may also be used to assess a client’s need for additional services.

Full Screen means the use of a Colorado Medicaid approved evidence-based screening tool to identify clients at risk for substance abuse problems.

Screening, Brief Intervention and Referral to Treatment (SBIRT) means comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

#### **8.747.2 CLIENT ELIGIBILITY**

8.747.2.A. All clients 12 years of age and older are eligible to receive this service.

**8.747.3 PROVIDER REQUIREMENTS**

8.747.3.A. Screening, Brief Intervention and Referral to Treatment services must be provided by, or under the supervision of, a licensed health care professional.

8.747.3.B. The following licensed professionals are eligible to provide services or supervise staff that are providing services:

1. Licensed Physician
2. Physician Assistant
3. Nurse Practitioner
4. Dentist
5. Psychologist with PhD. or PsyD.
6. Licensed Clinical Social Worker (LCSW)
7. Marriage and Family Therapist
8. Licensed Professional Counselor (LPC)
9. Licensed Addiction Counselor (LAC)
10. Certified Addictions Counselor III

8.747.3.C. All licensed individuals must be trained in order to provide or supervise individuals providing Screening, Brief Intervention and Referral to Treatment services.

1. A minimum of four (4) hours Screening, Brief Intervention and Referral to Treatment training is required.

8.747.3.D. All non-licensed individuals must be trained in Screening, Brief Intervention and Referral to Treatment services in order to provide services; including the following requirements:

1. Be under the supervision of a licensed and trained Screening, Brief Intervention and Referral to Treatment services provider.
2. 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 Screening, Brief Intervention and Referral to Treatment services.
3. Complete a minimum of 30 hours of face-to-face client contact within their respective field. This may include internships, on the job training, or professional experience. This contact may include, but does not have to be directly related to Screening, Brief Intervention and Referral to Treatment services training.

**8.747.4 COVERED SERVICES**

8.747.4.A Screening, Brief Intervention and Referral to Treatment services are covered for risky substance use or abuse including alcohol and drugs.

1. A full screen, using a Colorado Medicaid approved screening tool, shall be limited to two (2) per client per state fiscal year.

8.747.4.B. Brief intervention services may be provided on the same date of service as the full screen, or on subsequent days.

1. The Brief Intervention shall be limited to two (2) sessions per client per state fiscal year. Each session is limited to two (2) units per session, at 15 minutes per unit.

**8.747.5 NON-COVERED SERVICES**

8.747.5.A Non-covered services include:

1. Pre-screen or brief screen.

**8.747.6 REIMBURSEMENT**

8.747.6.A Providers may submit for reimbursement under either CPT or HCPC codes, but not both.

8.747.6.B Screening, Brief Intervention and Referral to Treatment services provided by Federally Qualified Health Centers under supervision, as defined in Section 8.700.1, will be reimbursed in the encounter rate.

8.747.6.C Screening, Brief Intervention and Referral to Treatment services may be provided on the same day as other Evaluation & Management services.

8.747.6.D Any claims reimbursed for more than the maximum units per year are subject to recovery by the Department.

10 CCR 2505-10 8.440  
Nursing Facility Services

**8.440 NURSING FACILITY BENEFITS**

Special definitions relating to nursing facility reimbursement:

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.
2. "Actual cost" or "cost" means the audited cost of providing services.
3. "Administration and General Services Costs" means costs as defined at 8.443.8.
4. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boeckh Commercial Underwriter's Valuation System for Nursing Homes."  

The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.
5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state
6. a. "Base value" means:
  - i) The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.
  - ii) The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (i) of this paragraph (a).
  - b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.
  - c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.
7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.
8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.
9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.
10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the

amount of relative resources required to provide care to that resident.

11. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.
12. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.
13. "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities are not included as class I facilities.
14. "Core Components" means the health care, administrative and general and fair rental allowance for capital-related assets prospective per diem rate components.
15. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.
16. "Direct or indirect health care services costs" means the costs incurred for patient support services as defined at 8.443.7
17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.
18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.
20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.
21. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.
22. "Median per diem cost" means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.
23. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid programs.
24. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.
25. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.
26. "Nursing facility provider" means a facility provider that meets the state nursing facility licensing standards established pursuant to section 25-1.5-103 (1) (a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.
27. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.
28. "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.
29. "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patients days in computing per diem cost.

30. "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.
31. "Per diem rate" means the daily dollar amount of reimbursement that the state department shall pay a nursing facility provider per patient.
32. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 CFR 433.55.
33. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.
34. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.
35. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents according to their clinical and functional status identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.
36. "Statewide average per diem rate" means the average daily dollar amount of the per patient payments to all Medicaid-participating facility providers in the state.
27. "Medicare patient day" means all days paid for by Medicare. For instance, a Medicare patient day includes those days where Medicare pays a Managed Care Organization for the resident's care.
38. "Per diem fee" means the daily dollar amount of provider fee that the state department shall charge a nursing facility provider per non-Medicare day.
39. "Substandard Quality of Care means one or more deficiencies related to participation requirements under [42 CFR 483.13](#) , resident behavior and facility practices, [42 CFR 483.15](#) , quality of life, or [42 CFR 483.25](#) , quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F)" per State Operations Manual, chapter 7.
40. "Supplemental Medicaid Payment" means a lump sum payment that is made in addition to a provider's per diem rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

#### **8.440.1 SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT**

8.440.1.A. Payment to nursing facilities, swing-bed facilities and intermediate care facilities for the mentally retarded shall be an all inclusive per diem rate, except as provided for within this rule. This rate covers the necessary services to the resident, including room and board, as well as nursing and ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility.

8.440.1.B. The following general service areas shall be provided within the per diem rate:

1. Nursing services, therapies, aide services and medically related social services;
2. Dietary services;
3. Activities program;
4. Room/bed maintenance services;
5. Routine personal hygiene items and services; and
6. Laboratory services.

a. Waivered laboratory services provided by nursing facilities enrolled in the Medicaid program are subject to the requirements of the Clinical

Laboratory Improvement Amendments of 1988 (CLIA) as set forth in 42 C.F.R. 493, October 1, 1994 edition. No amendments or later editions are incorporated. Facilities that collect specimens, including drawing blood specimens, but do not perform testing of specimens, are not subject to CLIA requirements. A facility shall obtain a Certificate of Waiver from the Centers for Medicare and Medicaid or its designated agency if the facility only performs waived tests as defined by CLIA.

- b. Copies are available for inspection and available at cost at the following address: Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1818; or may be examined at any State Publications Depository Library.

8.440.1.C. Each nursing facility shall furnish, within the per diem rate, equipment necessary to the operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation care. Such equipment includes, but is not limited to, the following:

1. Adaptive equipment for activities of daily living;
2. Air mattresses, other special mattresses, sheepskins and other devices for preventing/treating decubitus ulcers;
3. Apnea monitors and necessary supplies and equipment;
4. Atomizers;
5. Autoclaves and sterilizers;
6. Bath equipment, i.e., raised and/or padded toilet seats, trapeze benches, tub/shower stools or benches;
7. Bedrails, footboards, trapeze bars, traction and fracture frames, bedside stands;
8. Bed linens;
9. Beds, including hospital beds;
10. Blood glucose monitors;
11. Commode chairs;
12. Deodorizers;
13. Emesis basins;
14. Flameproof curtains;
15. Flashlights;
16. Foot pumps;
17. Gerry chairs, cushioned chairs;
18. Ice bags or equivalent;
19. Intermittent positive pressure breathing equipment, including Sodium Chloride or sterile water required for operation;
20. Irrigating solutions, i.e., Acetic Acid, Potassium Permanganate, Sodium Chloride, and sterile water;
21. Lifts, i.e., hydraulic, tub, slings;
22. Lymphedema pumps and compressors;
23. Medically necessary manual or power wheelchairs for intermittent and full-time use, including cushions and pads as required for the prevention or treatment of skin breakdown, if purchased by the nursing facilities.

- a. Wheelchairs, if required, shall meet the specific needs of the resident and shall be ordered by a physician. The Primary Care Physician shall concur that the wheelchair being prescribed for the resident is medically necessary.
- b. All costs associated with the purchase of the wheelchair shall be charged to the health care line of the nursing facility. Wheelchair expenses shall be reported in the appropriate health care line of the Med-13
- c. The wheelchair shall be sent with the resident in the event the resident is transferred to another facility or returns home. The transferring facility shall expense the remainder of the chair in the fiscal year during which the transfer occurs.

24. Medicine cups;
25. Oxygen masks, regulators, humidifiers, hoses, nasal catheters, as needed, for the administration of oxygen;
26. Percussors and respirators;
27. Positioning pillows;
28. Reading lights;
29. Scissors, forceps, and nail files;
30. Sitz baths;
31. Sphygmomanometers, stethoscopes, and other examination equipment;
32. Splints;
33. Stryker pads;
34. Suction apparatus and gavage tubing;
35. Supplies and equipment necessary for delivery of special dietary needs;
36. Surgical stockings for routine use;
37. Ventilators and related equipment and supplies;
  
38. Walkers, crutches, canes and medically necessary accessories for ambulatory devices;
  
39. Weighing scales.

8.440.1.D. All supplies, including disposables, necessary for effective resident care shall be provided by the nursing facility within the per diem rate. Such supplies include, but are not limited to, the following:

1. Band-Aids, gauze pads, dressings and bandages;
2. Bedside utensils, bedpans, basins;
3. Catheters and related supplies, irrigating trays and accessories;
4. Charting supplies;
5. Colostomy and ileostomy bags, supplies, and dressings, ostomy supplies;
6. Disposable sterile nursing supplies including, but not limited to, cotton, face masks, gloves, tape, finger cots;
7. Drinking tubes/straws, water pitchers/glasses;

8. Fleece pads;
9. Foot soaks;
10. Hypodermic syringes and needles, including syringes and needles for insulin administration, intravenous supplies and equipment and related equipment;
11. Minor medical surgical supplies;
12. Miscellaneous applicators;
13. Nebulizers, recreational/therapeutic equipment and supplies to conduct on-going activities program;
14. Safety pins;
15. Thermometers;
16. Tongue depressors;
17. Tracheostomy care kits, cleaning supplies;
18. Urinals, urinary bags, and tubes and supplies.

8.440.1.E. Routine personal hygiene items/services shall be provided by the nursing facility within the per diem rate. These items include, but are not limited to, hair hygiene services (i.e., simple trims, such as trimming bangs or cutting of some hair that may need minor cutting in the back) hair hygiene supplies (i.e., shampoo, hair conditioner, comb, brush); bath soap, disinfecting soaps or specialized cleaning agents when indicated to treat special skin problems or to fight infection; razors, shaving cream; toothbrush, toothpaste, mouthwash, denture adhesive, denture cleanser, dental floss; moisturizing lotion; tissues, cotton balls, cotton swabs; deodorant) incontinence care and supplies (i.e., pads, cloth and disposable diapers, pants, liners, sanitary napkins and related supplies) towels, washcloths; and hospital gowns; bathing; shaving; nail hygiene services (i.e., routine trimming, cleaning and filing, not polishing).

8.440.1.F. Various over-the-counter (OTC) drugs and supplies as required to meet the residents' assessed needs shall be furnished by the facility, within the per diem rate, at no charge to the resident. OTC drugs/supplies including but not limited to:

1. Artificial tears;
2. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now or in the future;
3. Cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;
4. Douches;
5. Evacuant suppositories, laxatives, stool softeners, enemas;
6. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other antiseptics/germicides, Betadine, PhisoHex, chlorhexidene gluconate, providone/iodine solution and wash, epsom salt;
7. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other ointments used in treatment of wounds;
8. Vitamins (multi and single) and mineral supplements.

8.440.1.G. The following services and provisions shall be provided by the facility within the per diem rate:

1. Food and dietary services, including special diets, supplements and nutrients ordered by the physician, in accordance with the needs of the residents and appropriate licensing requirements;

2. Room for accommodation of the resident in accordance with licensing requirements, including storage for personal belongings, bedside equipment, suitable bed, clean and comfortable mattress, pillows and an adequate supply of clean linen;
3. Maintenance of clean, comfortable and sanitary environment through provision of heat, light, ventilation and sanitation to meet health and aesthetic needs of the resident, in accordance with the physicians' orders and licensing regulations;
4. Basic personal laundry, excluding dry-cleaning, mending, hand washing, or other specialties.
5. Consultant services when the facility employs or contracts with consultants in an effort to meet regulations.
6. Specialized rehabilitative services, including, but not limited to, physical therapy, speech-language pathology, occupational therapy and mental health rehabilitative services for mental illness and mental retardation, when required in the resident's comprehensive plan of care. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel. The facility shall provide the required services or obtain the required services from a provider of specialized rehabilitative services.
7. Ongoing activities program directed by a qualified professional, to meet the interests and the physical, mental and psychosocial well-being of each resident. The nursing facility can charge for entertainment and social events that are outside the scope of the required activities program.

#### **8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT**

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs funds if requested, in writing by a resident and/or the resident's family:

1. Cosmetic and grooming items and services in excess of those for which payment is allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow, rouge/blush, haircuts, beyond simple trimming, normally performed by licensed barbers or beauticians;
2. Gifts purchased on behalf of a resident;
3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility, prescribed by the resident's physician;
4. Items or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that:
  - a. The resident has made an informed decision supported by a statement in the Personal Needs Funds file that he/she/family is willing to use personal funds.
  - b. The balance in the Personal Needs Funds in the resident's ledger is sufficient to cover the charge.
5. Personal clothing and dry cleaning;
6. Personal comfort items, including smoking materials, notions, novelties and confections/candies;
7. Personal reading material, subscriptions;
8. Private room;
9. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;
10. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of

each resident. If the resident refuses the prepared food the facility shall offer substitutes. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item pursuant to 42 C.F.R. 483.35.

11. Telephone, television/radio for personal use, if not equally available to all residents.
12. Provider fee.
13. Prescription drugs, with certain specific exemptions.
14. Ambulance and medical transport, including emergent and non-emergent.
15. Oxygen
16. Physician fees
17. Non-nursing costs, including but not limited to direct and indirect outpatient therapy, assisted living, independent living, adult day care and meals-on-wheels.

8.440.2.B. The Department's approval shall be required in order for a resident or his/her relatives to be billed for the following:

1. The physician orders that a full-time R.N. or L.P.N. is needed. The R.N. or L.P.N. is not employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room.
2. The physician orders a private room.
3. The attending physician shall indicate the medical necessity on the resident's chart for either service above and shall submit to the Department a completed copy of Form 10013 (Physician's Request for Additional Benefits).
4. Upon approval of the Form 10013, payment for such services may be received from the resident's personal needs fund, relatives or others.

8.440.2.C The following items are allowable costs for class II and class IV facilities only:

1. Eye/Hearing examinations
2. Eyeglasses and repairs
3. Hearing aids and batteries

Benefit	Mental Health Services
What is Covered	Treatment for issues with mental health on a one-on-one basis, in a group, or with your family.
What is NOT Covered?	NA
Limits	<p>Only 35 outpatient visits for services on a one-on-one basis each year are covered.</p> <p>Inpatient mental health treatment in a hospital with 24 hr care is limited to 45 days per state fiscal year for adults age 21 and over.</p>
<p><b>10 CCR 2505-10 8.212</b>  <b>Community Mental Health Services</b></p>	
<p><b>8.212.1 ENROLLMENT</b></p> <p>8.212.1.A. The following individuals are not eligible for enrollment in the Community Mental Health Services program:</p> <ol style="list-style-type: none"> <li>1. Qualified Medicare Beneficiary only (QMB-only).</li> <li>2. Qualified Working Disabled Individuals (QWDI).</li> <li>3. Qualified Individuals 1 (QI 1).</li> <li>4. Special Low Income Medicare Beneficiaries (SLMB).</li> <li>5. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved medical condition.</li> <li>6. Program of All-Inclusive Care for the Elderly (PACE).</li> <li>7. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan who are: <ol style="list-style-type: none"> <li>a. Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI)</li> <li>b. Found by a criminal court to be Incompetent to Proceed (ITP)</li> <li>c. Ordered by a criminal court to the Institute for evaluation (eg. Competency to proceed, sanity, conditional release revocation, pre-sentencing).</li> </ol> </li> <li>8. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.</li> <li>9. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Mental Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.</li> <li>10. Classes of individuals determined by the Department to require exclusion from the Community Mental Health Services program, defined as individuals residing in State Regional Centers for people with developmental disabilities and associated satellite residences for more than 90 days.</li> <li>11. Individuals who receive an individual exemption as set forth at 8.212.2.</li> </ol>	

12. Individuals while determined presumptively eligible for Medicaid.

13. Children or youth in the custody of the Colorado Department of Human Services -Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. 25.5-4-103 or a Residential Child Care Facility (RCCF) as defined in C.R.S. 26-6-102.

8.212.1.B. All other Medicaid clients shall be enrolled in the Community Mental Health Services program, into a behavioral health organization in the client's geographic area.

1. The Department automatically re-enrolls a client into the same behavioral health organization if there is a loss of Medicaid eligibility of two months or less.

#### **8.212.2 INDIVIDUAL EXEMPTIONS**

8.212.2.A. A client may request to be exempt from enrollment in the Community Mental Health Services program if:

1. The client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or
2. The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.

8.212.2.B. If the client requests an exemption because the client's existing provider is not in the provider network, based on Section 8.212.2.A.1:

1. The client shall notify the behavioral health organization of his/her request to receive necessary mental health services from the provider with whom the client has established a clinical relationship.
2. Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine whether it can contract with the client's chosen provider to provide necessary mental health services to the client and provide written notice to the client and the client's provider of that determination.
3. If the behavioral health organization is unable to approve the client's request, the notice shall:
  - a. Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's mental health needs;
  - b. Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.
4. The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.
5. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.

8.212.2.C. If the client requests an exemption because continued enrollment would not be in the best clinical interest of the client, based on Section 8.212.2.A.2:

1. The client shall request an exemption from the Department.
2. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.

8.212.2.D. A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.

- 8.212.2.E. A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.
- 8.212.2.F. A client who is enrolled in the Community Mental Health Services program and is requesting an exemption shall continue to be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.
- 8.212.2.G. A client who wants to reenroll in the Community Mental Health Services program shall notify the Department. The client will be reenrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral health organization of the reenrollment prior to the effective date of reenrollment.
- 8.212.2.H. A client who has been exempted from enrollment in the Community Mental Health Services program because the program was not in the best clinical interest of the client, as described in Section 8.212.2.A.2, may be re-enrolled by the Department into the Community Mental Health Services program after a period of exemption, if the client demonstrates a clear need for a behavioral health organization to manage his or her mental health care.
1. The Department shall notify the client and the behavioral health organization of the re-enrollment at least ten (10) calendar days prior to the effective date of re-enrollment.

### **8.212.3 CLIENT RIGHTS AND PROTECTIONS**

- 8.212.3.A. A client enrolled in the Community Mental Health Services program shall have the following rights and protections:
1. To be treated with respect and with due consideration for his/her dignity and privacy.
  2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
  3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.
  4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
  5. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 CFR Part 164.
  6. To exercise his/her rights without any adverse effect on the way he/she is treated.
  7. To enforce, pursuant to Section 8.209, the provisions of the community mental health services contracting regarding rights or duties owed to the client under the contract.

### **8.212.4 MENTAL HEALTH SERVICES**

- 8.212.4.A. The following are required services of the Community Mental Health Services program:
1. Inpatient Hospital -- A program of psychiatric care in which the client remains 24 hours a day in a facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
  2. Under 21 Psychiatric -- A program of care for clients under age 21 in which the client remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

3. 65 and Over Psychiatric -- A program of care for clients age 65 and over in which the client remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year.
4. Outpatient -- A program of care in which the client receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day, including:
  5. Physician services, including psychiatric care – Services provided within the scope of practice of medicine as defined by State law.
  6. Rehabilitative Services – Any remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of mental/emotional disability and restoration of a client to his/her best possible functional level, including:
    - a. Individual Psychotherapy - Therapeutic contact with one client of more than 30 minutes, but no more than two (2) hours. This service, in conjunction with Individual Brief services, is limited to 35 visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
    - b. Individual Brief Psychotherapy - Therapeutic contact with one client of up to and including 30 minutes. This service, in conjunction with Individual services, 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.
    - c. Group Psychotherapy - Therapeutic contact with more than one client, of up to and including two (2) hours.
    - d. Family Psychotherapy – Face to face therapeutic contact with a client and family member(s), or other persons significant to the client, for improving client-family functioning. Family psychotherapy is appropriate when intervention in the family interactions is expected to improve the client's emotional/behavioral disturbance. The primary purpose of family psychotherapy is treatment of the client.
    - e. Mental Health Assessment – Face to face clinical assessment of a client by a mental health professional that determines the nature of the client's problem(s), factors contributing to the problem(s), a client's strengths, abilities and resources to help solve the problem(s), and any existing diagnoses.
    - f. Pharmacologic 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.
    - g. Outpatient Day Treatment – Therapeutic contact with a client in a structured, non-residential program of therapeutic activities lasting more than four (4) hours but less than twenty-four (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; expressive and activity therapies; and coordination of needed services with other agencies. When provided in an outpatient hospital program, may be called "partial hospitalization."
    - h. Emergency/Crisis Services - Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to crisis situation with a client, including associated laboratory services, as indicated.
7. Pharmacy Services – Prescribed drugs when used in accordance with 10 CCR 2505-10 Section 8.800, Pharmaceuticals.
8. Case Management - Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician.
9. School-Based Mental Health Services - Mental health services provided to school aged children and adolescents on site in their schools, with the cooperation of the schools.

8.212.4.B. Alternative services of the Community Mental Health Services program are:

1. Vocational -- Services designed to help adult and adolescent clients who are ineligible for state vocational rehabilitation services to gain employment skills and employment. Services are skill and support development interventions, educational services, vocational assessment, and job coaching.
2. Assertive Community Treatment (ACT) – Comprehensive, locally-based, individualized treatment for adults with serious mental illness, that is available 24 hours a day, 365 days a year. Services include case management, initial and ongoing mental health assessment, psychiatric services, employment and housing assistance, family support and education, and substance abuse services for individuals with co-occurring diagnoses of substance abuse and mental illness.
3. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services are assessment, care plan development, multi-system referrals, assistance with wraparound and supportive living services, monitoring and follow-up. Intensive case management may be provided to children/youth under EPSDT.
4. Clubhouse and drop-in center services – Peer support services for people who have mental illness, provided in a Clubhouse or Drop-In Center setting. Clubhouse participants may use their skills for clerical work, data input, meal preparation, providing resource information and outreach to clients. Drop-in Centers offer planned activities and opportunities for individuals to interact socially, promoting and supporting recovery.
5. Recovery Services – Community-based services that promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, rights protection, social supports. Services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring, consumer and family support groups, warm lines, and advocacy services.
6. Residential Services – Twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, appropriate for adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Services are provided in the setting where the client is living, in real-time, with immediate interventions available as needed. Clinical interventions are assessment and monitoring of mental and physical health status; assessment and monitoring of safety; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; individual, group and family therapy; medication management; and behavioral interventions. Residential services may be provided to children/youth under EPSDT.
7. Prevention/Early Intervention Services – Proactive efforts to educate and empower individuals to choose and maintain health life behaviors and lifestyles that promote mental health. Services include mental health screenings; educational programs promoting safe and stable families; senior workshops related to common aging disorders; and parenting skills classes.
8. Respite Care – Temporary or short-term care of a child, youth or adult client provided by adults other than the birth parents, foster/adoptive parents, family members or caregivers that the client normally resides with. Respite is designed to give the caregivers some time away from the client to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. Respite care providers are specially trained to serve individuals with mental health issues.

#### **8.212.5 EMERGENCY SERVICES**

8.212.5.A. A client enrolled in the Community Mental Health Services program shall seek all mental health services from the behavioral health organization with which he/she is enrolled except as specified in 8.212.5.B.

8.212.5.B. Clients with an emergency medical condition may seek emergency services outside of the network of the behavioral health organization in which

they are enrolled.

8.212.5.C. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention or mental health services to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

8.212.5.D. Emergency services means covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services.
2. Needed to evaluate or stabilize an emergency medical condition.

#### **8.212.6 ESSENTIAL COMMUNITY PROVIDERS**

8.212.6.A. In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.
2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.
3. Federally Qualified Health Centers (FQHCs).
4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.
5. Family Medicine Residency Training Programs that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
7. State certified Title X Family Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.
9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.
10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8.212.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale

for patients/families at or below 185% of the Federal Poverty Level.

8.212.6.C. Health care providers, except those set forth a 8.212.6.A(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.

DRAFT

Benefit	Early and Periodic Screening, Diagnosis & Treatment (EPSDT)
What is EPSDT?	<p>The EPSDT Program is for all Colorado Medicaid children, ages 0 through 20. EPSDT provides comprehensive and preventive health care services, which include screenings and tests that are meant to prevent medical, dental, vision, hearing and development problems early in the child's life. If the healthcare provider finds a medical problem through an office visit or one of the screenings listed below, Medicaid will cover the necessary treatment. Medicaid will also cover treatment for medical problems discovered at any visit, not just through the screening or tests.</p> <p>EPSDT screenings are the same as a well child visit or an annual visit and may include any of the following, along with guidance and education about promoting health and preventing disease:</p> <ul style="list-style-type: none"> <li>• Health and Development History (including assessment of both physical and mental health development) - the child, parent, or another responsible adult who knows the child's health history may provide information and answer questions asked by the provider. <ul style="list-style-type: none"> <li>○ Developmental Assessment (when appropriate)</li> <li>○ Nutrition Assessment and Counseling</li> <li>○ Autism Screening (when appropriate)</li> <li>○ Depression Screen (when appropriate)</li> </ul> </li> <li>• Comprehensive Unclothed Physical Exam including: <ul style="list-style-type: none"> <li>○ Growth Chart Measurements: Height, Weight, and Head Circumference</li> <li>○ Physical inspection includes an examination of all organ systems.</li> </ul> </li> <li>• Appropriate Immunizations (Shots)</li> <li>• Appropriate Lab Tests <ul style="list-style-type: none"> <li>○ Lead Toxicity Screening</li> <li>○ Sickle Cell Disease</li> <li>○ Anemia</li> <li>○ Tuberculosis (TB)</li> <li>○ Diabetes</li> </ul> </li> </ul> <p>If a child is found to have any of the tested conditions, then the child's provider must treat the conditions and provide follow up testing, when necessary.</p>

- Hearing Test
- Health Education
  - Health education and counseling to parents (or guardians) and children is designed to help the child and parent or guardian understand what to expect about the child's development. It will also provide information about the benefits of a healthy lifestyle, and accident and disease prevention.
- Dental Screening
- Vision Test
- Assessment of Sexual Development - the provider may offer counseling on the following:
  - Normal development
  - Prescription drugs
  - Sexually transmitted infections and diseases
  - Birth control
  - Testing
  - Referral to other resources

## 10 CCR 2505-10 8.280

**Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Services for Children**

## 8.280.1 DEFINITIONS

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid.

Early and Periodic Screening, Diagnosis and Treatment Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need.

EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care.

EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below. Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and
2. Meets at least one of the following criteria:
  - a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
  - b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.

- c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
- d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

#### **8.280.2 EPSDT ELIGIBILITY**

A child or youth age 20 and under enrolled in Medicaid is eligible for EPSDT services.

#### **8.280.3 EPSDT OUTREACH AND CASE MANAGEMENT**

8.280.3.A. EPSDT Outreach and Case Management entities shall provide children, their parents or legal guardians (based on the current eligibility information received from the Department) the following within 60 days of eligibility through oral communication including face to face meetings, discussions or telephone conversations as well as written materials:

1. Information about EPSDT services and how to access them.
2. Education on the importance of preventive health care.
3. Assistance in selecting a Primary Care Physician (PCP) or Managed Care Organization (MCO), and to supply a list of available options if requested. Children without a PCP shall be informed of the choices of PCPs and/or MCOs. Families/children shall notify the enrollment broker of their choice as described in 10 C.C.R. 2505-10, Section 8.205.
4. Assistance with coordinating primary health coverage with Medicaid benefits.
5. Assistance in arranging appointments with providers.
6. Follow-up when an appointment is not kept including efforts to assist with rescheduling the missed appointment.
7. Assistance with reporting newborns to the local department of human/social services.
8. A current list of covered and uncovered services available in the community.
9. Information regarding non-emergency medical transportation if such assistance is required and approved.

#### **8.280.4 EPSDT SERVICES**

8.280.4.A. Periodic screening is a procedure used to determine a child's mental and physical growth progress, and to identify a disease or abnormality. Screening identifies additional diagnosis and treatments of physical or emotional problems.

1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado periodicity schedules.
2. The periodicity schedules describe the intervals at which preventive physical, sensory, developmental and behavioral screening, including vision; hearing and dental services shall be performed for enrolled children and youth age 20 and under. The periodicity schedules also include the recommended frequency of follow-up examinations.
3. The components of a screen shall include:
  - a. A comprehensive unclothed physical exam.
  - b. A detailed health and development history.
  - c. An assessment of vision, hearing, mouth, oral cavity and teeth, including referral to a dentist beginning at age 1, mental/behavioral health, nutritional status, cardiovascular and respiratory function, genital/urinary and gastrointestinal systems.

d. A developmental assessment including a range of activities to determine whether a child's emotional and developmental processes fall within a benchmarked range of achievement schedule according to the child's age group and cultural background. This assessment shall include self-help and self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills and appropriate mental/behavioral health screening.

e. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.

f. Lead Toxicity Screening - All children are considered at risk and should be screened for lead poisoning via blood testing. Children between the ages of 36 months and 72 months of age should receive a screening blood lead test if they have not been previously screened for lead poisoning.

g. Any appropriate age-specific screening or laboratory tests at intervals recommended by the Colorado Periodicity Schedule.

h. Health education and anticipatory guidance.

4. Screenings shall be age appropriate and performed in a culturally and linguistically sensitive manner by a provider qualified to furnish primary medical and/or mental health care services.

5. Results of screenings and examinations shall be recorded in the child's medical record. Documentation shall include at a minimum identified problems and negative findings and further diagnostic studies and/or treatments needed and date ordered.

#### 8.280.4.B. Inter-Periodic exam

Inter-periodic exam shall be any health care that occurs outside the periodic preventive care screening such as a further diagnosis, evaluation, acute or sick care.

#### 8.280.4.C. Diagnosis and treatment

1. When a screening examination indicates the need for further evaluation of the individual's health, diagnostic services are provided.

2. Treatment to correct or ameliorate defects, physical and mental illnesses or conditions discovered by the screening and diagnostic services shall be available.

#### 8.280.4.D. Other health care services

Other health care services may include expanded EPSDT benefits if the need for such services is identified during a periodic screening or inter-periodic exam.

The services are a benefit when they meet the following requirements:

1. The service is in accordance with generally accepted standards of medical practice.

2. The service is clinically appropriate in terms of type, frequency, extent, and duration.

3. The service provides a safe environment or situation for the child.

4. The service is not for the convenience of the caregiver.

5. The service is medically necessary.

6. The service is not experimental or investigational and is generally accepted by the medical community for the purpose stated.

7. The service is the least costly, effective means.

a. Early language intervention for children ages birth through three with a hearing loss may be provided by audiologists, speech therapists,

- speech pathologists and Colorado Home Intervention Program (CHIP) providers.
- b. Family Planning Services shall be provided in accordance with 10 C.C.R. 2505-10, Sections 8.730 et seq.
  - c. Obstetrical services shall include prenatal care services and physician or certified nurse-midwife services in pregnancy, labor, delivery and 60 days postpartum.
  - d. Mental and behavioral health care and treatment shall be provided in accordance with the State Plan, Sections 3.1 and 4.39.
  - e. Wrap-around services
    - i) Wrap-around services include those services not included in the client's MCO benefit package, or services that exceed coverage limitations under the contract between the MCO and the Department.
  - f. EPSDT extraordinary home health services shall be provided in accordance with 10 C.C.R. 2505-10, Sections 8.257 et seq.

### **8.280.5 LIMITATIONS/SPECIAL CONSIDERATIONS**

8.280.5.A. Experimental services or procedures are excluded.

8.280.5.B. Services or items not generally accepted as effective by the medical community are excluded.

8.280.5.C. Pharmaceutical items not requiring a prescription are excluded unless prior authorized and medically necessary.

8.280.5.D. Determination of the refractive state only is allowable as a partial vision screening. The code shall not be billed with general ophthalmologic examinations or other evaluation and management codes. Separate or "stand-alone" charges for refractions are not billable to clients as non-benefit services.

8.280.5.E. Eyeglasses are a benefit only when ordered by an ophthalmologist or an optometrist. Vision benefits are limited to single or multi-focal clear plastic lenses and one standard frame. Repair of eyeglasses is covered only when due to broken frames or lenses. Replacement glasses shall be provided when medically necessary or when the glasses are damaged to the extent that repairs are not cost effective.

1. If a child, parent or legal guardian desires options that have additional costs, the amount reimbursed for standard frames and clear lenses shall be applied to the total cost of these services. This shall also apply to repair or replacement of broken eyeglasses. The EPSDT provider shall be permitted to charge the child for the difference between the retail price of the service and the amount paid by the Department. Providers shall notify the child and the child's parent or legal guardian or the child's designated client representative in writing of the difference and obtain the signature of the child's parent or guardian or designated client representative indicating agreement to pay the additional costs.
2. Contact lenses or orthoptic vision treatment services shall be a benefit when medically necessary and shall require prior authorization submitted by an Ophthalmologist, Optometrist, or Optician.
3. Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist documents Medical Necessity that is confirmed by pre-treatment case review. Orthodontists shall submit requests for prior authorization of covered orthodontic services.

### **8.280.6 REFERRALS**

When a client is enrolled a managed care plan, a referral from his/her primary care physician may be required for care provided by anyone other than the

primary care physician. Any client may self-refer for routine vision, dental, hearing, mental health services or family planning services.

**8.280.7 PRIOR AUTHORIZATIONS**

Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing and pharmaceuticals. Prior authorization of services is not a guarantee of payment.

**8.280.8 REIMBURSEMENT**

Reimbursement shall be in accordance with the regulations for pricing health services as reflected at 10 C.C.R. 2505-10, Section 8.200 for all EPSDT medical screening, diagnostic and treatment services.